

Фарид Исмагильевич Белялов



# Клинические рекомендации по психосоматике: кардиология

РЕГИОНАЛЬНЫЙ КОНГРЕСС РКО



РЕГИОНАЛЬНЫЕ  
КОНГРЕССЫ РКО

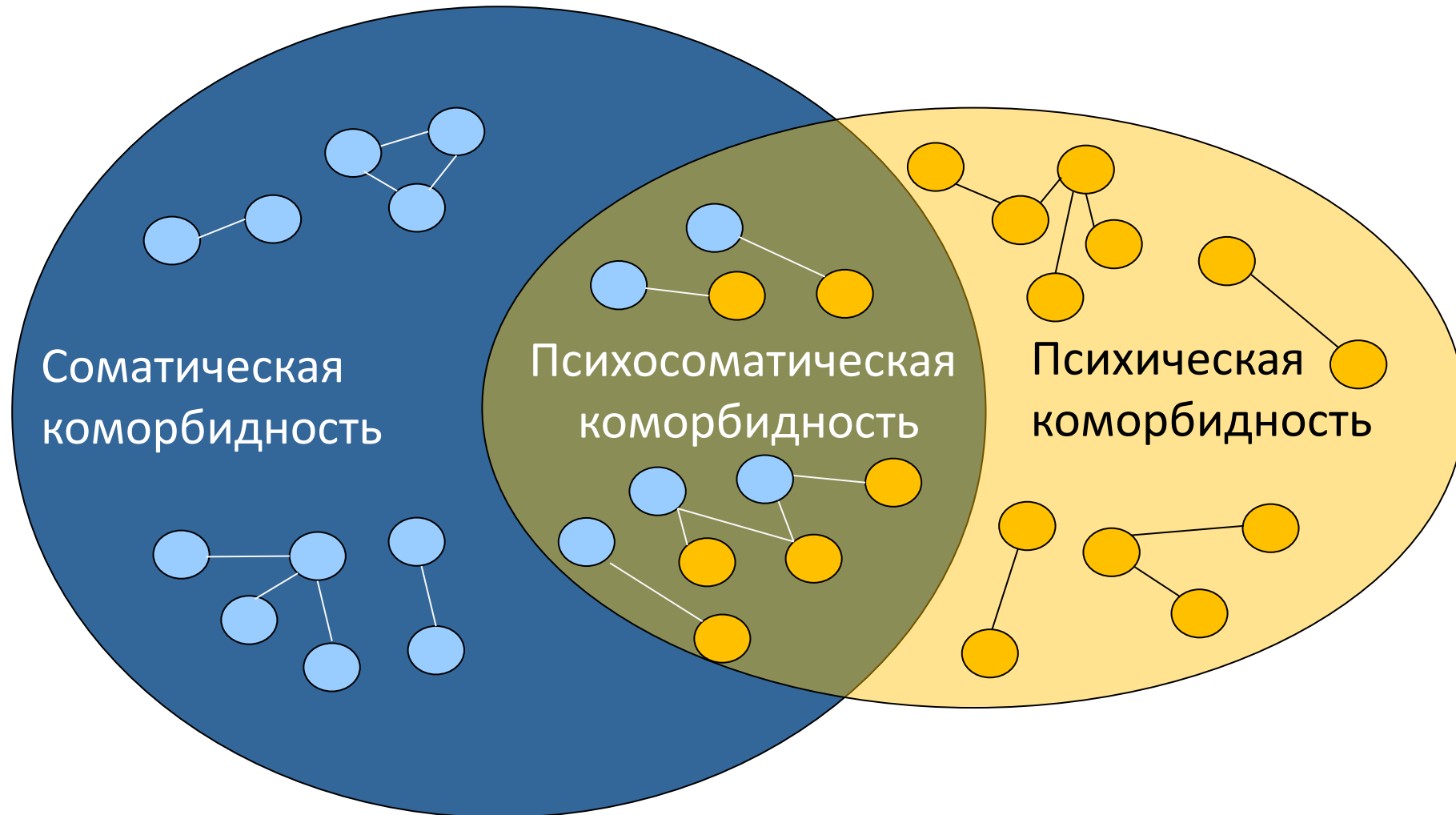
Кардиология, коморбидность и психосоматика 2022

