комбінаті перевищує середнє (1388,62±70,9) за кількістю випадків і високим (106,15±4,34) за кількістю днів непрацездатності на 100 робітників за шкалою Л.Є. Боткіна характеризується як вищий за середній та високий відповідно. В структурі захворюваності найбільшу питому вагу мають захворювання органів дихання, травми, захворювання кістково-м'язової системи. Проведені дослідження доводять необхідність встановлення динамічного нагляду, моніторингу за станом здоров'я кожного конкретного працівника з метою своєчасного виявлення початкових проявів професійного захворювання та обов'язкового проведення відновлювального лікування з метою збереження працездатності працівника у своїй професії, що відкриває перспективи для подальших наукових досліджень, спрямованих на розроблення та впровадження профілактичних заходів.

Ключові слова: умови праці, захворюваність, видобування та переробка залізної руди, гірничо-металургійний комплекс.

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1388,62±70,9 дней нетрудоспособности на 100 работающих, который по шкале Л. Е. Ноткина характеризуется как выше среднего и высокий соответственно. В структуре заболеваемости наибольший удельный вес имеют болезни органов дыхания, травмы, болезни костно-мышечной системы. Проведенные исследования доказывают необходимость установления динамического надзора, мониторинга за состоянием здоровья каждого конкретного работника с целью своевременного выявления начальных проявлений профессионального заболевания и обязательного проведения восстановительного лечения с целью сохранения трудоспособности работника в своей профессии, что открывает перспективы для дальнейших научных исследований, направленных на разработку и внедрение профилактических мероприятий.

Ключевые слова: условия труда, заболеваемость, добыча и переработка железной руды, горно-металлургический комплекс.

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FOCUS ON SLEEP PROBLEMS IN PATIENTS WITH SOMATOFORM DISORDERS

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One of the most important non-specific symptoms of the somatoform disorders is sleep disturbance. The existence of direct correlations between the intensity of pain and other unpleasant bodily sensations and the duration and intensity of sleep disturbances has been proved. The purpose of the study was to analyze the sleep function in patients suffering from somatoform disorders and to develop a complex medical care system for such patients. 96 outpatient subjects with a diagnosis of somatoform disorder (F.45 by ICD-10) were examined. The list of Robbins symptoms was used for a clinical evaluation; Hamilton Rating Scale for Depression was used to assess the emotional state of patients. Ananalysis of the presence and intensity of sleep disorders was conducted on the Pittsburgh Sleep Quality Index. Patients received SSRI antidepressants as a basict herapy. Patients of the treatment group were additionally treated with cinazepam. A significant improvement in sleep quality from the therapy beginning in patients from the treatment group receiving combined treatment (SSRI antidepressants and cinazepam) was showed, which correlated with a significant decrease in the intensity of depressive symptoms in this group. The combined use of SSRI antidepressants and cinazepam significantly affects the rate of reduction of sleep disorders, unpleasant somatic sensations, as well as symptoms of mental and somatic anxiety, reduces the severity of depressive-hypochondriac symptoms, improves mood and quality of life of patients with somatoform disorders.

Keywords: somatoform disorders, depressive symptoms, sleep disturbances

Physical symptoms are considered to be the primary reason why patients seek medical assistance and consult primary medical care specialists. However, at least 30% of physical symptoms cannot be explained by physiological disturbances, and 20-25% of patients are diagnosed with these symptoms constantly in the course of a lifetime [5, 9, 11, 15]. Neurotic spectrumdiseases, in which somatoform disorders are often diagnosed, belong to one of the most common causes of such state. By various estimates, prevalence of somatoform disorders in the world is 1-2% of overall population (APA, 2004). Nowadays, authors point at essential classification differences in DSM-V and ICD-10 regarding nosological categories and diagnostic criteria when diagnoses are related to the group of somatoform disorders [8, 16, 18, 19]. However, there are several common clinical features among patients, such as: the presence of persistent, long-lasting unpleasant bodily sensations of various intensity and nature in a patient, which cannot be explained by somatic causes and which come with the feeling of anxiety and various disorders of autonomic nervous system (tachycardia, tremor, excessive perspiration, etc.), leading to lowering of social functioning and deterioration of the patient's life quality [4]. One of the most important nonspecific symptoms belonging to the group of somatoform disorders (clinicians not always give enough attention to it) is sleep disturbance [1, 6, 7]. Interconnection between unpleasant physical sensations and sleep disturbance is one

