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INITIAL CLINICAL, VEGETATIVE, PSYCHOEMOTIONAL CONDITION OF PATIENTS WITH PAIN SYNDROME AFTER ISCHEMIC AND HEMORRHAGIC STROKE

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Annotation.Stroke is one of the most frequent neurological diseases with high prevalence, disability and mortality, which is an urgent medical and social problem. More than 1 million stroke patients live in Russia, with about 500 thousand new cases of stroke occurring annually [1, 2]. The incidence of stroke ranges from 10 to 20 per 10,000 people aged 55 to 64 years, increasing over 200 cases per 100,000 among people over 85 years [3]. Stroke, depending on the nature and localization, causes a wide range of neurological disorders associated with physical disability, as well as a variety of cognitive and neuropsychiatric disorders that complicate rehabilitation, domestic and social adaptation and the quality of life of both patients themselves and their caregivers.

Keywords: hemorrhagic stroke, treatment, observation, patients.

The main clinical features of patients were as follows. The average age of patients in both groups patients did not observe significant statistical differences. The pain episodes in a month were 3.23 days. The duration of the pain episodes was 9.62 minutes

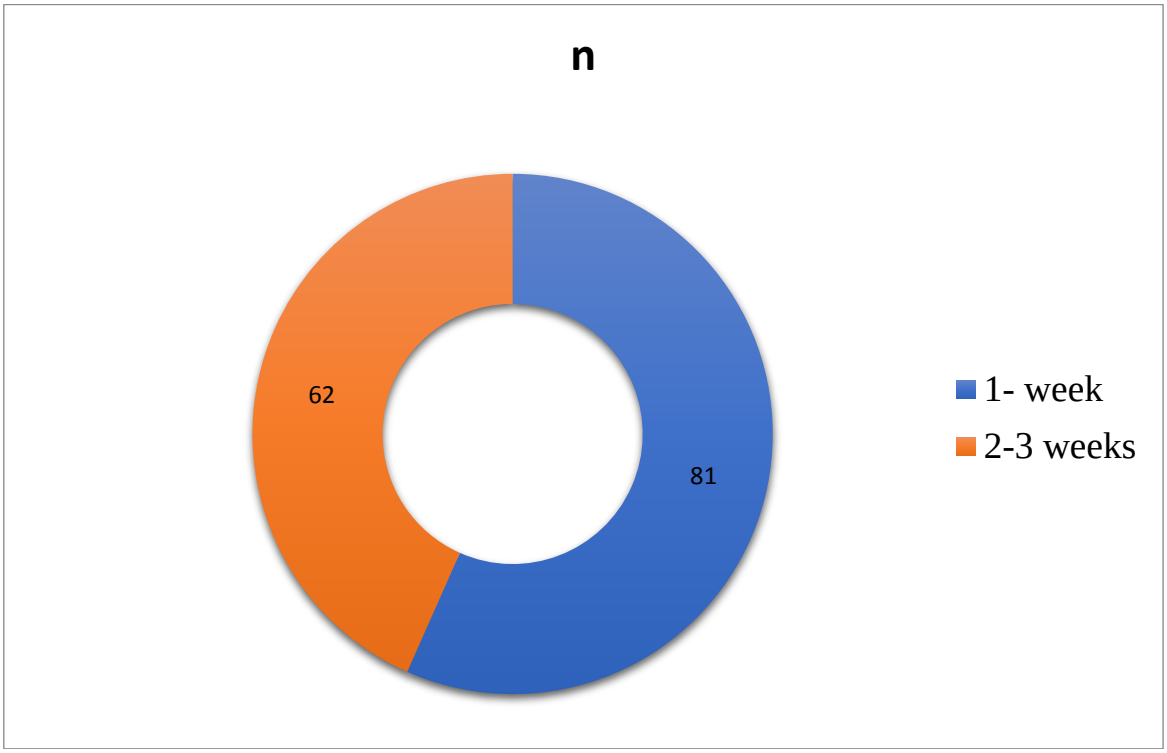
1.1- table

Main clinical features of patients

	1-group 2- group Mann-Whitney Criterion		1- group 2- group Mann-Whitney Criterion		1 group 2- group Mann-Whitney Criterion	
	M	m	M	m	Z	P
Age	59,27	0,95	56,68	1,01	-1,694	0,090
Duration of illness (year)	6,01	0,38	5,19	0,49	-2,386	0,017
Ogrick episodes in a month (day)	3,23	0,23	3,01	0,21	-0,562	0,574
Gabapentin (300 mg) daily	414,08	17,41	391,67	16,40	-0,938	0,348
Ogrick episode continuity (minute	9,62	0,45	9,67	0,60	-0,876	0,381

Patients examined for persistent pain syndrome were observed in the majority of cases, with 81 (56.6%) cases in the first week after acute stroke (R = 0.023).

The viability of pain syndrome was assessed using the vash scale. On the Vash scale, the distribution of pain syndrome by time of occurrence is as follows (figure 3.1). The pain that occurs in Week 1 after a stroke is 81 patients, while patients who experience pain in week 2-3 after a stroke are 62.

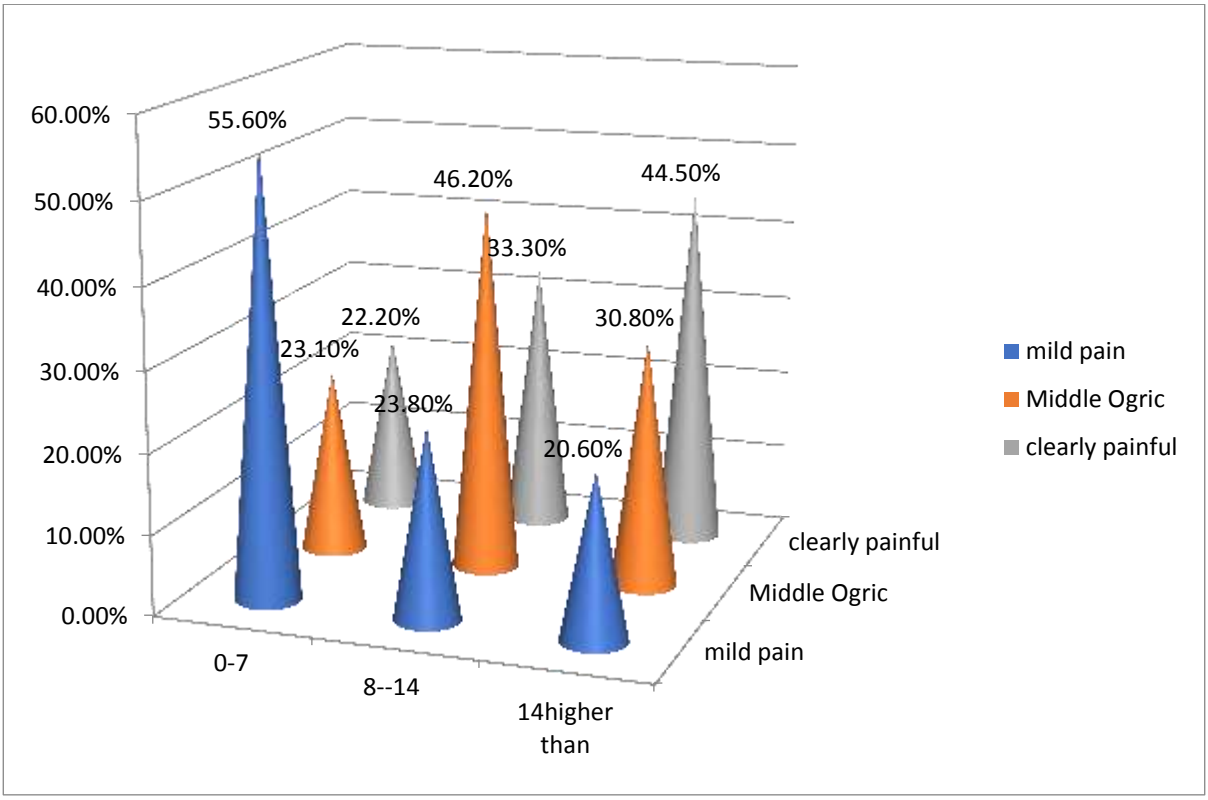


1.2 table. Distribution of patients according to the time of the appearance of pain

