THE ROLE OF NURSING STAFF IN THE REHABILITATION OF PATIENTS WITH BRONCHIAL ASTHMA

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Abstract. *A more detailed and accurate clinical picture of asthma was described by Aretheus of Cappadocia (1st century AD) in his essay "On the Causes and Symptoms of Chronic Diseases", devoting a separate chapter to it. Areteus in his essay described two forms of the disease, accompanied by difficulty in breathing, noting that one of them, characterized by orthopnea, is associated with heart disease; the second, provoked by cold moist air and accompanied by spastic difficulty in breathing and wheezing, is a disease of the lungs—thus. Aretaeus divided asthma into two forms: cardiac and bronchial. Claudius Galen, who wrote, among other works, the work "On Difficulties in Breathing" (lat. De difficultate respirationis), adhered to the Hippocratic approach to explaining the causes of asthma, explaining them by the accumulation of viscous sputum in the bronchi and, following Areteus, accepting the division of asthma into two forms.*

Keywords: *asthma, disease, communication, chronic, sputum.*

РОЛЬ СРЕДНЕГО МЕДИЦИНСКОГО ПЕРСОНАЛА В РЕАБИЛИТАЦИИ БОЛЬНЫХ БРОНХИАЛЬНОЙ АСТМОЙ

Аннотация. *Более подробную и точную клиническую картину астмы описал Аретей Каппадокийский (I в. н.э.) в своем сочинении «О причинах и симптомах хронических болезней», посвятив ей отдельную главу. Аретей в своем сочинении описал две формы болезни, сопровождавшиеся затруднением дыхания, отметив, что одна из них, характеризующаяся ортопноэ, связана с пороком сердца; второй, провоцируемый холодным влажным воздухом и сопровождающийся спастическим затруднением дыхания и хрипами, является заболеванием легких, т. е. Aretaeus разделил астму на две формы: сердечную и бронхиальную. Клавдий Гален, написавший, в числе прочих работ, труд «О затруднениях дыхания» (лат. de hardate respirationis), придерживался гиппократовского подхода к объяснению причин астмы, объясняя их скоплением вязкой мокроты в бронхах и, вслед за Аретеем, приняв разделение астмы на две формы.*

Ключевые слова: *бронхиальная астма, заболевание, связь, хронический, мокрота.*

INTRODUCTION

Ibn Sina (X-XI centuries) in the "Canon of Medicine" gave a description of asthma close to hippocratic - as a chronic disease, accompanied by sudden attacks of suffocation, similar in their spastic character to epileptic seizures, "Canon" by Ibn Sina translated by Gerard of Cremona into Latin spread in medieval Europe and became one of the main texts used for medical education in Italy throughout the Middle Ages and the Renaissance. Until the middle of the 18th century, quite little attention was paid to this disease, apparently, the doctors of that time did not single out asthma attacks in patients in any one disease. The German scientists Kurshman

and Leiden made a great contribution to the study of asthma in modern times. It was they who systematized and described the clinical manifestations of asthma, highlighting a number of cases of sudden suffocation as a separate disease. Unfortunately, the technical level of that time did not allow to effectively deal with the disease, and unequivocally establish its cause.

MATERIALS AND METHODS

At the beginning of the 20th century, the allergic theory of bronchial asthma was created. It belonged to the Russian scientists Manoilov and Golubev. The first documented use of adrenaline in the treatment of bronchial asthma dates back to 1905. Soviet scientists A.D. Ado and P.K. Bulatov in 1969 were the first to propose a classification of bronchial asthma according to the causes of its occurrence. Oral corticosteroids began to be used in the 1950s, short-acting selective β2-agonists came into wide use in the 1960s. Currently, bronchial asthma has become widespread due to allergens and stress.

RESULTS

The prevalence of bronchial asthma in the world is from 4 to 10%. According to statistics, about 10% of the adult population and 15% of children suffer from asthma in Russia, and in recent years the situation has worsened even more, the frequency of asthma and the severity of its course have increased. According to some reports, the number of people with bronchial asthma has doubled over the past 25 years.

