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ЕЖЕМЕСЯЧНЫЙ НАУЧНЫЙ ЖУРНАЛ

Медицинские новости Грузии
საქართველოს სამედიცინო სიახლენი

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ЕЖЕМЕСЯЧНЫЙ НАУЧНЫЙ ЖУРНАЛ

ТБИЛИСИ - НЬЮ-ЙОРК

GMN: Georgian Medical News is peer-reviewed, published monthly journal committed to promoting the science and art of medicine and the betterment of public health, published by the GMN Editorial Board and The International Academy of Sciences, Education, Industry and Arts (U.S.A.) since 1994. **GMN** carries original scientific articles on medicine, biology and pharmacy, which are of experimental, theoretical and practical character; publishes original research, reviews, commentaries, editorials, essays, medical news, and correspondence in English and Russian.

GMN is indexed in MEDLINE, SCOPUS, PubMed and VINITI Russian Academy of Sciences. The full text content is available through EBSCO databases.

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3. Submitted material must include a coverage of a topical subject, research methods, results, and review.

Authors of the scientific-research works must indicate the number of experimental biological species drawn in, list the employed methods of anesthetization and soporific means used during acute tests.

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3. სტატიაში საჭიროა გაშუქდეს: საკითხის აქტუალობა; კვლევის მიზანი; საკვლევი მასალა და გამოყენებული მეთოდები; მიღებული შედეგები და მათი განსჯა. ექსპერიმენტული ხასიათის სტატიების წარმოდგენისას ავტორებმა უნდა მიუთითონ საექსპერიმენტო ცხოველების სახეობა და რაოდენობა; გაუტკივარებისა და დაძინების მეთოდები (მწვავე ცდების პირობებში).

4. სტატიას თან უნდა ახლდეს რეზიუმე ინგლისურ, რუსულ და ქართულ ენებზე არანაკლებ ნახევარი გვერდის მოცულობისა (სათაურის, ავტორების, დაწესებულების მითითებით და უნდა შეიცავდეს შემდეგ განყოფილებებს: მიზანი, მასალა და მეთოდები, შედეგები და დასკვნები; ტექსტუალური ნაწილი არ უნდა იყოს 15 სტრიქონზე ნაკლები) და საკვანძო სიტყვების ჩამონათვალი (key words).

5. ცხრილები საჭიროა წარმოადგინოთ ნაბეჭდი სახით. ყველა ციფრული, შემაჯამებელი და პროცენტული მონაცემები უნდა შეესაბამებოდეს ტექსტში მოყვანილს.

6. ფოტოსურათები უნდა იყოს კონტრასტული; სურათები, ნახაზები, დიაგრამები - დასათაურებული, დანომრილი და სათანადო ადგილას ჩასმული. რენტგენოგრამების ფოტოასლები წარმოადგინეთ პოზიტიური გამოსახულებით **tiff** ფორმატში. მიკროფოტოსურათების წარწერებში საჭიროა მიუთითოთ ოკულარის ან ობიექტივის საშუალებით გადიდების ხარისხი, ანათალების შეღებვის ან იმპრეგნაციის მეთოდი და აღნიშნოთ სურათის ზედა და ქვედა ნაწილები.

7. სამამულო ავტორების გვარები სტატიაში აღინიშნება ინიციალების თანდართვით, უცხოურისა – უცხოური ტრანსკრიპციით.

8. სტატიას თან უნდა ახლდეს ავტორის მიერ გამოყენებული სამამულო და უცხოური შრომების ბიბლიოგრაფიული სია (ბოლო 5-8 წლის სიღრმით). ანბანური წყობით წარმოდგენილ ბიბლიოგრაფიულ სიაში მიუთითეთ ჯერ სამამულო, შემდეგ უცხოელი ავტორები (გვარი, ინიციალები, სტატიის სათაური, ჟურნალის დასახელება, გამოცემის ადგილი, წელი, ჟურნალის №, პირველი და ბოლო გვერდები). მონოგრაფიის შემთხვევაში მიუთითეთ გამოცემის წელი, ადგილი და გვერდების საერთო რაოდენობა. ტექსტში კვადრატულ ფჩხილებში უნდა მიუთითოთ ავტორის შესაბამისი N ლიტერატურის სიის მიხედვით. მიზანშეწონილია, რომ ციტირებული წყაროების უმეტესი ნაწილი იყოს 5-6 წლის სიღრმის.

9. სტატიას თან უნდა ახლდეს: ა) დაწესებულების ან სამეცნიერო ხელმძღვანელის წარდგინება, დამოწმებული ხელმოწერითა და ბეჭდით; ბ) დარგის სპეციალისტის დამოწმებული რეცენზია, რომელშიც მითითებული იქნება საკითხის აქტუალობა, მასალის საკმაობა, მეთოდის სანდოობა, შედეგების სამეცნიერო-პრაქტიკული მნიშვნელობა.

10. სტატიის ბოლოს საჭიროა ყველა ავტორის ხელმოწერა, რომელთა რაოდენობა არ უნდა აღემატებოდეს 5-ს.

11. რედაქცია იტოვებს უფლებას შეასწოროს სტატია. ტექსტზე მუშაობა და შეჯერება ხდება საავტორო ორიგინალის მიხედვით.

12. დაუშვებელია რედაქციაში ისეთი სტატიის წარდგენა, რომელიც დასაბეჭდად წარდგენილი იყო სხვა რედაქციაში ან გამოქვეყნებული იყო სხვა გამოცემებში.

აღნიშნული წესების დარღვევის შემთხვევაში სტატიები არ განიხილება.

Содержание:

Savchuk R., Kostyev F., Dekhtiar Y.
URODYNAMIC PATTERNS OF ARTIFICIAL BLADDER 7

Тяжелов А.А., Карпинская Е.Д., Карпинский М.Ю., Браницкий А.Ю.
ВЛИЯНИЕ КОНТРАКТУР ТАЗОБЕДРЕННОГО СУСТАВА НА СИЛУ МЫШЦ БЕДРА 10

Тандилава И.И., Урушадзе О.П., Цецхладзе Д.Ш., Цецхладзе Г.Н., Путкарадзе М.Ш.
РОЛЬ И МЕСТО ВИРТУАЛЬНОЙ КТ-КОЛОНОСКОПИИ В КОМПЛЕКСНОЙ
ЛУЧЕВОЙ ДИАГНОСТИКЕ ЗАБОЛЕВАНИЙ ТОЛСТОЙ КИШКИ 19

Dosbaev A., Dilmagambetov D., Illyasov E., Tanzharykova G., Baisalbayev B.
EFFECTIVENESS OF EARLY VIDEO-ASSISTED MINI-ACCESS SURGERY
IN TREATMENT OF COMPLICATED FORMS OF TUBERCULOUS PLEURISY 23

Dvali M., Tsertsvadze O., Skhirtladze Sh.
USE OF OPTICAL COHERENCE TOMOGRAPHY IN DETECTION OF CYSTOID MACULAR EDEMA
AFTER TREATMENT WITH NONSTEROIDAL ANTI-INFLAMMATORY DRUGS 28

Zabolotnyi D., Zabolotna D., Zinchenko D., Tsvirinko I., Kizim Y.
DIAGNOSIS AND TREATMENT OF PATIENTS WITH SINONASAL INVERTED PAPILLOMA 31

Smolyar N., Lesitskiy M., Bezvushko E., Fur N., Hordon-Zhura H.
ENAMEL RESISTANCE IN CHILDREN WITH MALOCCLUSIONS 37