10 ИЮНЯ 2022 ГОДА | ИРКУТСК



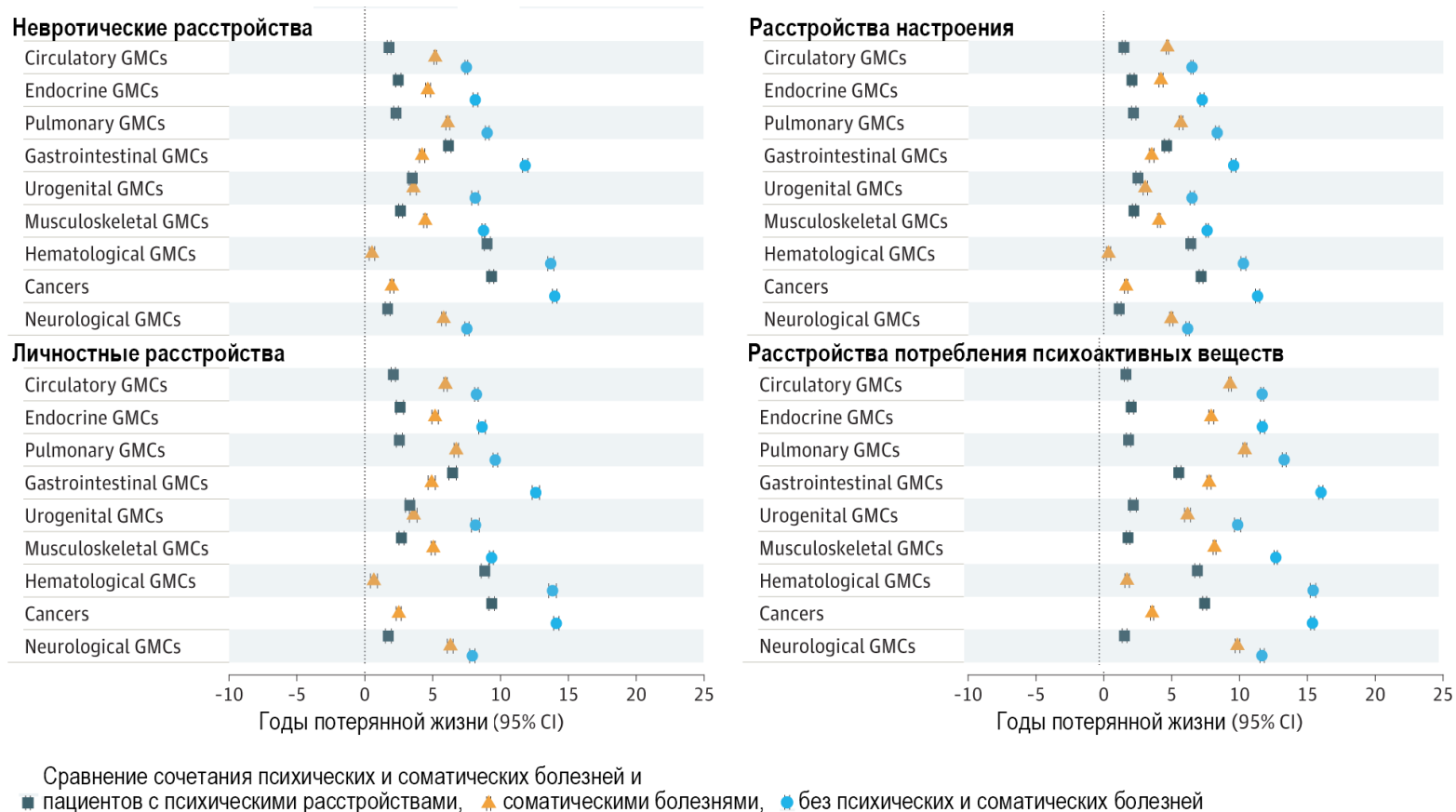
*Автор заявляет об отсутствии  
конфликта интересов*

# Виды коморбидности



**Психосоматическая коморбидность отражает более тяжелые системные расстройства**

# Соматические, психические болезни и годы потерянной жизни

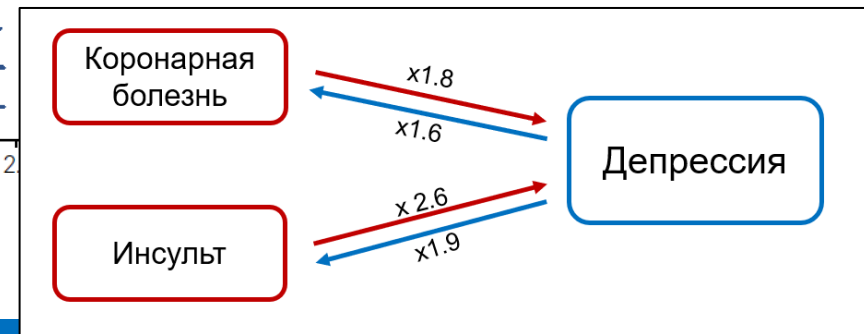
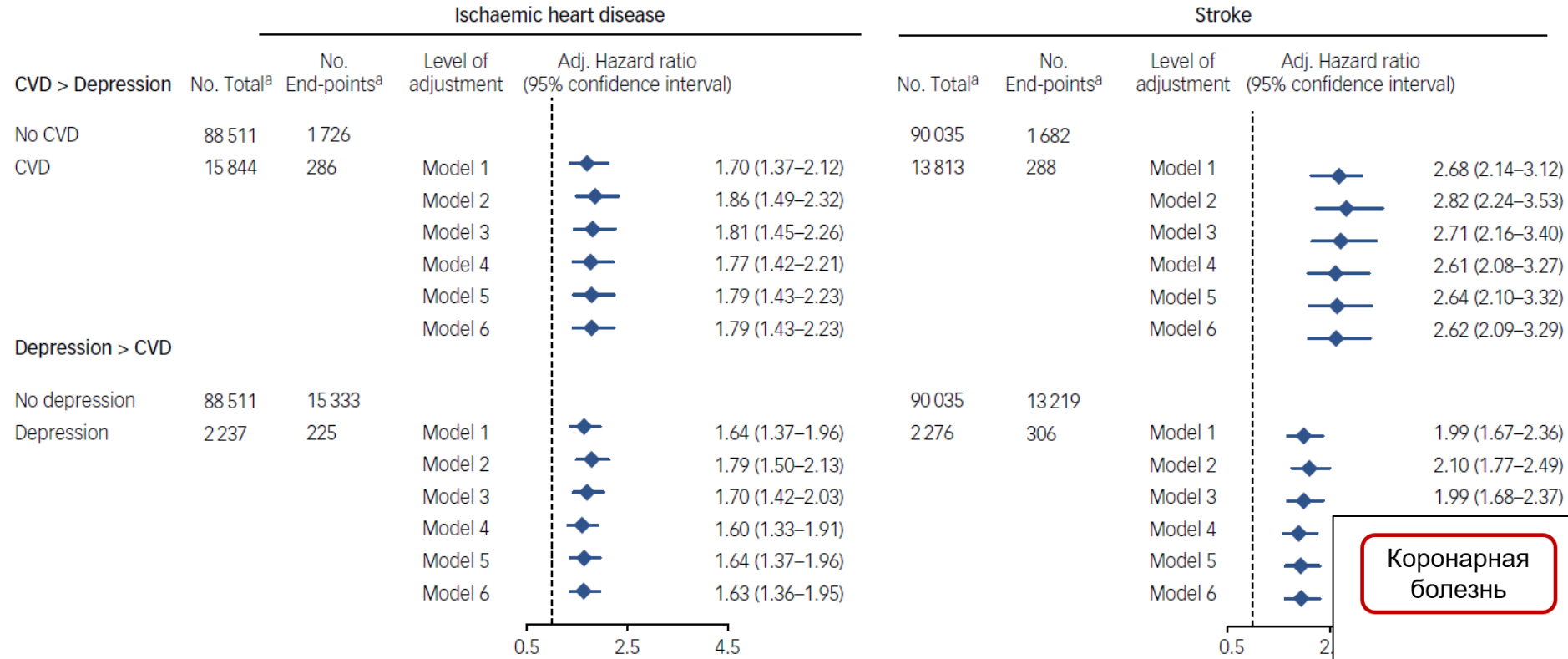


