

group B (β -blockers) in 12.5% cases in Ukraine; but only group C (CCBs) was administered in Nigeria as monotherapy.

Combined treatment was prescribed to 47.5% patients in Ukraine and 83.33% patients in Nigeria. There were combination A+D (diuretic) in 10%, B+D in 5%, A+B in 2.5%, A+C in 2.5%, A+C+D in 5%, A+B+D in 12.5 %, A+B+C in 2.5%, A+B+C+D in 5 % patients in Ukraine. Nigerian patients were administered combinations C+D in 11.66%, A+C in 25 %, A+C+D in 38.33%, C+ α -blockers in 6.66%, D+ α -blockers in 1.67%. B-blocker were not prescribed to Nigeria patients, and α -blockers were not administered in Ukrainian cases.

The most common mistake for Ukrainian cases was no prescription antihypertensive drugs for 5% cases, combination ARB and ACE inhibitors in 2.5%, combination CCB and BB in 2.5% cases. The most common mistake for Nigerian cases was prescription of amlodipine and nifedipine to the same patients 13.33% cases, combination of ARB and ACE in 8.33%, using antiplatelet for patient who has only hypertension in 6.67% cases. Adherence of doctors to follow national guidelines was in 57.5 % Ukrainian cases and in 61.66% Nigerian cases.

Conclusions. There are significant differences in practical prescriptions of antihypertensive treatment (as mono as combined) in Ukraine and Nigeria, which could not be explained only racial conditions.

DESIGN AND DEVELOPMENT OF GUIDELINES FOR PHARMACEUTICAL CARE IN PATIENTS WITH CORONARY ARTERY DISEASE IN UKRAINE

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Introduction. Cardio-vascular diseases (CVD) take 37.1% of the morbidity and the first leading cause of premature mortality in Ukraine that amounted 66.3%. Morbidity rate of coronary artery disease (CAD) in combination with hypertension is about 59 % of the total CVD. Evidently, there are some factors in the healthcare system in Ukraine such as expensive medical services for averages citizen, low educational population, increasing of risk factors of CVD do not allow to reduce these rate. In the nowadays concept of responsible self-treatment decisive role must play a pharmacist, who gives informational medical help for patients with CAD.

Materials and methods. We based on literature review of symptoms of CAD, clinical pharmacology of drugs using in treatment of CAD, and we learn legislative base regarding pharmaceutical care both in Ukraine and worldwide.

Results and discussion. Symptoms of CAD mostly are characterized by chest pain. So, algorithm of pharmacist's action relate with him understanding differential diagnostic approach of coronary conditioned chest pain. The pressing nature of the chest pain, the special conditions of appearance of it will indicate to CAD. There are some another signs of CAD as dyspnoe, acrocyanosis, palpitation, edema of low extremities. Pharmacist should pay attention on medicamental anamnesis, especially side effects of drugs used before, for example withdraw effect of beta-blockers, tolerant of nitrate, gastrotoxicity of acetylsalicylic acid, etc. In case of prescription by a doctor several drugs for one case pharmacist should analyze drug-drug interaction and interaction these drugs with food, alcohol, nicotine.

We have developed an algorithm of conversation of pharmacist and patient with CAD including all mentioned issue. Special attention was paid to threatening symptoms in CAD that require urgent physician intervention. There are drop in blood pressure, loss of consciousness, chest pain last more than 30 min, increasing dyspnoe, coughing and fever, black stools, and other.

Conclusions. Pharmaceutical care in patients with CAD in the nowadays concept of responsible self-treatment should include pharmacist participation in early diagnosis of CAD, rendering first aid, counseling regarding side effects, drug-drug interactions and contraindications of drugs that prescribed by a doctor. Correct tactics of pharmacist will improve the quality of medical care for patients with chest pain; it will contribute to the early diagnostic of CAD, and it will increase lifetime of the patients with CAD.