Ivanyushko T., Polyakov K., Usatov D., Petruk P.
THE CONTENT OF NK CELLS AND THEIR SUBTYPES
IN THE CASE OF DRUG-INDUCED JAW OSTEONECROSIS 41

Antonenko M., Reshetnyk L., Zelinskaya N., Stolyar V., Revych V.
DIVERSITY OF TREATMENT OF GENERALIZED PERIODONTAL DISEASES 46
IN PATIENTS WITH ANOREXIA NERVOSA

Косырева Т.Ф., Абакелия К.Г.
СОВРЕМЕННЫЕ ПРЕДСТАВЛЕНИЯ О ВЛИЯНИИ ПИЩЕВЫХ ЖИДКОСТЕЙ
НА СОСТОЯНИЕ ЗУБОЧЕЛЮСТНОЙ СИСТЕМЫ (ОБЗОР) 52

Sharashenidze M., Tkeshelashvili V., Nanobashvili K.
DENTAL FLUOROSIS PREVALENCE, SEVERITY AND ASSOCIATED RISK FACTORS
IN PRE-SCHOOL AGED CHILDREN RESIDING IN FLUORIDE DEFICIENT REGIONS OF GEORGIA 57

Горбатюк О.М., Солейко Д.С., Курило Г.В., Солейко Н.П., Новак В.В.
УРГЕНТНЫЕ ХИРУРГИЧЕСКИЕ ВМЕШАТЕЛЬСТВА ПРИ БОЛЕЗНИ КРОНА У ДЕТЕЙ 61

Беш Л.В., Слюзар З.Л., Мацюра О.И.
ОПТИМИЗАЦИЯ АЛЛЕРГЕН-СПЕЦИФИЧЕСКОЙ ИММУНОТЕРАПИИ У ДЕТЕЙ, БОЛЬНЫХ
БРОНХИАЛЬНОЙ АСТМОЙ: ОСОБЕННОСТИ ОТБОРА ПАЦИЕНТОВ И МОНИТОРИНГ ЭФФЕКТИВНОСТИ 67

Tchkonia D., Vacharadze K., Mskhaladze T.
THE EFFICACY OF ENDOBRONCHIAL VALVE THERAPY IN COMPLEX TREATMENT 73
OF BRONCHO-PLEURAL FISTULAS

Gogichaishvili L., Lobjanidze G., Tsertsvadze T., Chkhartishvili N., Jangavadze M.
DIRECT-ACTING ANTIVIRALS FOR HEPATITIS C DO NOT AFFECT THE RISK OF DEVELOPMENT
OR THE OUTCOME OF HEPATOCELLULAR CARCINOMA 76

Грек И.И., Рогожин А.В., Кушнир В.Б., Колесникова Е.Н., Кочуева М.Н.
ВЛИЯНИЕ УРОВНЯ ПОТРЕБЛЕНИЯ АЛКОГОЛЯ НА ТЕЧЕНИЕ И ЭФФЕКТИВНОСТЬ ЛЕЧЕНИЯ
ВПЕРВЫЕ ДИАГНОСТИРОВАННОГО ТУБЕРКУЛЁЗА ЛЁГКИХ 81

Tsaryk V., Swidro O., Plakhotna D., Gumeniuk N., Udovenko N.
COMMON VARIABLE IMMUNODEFICIENCY AMONG KYIV RESIDENTS:
HETEROGENEITY OF MANIFESTATIONS (CLINICAL CASE REVIEW) 88

Марута Н.А., Панько Т.В., Каленская Г.Ю., Семикина Е.Е., Денисенко М.М.
ПСИХООБРАЗОВАТЕЛЬНАЯ ПРОГРАММА В ПРОФИЛАКТИКЕ ПСИХИЧЕСКОГО ЗДОРОВЬЯ
ВНУТРЕННЕ ПЕРЕМЕЩЕННЫХ ЛИЦ 92

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Babalian V., Pastukh V., Sykal O., Pavlov O., Rudenko T., Ryndenko V.
MANAGEMENT OF EMOTIONAL DISORDERS IN ELDERLY PATIENTS
UNDERGOING SURGICAL TREATMENT OF PROXIMAL FEMORAL FRACTURES 99

Нанеишвили Н.Б., Силагадзе Т.Г.
ОЦЕНКА НЕВЕРБАЛЬНОГО ИНТЕЛЛЕКТА И СОЦИАЛЬНОГО ФУНКЦИОНИРОВАНИЯ
БОЛЬНЫХ ШИЗОФРЕНИЕЙ, МАНИФЕСТИРОВАННОЙ В ДЕТСКОМ И ПОДРОСТКОВОМ ВОЗРАСТЕ 107

Смагулов Б.
СОЦИОДЕМОГРАФИЧЕСКАЯ ХАРАКТЕРИСТИКА СУИЦИДЕНТОВ
ТЮРКСКИХ И СЛАВЯНСКИХ НАЦИОНАЛЬНОСТЕЙ 113

Asatiani N., Todadze Kh.
NEUROLOGICAL DISORDERS AMONG THE USERS OF HOMEMADE ARTISANAL EPHEDRONE
PSYCHOSTIMULANTS AND INVESTIGATION OF THIOGAMMA EFFICACY IN THEIR TREATMENT........ 117

Фартушок Т.В.
COVID-19: АКТУАЛЬНЫЕ ВОПРОСЫ ДЕЯТЕЛЬНОСТИ КЛИНИК ВО ВРЕМЯ ПАНДЕМИИ 122

Dondoladze Kh., Nikolaishvili M., Museliani T., Jikia G., Zurabashvili D.
IMPACT OF HOUSEHOLD MICROWAVE OVEN NON-IONIZING RADIATION
ON BLOOD PLASMA CORTISOL LEVELS IN RATS AND THEIR BEHAVIOR........ 132

Ivanov O., Haidash O., Voloshin V., Kondratov S., Smirnov A.
INFLUENCE OF THE ACTING SUBSTANCE “SODIUM DICLOFENAC” ON BONE MARROW CELLS........ 137

Tuleubaev B., Saginova D., Saginov A., Tashmetov E., Koshanova A.
HEAT TREATED BONE ALLOGRAFT AS AN ANTIBIOTIC CARRIER FOR LOCAL APPLICATION 142

Kakabadze M.Z., Paresishvili T., Kordzaia D., Karalashvili L., Chakhunashvili D., Kakabadze Z.
RELATIONSHIP BETWEEN ORAL SQUAMOUS CELL CARCINOMA AND IMPLANTS (REVIEW) 147

Удод А.А., Центило В.Г., Солодкая М.М.
КРАНИОМЕТРИЧЕСКИЕ ПАРАМЕТРЫ И МОРФОЛОГИЧЕСКИЕ ОСОБЕННОСТИ
ВЕРХНЕЙ ЧЕЛЮСТИ ЧЕЛОВЕКА 151

Удод А.А., Помпий А.А., Крищук Н.Г., Волошин В.А.
ИССЛЕДОВАНИЕ НАПРЯЖЕННО-ДЕФОРМИРОВАННЫХ СОСТОЯНИЙ
РАЗЛИЧНЫХ КОНСТРУКЦИЙ АДГЕЗИВНЫХ МОСТОВИДНЫХ ПРОТЕЗОВ 156

Дорофеева Л.М., Карабин Т.А., Менджул М.В., Хохлова И.В.
ЭМБРИОН И ПЛОД ЧЕЛОВЕКА: ПРОБЛЕМЫ ПРАВОВОЙ ЗАЩИТЫ 162

