THERAPY MISTAKES OF SUICIDAL BEHAVIOR IN PSYCHIATRIC HOSPITALS

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Suicides and suicide attempts in psychiatric clinic are of relatively small proportion, but they are a clinically significant part of suicide behavior. Drug therapy of depressions at patients with the heaviest forms of suicide behavior and high suicide risk is carried out in the hospital. Adequately selected therapeutic strategy in this case is one of the major anti-suicide factors. At the same time, the incorrect choice of psychopharmacotherapy can significantly increase suicidal feelings of the patient, lead to realization of the remaining suicide plans.

The research of the objective was an improvement of the suicidological help in psychiatric hospitals by identification of therapeutic risk factors of suicide behavior during treatment in a psychiatric hospital and in early terms after discharge from the hospital. To achieve the objectives of complex psychiatric and klinikopsychological examination of patients with suicide attempts was conducted during treatment in psychiatric hospitals of Bryansk and Smolensk in 2012-2014 and in early terms after discharge from the hospital. The controlled group consisted of patients with mental disorder, but without suicide behavior, comparable on gender and age and nosological structure. Criteria for inclusion were the existence of suicide behavior during treatment in a psychiatric hospital or in early terms after discharge from the hospital according to the informed patient's consent.

42 episodes of suicide behavior, were studied 11 episodes were suicides. Average age of patients was 35.3±13. 2 years. 46% of cases of suicide behavior were registered directly in a hospital, 4% - of them were during medical holiday, 30% - were on treatment in a day hospital and 20% - within were 7 days after discharge from the hospital. In the analysis of a temporary factor, two critical moments for realization of suicide intentions were revealed: the first week of hospitalization (23%) and hospitalization terms in a hospital more than 60 days (62%). The analysis of the drug therapy appointed to the patients who committed a suicide attempt revealed the following negative tendencies: absence or rare correction of drug treatment in 80% of cases; a sudden removal of sedative drugs on the eve of suicide activity - 50% of cases; prescription of antidepressants with the stimulating action in the doses exceeding a therapeutic dose in 47% of cases, from which 75% of cases was followed by simultaneous cancellation of sedative and antipsychotic therapy without any justification in the history of an illness.

So, the prognostic significance for risk assessment of realization of suicide plans by patients of psychiatric hospitals is the dynamic evaluation of the suicide status of patients at long hospitalization, at registration during medical holidays and just before an discharge from the hospital. Suicide activity at late stages of treatment is rather often an obvious indicator of an inefficiency of medical actions, and also can testify the development of social disadaptation of the patient in connection with long stay in psychiatric hospital, an invalidization because of progressive mental disorder. The developed medical and rehabilitation programs taking into account the revealed factors will allow to increase quality of the suicidological help by decrease of level of suicide activity and the prevention of hospital suicides.

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ABILITIES OF COGNITIVE AND SOMATIC STATUS'S CORRECTION IN PATIENTS WITH ARTERIAL HYPERTENSION AND RISK FACTORS FOR KIDNEY DAMAGE DURING THE SANATORIUM TREATMENT

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Background: The high prevalence of hypertension and chronic kidney disease (CKD), as well as their impact on the formation of cognitive impairment, which significantly affect the quality of life of patients, forced to look for new ways of early diagnosis, treatment and prevention of these diseases. It seems rational to organize treatment and preventive measures of patients with hypertension at the sanatorium stage, but its scientific justification is fragmentary.

The aim of the study is to assess the dynamics of correction of cognitive and somatic status of patients with hypertension and CKD risk factors in the process of sanatorium treatment.

Subjects and methods: 200 patients (114 women, 86 men, mean age 55±1.2 years) with a diagnosis of essential arterial hypertension of 1-2 stage were examined and treated in FSBI «Podmoskovye» United Sanatorium (average term of treatment 16.4±3.7 days). Patients underwent a basic program for the treatment of cardiovascular diseases, which included consultations of doctors-specialists and complex medical procedures (group and individual gymnastics in the pool and in the gym, hand massage, swimming in the pool, walking including Nordic walking, magnetotherapy, electrotherapy, laser therapy, balneotherapy, including baths and showers, individual and group psychotherapy, diet, xenon therapy, acupuncture). Patients were examined in the first 1-2 days after arrival at the sanatorium and 1 day before departure. The study included the following methods: general clinical examination (anthropometric indicators, daily monitoring of arterial pressure, electrocardiogram), clinical laboratory tests (blood biochemical parameters, including creatinine level), assessment of risk factors for CKD (urine analysis for albuminuria, glomerular filtration rate), neuropsychological tests (test of 10 words – verbal memory, 5 figures - visual memory, Schulte table – voluntary attention, the Counting – rate of mental efficiency's speed, scales MMSE, FAB). Statistical processing was carried out using the software package SPSS Statistics 18.00. Criteria were used U-Mann-Whitney, x^2 Pearson's, correlation analysis Spearman, regression analysis, factor analysis, relative risk (RR).