**Ожидаемая продолжительность жизни и выживаемость снижены у пациентов с коморбидными психическими и соматическими болезнями по сравнению с пациентами, у которых были только психические или соматические болезни**

## Наблюдательное исследование

Momen NC, et al. Mortality Associated With Mental Disorders and Comorbid General Medical Conditions. JAMA Psychiatry. 2022;79(5):444–453.

# Двунаправленные психосоматические связи



**Двунаправленные психосоматические связи и не объясняются традиционными факторами риска и стрессом**

# Рекомендации и позиции по психосоматике

## Медицина, общая практика

American College of Emergency Physicians (ACEP)  
American Psychiatric Association (APA)  
Canadian Network for Mood and Anxiety Treatments (CANMAT)  
National Institute for Health and Care Excellence (NICE)  
US Veterans Affairs/Department of Defense (VA/DoD)  
World Health Organization (WHO)  
**Байкальская психосоматическая ассоциация (БПА)**  
Ассоциация врачей общей практики/Национальная медицинская ассоциация по изучению сочетанных заболеваний

## Психиатрия

American Psychiatric Association (APA)  
Royal Australian and New Zealand College of Psychiatrists (ANZJP)

## Кардиология

American Academy of Family Physicians (AAFP)  
American Heart Association (AHA)  
American Psychiatric Association (APA)  
American Stroke Association (ASA)  
European Society of Cardiology (ESC)  
European Association of Preventive Cardiology (EAPC)  
European Society of Hypertension (ESH)  
European Psychiatric Association (EPA)  
International Society for Heart & Lung Transplantation (ISHLT)  
National Heart Foundation of Australia (NHFA)



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## 7. Family history

Major depressive disorder is one and one-half to three times as common among those with a first-degree biological relative affected with the disorder as in the general population. In addition, the rates of depression, anxiety, and other disorders are increased more than two- to six-fold in the offspring of depressed parents. A family history of depression is associated with an earlier age at onset of depression (790), and children of depressed parents are more likely to have depression with a chronic and recurrent course (791). Furthermore, a family history of recurrent major depressive disorder increases the chances that the patient's own illness will be recurrent and that the patient will not fully recover between episodes (792). A family history of bipolar I disorder, bipolar II disorder, or acute psychosis probably increases the chances that the patient's own major depressive disorder is a manifestation of bipolar rather than unipolar depression, and that antidepressant medication therapy may incite a switch to mania (793). Patients with such a family history should be questioned particularly closely regarding a prior history of mania or hypomania and should be carefully observed for signs of a switch to mania during treatment with antidepressant medication.

There are no real predictors of response to individual antidepressants, yet in the absence of other information clinicians sometimes rely on family history of therapeutic benefit to select a specific medication for a family member. Although it does not have specific support in the literature, this practice appears reasonable.

## C. TREATMENT IMPLICATIONS OF CO-OCCURRING GENERAL MEDICAL CONDITIONS

In patients with co-occurring medical conditions, there is a higher prevalence of major depressive disorder than in the general population. Furthermore, co-occurring medical conditions in patients with major depressive disorder are associated with poorer outcome (794, 795). A number of medical conditions are known to cause mood symptoms, such as stroke, hypothyroidism, carcinoma of the pancreas, and many others. Apart from directly causing depressive symptoms, debilitating, painful, and chronic medical conditions often constitute an ongoing stressor that predisposes patients to depressive episodes. Nevertheless, a depressive episode, in any context, is never a "normal" response to illness and consequently warrants treatment.

In addition to the increased risk of major depressive

such as heart disease. (796). Due to the interrelationship between depression and medical illness, it is very important to recognize and treat depressive symptoms in medically ill patients, and vice versa. The psychiatrist should also attend to the potential for interactions between antidepressants and the co-occurring medical conditions as well as any nonpsychiatric medications that the patient may be taking.

### 1. Hypertension

The presence of treated or untreated hypertension influences the choice of an antidepressant, as a few antidepressant medications have been associated with increased blood pressure. With SNRIs such as venlafaxine and desvenlafaxine, dose-dependent elevations in blood pressure are usually mild, although more severe hypertension has been observed (166, 797). However, another study found no increase in hypertension with duloxetine dosed at 80 mg/day (798). Hypertension induced by SNRIs may respond to a decrease in the medication dose, or an alternate antidepressant medication may be considered. Alternatively, for a patient with well-controlled depressive symptoms, it may be preferable to add an antihypertensive rather than risk a depressive relapse or recurrence with medication tapering.