Корчева Т.В., Невельская-Гордеева Е.П., Войтенко Д.А.
ВРАЧЕБНАЯ ТАЙНА: МЕДИЦИНСКИЙ, УГОЛОВНО-ПРОЦЕССУАЛЬНЫЙ
И ФИЛОСОФСКО-ПРАВОВОЙ АСПЕКТЫ ЕЁ РАЗГЛАШЕНИЯ (ОБЗОР) 166

Бортник С.Н., Калениченко Л.И., Слинько Д.В.
ОТДЕЛЬНЫЕ АСПЕКТЫ ЮРИДИЧЕСКОЙ ОТВЕТСТВЕННОСТИ МЕДИЦИНСКИХ РАБОТНИКОВ
НА ПРИМЕРЕ УКРАИНЫ, ГЕРМАНИИ, ФРАНЦИИ, США........ 171

Fyl S., Kulyk O., Fedotova H., Lelet S., Vashchuk N.
MEDICAL MALPRACTICE AND LEGAL LIABILITY IN THE RENDERING OF HEALTHCARE
SERVICES IN UKRAINE........ 178

Pavlov S., Nikitchenko Y., Tykhonovska M.
THE IMPACT OF THE CHEMICAL AGENTS OF DIFFERENT PHARMACOLOGICAL GROUPS
ON THE KLOTHO PROTEIN CONCENTRATION IN THE CARDIOMYOCYTE
AND NEUROCYTE SUSPENSION IN 120 MINUTE HYPOXIA IN VITRO........ 184

Gorgiladze N., Zoidze E., Gerzmava O.
IMPLEMENTATION OF QUALITY VALIDATION INDICATORS IN HEALTHCARE........ 188

Mikava N., Vasadze O.
PROSPECTS IN MEDICAL TOURISM IN GEORGIA- CHALLENGES, AND BARRIERS IN HEALTHCARE SECTOR 194

MANAGEMENT OF EMOTIONAL DISORDERS IN ELDERLY PATIENTS UNDERGOING SURGICAL TREATMENT OF PROXIMAL FEMORAL FRACTURES

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Proximal femoral fractures are a common disease with high actuality. This problem is especially significant for elderly patients. Number of elderly patients with such fractures increases annually, and they are at high risk of receiving such fractures [1]. According to various authors, proximal femoral fractures make 9.00% –45.00% of all skeletal fractures in older patients [2]. High rates of prevalence, disability and mortality due to proximal femoral fractures cause significant economic costs and define the subject of these fractures as an important medical and socio-economic problem [3].

Epidemiological data indicate a progressive increase in such fractures with an increase in age characteristics, and in patients after 50 years, it almost doubles in every 10 years. In countries around the world (USA, Sweden, Norway, Italy, Spain, Great Britain, Canada, Finland, Asia and others), a constant increase in the frequency of such fractures is recorded due to the general aging of the world population and an increase in the prevalence of osteoporosis among the population [4, 5]. According to the latest data from the British National Hip Fracture Database (NHFD), 91.60% of such fractures are recorded in patients older than 70 years, most of which (72.00%) are women [6]. All over the world, the prevalence of such fractures in the female population compared with male is noted [7, 8]. The ratio of men to women is approximately 1: 3 with slight fluctuations in different countries [9].

According to prognosis, the number of proximal femoral fractures cases will progressively grow [10] and will reach 4.5 million cases annually [11] or even 6.26 million [12] by 2050. According to the National Osteoporosis Fund, by 2040 more than 500,000 acute hip fractures will be recorded annually. It is stated that government expenditures will constantly increase due to this problem as a result of increased life expectancy [13]. Currently, socio-economic costs constitute about 0.10% of all diseases worldwide and 1.40% in developed countries [14-16].

For patients themselves, hip fracture is a potentially catastrophic problem due to a significant percentage of negative consequences. According to research, approximately 30.00% of these patients will die within the first year after injury [17], and among those who survive, the vast majority will have long-term medical and social problems that significantly reduce their levels of active lifestyle [18].

In response to the magnitude and significant severity of the problem of treating proximal femoral fractures, many countries have developed national treatment algorithms based on practical results and supported by systematic literature reviews [19-21]. These recommendations point to the need for coordinated multidisciplinary efforts for the effective treatment of hip fractures. Modern models of treatment for such patients (the "Hip Fracture Program" in the UK, the "Orthogeriatric Medical Assistance Model" in Australia and others) fully recognize the necessity and importance of interdisciplinary care in the treatment of such patients [22] to optimize their care [23]. The developed recommendations confirm that effective management of hip fracture treatment must necessarily take into account a coordinated and integrated approach to the patient throughout the entire period of his treatment and rehabilitation.

In addition to the need for a multidisciplinary approach, the effectiveness of treatment depends on the presence of a concomitant pathology and its timely correction. During aging, the human body undergoes significant structural and functional changes in almost all organs and systems: significant metabolic disorders, a decrease in the protective reactions of the body systems and many functional disorders, which leads to the appearance of various concomitant diseases and the development of possible complications of the surgical treatment of hip fractures in the elderly. Polymorbidity (comorbidity) of diseases in elderly patients and their chronicity leads to the development of possible significant complications of surgical treatment [24]. Most often, patients with a hip fracture note the presence of diseases such as diabetes, movement disorders, cardiovascular and other diseases; and in 40.00%, patients report the presence of cognitive impairment [25-27]. The results of systematic reviews indicate a significant possibility of the negative impact of cognitive impairment, emotional disturbances, and dementia on the results of the treatment of hip fractures [28-33].

Most of the studies indicate the actuality of the problem of mental disorders of various origins. This subject is especially relevant for elderly, since in this age group manifestations of a neuropsychiatric nature are significantly increased, and they are at a risk for various mental disorders. This is due to physiological processes intrinsic to the elderly organism [34-36]. In the general population among individuals aged 65, the frequency of dementia is 3.00–7.70%; and for persons over 85 years old - 20.00–45.00% [37-39]. A significant part of cognitive disorders in the elderly age manifests itself with emotional disturbances of the anxiety-depressive spectrum. Often there are cases of a development of a vivid picture of "masked" emotional disturbances provoked by external factors (sudden significant psycho-emotional stressful overload). These "stress-strokes" can be a sudden loss of loved ones, an abrupt change in the familiar environment, the detection of a severe somatic disease, physical injury, the need for long-term treatment or surgery (which is typical for the treatment of a hip fracture) and etc. Such situations can cause significant psychoemotional experiences and sudden anxiety-depressive "bursts".

In connection with the above, we set the goal of the study: to identify key aspects of the management of emotional disorders in the practice of operative treatment of proximal femoral fractures in elderly patients.

Objectives of the study are:

- to establish the levels of emerging emotional disorders of the anxiety-depressive spectrum in elderly patients undergoing operative treatment of proximal femoral fractures and mechanisms for their correction;

-to analyse the results of drug treatment of emotional disorders, that occur during operative treatment of proximal femoral fractures in elderly patients.

Material and methods. 24 patients who needed surgical treatment of proximal femoral fracture and were at risk for the development of psycho-emotional disorders due to the presence of emotional disorders of an anxiety-depressive nature were examined. The presence of such disorders was recorded at the time of admission, before and after surgical treatment using specialized psychodiagnostic techniques. Mini Mental State Examina-

tion (MMSE), modified Hachinski ischemic scale (Hachinski al.), Frontal assessment battery (FAB), Spielberg-Khanin Scale of Reactive and Trait Anxiety, The Zung Self-Rating Depression Scale were used.