DISCUSSION

Healthy parents practically do not threaten their children with anything, the risk of developing asthma in a child is only 20% (in official medicine, this is considered a normal risk). But if at least one parent is sick in the family, then the risk of childhood illness increases to 50%. when both mother and father are sick, in 70 cases out of 100, the child gets sick. Already at the very beginning of the 21st century, the mortality rate in the world compared to the 90s increased by 9 times! And about 80% of childhood deaths due to bronchial asthma occur between the ages of 11 and 16! Regarding the age at which they begin to get sick: more often the onset of the disease occurs in children under 10 years old - 34%, from 10 to 20 years old - 14%, from 20 to 40 years old - 17%, from 40 to 50 years old - 10%, from 50 - 60 years old - 6%, older - 2%. Often the first attacks of the disease begin in the first year of life. Bronchial asthma in children in early childhood is unusual, often mistaken for whooping cough, bronchopneumonia, bronchoadenitis (primary tuberculous bronchial lymphadenitis in children). In the Krasnodar Territory, more than 30 thousand people suffer from bronchial asthma, of which 7.5 thousand are children. The prevalence of the disease in different countries varies widely. The largest number of cases in Scotland - 18.4% of the total population suffers from bronchial asthma. The lowest is in Macau[50] - 0.7% of the diseased of the total population. The prevalence of the disease in the United States is 5%. In the Krasnodar Territory, 3% of the total population suffer from bronchial asthma.

CONCLUSIONS

There are a number of risk factors that contribute to the onset and development of asthma in certain individuals.

Heredity. Much attention is paid to the genetic factor. Cases of concordance are described, that is, when both of the identical twins were ill with bronchial asthma. Often in clinical practice there are cases of asthma in children whose mothers are sick with asthma; or cases in several generations of the same family. As a result of clinical and genealogical analysis,

it was found that in 1/3 of patients the disease is hereditary. There is a term atopic bronchial asthma - allergic (exogenous) bronchial asthma, which is hereditary. In this case, if one of the parents has asthma, the probability of asthma in the child is 20-30%, and if both parents are sick, this probability reaches 75%. The PASTURE study, which observed the development of atopy in newborns in farmers' families and in monozygotic twins, showed that, despite a genetic predisposition, the development of the disease can be prevented by eliminating provoking allergens and by correcting the immune response during pregnancy. Norwegian scientists (Matthias Wjst et al.) found that the place and time of birth do not affect the formation of allergic reactions and bronchial asthma.

Professional factors. The effect of biological and mineral dust, harmful gases and fumes on the occurrence of respiratory diseases was studied in 9144 people at 26 centers in the ECRHS study. Women mainly contacted with biological dust, and men 3-4 times more often than women with mineral dust, harmful gases and fumes. Chronic cough with sputum production more often occurred in people who were in contact with harmful factors; it is in this population that cases of first-time bronchial asthma have been recorded. Over time, nonspecific bronchial hyperreactivity in people with occupational asthma does not disappear, even with a decrease in contact with a harmful occupational factor. It has been established that the severity of occupational asthma is mainly determined by the duration of the disease and the severity of symptoms, and does not depend on age, gender, harmful occupational factors, atopy, or smoking.

environmental factors. The 9-year epidemiological study ECRHS-II, which included 6588 healthy individuals exposed during the specified period to a number of adverse factors (exhaust fumes, smoke, high humidity, harmful fumes, etc.), showed that 3% of those observed at the end of the study had complaints corresponding to the defeat of the respiratory system. After a statistical analysis of demographic, epidemiological and clinical data, it was concluded that 3 to 6% of new cases of the disease are provoked by exposure to pollutants.

Food. Studies in France, Mexico, Chile, Great Britain, Italy on the influence of diet on the course of the disease showed that people who consume plant products, juices rich in vitamins, fiber, antioxidants have a slight tendency to a more favorable course of bronchial asthma, while how the consumption of animal products rich in fats, proteins and refined easily digestible carbohydrates is associated with a severe course of the disease and frequent exacerbations.

Microorganisms. For a long time there was an idea about the existence of asthma of an infectious-allergic nature (classification by Ado and Bulatov).

triggers. Triggers, that is, factors that cause asthma attacks and exacerbation of the disease, are allergens for exogenous bronchial asthma and NSAIDs for aspirin bronchial asthma, as well as cold, strong odors, physical stress, and chemical agents.

Allergens. Most allergens are found in the air. These are plant pollen, microscopic fungi, house and library dust, exfoliating epidermis of house dust mites, hair of dogs, cats and other domestic animals. The degree of reaction to the allergen does not depend on its concentration. Some studies have shown that exposure to mite, house dust, cat and dog dander, and Aspergillus allergens causes sensitization to these allergens in children under 3 years of age. The relationship between allergen exposure and sensitization depends on the type of allergen, dose, duration of exposure, age of the child, and possibly genetic predisposition.

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