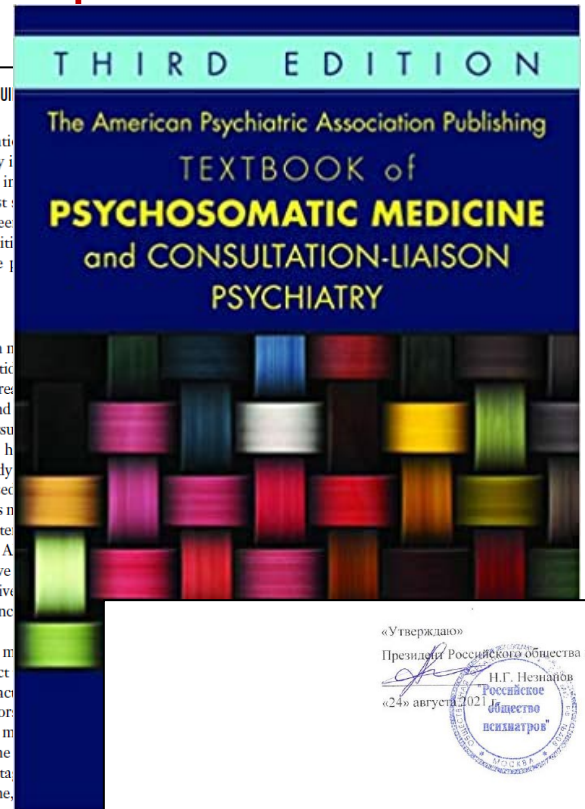
Antihypertensive agents and antidepressant medications may interact to either intensify or counteract the effect of the antihypertensive therapy (799). The action of antihypertensive agents that block alpha receptors (prazosin) may be intensified by antidepressant medications that block these same receptors, notably the tricyclics and trazodone. Tricyclic antidepressants may antagonize the therapeutic actions of guanethidine, clonidine, and pho-methyllopa. Concomitant antihypertensive treatment, especially with diuretics, increases the likelihood that TCAs, trazodone, or MAOIs will induce symptomatic orthostatic hypotension.

Side effects of antihypertensive agents, such as fatigue or sexual dysfunction, may also confound the evaluation and interpretation of depressive symptoms. It has also been thought that beta-blockers, especially propranolol, may account for depressive symptoms in some patients, but this association has been questioned (700, 701).

### 2. Cardiac disease

Depression increases the risk of cardiovascular disease (800). In addition, patients who are depressed following a myocardial infarction have an increased rate of mortality, compared with patients without depression (801–803).

APA PRACTICE GUIDELINE



«Утверждаю»  
Президиум Российского общества психиатров  
И.Г. Немайов  
Российское общество психиатров  
«24» августа 2021 г.

**Депрессивный эпизод, Рекуррентное депрессивное расстройство**

Кодирование по Международной статистической классификации болезней и проблем, связанных со здоровьем: F32/F33  
Возрастная группа: взрослые  
Год утверждения (частота пересмотра): 2021

## В отечественных рекомендациях РОП нет психосоматических разделов

APA. Treatment of Patients With Major Depressive Disorder. Am J Psychiatry. 2010;167(suppl):1-152.

APA Clinical Practice Guideline for the Treatment of Depression Across Three Age Cohorts. 2019. 82 p.

# Рекомендации кардиологических обществ

## 2019 ESC Guidelines for the diagnosis and management of chronic coronary syndromes

### The Task Force for the diagnosis and management of chronic coronary syndromes of the European Society of Cardiology (ESC)

**Authors/Task Force Members:** Juhani Knuuti\* (Finland) (Chairperson), William Wijns\* (Ireland) (Chairperson), Antti Saraste (Finland), Davide Capodanno (Italy), Emanuele Barbato (Italy), Christian Funck-Brentano (France), Eva Prescott (Denmark), Robert F. Storey (United Kingdom), Christi Deaton (United Kingdom), Thomas Cuisset (France), Stefan Agewall (Norway), Kenneth Dickstein (Norway), Thor Edvardsen (Norway), Javier Escaned (Spain), Bernard J. Gersh (United States of America), Pavel Svitil (Czech Republic), Martine Gilard (France), David Hasdai (Israel), Robert Hatala (Slovak Republic), Felix Mahfoud (Germany), Josep Masip (Spain), Claudio Muneretto (Italy), Marco Valgimigli (Switzerland), Stephan Achenbach (Germany), Jeroen J. Bax (Netherlands)

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### Стабильная ишемическая болезнь сердца. Клинические рекомендации 2020

Российское кардиологическое общество (РКО)

При участии: Национального общества по изучению атеросклероза (НОА), Национального общества по атеротромбозу (НОАТ), Ассоциации сердечно-сосудистых хирургов России (АССХ).

Одобрено Научно-практическим Советом Минздрава Российской Федерации

**Президиум Рабочей группы:** Барбараш О.Л., Карпов Ю.А., Кашталап В.В.\*, Бощенко А.А., Руда М.М.

**Члены Рабочей группы:** Акчурин Р.С., Алекаян Б.Г., Аронов Д.М., Беленков Ю.Н., Бойцов С.А., Болдуева С.А., Бубнова М.Г., Васюк Ю.А., Габинский Я.Л., Галявич А.С., Глезер М.Г., Голубев Е.П., Голухова Е.З., Гринштейн Ю.И., Давидович И.М., Ежов М.В., Карпов Р.С., Кореннова О.Ю., Космачева Е.Д., Кошельская О.А., Кухарчук В.В., Лопатин Ю.М., Миронов В.М., Марцевич С.Ю., Миролюбова О.А., Михин В.П., Недошивин А.О., Олейников В.Э., Панов А.В., Панченко Е.П., Перепеч Н.Б., Петрова М.М., Поздняков Ю.М., Протасов К.В., Савенков М.П., Самко А.Н., Скибицкий В.В., Соболева Г.Н., Шалаев С.В., Шапошник И.И., Шевченко А.О., Шевченко О.П., Ширяев А.А., Шляхто Е.В., Чумакова Г.А., Якушин С.С.