Results and discussion. Elderly patients with proximal femoral fractures were screened for the presence of cognitive disorders and the degree of cognitive impairment using the MMSE scale at the time of admission. The etiology of existing cognitive disorders was studied using the modified Khachinsky Ischemic Scale, and the degree of impairment and possible lesion sites were studied using the FAB. After that, the psychodiagnosis was performed using the Spielberg-Khanin Reactive and Trait Anxiety Scale and the The Zung Self-Rating Depression Scale. In the presence of such disorders, the patient was assigned to the risk group for the drug treatment. Using the scales mentioned above, we formed a risk group of 24 patients with proximal femoral fractures and manifestations of cognitive and emotional disorders (Table 1). Male - 9 (37.50%) patients, and female - 15 (62.50%). The average age of all patients was 82.70±1.00 (among men - 81.70±2.10, among women - 83.30±1.00).

To prevent the development of psychopathological symptoms among patients at risk undergoing operative treatment of proximal femoral fracture, drug treatment of cognitive disorders and emotional disturbances of the anxiety-depressive spectrum was performed. To determine the effectiveness of drug treatment of emotional disorders, two subgroups were formed (I - using drug treatment of cognitive and emotional disorders and II - without drug treatment) - 12 patients in each.

Due to the presence of high stressful tension in patients at risk due to the need for long-term treatment, we studied the levels of anxiety (reactive and trait) and depressive levels in patients at the time of admission to the clinic. According to the levels of reactive anxiety (occurs as a reaction to stressors, most often socio-psychological), moderate and high levels are noted (Table 2). Most patients at risk had a high level of reactive anxiety - 14 (58.33%) patients (equally in subgroups I and II - 7 (29.17%) patients in each) compared with moderate levels (10 (41.67%) patients) - equally I and II subgroups (5 (20.83%) patients in each). In the subgroups I and II with moderate and high levels of reactive anxiety, a predominance of female patients was noted: subgroup I – female patients with a moderate level - 3 (12.50%), and with a high level -5 (20.83%); subgroup II – 3 (12.50%) and 4 (16.67%) female patients respectively.

Among all patients at risk (Table 3), the majority of patients with a high level - 14 (58.33%) patients (8 (33.33%) in subgroup I and 6 (25.00%) in II subgroup) were detected, based on the levels of trait anxiety (gives an idea of a person's tendency to be affected by certain stressors due to personality traits). Patients

Table 1. Grouping the examined patients by sex and age characteristics (abs.n.,%)

Gender		**Average age**	
Male	Female	Male	Female
9 (37,50%)	15 (62,50%)	81,70±2,10	83,30±1,00
In total	24 (100,00%)	82,70±1,00	

Table 2. Levels of reactive anxiety in patients at risk at time of admission (abs.n.,%)

Patient subgroups		**Level of reactive anxiety**							
		Low		**Moderate**		**High**		**In total**	
		abs.n.	**%**	**abs.n.**	**%**	**abs.n.**	**%**	**abs.n.**	**%**
I	Male	-	-	2	8,33	2	8,33	4	16,67
	Female	-	-	3	12,50	5	20,83	8	33,33
	In total	-	-	5	20,83	7	29,17	12	50,00
II	Male	-	-	2	8,33	3	12,50	5	20,83
	Female	-	-	3	12,50	4	16,67	7	29,17
	In total	-	-	5	20,83	7	29,17	12	50,00
In total		-	-	10	41,67	14	58,33	24	100,00

Table 3. Levels of trait anxiety in patients at risk at the time of admission (abs.n.,%)

Patient subgroups		**Level of trait anxiety**							
		Low		**Moderate**		**High**		**In total**	
		abs.n.	**%**	**abs.n.**	**%**	**abs.n.**	**%**	**abs.n.**	**%**
I	Male	-	-	1	4,17	3	12,50	4	16,67
	Female	-	-	3	12,50	5	20,83	8	33,33
	In total	-	-	4	16,67	8	33,33	12	50,00
II	Male	-	-	2	8,33	3	12,50	5	20,83
	Female	-	-	4	16,67	3	12,50	7	29,17
	In total	-	-	6	25,00	6	25,00	12	50,00
In total		-	-	10	41,67	14	58,33	24	100,00

with a moderate level were 10 (41.67%) patients - 4 (16.67%) and 6 (25.00%), in subgroups I and II respectively.

In two subgroups, the predominance of female patients was established: I - 3 (12.50%) and 5 (20.83%), moderate and high levels of anxiety; Subgroup II - 4 (16.67%) and 3 (12.50%) female patients respectively.

According to the results of the study of depressive levels of patients at risk, the presence of a depressive state of varying severity was observed (Table 4).

Subdepressive state - 18 (75.00%) patients and mild depression - 6 (25.00%) patients. Differences between the examined patients in subgroups I and II have not been established. The prevalence of female patients in comparison with male patients was noted: subgroup I - 2 (8.33%) and 6 (25.00%) female patients (mild depression and subdepressive state respectively); Subgroup II - 2 (8.33%) and 5 (20.83%) female patients, respectively.

The presence of limit levels between moderate and high levels of anxiety and manifestations of mild depression and a subde-

Table 4. Levels of depression in patients at risk at the time of admission (abs.n.,%)

Patient subgroups		**Levels of depression**							
		No depression		**Mild depression**		**Subdepressive state**		**In total**	
		abs.n.	**%**	**abs.n.**	**%**	**abs.n.**	**%**	**abs.n.**	**%**
I	Male	-	-	1	4,17	3	12,50	4	16,67
	Female	-	-	2	8,33	6	25,00	8	33,33
	In total	-	-	3	12,50	9	37,50	12	50,00
II	Male	-	-	1	4,17	4	16,67	5	20,83
	Female	-	-	2	8,33	5	20,83	7	29,17
	In total	-	-	3	12,50	9	37,50	12	50,00
In total		-	-	6	25,00	18	75,00	24	100,00

Table 5. Levels of reactive anxiety in patients at risk at the time of admission (M±m)

Patient subgroups		**Levels of reactive anxiety**
I	Male	43,61±0,03
	Female	42,24±0,12
	In total	42,92±0,07
II	Male	42,18±0,11*
	Female	42,05±0,07*
	In total	42,12±0,10*
In total		42,52±0,05

*notes: * - differences are reliable between subgroups I and II*

Table 6. Levels of trait anxiety in patients at risk at the time of admission (M±m)

Patient subgroups		**Levels of trait anxiety**
I	Male	42,18±0,12
	Female	43,41±0,19
	In total	42,80±0,11
II	Male	41,14±0,08*
	Female	42,19±0,12*
	In total	41,67±0,04*
In total		42,23±0,07

*notes: * - differences are reliable between subgroups I and II*

Table 7. Levels of depression in patients at risk at the time of admission (M±m)

Patient subgroups		**Levels of depression**
I	Male	58,16±0,14
	Female	59,14±0,07
	In total	58,65±0,12
II	Male	58,19±0,08*
	Female	58,16±0,03*
	In total	58,18±0,11*
In total		51,41±0,07

*notes: * - differences are reliable between subgroups I and II*

pressive state in patients at risk is noted, according to the general levels of anxiety and depression (Tables 5-7).

The obtained results are explained by the development of psychoemotional disorders of the anxiety-depressive spectrum under the influence of awareness of the need for surgical treatment and a long postoperative period, the necessity of undergoing rehabilitation measures, a significant decrease in the quality of life, the need for outside care, etc., which are significant stressful factors.