of the most important research issues during the past decades. In particular, it has been proved that sleep problems of various natures are observed among 80-90% of patients with chronic pain symptoms; besides, there are direct correlation relationships between intensity of pain or other unpleasant bodily sensations and sleep disturbance duration as well as its intensity [2, 5, 6, 12]. Certain researches prove that insomnia symptoms may essentially increase the risk of chronic pain syndrome development among the people who earlier did not suffer from this disorder [6]. Among other things that cause the abovementioned changes is impairment of endocrine regulation of hypothalamic-pituitary-adrenal system, influencing bodily sensations and general well-being of a person. It has been proved that insomnia causes substantial impairments primarily in cortisol and ACTH secretion, in particular high level of these hormones at night and in the early morning among the patients with sleep disturbance as compared to the people with satisfactory quality and duration of sleep [2, 9, 11]. A number of studies have shown that cortisol secretion imbalance at night and in the early morning is a possible predictor of unpleasant bodily sensations, especially pain sensations of various geneses including chronic pain that not always has a visible clinical cause [17]. Therefore, high level of cortisol may be observed both due to anxiety level growth, occurring along with somatoform disorders, and impairment of cortisol regulation in cases of insomnia [4, 17]. Thus, it is necessary to carry out more thorough and detailed study of sleep function in patients with somatoform disorders; and if deviations are revealed, there is a necessity to apply a multidimensional approach to the treatment of such states, one of the aspects of which is sleep management in the given patient population [5, 6, 12, 14].

The purpose of the work was to study of sleep function in patients suffering from somatoform disorders; to develop an integrated system of medical care for such patients.

Materials and methods. According to the principles of clinical studies and with due account for ethical approaches, we examined 96 outpatients subjects diagnosed with somatoform disorder (F.45) according to ICD-10 classification. Among them 68 people (at the ages from 23 to 52, men and women) with clinical features of sleep disturbances conformed to inclusion criteria. According to nosological parameters 38 patients (55, 9%) were diagnosed with undifferentiated somatoform disorder (F45.1), and 30 (44, 1%) – with somatoform autonomic dysfunction (F45.3). According to clinical psychopathological examination, it was established that patients of the studygroup expressed anxiety and depression.

Clinical prevalence and frequency of patients' complaints is presented in Table 1. Symptoms from the "Robbins list" were used in order to collect and integrate the data for somatoform disorder assessment. Robbins et al. [13] explored 23 symptoms associated with functional syndromes. These symptoms are clustered into five syndromes: pain, fatigue, irritablebowel, somatic symptoms of anxiety, and somatic symptoms of depression.

Table 1.

Frequency and prevalence of somatic symptoms among the patients under study

Symptoms	F45.1		F45.3	
	N= 38	%	N=30	%
Back pain	12	31.6	5	16. 7
Joint pain	10	26.3	3	10.0
Extremity pain	13	34.2	7	23.3
Headaches	21	55.3	12	40.0
Weakness	26	68.4	14	46. 7
Fatigue	30	78.9	24	80.0
Sleep disturbance	38	100.0	30	100.0
Difficulty concentrating	25	65.8	14	46.7
Loss of appetite	21	55.3	8	26. 7
Weight change	22	57. 9	12	40.0
Restlessness	36	94.7	26	86. 7
Slowdown of thinking	17	44.7	14	46.7
Chest pain	14	36.8	7	23.3
Shortness of breath	9	23.7	8	26.7
Palpitation	7	18.4	11	36.7
Dizziness	16	42.1	17	56.7
Lump in throat feeling	8	21.1	8	26.7
Numbness	7	18.4	6	20.0
Nausea	4	10.5	6	20.0
Diarrhea	3	7. 9	5	16.7
Bloating and/or hyperperistalsis	7	18.4	12	40.0
Constipations	7	18.4	7	23.3
Abdominal pain	19	50.0	3	10.0

As reflected by the represented data, in case of undifferentiated somatoform disorder the most common symptoms were pain sensations with various localizations, difficulties concentrating, chronic fatigue, appetite disorders and weight changes. In patients with somatoform autonomic dysfunction complaints of autonomiccharacter prevail, particularly palpitation, dizziness, epigastric discomfort with chronic fatigue, concentration difficulties, intense feeling of inner restlessness. All patients had sleep disorders.

