чие микро- и макрососудистых осложнений является важным предиктором развития слуховых нарушений, что обосновывает необходимость регулярного аудиологического скрининга в этой группе.

Выводы

Слуховые нарушения субъективно отмечают 74,5% пациентов с СД и доминирующими симптомами являются головокружение (89,5%), шум в ушах (65,8%) и снижение слуха (57,9%). Установлена достоверная связь (χ^2=5,22; p<0,05) между развитием слуховых расстройств и наличием микро- и макрососудистых осложнений СД, что позволяет рассматривать их как важный предиктор поражения слухового анализатора. Статистически значимой связи между жалобами на слух и такими показателями, как стаж заболевания, тип СД, уровень HbA1c, АГ или ИБС, в ходе исследования не выявлено. У 57,9% пациентов с жалобами на слух выявлено влияние экзогенных факторов (профессиональный шум, черепно-мозговые травмы, отиты), что требует учета данных факторов при сборе анамнеза. Полученные данные обосновывают необходимость регулярного аудиологического обследования пациентов с СД, особенно при наличии сосудистых осложнений, для раннего выявления и коррекции слуховых нарушений.

СПИСОК ИСПОЛЬЗОВАННОЙ ЛИТЕРАТУРЫ

1. Дедов, И. И. Осложнения сахарного диабета (клиника, диагностика, лечение, профилактика) / И. И. Дедов. – М., 1995. – 46 с.

2. Жукова, Л. А. Количественная оценка выраженности нейропатии у больных сахарным диабетом, ее профилактика и лечение / Л. А. Жукова, Т. Ю. Лебедев, А. А. Гуламов. – М., 2003. – 26 с.

3. Программа профилактики тугоухости и глухоты // Всемирная организация здравоохранения. – URL: https://www.who.int/deafness/world-hearing-day/2019/en/ (дата обращения: 13.08.2024).

4. Показатели сосудистой жесткости как ранние маркеры сердечно-сосудистого риска у пациентов молодого возраста с избыточной массой тела : обзор литературы / Ю. Х. Х. Хуссейн [и др.]. // Кардиология в Беларуси. – 2025. – Т. 17, № 3. – С. 410–420.

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CLINICAL AND PSYCHOSOCIAL EVALUATION OF PATIENTS WITH ISCHEMIC HEART DISEASE

Introduction

*Ischemic Heart Disease (*IHD) is the leading cause of mortality and morbidity worldwide, resulting from an imbalance between myocardial oxygen supply and demand [1]. While often driven by obstructive atherosclerosis – a process accelerated by modifiable risk factors such as hypertension, diabetes mellitus, and obesity – the clinical presentation of IHD is highly heterogeneous. It is influenced by a complex interplay of metabolic risk factors, lifestyle behaviors, and cultural perceptions [2, 3].

Many patients globally face "systemic diagnostic delays" because their symptoms do not align with classic "crushing" chest pain instead, they present with vague discomfort that leads to late-stage complications and a poorer quality of life [1, 5]. This diagnostic challenge is compounded by the fact that standard risk assessment tools may not adequately capture the variable impact of

ethnicity and socioeconomic status on disease progression and outcomes [2, 3]. Consequently, a growing body of evidence emphasizes the need for population-specific approaches to both the recognition and management of IHD, moving beyond generalized guidelines to address the unique clinical and psychosocial profiles of different patient groups [1, 5].

Goal

This research aims to evaluate the clinical, physical, and emotional status of 30 Belarusian patients with Ischemic Heart Disease (IHD). Furthermore, it seeks to identify specific risk factor profiles and diagnostic journey patterns within this cohort.

Material and methods of research

The study analyzed a sample of 30 Belarusian patients (aged 47–85) diagnosed with IHD. Clinical research was conducted at the Gomel City Clinical Hospital № 3. Two primary instruments were deployed: the Seattle Angina Questionnaire (SAQ) to measure physical limitations and angina frequency, and the HeartQoL to assess emotional and social health. Data were collected and analyzed using SPSS statistical software.

The results of the research and their discussion

Clinical evaluation of the 30 Belarusian patients reveals a striking "treatment paradox": despite universal access to state-funded healthcare, objective disease control remains inadequate. While 97% of these patients regularly take prescribed medications provided free of charge, 74% of hypertensive patients fail to achieve adequate blood pressure control (consistently exceeding 140/90 mmHg), and 87% of diabetic patients maintain HbA1c levels above 7.5%. This indicates that medication availability alone does not guarantee clinical success without addressing lifestyle behaviors. In contrast, Arab populations face different challenges; a critical surge in metabolic disorders often leads to "Early Vascular Aging," causing IHD to manifest 10–20 years earlier than in the Belarusian group [1, 2]. Meanwhile, African populations exhibit a genetic predisposition to "Resistant Hypertension," a phenotype that is physiologically more aggressive and harder to stabilize than the hypertension observed in this Belarusian sample [1, 5].