When conducting drug treatment of emotional disorders of the anxiety-depressive spectrum in the patient subgroup I, a significant improvement in the emotional background was observed. A decrease in general vulnerability and irritability was observed amid drug correction (subgroup I) during surgical treatment; a significant decrease in the affective concentration of attention on the illness and the need for surgical treatment; absence of loss of autopsychic and allopsychic orientation; a significant increase in mood and overall emotional background; the development of an optimistic orientation; reduction (and in some patients a complete absence) of signs of anxiety, fear and agitation; the complete absence of thoughts of auto-aggressive or suicidal orientation.

A deterioration of existing anxiety-depressive disorders was noted in patients at risk in subgroup II (did not receive drug treatment of emotional disorders): increased general vulnerability and irritability, affective concentration of attention on trauma and the need for long-term surgical treatment; in some patients, there was a short-term psychotic loss of autopsychic and allopsychic orientation; general emotional background worsened; there was a significant deterioration in mood and the development of a significant pessimistic emotional background; dissatisfaction with surrounding events and individuals was noted; increased manifestations of anxiety, fear and agitation; some patients developed suicidal thoughts and auto-aggressive behavior. These characteristics were confirmed by the results of a study conducted using the Spilberger-Khanin Scale of Reactive and Trait Anxiety and The Zung Self-Rating Depression Scale - Table. 8, 9.

According to the results of the study of the levels of reactive anxiety in 3 (12.5%) patients in subgroup I, a decrease in the level of anxiety from high to moderate (1 (4.17%) male and 2 (8.33%) female patients) was detected. According to the results of the study of the levels of trait anxiety, 3 (12.5%) patients in subgroup I noted a decrease in the level of anxiety from high

Table 8. Levels of reactive and trait anxiety in patients at risk at the operative stage (abs. n %)

Patient subgroups		**Levels of reactive anxiety**							
		Low		**Moderate**		**High**		**In total**	
		abs.n.	**%**	**abs.n**	**%**	**abs.n.**	**%**	**abs.n.**	**%**
I	Male	-	-	3	12,50	1	4,17	4	16,67
	Female	-	-	5	20,83	3	12,50	8	33,33
	In total	-	-	8	33,33	4	16,67	12	50,00
II	Male	-	-	2	8,33	3	12,50	5	20,83
	Female	-	-	3	12,50	4	16,67	7	29,17
	In total	-	-	5	20,83	7	29,17	12	50,00
In total		-	-	13	54,17	11	45,83	24	100,00
Levels of trait anxiety									
I	Male	-	-	3	12,50	1	4,17	4	16,67
	Female	-	-	4	16,67	4	16,67	8	33,33
	In total	-	-	7	29,17	5	20,83	12	50,00
II	Male	-	-	2	8,33	3	12,50	5	20,83
	Female	-	-	4	16,67	3	12,50	7	29,17
	In total	-	-	6	25,00	6	25,00	12	50,00
In total		-	-	13	54,17	11	45,83	24	100,00

Table 9. Levels of depression in patients at risk at the operative stage (abs.n.,%)

Patient subgroups		**Levels of depression**							
		No depression		**Mild depression**		**Subdepressive state**		**In total**	
		abs.n.	**%**	**abs.n.**	**%**	**abs.n.**	**%**	**abs.n.**	**%**
I	Male	-	-	2	8,33	2	8,33	4	16,67
	Female	-	-	4	16,67	4	16,67	8	33,33
	In total	-	-	6	25,00	6	25,00	12	50,00
II	Male	-	-	1	4,17	4	16,67	5	20,83
	Female	-	-	2	8,33	5	20,83	7	29,17
	In total	-	-	3	12,50	9	37,50	12	50,00
In total		-	-	9	37,50	15	62,50	24	100,00

Table 10. Psychopathological disorders in patients at risk during operative treatment (abs.n.%)

Patient subgroups		Psychopathological disorders					
		absent		exist		In total	
		abs.n.	%	abs.n.	%	abs.n.	%
I	Male	4	16,67	-	-	4	16,67
	Female	8	33,33	-	-	8	33,33
	In total	12	50,00	-	-	12	50,00
II	Male	2	8,33	3	12,50	5	20,83
	Female	2	8,33	5	20,83	7	29,17
	In total	4	16,67	8	33,33	12	50,00
In total		16	66,67	8	33,33	24	100,00

Table 11. Psychopathological manifestations in patients at risk during operative treatment (abs.n.%)

Patient subgroups		Main psychopathological disorders											
		*		**		***		****		*****		In total	
		abs.n.	%	abs.n.	%	abs.n.	%	abs.n.	%	abs.n.	%	abs.n	%
I	Male	-	-	-	-	-	-	-	-	-	-	4	16,67
	Female	-	-	-	-	-	-	-	-	-	-	8	33,33
	In total	-	-	-	-	-	-	-	-	-	-	12	50,00
II	Male	3	12,50	2	8,33	1	4,17	3	12,50	3	12,50	5	20,83
	Female	5	20,83	2	8,33	2	8,33	5	20,83	5	20,83	7	29,17
	In total	8	33,33	4	16,67	3	12,50	8	33,33	8	33,33	12	50,00
In total		8	33,33	4	16,67	3	12,50	8	33,33	8	33,33	24	100,0

*notes: * - affective concentration of attention; ** - auto-psychic and allopsychic disorientation;*
**** - suicidal thoughts; **** - auto-aggressive manifestations; ***** - aggressive behavior*

to moderate (2 (8.33%) male and 1 (4.17%) female patients). According to the levels of depression in 3 (12 50%) patients in subgroup I (1 (4.17%) male and 2 (8.33%) female patients), depressive symptoms decreased to the level of mild depression.

In the second subgroup of the risk group (did not receive drug treatment of emotional disorders), a deterioration of the emotional background was noted up to the appearance of various psychopathological manifestations (Table 10) due to significant psychoemotional overstrain as a result of the necessity of a long significant limitation of physical activity, a significant rehabilitation postoperative period, long term restriction of everyday activity, and significant limitations in the quality of life. 8 patients (33.33%) - 3 (12.50%) male and 5 (20.83%) female patients in the subgroup II noted the appearance of psychopathological symptoms during surgical treatment. In the subgroup I, during drug treatment amid surgical treatment, none of the patients showed the appearance of psychopathological symptom, (Table 10).

The study determined main psychopathological disorders present in the subgroup II, which emerged due to significant psychological overstrain as a result of the necessity of operative treatment (Table 11).

An affective concentration of attention on own problem (the necessity of a long surgical treatment and a significant postoperative rehabilitation period) was noted - 8 (33.33%) patients (3 (12.50%) male and 5 (20.83%) female patients); autopsychic and allopsychic disorientation (4 (16.67%) patients - 2 (8.33%) male and - 2 (8.33%) female patients); suicidal thoughts (3 (12.50%) patients - 1 (4.17%) male and 2 (8.33%) female patients) and auto-aggressive manifestations with aggressive behavior - in 8 (33.33%) patients (3 (12.50%) male and 5 (20.83%) female patients).