In order to assess patients' emotional state Hamilton Rating Scale for Depression (HRDS) [10] was used, as it allows to clinically rate the severity of depression and its dynamics in the course of treatment. Main items of the scale foresee the assessment of depressive symptoms: mood, feeling of guilt, suicidal intentions, insomnia (including separate assessment of initial, mild and delayed insomnias), performance capability, retardation, agitation, psychic and somatic anxiety, gastrointestinal, general somatic and genital symptoms, hypochondria, weight loss, and assessment of the patient's critical view towards his/her disease. Data interpretation according to HRDS scale is the following: 0-13 points – normal (no depression), 14-17 points – mild depression, 18-25 points – moderate depression, more than 25 points – severe depression.

All the patients enrolled in study were divided into two groups, depending on the therapy schema: treatment group – TG (n=36) and control group – CG (n=32), both equal in socio-demographic, clinical and psychopathologic characteristics (according to HRDS, the patients' condition corresponded to mild depression). TG wasconsisted of 24 patients with undifferentiated somatoform disorder (66.7%) and 12 patients with somatoform autonomic dysfunction (33.3%). CGwas consisted of 16 patients with undifferentiated somatoform disorder and 16 patients with somatoform autonomic dysfunction (50% and 50% accordingly). All patients took antidepressants from selective serotonin reuptake inhibitor (SSRI) group – paroxetine in an average dose of 20 mg per day, citalopram in an average dose of 20 mg per day, escitalopram in an average dose of 10 mg per day. TG patients additionally took cinazepam in a dose of 2 mg at bedtime for 10 days.

Results of the study and their discussion. At baseline patients of both groups were commensurable on clinical symptoms and average assessment of symptoms according to HDRS, which was 15, 44±0,27 points in the treatment group and 15. 31±0.22 points in the control group(p>0.05).

Clinical psychopathologic patientsexamination was carried out on the 5th, 7th, 10th, 14th and 28th days of treatment. Assessment of patients' emotional state was carried out before the treatment initiation and in dynamics – on the 7th, 14th and 28th days of treatment. Clinical examination of the treatment group revealed sleep quality improvement, particularly falling asleep and sleep duration on the 5th day of study. Besides, patients from the treatment group pointed out lowering of anxiety symptoms. Dynamics of changes in the emotional state of patient population is graphically presented in fig. 1.
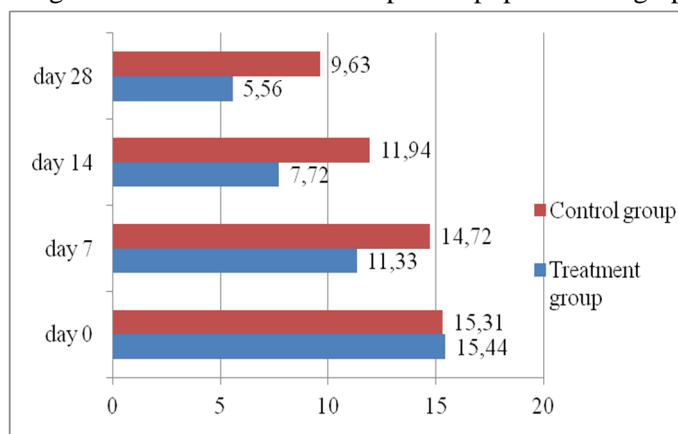

Fig. 1. Dynamics of depressive symptoms in patients of both treatment and control groups according to Hamilton Scale (HDRS)

Analysis of finding data made it clear that reduction of depression severity according to HDRS in patients from the treatment group after 7 days since treatment initiation was significant (15.44±0.21 to 11.33 ± 0.35, p<0.05) while patients from the control group did not show significant improvements (15.31±0.22 to 14.72±0.22, p>0.05).

