electric impulse is not extinguished, it's free to go through a closed stake in myocardium a bit. The frequency of the PVS occupy the leading position – 62,6%.

Aim. Analysis and researching Ukrainian and foreign recommendations for pharmacotherapy PVS.

Materials and methods. Order of Ministry of Health of Ukraine No. 667 of November 20, 2008, AHA/ACC/HRS Guideline for Management of Patients With Ventricular Arrhythmias and the Prevention of Sudden Cardiac Death (2017) has been analysed.

Results and discussion. For symptomatic PVS in patients with postinfarct, cardiac sclerosis is most appropriate to use B-adrenergic blockators: amiodarone abo sotalol. People with heart failure (HF), ACE inhibitors, potassium-sparing diuretic, peripheral vasodilators using provides indirect antiarrhythmic effect due to hemorrhagic neurodevelopmental disorder. But, heart glikosydes and loop diuretics can provide arrhythmogenesis. When amiodarone with digoxin are combinated, the dose of the digoxin should be reduced by half to evolve the risk of glucose-toxic intoxication. By recommendation of the Ukrainian Association of cardiologists people with malignant PVS who have a reduced ejection fraction of the left ventrycle and HF amidaron withs mall amount of B-adrenergic medication indicated.

Conclusions. The main strategy of treatmant people with PVS, and advisability its elimination by the antiarrhythmic drugs are determined depending on the ratio of the potential benefits of treatment for the elimination of arrhythmias, improvement in the prognosis of survival and the risk of arrhythmogenic and other side effects of pharmacotherapy.

MODERN APPROACHES TO PHARMACOTHERAPY OF SCHIZOPHRENIA

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Introduction. Schizophrenia is a chronic and severe mental disorder that affects how one thinks, feels, and behaves. It may seem to sick people that they have lost touch with reality. The disorder arises on the basis of hereditary predisposition, has a continuous or impulsive course and leads to peculiar changes of personality in the form of disintegration of the psyche, autism, emotional impoverishment and decreased activity. The prevalence of schizophrenia is about 1% in the world. The average age at onset is early to mid 20s in women and somewhat earlier in men.

Aim. Study of modern standards of medical care for patients with schizophrenia.

Materials and methods. We conducted an analysis of articles, an adapted clinical guideline based on evidence, a unified clinical protocol providing medical care for patients with schizophrenia.

Results and discussion. Schizophrenia may progress through several phases, although duration and patterns of phases can vary. Generally, symptoms are categorized as positive: delusions, hallucinations; negative: blunted affect, poverty of speech, anhedonia, asociality; disorganized: thought disorders, bizarre behavior; cognitive: deficits in information processing and problem solving.

Treatment of schizophrenia includes antipsychotic drugs, rehabilitation with community support services, and psychotherapy in order to reduce symptoms. Conventional antipsychotics: chlorpromazine, thioridazine, trifluoperazine, fluphenazine or second-generation antipsychotics should be used in the first episode of schizophrenia. At the stage of active therapy, second-generation antipsychotics are preferred: amisulpride, olanzapine or risperidone, starting with the minimum doses. Then it is possible to reduce the dose of the antipsychotics or prescribe long-acting antipsychotics at the stage of stabilization therapy. During supportive therapy, the minimum therapeutically effective doses of antipsychotics used at the previous stages of therapy are recommended. Clozapine should be offered for patients who have treatmentresistant schizophrenia.

Conclusion. Thus, we have studied and analyzed the current standards of medical care for patients with schizophrenia, according to which treatment is performed according to the individual development of the disease.

PHARMACOTHERAPY OF THE COMMUNITY-ACQUIRED PNEUMONIA

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Introduction. Despite of success achieved by mankind in diagnostic and treatment of community-acquired pneumonia (CAP), this infectional disease keeps on being a life-threatening condition. Therapy lines often change due to different reasons: creation and emergence of new antibiotics more effective than existing drugs, increasing of pathogen resistance and others. Different countries sometimes offer identical therapy regimens for treatment of CAP but sometimes they are critically different. That encourages healthcare providers to constantly monitor new protocols of medical help and proposed combination of antibiotics.

Aim. To review medical care protocols with recommendations from Nice GuideLine, Merck Manual, American Thoracic Society and to compare them with Ukrainian adapted clinical guidance (last version, 2019).

Materials and methods. Theoretical methods were used (searching, collecting, comparing, analyzing and processing of information) in creation of the work. The exploration was hold by the analysis of the literature sources - European guidelines, treatment protocols of for the treatment of community-acquired pneumonia.

Results and discussion. Almost all of the guidelines divide lines of therapy for four different groups of patients: group of low severity without modification factors, group of low severity with modification factors, group of moderate severity and group of high severity. First two groups can be treated in the outpatient setting, other two groups are only for the inpatient treatment or even intensive care unit. Thus, the severity of the patient`s condition determines the location of treatment. It is often impossible to determine the main pathogen immediately, so people with CAP receive empirical antibiotic therapy to the moment of obtaining the results of presence bacterial culture in patient's expectoration.

Group of low severity without modification factors is treated with aminopenicillin as first-choice drug, macrolide or tetracycline as alternative drug, or fluoroquinolone as second-line drug. Oral monotherapy is recommended.

Group of low severity with modification factors is treated by protected aminopenicillin as first-choice drug, fluoroquinolone or cephalosporin of the third generation as alternative one. Fluoroquinolones are also used in second-line treatment. Foreign protocols recommend combining protected aminopenicillin with macrolide or tetracycline, another combinations – cephalosporin of the second or the third generation with macrolide or with tetracycline. Oral use is preferred both for monotherapy and for combinations.

Group of moderate severity has combination of macrolide with protected aminopenicillin or with cephalosporine of the third generation as the first-choice therapy. Second-line treatment includes parenteral monotherapy with fluoroquinolone, or macrolide and carbapenem combination, or macrolide and cephalosporin of fifth generation combination. Macrolides must be applied only orally, other antibiotic in the combination is for the parenteral use. Therapy by the foreign protocols is identical, but they also offer a combination of the beta-lactam (penicillin or cephalosporin of the third and the fifth generations) with tetracycline.