Conclusions. As a result of determining the key aspects of the management of emotional disorders in the practice of operative treatment of proximal femoral fractures in elderly patients:

1. The presence of moderate (41.67%) and high (58.33%) levels of reactive and trait anxiety in elderly patients with proximal femoral fractures and emotional disorders is noted. The presence of a depressive state of varying severity was recorded: a subdepressive state (75.00%) and mild depression (25.00%). The general levels of reactive and trait anxiety and depressive disorders showed the presence of limit levels between moderate, high (reactive and trait anxiety) and mild depression and sub-depressive state (depressive disorders): reactive anxiety (42.52±0.05), trait anxiety (42.23±0.07) and depressive disorders (51.41±0.07).

2. It is proved that the treatment of emotional disturbances of the anxiety-depressive spectrum lead to a significant levelling in existing psychological changes (a decrease in the increased general vulnerability and irritability; a significant decrease in the affective concentration of attention on own disease and the necessity of surgical intervention; absence of loss of autopsychic and allopsychic orientation; a significant increase in mood and overall emotional background; the appearance of an optimistic orientation; decrease (or complete absence) of signs of anxiety, fear and agitation; the complete absence of thoughts of auto-aggressive or suicidal orientation).

3. The deterioration of the existing emotional disorders of the anxiety-depressive spectrum among patients at risk in the absence of drug treatment has been established: increased psychological changes; increase in general vulnerability, irritability and affective focus on trauma and the necessity of long-term surgical treatment; short-term psychotic loss of autopsychic and allopsychic orientation (in some patients); deterioration of the

emotional background and mood and the development of a significant pessimistic orientation; dissatisfaction with surrounding events and individuals; increased manifestations of anxiety, fear and agitation; the appearance of suicidal thoughts and auto-aggressive manifestations (in some patients).

REFERENCES

1. Alan M. Rathbun, Michelle D. Shardell, Elizabeth A. Stuart, Ann L. Gruber-Baldini, Denise Orwig, Glenn V. Ostir, Gregory E. Hicks, Marc C. Hochberg, Jay Magaziner Persistence of Depressive Symptoms and Gait Speed Recovery in Older Adults after Hip Fracture. // Int J Geriatr Psychiatry. 2018 Jul; 33(7): 875–882. Published online 2018 Feb 26. doi: 10.1002/gps.4864
2. Alan M. Rathbun, Michelle Shardell, Denise Orwig, Ann L. Gruber-Baldini, Glenn Ostir, Gregory E. Hicks, Ram R. Miller, Marc C. Hochberg, Jay Magaziner Effects of Pre-Fracture Depressive Illness and Post-Fracture Depressive Symptoms on Physical Performance Following Hip Fracture // J Am Geriatr Soc. 2016 Nov; 64(11): e171–e176. doi: 10.1111/jgs.14487
3. Alexiou KI, Roushias A, Varitimidis SE, Malizos KN. Quality of life and psychological consequences in elderly patients after a hip fracture: a review. // Clin Interv Aging. 2018 Jan 24;13:143-150. doi: 10.2147/CIA.S150067. PMID: 29416322; PMCID: PMC5790076.
4. Analysis of the hip fracture records of a central training and research hospital by selected characteristics / D. Cankaya et al. // Turkısh J. of Medıcal Scıences. 2016. Vol. 46 (1). P. 35–41. doi: 10.3906/ sag-1406-150
5. Australian and New Zealand Guideline for Hip Fracture Care. Sep 2014. URL: www.anzhfr.org/guidelines)
6. Bernardo J. Reyes, Daniel A. Mendelson, Nadia Mujahid, Postacute Management of Older Adults Suffering an Osteoporotic Hip Fracture: A Consensus Statement From the International Geriatric Fracture Society Geriatr Orthop Surg Rehabil. 2020; 11: 2151459320935100. Published online 2020 Jul 16.
7. Clift B., Tibrewal S. B. Fractures of the Lower Limb (includes foot). Available from.URL:https://www.researchgate.net/publication/254506497 Fractures of the Lower Limb includes foot Accessed: May 30, 2015
8. Cristancho P, Lenze EJ, Avidan MS, Rawson KS. Trajectories of depressive symptoms after hip fracture. // Psychol Med. 2016;46(7):1413-1425. doi:10.1017/S0033291715002974
9. Dautel A, Eckert T, Gross M, et al. Multifactorial intervention for hip and pelvic fracture patients with mild to moderate cognitive impairment: study protocol of a dual-centre randomised controlled trial (OF-CARE). // BMC Geriatr. 2019;19(1):125. Published 2019 Apr 30. doi:10.1186/s12877-019-1133-z
10. Epidemiological study of the effects of gender, age, mobility and time of injury on proximal femoral fractures [Czech] / L. Zelenka et al. // Acta Chirurgiae Orthopaedicae et Traumatologiae Cechoslovaca. 2018. Vol. 85 (1). P. 40–45.
11. Fernandez M. A., Griffin X. L., Costa M. L. Management of hip fracture // Br. Med. Bulletin. 2015. Vol 115. P. 165–172. doi: 10.1093/bmb/ldv036
12. Lauren A. Beaupre, Ellen F. Binder, Ian D. Cameron, et al. Maximising functional recovery following hip fracture in frail seniors. Best Pract Res Clin Rheumatol. 2013 Dec; 27(6): 771–788. doi: 10.1016/j.berh.2014.01.001
13. Lind J, Mahler M. A systematic mixed methods review: Recovering from a hip fracture in a health promoting perspective. // Nurs Open. 2018;6(2):313-329. Published 2018 Nov 18. doi:10.1002/nop2.214
14. Magaziner J, Chiles N, Orwig D. Recovery after Hip Fracture: Interventions and Their Timing to Address Deficits and Desired Outcomes--Evidence from the Baltimore Hip Studies. // Nestle Nutr Inst Workshop Ser. 2015;83:71-81. doi: 10.1159/000382064. Epub 2015 Oct 20. PMID: 26484873; PMCID: PMC5494960.
15. Management of hip fractures in the elderly / K. C. Roberts et al. // J. Am Acad. Orthop. Surg. 2015. Vol. 23. P. 131–137.
16. Management of hip fracture in older people. A national clinical guideline // Scottish Intercollegiate Guidelines Network (SIGN), 2009. URL: www.sign.ac.uk
17. Mattisson L., Bojan A., Enocson A. Epidemiology, treatment and mortality of trochanteric and subtrochanteric hip fractures: data from the Swedish fracture register // BMC Musculoskelet Disorders. 2018. Vol. 19 (1). P. 369. doi: 10.1186/s12891-018-2276-3
18. McGilton KS, Chu CH, Naglie G, van Wyk PM, Stewart S, Davis AM. Factors Influencing Outcomes of Older Adults After Undergoing Rehabilitation for Hip Fracture. // J Am Geriatr Soc. 2016;64(8):1601-1609. doi:10.1111/jgs.14297
19. Mundi S., Chaudhry H., Bhandari M. Systematic review on the inclusion of patients with cognitive impairment in hip fracture trials: a missed opportunity? // Can J. Surg. 2014. Vol. 57 (4). E141–E145. doi: 10.1503/cjs.023413
20. Nemes S, Lind D, Cnudde P, et al. Relative survival following hemi-and total hip arthroplasty for hip fractures in Sweden. // BMC Musculoskelet Disord. 2018;19(1):407. Published 2018 Nov 23. doi:10.1186/s12891-018-2321-2
21. On epidemiology of fractures and variation with age and ethnicity / N. C. Harvey et al. // Bone. 2016. Vol. 93. P. 230–231. doi: 10.1016/ j.bone.2016.07.011
22. Rapp K, Büchele G, Dreinhöfer K, Bücking B, Becker C, Benzinger P. Epidemiology of hip fractures : Systematic literature review of German data and an overview of the international literature. Epidemiologie von Hüftfrakturen : Systematisches Literaturreview deutscher Daten und ein Überblick über die internationale Literatur. // Z Gerontol Geriatr. 2019;52(1):10-16. doi:10.1007/s00391-018-1382-z
23. Rathbun AM, Shardell M, Orwig D, et al. Effects of Prefracture Depressive Illness and Postfracture Depressive Symptoms on Physical Performance After Hip Fracture. // J Am Geriatr Soc. 2016;64(11):e171-e176. doi:10.1111/jgs.14487
24. Rathbun AM, Shardell MD, Stuart EA, et al. Persistence of depressive symptoms and gait speed recovery in older adults after hip fracture. // Int J Geriatr Psychiatry. 2018 Jul;33(7):875-882. doi: 10.1002/gps.4864. Epub 2018 Feb 26. PMID: 29480573; PMCID: PMC5995625.
25. Rawson KS, Dixon D, Nowotny P, et al. Association of functional polymorphisms from brain-derived neurotrophic factor and serotonin-related genes with depressive symptoms after a medical stressor in older adults. // PLoS One. 2015 Mar 17;10(3):e0120685. doi: 10.1371/journal.pone.0120685. Erratum in: PLoS One. 2015;10(4):e0126451. PMID: 25781924; PMCID: PMC4363147.
26. Rathbun AM, Magaziner J, et al. Older men who sustain a hip fracture experience greater declines in bone mineral density at the contralateral hip than non-fractured comparators. // Osteoporos Int. 2018;29(2):365-373. doi:10.1007/s00198-017-4280-0
27. Recovery of healthrelated quality of life in a United Kingdom hip fracture population: the Warwick Hip Trauma Evaluation — a prospective cohort study / X. L. Griffin et al. // Bone Joint J. 2015. Vol. 97-B. P. 372–382.
28. Reyes BJ, Mendelson DA, Mujahid N, et al. Postacute Management of Older Adults Suffering an Osteoporotic Hip Fracture: A Consensus Statement From the In-