Significant improvement in the patients from control group was revealed on the 14th day of treatment (15.31±0.22 to 11.94±0.33, p<0.05). We also compared depression severity according to HDRS in both groups on the 14th and 28th days of treatment; the revealed data indicate significant improvement in patients from the treatment group as compared to patients from the control group. Therefore, on the 14th day the following difference in assessment was revealed: 7.72±0.41(treatment subjects) versus 11.94±0.33 (control subjects), p<0.05. On the 28th day the difference was the following: 5.56±0.49 (treatment group) versus 9.63±0.43 (control group), p<0.05. Generally, improvement as compared to the initial condition in patients from the treatment group was 64.0%, and in patients from the control group– 37.1% accordingly.

Presence and intensity of sleep disturbance were defined by The Pittsburgh Sleep Quality Index– PSQI [3], which makes it possible to analyze quality, duration and efficiency of sleep. It consists of 19

items, characterizing seven components: subjective sleep quality, sleep latency, sleep duration, sleep efficiency, sleep disturbances, use of sleeping medication, and daytime dysfunction. Each component is scored 0 to 3 points with a total score of 0 to 21. Higher scores indicate worse sleep quality. Total score PSQI > 5 indicates poor sleep quality and considerable difficulties at least in two areas or moderate difficulties more than in three areas. Examination of sleep quality index (PSQI) in our work was carried out on day 0 (for screening purposes) and on the 28th day (in order to compare total sleep index and its separate categories). Outcome data are presented in table 2.

Table 2

Sleep quality index value PSQI (М±м) and its dynamics in the course of research

No.	Category	Basic group (n=36)		Control group (n=32)	
		Day 0	28th day	Day 0	28th day
1.	General sleep quality	1.74±0.23	0.11±0.01	1.71±0.15	1.94±0.32
2.	Sleep latency	1.69±0.37	0.18±0.03	1.74±0.24	1.12±0.15
3.	Sleep duration	1.62±0.28	0.21±0.02	1.54±0.16	0.63±0.06
4.	Sleep efficiency	1.91±0.26	0.14±0.02	1.84±0.28	1.72±0.26
5.	Sleep disturbances	1.37±0.21	0.12±0.02	1.57±0.22	0.57±0.06
6.	Use of sleeping medication	0.04±0.01	0.04±0.01	0.18±0.02	0.64±0.03
7.	Daytime dysfunction	2.16±0.29	0.17±0.02	2.25±0.34	1.04±0.17
8.	Total score	10.53±0.24	0.97±0.03*.**	10.83±0.21	7.66±0.15*

Note: *$p \leq 0.05$- as compared to the initial value (day 0), ** $p \leq 0.05$- as compared to the control group values

The results obtained prove the presence of sleep disorders in patients from the study groups, and what is more, the groups were commensurable in terms of quantitative and qualitative values (day 0). Sleep quality index value (PSQI)fortreatment group was 10.53±0.24 scores, for control group 10.83±0.21 scores (p>0.05).35.3% of patients (24 patients) marked subjective sleep quality as "very bad", 58.8% of cases (40 patients) – as "fairly bad", 5,9% (4 patients) – as "fairly good". More than half of patients (54.4% – 37 patients) noted sleep latency of more than 3 hours every night, an average sleep duration of the patient population was 6.2±0.25 hours. Sleep efficiency was defined as a ratio of a number of hours slept to a number of hours spent in bed; according to this category, patient population slept on average 68.4% of total time in bed. According to the conducted survey, most common causes of sleep disturbances were sensations of pain (21.6%), cold or burning sensation (24.3%), shortness of breath (26.7%), nightmares (22.7%) and combination of symptoms when patients were not able to single out predominant symptoms (4.7%). At the beginning of the research only 17.7% (12 patients) were taking sleeping medication (these were mainly over-the-counter herbal medicinal products). Feeling sleepy and, as a consequence, low efficiency of daily daytime activity was the chief complaint of patients, and that considerably influenced the general state of patients. At the endpoint of the research (28th day) we observed significant improvement of sleep function in patients from the treatment group (by 90.8%); the result in the control group amounted to 29.3% as to the initial values.