Pain syndrome expression latency on the Vash scale showed the following indications (figure 3.2). Mild pain (1-4 points) accounted for 56.6%, moderate pain (5-7 points) 37.1%, pronounced pain (above 7 points) 6.3%, and most pain fell on the vash scale to mild to moderate pain.

The following indications were obtained when the sex dependence of pain relief was studied (figure 3.3). In men, the mild pain was 71 (63.9%), the middle 32 (28.8%), the obvious 8 (7.3%), while among women, the mild pain was 10 (31.2%), the middle 21 (65.6%), the obvious 1(3.1%). These indications indicate a high level of middle pain among women and mild pain among men, and this may be due to the emotional state of women.

The stroke weight dependence of pain syndrome (NIHSS) is estimated to be 60-70% below 10 points after 1 year, while the score up to 20 points is determined by a 4-16% bias. This result is necessary to plan thrombolytic therapy and assess its effectiveness. A guideline for thrombolytic therapy is the 3-5 point incidence of neurological deficits, which leads to the development of disability. Severe neurological deficits (above 25 points) are an indication against thrombolysis and do not significantly affect the outcome of the disease.



1.3 table. Expression of xolda pain syndrome depending on the type of stroke (according to the MRI result)

When studies of cases of pain relief related to whether or not a stroke was previously performed, the recurrent stroke was 27, with 116 first-time stroke patients. Mild pain in recurrent stroke was 55.6%, moderate pain was 40.7%, and pronounced pain was 3.7%. Those who had a stroke for the first time had mild pain at 52.6%, middle pain at 38.8%, and clear pain at 8.6%. Pain in the stroke was found not to depend on the recurrence of the stroke.

1.4- table.

Pain syndrome latency in relation to stroke recurrence

	Pain syndrome						total	
	light medium clear		light medium clear		light medium clear			
	n	%	n	%	n	%	n	%
Recurrent stroke	15	55.6	11	40.7	1	3.7	27	100
Stroke for the first time	61	52.6	45	38.8	10	8.6	116	100

Pain viability was studied according to the degree of spasticity of the affected mucha side. In doing so, the spastika was rated on a 5-point system. In this, normative muscle tone was observed in 50% of patients with mild pain.

1.5- table.

Severity of pain according to the degree of spasticity of the injured limb

	Right						left mucha					
	light		medium		clear		light		clear		medium clear	
	n	%	n	%	n	%	n	%	n	%	n	%
0	77	53,8	62	43,4	16	11,2	86	60,1	8	60.1	0	0,0

ball									6			
1 ball	45	31,5	44	30,8	32	22,4	45	31.5	45	31.5	16	11,2
2- 5 ball	21	14,7	37	25,8	95	66,4	12	8.4	12	8.4	127	88,8
total	143	100,0	143	100,0	143	100,0	143	100,0	143	100,0	143	100,0

The study involved patients engaged in the preparation and presentation of a relatively small number of visible moles (14.7%). Currently, there is a stationary inpatient inpatient hospital. In particular, a subgroup of patients and expressive spastic patients (66.4%). Left muchada yongil ogryklda hularda reference muscle precise tone (60.1%). Tubular and expressive spastic ESA 8.4% skeleton holda. During the conversation, the sides expressed satisfaction with the development of cooperation between Tajikistan and China. Nuclear syndrome and expressive spasticity 88.8% of cases, yongil spasticity 11.2% of apparent affinity (3.3 - degree).

The patient has a syndrome of a pronounced dull lifestyle, while it is possible to cause the disease in 23.4% of patients suffering from a dull heart.

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