## PATHOGENETIC SIGNIFICANCE OF HYPERLIPIDEMIA IN THE CLINICAL COURSE OF ARTERIAL HYPERTENSION

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Although hyperlipidemia is studied in many studies as one of the urgent problems in the medicine of civilized countries, according to statistics, it continues to grow rapidly. At the same time, the increasing incidence of hyperlipidemia among the younger population shows how serious the problem is.

Arterial hypertension and hypercholesterolemia, the risk of death from cardiovascular system diseases increases 3 times. The risk stratification of hypertension takes into account not only arterial blood pressure indicators, but also the presence of a number of other risk factors, damage to target organs (left ventricular hypertrophy, ultrasound signs of atherosclerosis of the trunk vessels, proteinuria) and the presence of concomitant diseases.

In clinical practice, the diagnosis of lipid metabolism disorders is based on the assessment of the state of the lipid spectrum, according to which the amount of total cholesterol, triglycerides, low-density lipoproteins and high-density lipoproteins is determined. Today, the treatment of lipid metabolism disorders and the selection of drugs are based on the risk of the cardiovascular system. It is known that the risk of developing ischemic heart disease increases from 1% to 2% in patients with hyperlipidemia in hypertension. 40% of adults with arterial hypertension in A QSh suffer from obesity (body mass index >30), and more than 3/1 of the obese population suffer from arterial hypertension.

Arterial hypertension, hyperlipidemia is invisible in the form of an increase in the amount of very low-density lipoprotein cholesterol and a decrease in the amount of highdensity lipoprotein cholesterol. Often, in this case, the amount of low-density lipoprotein ( low-density lipoprotein) cholesterol is either normal or slightly increased. The main risk factors of patients with hypertension include: levels of systolic arterial pressure and diastolic arterial pressure (arterial hypertension levels I-III); age (men over 55, women over 65); smoking; hyperlipidemia: total cholesterol > 6.5 mmol/l (250 mg/dL); or low density lipoprotein xs amount > 4.0 mmol/l (155 mg/dL); High-density lipoprotein <1.0 (for men) <1.2 (for women) mmol/l; family history of cardiovascular system diseases at an early age (age younger than 55 years for men and 65 years for women); abdominal obesity (abdominal circumference > 102 cm in men, > 88 cm in women); reactive protein > 1 mg/dL Hyperlipidemia is a violation of the ratio of atherogenic (mainly low-density lipoproteins) and non-atherogenic (high-density lipoproteins) lipoproteins, and hyperlipidemia is considered the leading risk factor for the development of atherosclerosis. For the first time, the largest epidemiological study (in particular Framingham and MRFIT) found a direct relationship between blood cholesterol levels and cardiovascular mortality. Further studies show that not only hypercholesterolemia, but also other disorders of lipid metabolism, such as an increase



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in the amount of triglycerides and a decrease in the amount of high-density lipoproteins (High-density lipoproteins), are also important in the development of atherosclerosis. In particular, a 1% decrease in high-density lipoproteins increases the risk of cardiovascular diseases by 3-4%. According to the INTERHEART studies, the violation of the ratio of atherogenic and non-atherogenic lipoproteins is a strong predictor of the development of acute myocardial infarction, regardless of age, gender and ethnicity. In A , if such hyperlipidemias are combined with hypertension, the risk level is even higher. In clinical studies, elimination of excess weight reduces the risk of developing arterial hypertension and the level of arterial hypertension in hypercholesterolemic patients . NO-synthase activity decreases. Thus, arterial hypertension and hypercholesterolemia have a synergistic effect on the vascular wall, leading to functional and structural changes leading to the development of atherosclerosis. In statistical studies, no difference was observed in the analysis of the level of arterial hypertension and high-density lipoprotein cholesterol, but the development of arterial hypertension is often observed in patients with a low level of high-density lipoprotein cholesterol.

In hyperlipidemia, on the pathogenetic basis of hemorheological indicators, the shift of cholesterol concentration in the erythrocyte membrane from the optimal level to one side or the other has a negative effect on the membrane surface tension viscosity and fluidity, which determines the deformability of erythrocytes. In most patients with arterial hypertension, hyperlipidemia is manifest in the form of an increase in the amount of very low-density lipoprotein cholesterol (very low-density lipoprotein) and a decrease in the amount of highdensity lipoprotein cholesterol. Often, in such a case, the level of low-density lipoprotein (lowdensity lipoprotein) cholesterol is either normal or slightly increased. According to various sources, free radical oxidation processes are activated and oxidant stress develops in hypertension, which leads to an increase in proatherogenic lipid metabolism disorders, an increase in the amount of low-density lipoprotein cholesterol and the level of atherogenicity. It is known that the risk of developing IUD increases from 1% to 2% in patients with hyperlipidemia in hypertension. In this case, an increase in the amount of triglycerides and low-density lipoprotein cholesterol increases the risk of developing complications in the cardiovascular system in patients with hypertension. In the Framingham study, middle-aged men with hypertension, whose arterial blood pressure did not exceed 160/95 mm Hg, had a 5-fold higher incidence of CHD compared to men with normal arterial blood pressure. According to other sources, every 10 mmHg increase in arterial blood pressure increases the risk of cardiovascular disease and complications by 30%. A negative impact of lipid spectrum disorders and atherosclerosis on arterial blood pressure has been demonstrated in studies conducted among the American population, and the study noted that increased levels of triglycerides and very low-density lipoproteins in patients were associated with increased arterial blood pressure.

Reducing excess weight leads to an increase in the amount of high-density lipoproteins. Each kilogram of weight loss causes a 0.01 mmol/l (0.4 mg/dL) increase in high-density lipoprotein. Aerobic physical activity, for example, walking 25-30 km per week at a fast pace, increases the amount of high-density lipoproteins by 0.05-0.15 mmol/l (3.1-6 mg/dl).

**Summary.** Considering that hyperlipidemia is a risk factor that can be corrected, it is important to maintain body weight through active promotion and implementation of a healthy lifestyle, not only in patients with arterial hypertension, but also in the entire

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population over 30 years of age. allows to lower the indicators and increase resistance of the cardiovascular system to physical stress.

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