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INFLUENCE OF DEPRESSION ON SOCIAL CHARACTERISTICS OF PATIENTS WITH MYOCARDIAL INFARCTION

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ABSTRACT
Annotation. Currently, the problem of comorbidity of depression and somatic diseases, in particular, the cardiovascular profile, is extremely urgent. This study examines the factors that predispose to the formation of post-infarct depression, and provides a characteristic of post-infarct depression itself.

KEYWORDS: depressive disorders, myocardial infarction, working capacity of patients.

INTRODUCTION
The high prevalence of mental pathology is noted both among the contingent of polyclinic institutions and in multi-specialty hospitals, where mainly mental disorders are represented by outpatient "neurotic" forms, among which somatized anxiety and depressive disorders predominate. Depression, regardless of its origin, developed against the background of existing severe somatic disease, significantly complicates its course and rehabilitation of the patient.[1,3,6] A number of studies have found that symptoms of depression are reliable predictors of mortality from cardiovascular diseases after a myocardial infarction.[5.7] Nervous and mental disorders in myocardial infarction are associated to a large extent with a violation of cerebral circulation, often of a functional nature, and sometimes due to thrombosis or thromboembolism of small blood vessels of the brain. Already in the acute period of myocardial infarction, the fear of death may appear, accompanied by anxiety, anxiety, and longing. Some patients are silent, motionless, while others, on the contrary, are extremely irritable.[4] In the clinic of psychopathological disorders in myocardial infarction, a large place is occupied by emotional disorders. In the first days of myocardial infarction, anxiety-depressive syndrome is most often detected.[2] Fear of death, longing, anxiety, and anxiety depression can be replaced by psychomotor agitation. Patients in this condition try to get out of bed, walk, talk a lot. In connection with the relevance and frequent occurrence of depression in patients after myocardial infarction, a clinical and psychopathological study of this contingent, which is being treated in the Bukhara regional cardiological dispensary, was undertaken.

The aim of the study was to analyze the influence of depressive disorders on the social characteristics of patients with myocardial infarction.

MATERIALS AND METHODS OF RESEARCH
121 patients were examined in a cardiological dispensary. The patients were divided into two groups: the first group consisted of 88 patients who had suffered an acute myocardial infarction, who subsequently developed depressive disorders, the second group - 33 patients who also suffered a myocardial infarction, but without symptoms of depression. The research methods were: clinical-psychopathological, clinical-catamnestic, the reliability of the results was evaluated using the Student's criterion**.**

RESULTS AND DISCUSSION
When describing the clinical features of depressive disorders in patients in the post-infarction period, it is necessary to note the selected variants of depression: anxiety (77.3%), melancholic (11.2%), dysphoric (4.8%), masked (6.7%). Regardless of the variant of depression in the conversation, patients primarily complained of pressing, compressing pain behind the sternum, radiating to the characteristic zones, and aching, stabbing in the left half of the chest. Patients expressed concerns about their physical condition, pain, and prospects for the future. From the subjective complaints indicating depressive disorders, depression, loss of strength, and a sense of hopelessness are noted. The same frequency of experiences reflected the fear of a repeat heart attack, pessimistic views on the future, and low self-esteem. Persons with higher education are more common in group 2 of the examined (72.7%), secondary special education is more typical for patients of group 1 (45.4%). Obviously, it matters that a person who is engaged in

mental work does not think about possible job loss, while a person who is engaged in more physical work is forced after a myocardial infarction to limit the load and change activities, which leads to a decrease or change of qualifications and can change not only the habitual rhythm of life of the patient, but also indirectly affect material prosperity. This is also confirmed by the fact that the cause of depression in patients with myocardial infarction in most cases (81.8%) is a real somatic disease (table 1).

Table № 1: The reasons for the development of depression.

The reasons for the development of depression	1 group	
	Abc	%
Absent	0	-
Psychological trauma	14	15,9±3,90
Real somatic disease	72	81,8±4,11
Physical exertion	0	-
The mental strain	2	2,3±1,60
Mental illness	0	-
Total	88	100

The onset of depression in the first days after a myocardial infarction (40.9% - within 1-7 days, 37.5% - within 8-30 days) confirms the idea that for a patient, the diagnosis of a myocardial infarction and the associated change in attitude to themselves, their habitual active life, is the most serious psychotraumatic factor. Obviously, the work of an internist, cardiologist in the early post-infarction period should be aimed at overcoming the stigma about the severity of a myocardial infarction, at developing a rational understanding of the disease, the possibility of a logical rethinking of life after a myocardial infarction.

Comorbidity of myocardial infarction and depression resulting from a heart attack affects the ability to work of patients (table 2). Thus, 27.3% of group 1 patients and 69.7% of group 2 patients ($p<0.001$) have reduced working capacity, while disability is significantly more common in group 1 patients (52.3% and 9.1% of patients ($p<0.001$), respectively). This can serve as an obvious proof of the negative impact of the joined depression on the social and labor adaptation of patients.

Table № 2: Working capacity of patients.

Working capacity	1 group		2 group		P
	abc	%	abc	%	
Conserved	18	20,4+-4,30	7	21,2±7,15	
Reduced	24	27,3+-4,75	23	69,7±7,80	0,001
Lost	46	52,3+-5,32	3	9,1±5,01	0,001
Increased	0	-	0	-	
total	88	100	33	100	

Due to the loss of working capacity, 30.7% of patients in group 1 and 57.6% of patients in group 2 ($p<0.01$) lost their qualifications, while 35.2% of patients in group 1 and 6.1% of patients in group 2 ($p<0.001$) were unable to continue working due to the loss of qualifications (table 3).

Table № 3: Qualification of patients after myocardial infarction.

Qualification	1 group		2 group		P
	abc	%	abc	%	
Former	16	18,2+-4,11	4	12,1±5,68	
Reduced	27	30,7+-4,92	19	57,6±8,60	0,01
Loss	31	35,2+-5,09	2	6,1±4,17	0,001
Change	14	15,9+-3,90	8	24,2±7,46	
total	88	100	33	100	

It should be noted that patients of group 2 more often changed their qualifications and type of activity in order to maintain their working capacity (15.9% of patients of group 1 and 24.2% of patients of group 2), while patients of group 1 preferred not to work.

Thus, for the majority of patients with myocardial infarction, the very fact of having a severe somatic disease is the cause of the development of depressive disorders, among which anxiety depressions are more common. Comorbidity of myocardial infarction and depression leads to a decrease in the ability to work and activity of patients.

CONCLUSIONS

1. It is necessary to optimize the provision of specialised (psychiatric) care for patients with myocardial infarction.
2. in the early post-infarction period, work with the patient should be aimed at overcoming the stigma about the severity of the myocardial infarction, at developing a rational understanding of the disease.
3. it is Important to organize modern psychiatric consultation services in cardiological hospitals, as well as to develop educational programs on clinical psychiatry and psychopharmacotherapy for cardiologists, cardiac surgeons and other specialists.

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