# Положения рекомендаций с классом и уровнем доказательств

sometimes at the expense of side-effects. Meta-analysis of medication-assisted weight loss found favourable effects on BP, glycaemic control, and ASCVD mortality.<sup>464</sup>

A very effective treatment option for extreme obesity or obesity with comorbidities is bariatric surgery. A meta-analysis indicated that patients undergoing bariatric surgery had over 50% lower risks of total ASCVD, and cancer mortality compared with people of similar weight who did not have surgery.<sup>465</sup>

#### 4.4. Mental healthcare and psychosocial interventions

**Recommendations for mental healthcare and psychosocial interventions at the individual level**

Recommendations	Class <sup>a</sup>	Level <sup>b</sup>
Patients with mental disorders need intensified attention and support to improve adherence to lifestyle changes and drug treatment. <sup>3,463</sup>	I	C
In ASCVD patients with mental disorders, evidence-based mental healthcare and interdisciplinary cooperation are recommended. <sup>100,113,466</sup>	I	B
ASCVD patients with stress should be considered for referral to psychotherapeutic stress management to improve CV outcomes and reduce stress symptoms. <sup>467–469</sup>	IIa	B
Patients with CHD and moderate-to-severe major depression should be considered for antidepressive treatment with an SSRI. <sup>470,471</sup>	IIa	B
In patients with HF and major depression, SSRIs, SNRIs, and tricyclic antidepressants are not recommended. <sup>472,473</sup>	III	B

ASCVD = atherosclerotic cardiovascular disease; CHD = coronary heart disease; CV = cardiovascular; HF = heart failure; SNRI = serotonin-norepinephrine reuptake inhibitor; SSRI = selective serotonin reuptake inhibitor.

<sup>a</sup>Class of recommendation.  
<sup>b</sup>Level of evidence.  
<sup>c</sup>Details explaining this recommendation are provided in the supplementary material section 2.1.

Treatment of an unhealthy lifestyle will reduce CVD risk as well as improve mental health. Smoking cessation, for instance, has a positive effect on depression outcomes,<sup>474,475</sup> as do exercise therapy<sup>113,476</sup> and healthy dietary practices.<sup>477</sup> Evidence-based interventions for smoking cessation, and improving PA and diet, are considered useful and applicable for persons with mental disorders.<sup>463,478–480</sup>

Mental disorders are associated with an increased risk of CVD and a worse prognosis in patients with ASCVD, due to CVD events or other death causes, including suicide.<sup>100,113,105</sup> Mental-health treatments effectively reduce stress symptoms and improve quality of life. Several observational studies indicate that treatment or remission of depression reduces CVD risk.<sup>113,481–484</sup> Psychological interventions in patients with CHD may reduce cardiac mortality (RR 0.79) and alleviate psychological symptoms.<sup>485</sup> Psychotherapy focusing on stress management in ASCVD patients improves CVD outcomes. In SUPRIMI (Secondary Prevention in Uppsala Primary Health Care project), patients in the intervention group had a 41% lower rate of

fatal and non-fatal first recurrent ASCVD events [hazard ratio (HR) 0.59] and fewer recurrent AMIs (HR 0.55).<sup>467</sup> In SWITCHD (Stockholm Women's Intervention Trial for Coronary Heart Disease), the intervention yielded a substantial reduction in all-cause mortality (OR 0.33).<sup>468</sup> A recent RCT reported that cardiac rehabilitation (CR) enhanced by stress management produced significant reductions in ASCVD events compared with standard CR alone (HR 0.49).<sup>469</sup> Concerning psychopharmacotherapy of patients with CHD and depression, selective serotonin reuptake inhibitor (SSRI) treatment lowers rates of CHD readmission (risk ratio 0.63) and all-cause mortality (risk ratio 0.56).<sup>470</sup> A recent RCT reported that, in patients with ACS and depression, treatment with the SSRI, escitalopram, resulted in a lower rate of the composite endpoint of all-cause mortality, myocardial infarction, or percutaneous coronary intervention (PCI) (HR 0.69).<sup>471</sup> Collaborative care for patients with CHD and depression has small beneficial effects on depression, but significantly reduces short-term major cardiac events.<sup>472</sup>

Concerning side-effects of psychopharmacological treatments, many psychiatric drugs are associated with an increased risk of sudden cardiac death.<sup>473</sup> In patients with HF, antidepressants are associated with increased risk of cardiac and all-cause mortality (HR 1.27; for details see supplementary material for section 4.4).<sup>472</sup> Therefore, ASCVD patients with complex mental disorders, and particularly those needing psychiatric drug treatment, require interdisciplinary

#### 4.5. Smoking intervention

**Recommendations for smoking intervention strategies**

Recommendations	Class <sup>a</sup>	Level <sup>b</sup>
All smoking of tobacco should be stopped, as tobacco use is strongly and independently causal of ASCVD. <sup>487,488</sup>	I	A
In smokers, offering follow-up support, nicotine replacement therapy, varenicline, and bupropion individually or in combination should be considered. <sup>489–494</sup>	IIa	A
Smoking cessation is recommended regardless of weight gain, as weight gain does not lessen the ASCVD benefits of cessation. <sup>495</sup>	I	B

ASCVD = atherosclerotic cardiovascular disease.  
<sup>a</sup>Class of recommendation.  
<sup>b</sup>Level of evidence.