Characteristics of sleeping disorders and their dynamics as a result of allocated therapy in patients from the study groups in the course of 14 days are illustrated in Table 3.

Table 3

Structure of sleep disorders and their on-treatment dynamics

Symptoms	Treatment group				Control group			
	Day 0		14th day		Day 0		14th day	
	n= 36	%	n= 36	%	n=32	%	n=32	%
Difficulties falling asleep	36	100.0	24	66.7	32	100	20	62.5
Insomnia	36	100.0	8	22.2	32	100	24	75
Late insomnia	30	83.3	8	22.2	24	75	22	68.75

Since the early days of therapy patients from the treatment group demonstrated significant improvement of sleep quality, and this was proved by clinical psychopathological examinations. As reflected by the represented data, patients from the treatment group noted significant improvement of sleep quality on the 14th day of therapy, which correlated to the significant lowering of depressive symptoms intensity in the given group.

An important aspect of the results of the conducted research is the detection of sleep dysfunctions in the patients with somatoform disorders as a key symptom that is in close correlation with physical symptoms and dysfunctions of the emotional state of patients from this group. Somatoform disorders and

their heterogenity was presented in several meta analysis reviews, and it was marked that in parallel with medically unexplained symptoms insomnia is more common than generally assumed [1, 5, 9, 19].

A comprehensive assessment of sleep in patients with somatoform disorders was conducted, basing on the use of algorithm for the diagnosis of sleep disturbances and psychometric scales, which allowed to study precisely the sleep characteristics of the patients from this group, which are: sleep quality, sleep duration, sleep efficiency, as well as subjective patient`s own assessment of sleep, as recommend by authors in Clinical Practice Guidelines for Sleep Disorders [7, 8,16].

Many different treatments options are now available to treat somatoform disorders. Edwards TM. et al. established that low dose antidepressant medication more effective for patient who fulfil the diagnostic criteria for somatoform disorders and noted that benzodiazepines are generally not useful [5]. There may be a small improvement in sleep quality with short-term use of low-dose doxepin and trazodone compared with placebo, as prowed by Everitt H. et al [6]. In another study authors focused on the task to distinguish between response and remission in insomnia patients taking hypnotics, however, magnitude of effect is mediated by underlying comorbidity and their treatments, with largest measures of effect seen in primary insomnia and lowest in depression and anxiety [12].

With the aim of correction sleep dysfunctions, cinazepam - a medication with a hypnotic effect – was included in the scheme of treating patients in addition to the generally accepted algorithm of pharmacological therapy. According to our study findings the complex therapy which included use of antidepressants from SSRI group and cinazepam showed a high effect in the reduction of sleep dysfunctions, as well as a significant improvement of somatic and emotional dysfunctions in treatment of somatoform disorders. We obtained the effectiveness of using cinazepam for treating comorbidity sleep disorders in complex treatment plan for somatoform disorders. Management of sleep disorders in coplex therapy of somatoform disorders with prescribing hypnotics are corresponds to the results of other researchers [4, 7, 14].

The obtained results indicate the expediency of a detailed and comprehensive examination of sleep characteristics in patients with somatoform disorder, as well as give reasons to recommend the use of benzodiazepine - cinazepam in the main scheme of treating somatoform disorders with sleep dysfunctions. Considering the received data it is to be noted that larger randomized controlled trials are needed to confirm cinazepam efficacy in treatment of somatoform disorders.

Understanding sleep problems in somatoform disorders and their treatment is challenging, but it will help to improve the management of somatoform disorders, increasing the quality of life in these patients. And detail clinical and diagnostic assessment is mandatory before starting the treatment.

Conclusion

The research has shown that sleep disorders are highly prevalent in patients suffering from somatoform disorders. Sleep dysfunctions, in particular its quality, duration and efficiency, have tight correlations with affective disorders in case of somatoform disorder as well as significant mutual influence on clinical features and course of disease, which has a large impact on the general well-being of patients with somatoform disorders.

Combined administration of antidepressants from SSRI group and cinazepam has a significant influence on the reduction speed of sleep disorders, unpleasant somatic sensations, as well as symptoms of mental and somatic anxiety, and consequently decreases severity of depressive hypochondriac symptoms, improves patients' mood and life quality.