ternational Geriatric Fracture Society. Geriatr Orthop Surg Rehabil. 2020;11:2151459320935100. Published 2020 Jul 16. doi:10.1177/2151459320935100
29. Ritchie CS, Kelley AS, Stijacic Cenzer I, Smith AK, Wallhagen ML, Covinsky KE. High Levels of Geriatric Palliative Care Needs in Hip Fracture Patients Before the Hip Fracture. // J Pain Symptom Manage. 2016;52(4):533-538. doi:10.1016/j.jpainsymman.2016.07.003
30. Scheffers-Barnhoorn MN, van Haastregt JC, Schols JM, et al. A multi-component cognitive behavioural intervention for the treatment of fear of falling after hip fracture (FIT-HIP): protocol of a randomised controlled trial.// BMC Geriatr. 2017;17(1):71. Published 2017 Mar 20. doi:10.1186/s12877-017-0465-9
31. Seematter-Bagnoud L, Frascarolo S, Büla CJ. How much do combined affective and cognitive impairments worsen rehabilitation outcomes after hip fracture ?. // BMC Geriatr. 2018;18(1):71. Published 2018 Mar 12. doi:10.1186/s12877-018-0763-x
32. Secular trends in hip fractures worldwide: opposing trends east versus west / G. Ballane, J. A. Cauley, M. M. Luckey, Gel-H. Fuleihan // The J. of Bone and Mineral Research. 2014. № 29 (8). P. 1745–1755. doi: 10.1002/jbmr.2218
33. Shibasaki K, Asahi T, Mizobuchi K, Akishita M, Ogawa S. Rehabilitation strategy for hip fracture, focused on behavioral psychological symptoms of dementia for older people with cognitive impairment: A nationwide Japan rehabilitation database. // PLoS One. 2018;13(7):e0200143. Published 2018 Jul 5. doi:10.1371/journal.pone.0200143
34. Stobbe J, Wierdsma AI, Kok RM, et al. The effectiveness of assertive community treatment for elderly patients with severe mental illness: a randomized controlled trial. // BMC Psychiatry. 2014;14:42. Published 2014 Feb 15. doi:10.1186/1471-244X-14-42
35. The management of hip fracture in adults. March 2014. URL: www.guidance.nice.org.uk/cg124
36. Trends in hip fracture rates in Taiwan: a nationwide study from 1996 to 2010 / T. Y. Wu et al. // Osteoporosis International. 2017. Vol. 28 (2). P. 653–665. doi: 10.1007/s00198-016-3783-4
37. Tseng, Ming-Yueh et al. Effects of interventions on trajectories of health-related quality of life among older patients with hip fracture: a prospective randomized controlled trial.// BMC Musculoskeletal Disorders // 2016. vol. 17 114. doi:10.1186/s12891-016-0958-2
38. Van Steenbergen, Liza N et al. More than 95% completeness of reported procedures in the population-based Dutch Arthroplasty Register. // Acta orthopaedica vol. 86,4 (2015): 498-505. doi:10.3109/17453674.2015.1028307
39. Xu G, Chen G, Zhou Q, Li N, Zheng X. Prevalence of Mental Disorders among Older Chinese People in Tianjin City. Can // J Psychiatry. 2017;62(11):778-786. doi:10.1177/0706743717727241

SUMMARY

MANAGEMENT OF EMOTIONAL DISORDERS IN ELDERLY PATIENTS UNDERGOING SURGICAL TREATMENT OF PROXIMAL FEMORAL FRACTURES

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The goal of our research was to study the to identify key aspects of the management of emotional disorders in the practice of operative treatment of proximal femoral fractures in elderly patients.

The study was conducted with 24 patients who needed surgical treatment of proximal femoral fracture and were at risk for the development of psycho-emotional disorders due to the presence of emotional disorders of an anxiety-depressive nature were examined. The presence of such disorders was recorded at the time of admission, before and after surgical treatment using specialized psychodiagnostic techniques. Mini Mental State Examination, modified Hachinski ischemic scale, Frontal assessment battery, Spielberg-Khanin Scale of Reactive and Trait Anxiety, The Zung Self-Rating Depression Scale were used.

Results of the clinical study of the Most patients at risk had a high level of reactive anxiety - 14 (58.33%) patients (equally in subgroups I and II - 7 (29.17%) patients in each) compared with moderate levels (10 (41.67%) patients) - equally I and II subgroups (5 (20.83%) patients in each). In the subgroups I and II with moderate and high levels of reactive anxiety, a predominance of female patients was noted: subgroup I – female patients with a moderate level - 3 (12.50%), and with a high level -5 (20.83%); subgroup II – 3 (12.50%) and 4 (16.67%) female patients respectively. As a result of determining the key aspects of the management of emotional disorders in the practice of operative treatment of proximal femoral fractures in elderly patients:the presence of moderate (41.67%) and high (58.33%) levels of reactive and trait anxiety in elderly patients with proximal femoral fractures and emotional disorders is noted. The presence of a depressive state of varying severity was recorded: a subdepressive state (75.00%) and mild depression (25.00%). The general levels of reactive and trait anxiety and depressive disorders showed the presence of limit levels between moderate, high (reactive and trait anxiety) and mild depression and sub-depressive state (depressive disorders): reactive anxiety (42.52±0.05), trait anxiety (42.23±0.07) and depressive disorders (51.41±0.07).

It is proved that the treatment of emotional disturbances of the anxiety-depressive spectrum lead to a significant levelling in existing psychological changes.The deterioration of the existing emotional disorders of the anxiety-depressive spectrum among patients at risk in the absence of drug treatment has been established.