#### 4.5.1. Smoking cessation

Stopping smoking is potentially the most effective of all preventive measures, with substantial reductions in (repeat) myocardial infarctions or death.<sup>487,488</sup> Lifetime gains in CVD-free years are substantial at all ages, and benefits are obviously even more substantial if other complications from smoking would be accounted for. From age 45 years, gains of 3–5 years persist in men to age 65 and in women to age 75 years (Figure 11). Even in heavy smokers (>20 cigarettes/day), cessation lowers CVD risk within 5 years, although it remains elevated beyond 5 years. Total health benefits will be even larger because of gain in non-CVD health.

## 4.4. Mental healthcare and psychosocial interventions

### Recommendations for mental healthcare and psychosocial interventions at the individual level

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In patients with HF and major depression, SSRIs, SNRIs, and tricyclic antidepressants are not recommended. <sup>472,473</sup>	III	B

- Пациентам с коронарной болезнью и умеренной/выраженной депрессией следует рассмотреть лечение СИОЗС (II A)



# Положения рекомендаций с классом и уровнем доказательств

## 3 National Heart Foundation of Australia grades of recommendation and levels of evidence for screening, referral and treatment for depression in patients with coronary heart disease (CHD)<sup>2</sup>

Recommendation	Grade <sup>2</sup>	Level <sup>2</sup>
1 For patients with CHD, it is reasonable to screen for depression	A	I
2 Treatment of depression in patients with CHD is effective in decreasing depression	A	I
3 Treatment of depression in patients with CHD improves CHD outcomes	D	II
4 Treatment of depression in patients with CHD changes behavioural risk factors/adherence	B	III-2
5 Exercise is an effective treatment of depression in patients with CHD	A	I
6 Exercise improves CHD outcomes in patients with CHD	B	II
7 Psychological interventions improve depression in patients with CHD	B	II
8 Psychological interventions improve CHD outcomes in patients with CHD and depression	D	II
9 SSRIs improve depression in patients with CHD	A	I
10 SSRIs improve CHD outcomes in patients with CHD and depression	D	III-1
11 Collaborative-care approach improves depression in patients with CHD	B	II
12 Collaborative-care approach improves CHD outcomes in patients with CHD and depression	D	II

SSRIs = selective serotonin reuptake inhibitors.



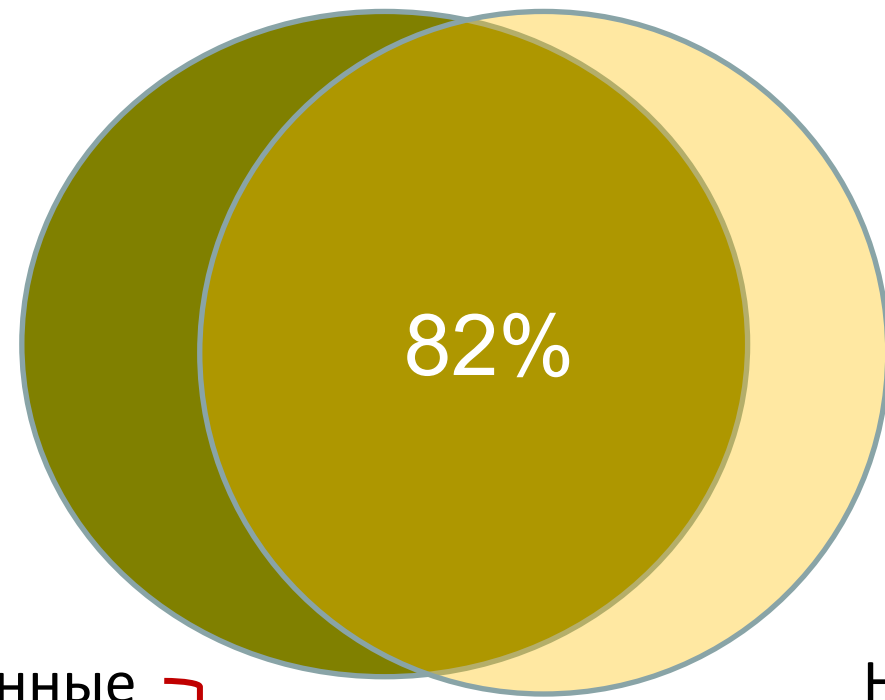
## 4 Treatment of depression in patients with coronary heart disease (CHD) – summary of treatment subgroup effects showing grade of recommendation and level of evidence

Treatment	Depression		CHD outcome	
	Grade <sup>2</sup>	Level <sup>2</sup>	Grade <sup>2</sup>	Level <sup>2</sup>
<b>Non-drug</b>				
Exercise	A	I	B	II
Psychological, including CBT	B	II	D	II
St John's wort*	D	—*	D	—*
n-3 fatty acids	D	II	D <sup>†</sup>	II
SAMe*	D	—*	D	—*
Collaborative	B	II	D	II
<b>Drug</b>				
SSRIs	A	I	D	III-1

CBT = cognitive behaviour therapy. SAMe = S-adenosylmethionine. SSRIs = selective serotonin reuptake inhibitors. \* Insufficient evidence to rate or no trials have been performed. † Data not available in patients with CHD. ◆

**Очень редко в психосоматические рекомендации включают класс (польза/эффект) и уровень доказательств (рандомизация, мнение)**

# Совпадение результатов мета-анализов рандомизированных и наблюдательных исследований



Рандомизированные  
исследования  
*Двойные слепые,  
многоцентровые,  
большие выборки*