Results: 104 (52%) patients with hypertension (group 1) were found risk factors for CKD, which, according to the recommendations by KDIGO and the Scientific society of Nephrologists of Russia, are reducing the level of glomerular filtration rate (GFR) less than 90 and more than 60 ml/min/1.73 m^2 and increasing albuminuria (AU) in the range of 10 to 29 mg/L. 96 (48%) of the remaining patients (group 2) were not observed signs of kidney damage. Prior to the start of sanatorium treatment, patients in group 1 compared to patients in group 2 had a significantly higher level of mean blood pressure. In group 1, the mean systolic blood pressure (SBP) was 148.3±8.6 mmHg., diastolic blood pressure (DBP) 94.8±8.8 mmHg. In group 2, the average level of SBP 141.4±7.2 mm Hg., DBP 85.3±6.1 mm Hg. In group 1 significantly lower mean GFR (69.1±3.4 ml/min/1.73 m^2 and 96.5±4.5 ml/min/1.73 m^2, respectively) and higher creatinine level (87.9±4.8 mmol/L and 71.7±3.2 mmol/L, respectively). In group 1, there was a significantly higher number of overweight patients (average BMI body mass index 36.7±3.2 kg/m^2 and 32.1±2.9 kg/m^2, respectively). In group 1, higher average total cholesterol (6.6±0.7 mmol/L and 6.1±0.9 mmol/L, respectively), low-density lipoproteins (LDL) level (4.8±2.9 mmol/L and 5.0±2.6 mmol/L, respectively) were found. Among patients of group 1 compared with group 2 patients noted significantly lower levels of verbal memory, as short-term (6.3±1.4 b. and 7.7±1.2 b.), and delayed memory (4.5±0.8 b. and 5.6±1.5 b. respectively). The level of visual memory was within the normal limits in both groups (4.7±0.4 b. and 4.8±0.1 b.). In group 1 patients, the rate of mental efficiency's speed (81.8±5.9 seconds. vs. 67,7±4.5 seconds.) and concentration of voluntary attention (75.1±5.7 sec. vs 71.4±6.2 sec.) were significantly worse than in group 2 patients. The average score of the MMSE scale among patients of group 1 (24.8±1.2 b.) corresponds to the indicator of moderate cognitive impairment, in group 2 this indicator is close to the border of the norm (26.9±1.3 b.). Indicators of the fab frontal dysfunction scale FAB are within the normal range (16.0±0.3 b. and 16.7±0.8 b. respectively). After a course of sanatorium treatment in patients in both groups positive dynamics on the majority of the studied indicators was stated. In both groups significantly improved SBP and DBP (group 1: SBP 139.2±3.4 mmHg., DBP 91.6±6.2 mm. Hg.; group 2: SBP 135.5±5.2 mm Hg., DBP 84.4±5.2 mmHg.), BMI (32.8±2.6 kg/m^2 and 29.9±2.4 kg/m^2, respectively), total cholesterol level (6.6±0.7 mmol/L and 5.8±0.5 mmol/L, respectively). Also in patients with hypertension and risk factors for CKD significantly improved the level of GFR from 69.1±3.4 ml/min/1.73 m^2 to 74.8±4.1 ml/min/1.73 m^2, reduced levels of AU from 14.8±1.7 mg/L to 11.9±1.2 mg/L with creatinine level from 87.9±4.8 mmol/L to 85.4±3.8 mmol/L. These data suggest the weakening of the influence of CKD risk factors on physiological processes in patients with hypertension. Among the patients in both groups showed improvement in cognitive processes in growth of short-term verbal memory (7.6±1.1 b. and 8.5±2.1 b. respectively) and delayed memory (4.9±0.2 b. and 6.2±1.1 b. respectively), improvement of concentration and volume of voluntary attention (70.4±3.7 sec. and 64.3±5.2 sec.), increasing the mental efficiency's speed (76.6±4.6 seconds and 65.2±5.8 sec. respectively.) In group 1, patients with hypertension and CKD risk factors showed significant improvement in cognitive processes, according to the results of the complex scale MMSE (26.9±2.3 b.). In patients of group 2, the average value of this scale passed into the normal range (27.4±0.5 b.). The index of frontal functions of the FAB scale significantly improved only in group 1 (16.9±0.4 b.).

According to the 95% confidence interval relative risk calculation, patients with hypertension and CKD risk factors have a 1.47 times higher risk of cognitive impairments than patients with hypertension only.

Conclusions: There is a tendency to reduce cardiovascular and renal risk without canceling or changing drug therapy in combination with improved cognitive functions in patients with hypertension in the process of complex multifactorial sanatorium treatment.