Keywords: management, emotional disorders, trait anxiety, reactive anxiety, levels of depression, proximal femoral fractures.

РЕЗЮМЕ

МЕНЕДЖМЕНТ ЭМОЦИОНАЛЬНЫХ РАССТРОЙСТВ ПРИ ХИРУРГИЧЕСКОМ ЛЕЧЕНИИ ПЕРЕЛОМОВ ПРОКСИМАЛЬНОГО ОТДЕЛА БЕДРА У БОЛЬНЫХ ПОЖИЛОГО И СТАРЧЕСКОГО ВОЗРАСТА

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Целью исследования явилось определение ключевых аспектов лечения эмоциональных расстройств в практике оперативного лечения переломов проксимального отдела бедренной кости у пожилых пациентов.

Обследовано 24 пациента, которые находились в группе риска по развитию психоэмоциональных расстройств вви-

ду наличия эмоциональных расстройств тревожно-депрессивного характера и нуждались в хирургическом лечении перелома проксимального отдела бедренной кости. Нарушения были зарегистрированы при поступлении, до и после хирургического лечения с использованием специализированных психодиагностических методик. Использовались мини-экзамен психического состояния, модифицированная ишемическая шкала Хачинского, батарея фронтальных оценок, шкала реактивной и личностной тревожности Спилберга-Ханина, шкала самооценки депрессии Зунга.

Для определения эффективности медикаментозного лечения эмоциональных расстройств сформированы две группы (I - медикаментозное лечение когнитивных и эмоциональных расстройств и II - без медикаментозного лечения) по 12 пациентов в каждой.

Анализ эмоциональных расстройств при хирургическом лечении перелома проксимального отдела бедренной кости у больных пожилого и старческого возраста выявил, что большинство пациентов имели высокий уровень реактивной тревожности - 14 (58,33%) пациентов - поровну в I и II группах, по 7 (29,17%) пациентов в каждой в сравнении со средним уровнем - 10 (41,67%) больных, поровну в I и II группах, по 5 (20,83%) пациентов в каждой. В I и II группах со средним и высоким уровнем реактивной тревожности отмечалось преобладание больных женского пола: I группа – со средним уровнем 3 (12,50%), с высоким - 5 (20,83%); II группа - 3 (12,50%) и 4 (16,67%) пациентки, соответственно. В практике оперативного лечения переломов проксимального отдела бедренной кости у пожилых пациентов выявлены умеренный (41,67%) и высокий (58,33%) уровни реактивной и личностной тревожности и депрессивное состояние разной степени тяжести - субдепрессивное состояние (75,00%) и легкая депрессия (25,00%). Анализ уровней реактивной и личностной тревожности и депрессивных расстройств выявил наличие предельных уровней между умеренной, высокой (реактивная и личностная тревожность) и легкой депрессией и субдепрессивным состоянием (депрессивные расстройства): реактивная тревожность - 42,52±0,05, личностная тревожность - 42,23±0,07 и депрессивные расстройства - 51,41±0,07. Лечение эмоциональных расстройств тревожно-депрессивного спектра приводит к значительному нивелированию существующих психологических изменений. Наблюдается обострение существующих эмоциональных расстройств тревожно-депрессивного спектра у пациентов группы риска при отсутствии медикаментозного лечения.

რეზიუმე

ემოციური დარღვევების მენეჯმენტი ბარძაყის ძვლის პროქსიმალური ნაწილის მოტეხილობის ქირურგიული მკურნალობის დროს ხანდაზმულებსა და მოხუცებში

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ხარკოვის დიპლომისშემდგომი განათლების სამედიცინო აკადემია, უკრაინა

კვლევის მიზანს წარმოადგენდა ემოციური დარღვევების მკურნალობის საკვანძო ასპექტების განსაზღვრა ბარძაყის ძვლის პროქსიმალური ნაწილის მოტეხილობის ქირურგიული მკურნალობის დროს ხანდაზმულ პაციენტებში.

გამოკვლეულია 24 პაციენტი შფოთვით-დეპრესიული ხასიათის ემოციური დარღვევებით, რომლებიც იმყოფებოდა ფსიქოემოციური დარღვევების განვითარების რისკის ჯგუფში და ესაჭიროებოდა ბარძაყის ძვლის პროქსიმალური ნაწილის მოტეხილობის ქირურგიული მკურნალობა. დარღვევები პაციენტის შემოსვლისას, ქირურგიული მკურნალობამდე და მის შემდეგ რეგისტრირდებოდა სპეციალიზებული ფსიქოსადიაგნოსტიკო მეთოდიკების გამოყენებით: ფსიქიკური მდგომარეობის მინი-გამოცდა, ხაჩინსკის მოდიფიცირებული იშემიური სკალა, ფრონტალური შეფასებების ჯგუფი, სპილბერგერის და ხანინის რეაქტიული და პიროვნული შფოთვის სკალა, ზუნგის დეპრესიის თვითშეფასების სკალა.

ემოციური დარღვევების ანალიზით ბარძაყის ძვლის პროქსიმალური ნაწილის მოტეხილობის ქირურგიული მკურნალობის დროს ხანდაზმულებსა და მოხუცებში გამოვლინდა, რომ რისკის ჯგუფის პაციენტების უმეტესობას ჰქონდა რეაქტიული შფოთვის მაღალი დონე – 14-ს (58,33%) I და II გუფებში, თანაბრად, 7 (29,17%) და 7 (29,17%), საშუალო – 10 (41,67%), I და II გუფებში თანაბრად, 5 (20,83%) და 5 (20,83%). I და II გუფებში რეაქტიული შფოთვის საშუალო და მაღალი დონით სჭარბობდა ქალები: I გუფში საშუალო დონით – 3 (12,50%), მაღალი დონით - 5 (20,83%); II გუფში, შესაბამისად, 3 (12,50%) და 4 (16,67%) პაციენტი. ბარძაყის ძვლის პროქსიმალური ნაწილის მოტეხილობის ქირურგიული მკურნალობის პრაქტიკაში ხანდაზმულ პაციენტებში გამოვლინდა რეაქტიული და პიროვნული შფოთვის სხვადასხვა ხარისხი - ზომიერი (41,67%) და მაღალი (58,33%), ასევე, დეპრესიული მდგომარეობის სხვადასხვა ხარისხი – სუბდეპრესიული მდგომარეობა - 75%, მსუბუქი დეპრესია - 25%.

რეაქტიული და პიროვნული შფოთვის და დეპრესიული დარღვევების ანალიზმა გამოავლინა მოსაზღვრე დონეების არსებობა საშუალო და მაღალ რეაქტიულ პიროვნულ შფოთვას, მსუბუქ დეპრესიასა და სუბდეპრესიულ მდგომარეობას შორის (დეპრესიული დარღვევები): რეაქტიული შფოთვა - 42,52±0,05, პიროვნული შფოთვა - 42,23±0,07 და დეპრესიული დარღვევები - 51,41±0,07. ემოციური დარღვევების შფოთვით-დეპრესიული სპექტრის მკურნალობა იწვევს არსებული ფსიქოლოგიური ცვლილებების მნიშვნელოვან ნიველირებას. მედიკამენტური მკურნალობის არარსებობის შემთხვევაში რისკის ჯგუფის პაციენტებში აღინიშნება არსებული ფსიქოლოგიური დარღვევების შფოთვით-დეპრესიული სპექტრის გამწვავება.