**Класс А, В**

Наблюдательные  
исследования  
*Проспективные, регистры,  
(псевдо)рандомизация*

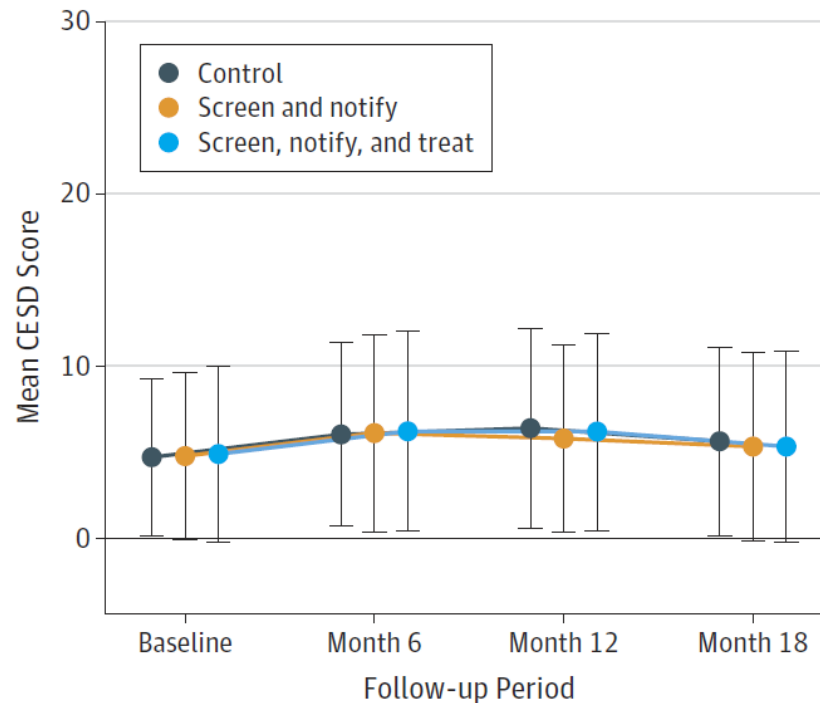
**Класс В**

# Проект рекомендаций по ведению психических расстройств у пациентов с коронарной болезнью

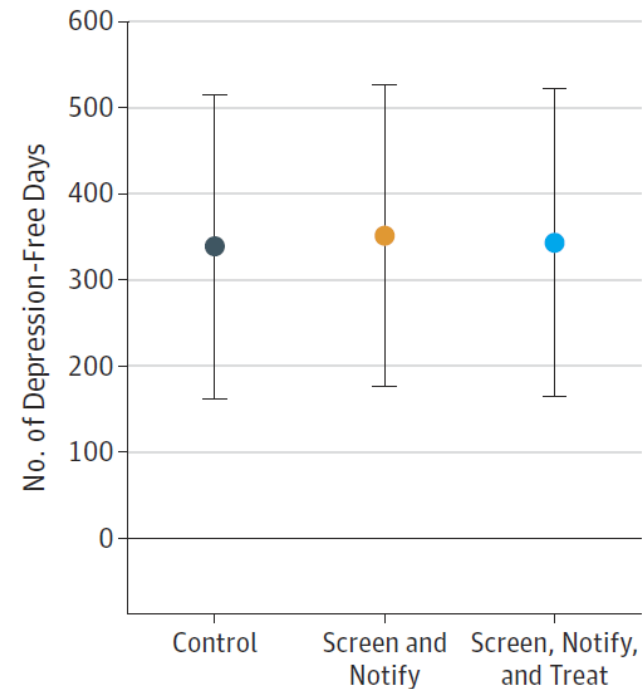
Рекомендации по диагностике	Класс
Кардиолог может диагностировать психическое расстройство и назначить психотропное лечение с последующим согласованием диагноза и лечения с психиатром	IC
При наличии характерных клинических признаков или подозрении на эмоциональное расстройство у пациента рекомендуется активное выявление депрессии и тревоги	IC
Психометрические шкалы (HADS, GAD, PHQ) могут использоваться для скрининга симптомов тревоги и депрессии у пациентов с повышенным риском психических расстройств, включая недавний острый коронарный синдром	IIb
Для диагностики психических расстройств следует использовать критерии классификации МКБ	IC

# Скрининг депрессии у пациентов с острыми коронарными синдромами

**A** Score per follow-up period



**B** Depression-free days per group



**У пациентов с острыми коронарными синдромами без депрессии в анамнезе скрининг депрессии не улучшает качество жизни и не снижает частоту депрессии**



# Психометрические шкалы

Patient Health Questionnaire, version	Area under curve (SE)	Cutoff score	Sensitivity, %	Specificity, %	Youden index
2	0.912 (0.0336)	>0	95.65	71.43	67.08
9	0.926 (0.0257)	>4	95.65	72.73	68.38
10	0.934 (0.0237)	>5	96.65	77.92	73.57

Pairwise comparison			
	Difference in area under curve (SE)	95% CI	P
2 vs 9	0.0141 (0.0321)	-0.0488 to 0.0771	.66
2 vs 10	0.0217 (0.0312)	-0.0394 to 0.0828	.49
9 vs 10	0.0076 (0.0043)	-0.0008 to 0.0160	.07

1. Снижение интереса или чувства удовольствия
2. Плохое настроение, подавленность или чувство безысходности