This research opens the perspective for a future study of the influence of hypnotic medication on the sleep quality, somatic and emotional symptoms of the patients with somatoform disorders.

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Реферати

У ФОКУСІ ПРОБЛЕМИ ПОРУШЕНЬ СНУ У ПАЦІЄНТІВ ІЗ СОМАТОФОРМНИМИ РОЗЛАДАМИ
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Одним із найважливіших неспецифічних симптомів групи соматоформних розладів є порушення сну. Доведено існуваня прямих кореляційних зв'язків між інтенсивністю больових та інших неприємних тілесних відчуттів і тривалістю та інтенсивністю порушень сну. Метою дослідження було вивчення функції сну у хворих, що страждають на соматоформні розлади та розробка комплексної системи медичної допомоги таким пацієнтам. Обстежено 96 амбулаторних пацієнтів, з діагнозом - соматоформний розлад (F.45 за МКХ-10). Для клінічної оцінки симптоматики використано перелік симптомів Роббінса, для оцінки емоційного стану пацієнтів застосовано шкалу депресії M. Hamilton (Hamilton Rating Scale for Depression – HRDS), аналіз наявності та інтенсивності порушень сну проводився за Пітсбурзьким індексом якості сну - PSQI (The Pittsburgh Sleep Quality Index). Хворі основної та контрольної груп отримували антидепресанти з групи СІЗЗС. Пацієнти основної групи додатково отримували циназепам. У пацієнтів основної групи, які отримували комбіноване лікування антидепресантами СІЗЗС та циназепамом було виявлено значне покращення якості сну з перших днів терапії, яке корелювало із достовірним зниженням інтенсивності депресивної симптоматики в даній групі. Комбіноване застосування антидепресантів з групи СІЗЗС та циназепаму істотно впливає на швидкість редукції розладів сну, неприємних соматичних відчуттів, а також симптомів психічної і соматичної тривоги, зменшує вираженість депресивно-іпохондричної симптоматики, сприяє покращенню настрою та якості життя пацієнтів.

Ключові слова: соматоформний розлад, депресивна симптоматика, порушення сну

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В ФОКУСЕ ПРОБЛЕМЫ НАРУШЕНИЙ СНА У ПАЦИЕНТОВ С СОМАТОФОРМНЫМИ РАССТРОЙСТВАМИ
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Одним из важнейших неспецифических симптомов группы соматоформных расстройств является нарушение сна. Доказано существование прямых корреляционных связей между интенсивностью болевых и других неприятных телесных ощущений и продолжительностью и интенсивностью нарушений сна. Целью исследования было изучение функции сна у больных, страдающих соматоформными расстройства и разработка комплексной системы медицинской помощи таким пациентам. Обследовано 96 амбулаторных пациентов с диагнозом - соматоформное расстройство (F.45 согласно МКБ-10). Для клинической оценки симптоматики использовано перечень симптомов Роббинса, для оценки эмоционального состояния пациентов применялась шкала депрессии M. Hamilton (Hamilton Rating Scale for Depression - HRDS), анализ наличия и интенсивности нарушений сна проводился по Питтсбургскому индексу качества сна - PSQI (The Pittsburgh Sleep Quality Index). Больные основной и контрольной групп получали антидепрессанты из группы СИОЗС в качестве базисного лечения. Пациенты основной группы дополнительно получали циназепам. У пациентов основной группы, получавших комбинированное лечение антидепрессантами СИОЗС и циназепамом было обнаружено значительное улучшение качества сна с первых дней терапии, которое коррелировало с достоверным снижением интенсивности депрессивной симптоматики в данной группе. Комбинированное применение антидепрессантов из группы СИОЗС и циназепама существенно влияет на скорость редукции расстройств сна, неприятных соматических ощущений, а также симптомов психической и соматической тревоги, уменьшает выраженность депрессивно-ипохондрической симптоматики, способствует улучшению настроения и качества жизни пациентов.

Ключевые слова: соматоформные расстройства, депрессивная симптоматика, нарушения сна

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