A distinctive pattern of symptom reporting was prevalent among the Belarusian patients, with 70% characterizing their sensations as "discomfort" and 47% using the term "heaviness." This understated language contributed to significant diagnostic delays: 70% of patients waited over a month before seeking medical attention, and 67% consulted three or more physicians before reaching a definitive diagnosis. This "muted" profile stands in sharp contrast to Arab populations, who typically report high-intensity symptoms like "crushing" or "burning" pain, which triggers a more rapid clinical response. However, the delay in Belarus is primarily "patient-driven" due to symptom interpretation, whereas African populations often suffer from "Systemic Bias," where healthcare systems are statistically slower to refer them for gold-standard tests, such as angiography, even when symptoms are accurately described [1, 5].

Functional and psychosocial assessments highlight a severe disconnect between psychological resilience and social connectivity. While 63% of the patients demonstrate high psychological "toughness" with low anxiety scores, they suffer from a 40% rate of social isolation and an alarming 83% prevalence of physical inactivity. Because 70% of these patients cannot perform basic tasks like climbing stairs, they frequently withdraw from social life. This isolation is particularly striking compared to Arab and African populations, who often benefit from a "Social Shield" provided by extended family structures. Despite reporting higher health-related anxiety than the Belarusians, these communal support systems significantly mitigate rates of social isolation and depression, providing a level of care coordination that is largely absent in the more individualistic Belarusian context [2, 5].

Metabolic risk factors and lifestyle habits further differentiate the Belarusian patients from global trends. While obesity (BMI >30) was present in 33% of the study population, smoking

emerged as a critical concern; 53% of male patients are current smokers, a rate significantly higher than the 30% reported in Arab groups and 25% in African American populations. Furthermore, while African populations are 25–30% less likely to be referred for angiography due to systemic disparities, such inequality was not observed in this Belarusian sample, reflecting the equalizing effect of universal healthcare access [1, 5].

Conclusions

The clinical analysis of this Belarusian sample highlights that universal healthcare accessibility does not inherently equate to therapeutic success. Despite nearly total medication adherence, the persistent failure to meet blood pressure and glycemic targets in over 70% of cases underscores a profound "lifestyle-treatment gap."

The study identifies two critical barriers to recovery: a "muted symptom culture" that leads to dangerous diagnostic delays, and a severe 83% inactivity rate that fosters social isolation. To improve outcomes, the clinical approach must shift from a purely pharmacological focus to structured cardiac rehabilitation. This transition must address sedentary behaviors and train healthcare providers to recognize "discomfort" as an urgent ischemic warning [4, 5].

LITERATURE

1. Racial and Ethnic Disparities in Heart Disease / CDC // Preventing Chronic Disease. – 2024. – Vol. 21. – URL: https://www.cdc.gov (date of access: 18.03.2025).

2. Socioeconomic and ethnic differences in cardiovascular risk / PMC // Nutrition, Metabolism and Cardiovascular Diseases. – 2009. – Vol. 19, № 9. – P. 617–624. – URL: https://pmc.ncbi.nlm.nih.gov (date of access: 18.03.2025).

3. Global trends in obesity and CAD / ScienceDirect // Progress in Cardiovascular Diseases. – 2022. – Vol. 70. – P. 2–9. – URL: https://doi.org (date of access: 18.03.2025).

4. Инфекционный эндокардит: эволюция возбудителей и клиники, диагностика, тактика и стратегия лечения / Н. М. Ведерко, Е. Г. Малаева, А. Н. Цырульникова [и др.]. // Проблемы здоровья и экологии. – 2014. – № 4(42). – С. 45–51.

5. Emergency conditions in internal organs diseases : a textbook for international students of higher education institutions majoring in General Medicine / E. G. Malaeva, T. V. Aleinikova, O. A. Yarmolenko, T. A. Kurman. – Gomel : Gomel State Medical University, 2025. – 283 p.

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ASSOCIATION BETWEEN MEDICATION ADHERENCE AND GLYCEMIC CONTROL IN TYPE 2 DIABETES MELLITUS

Introduction

Type 2 diabetes mellitus is a major public health concern, with increasing prevalence globally (World Health Organization). Persistent hyperglycemia leads to microvascular and macrovascular complications such as neuropathy, nephropathy, and retinopathy. Medication adherence is a critical determinant of glycemic control, yet poor adherence remains a common barrier [1–4]. The American Diabetes Association recommends maintaining HbA1c below 7% to prevent long-term complications.

Goal

Goal of this to evaluate adherence, glycemic control, and complication prevalence among patients with type 2 diabetes at Gomel City Clinical Hospital No. 3.