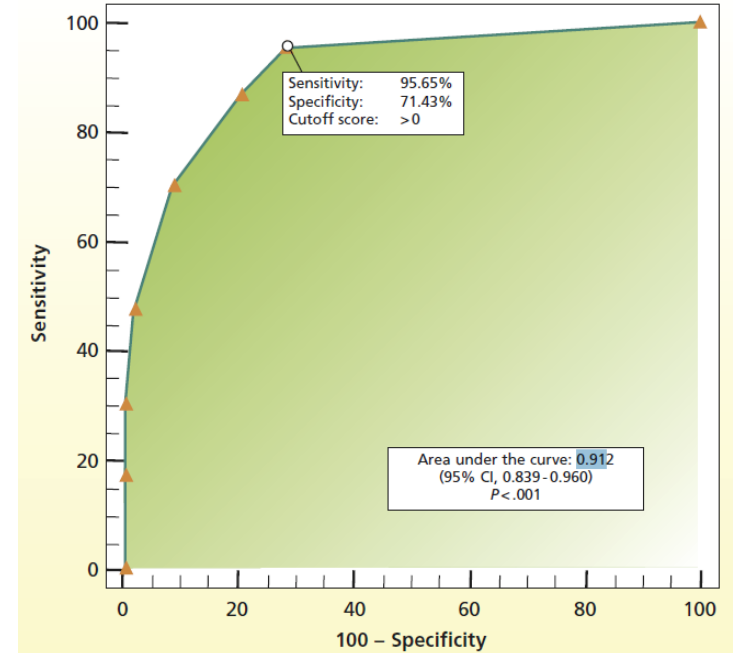
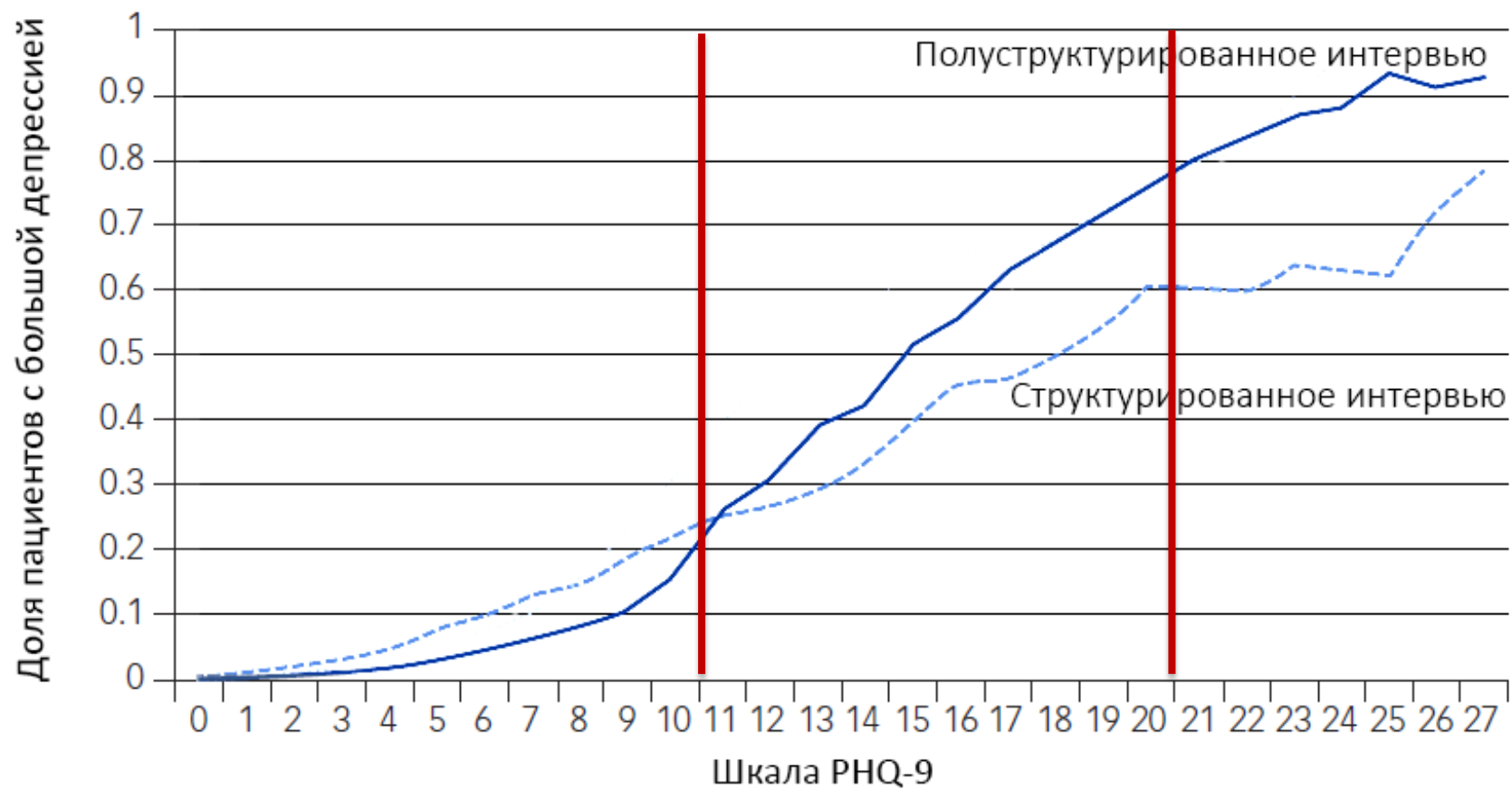


Figure 1 Receiver operating characteristic curve for 2-item Patient Health Questionnaire (PHQ-2).

**Для скрининга депрессии у госпитализированных пациентов с острым коронарным синдромом шкала PHQ-2 так же точна, как полная версия при использовании медсестрами**

## Наблюдательное исследование

# Шкала PHQ-9 и депрессивное расстройство



**Наличие выраженных симптомов депрессии по шкале  
не всегда соответствует наличию депрессивного расстройства**

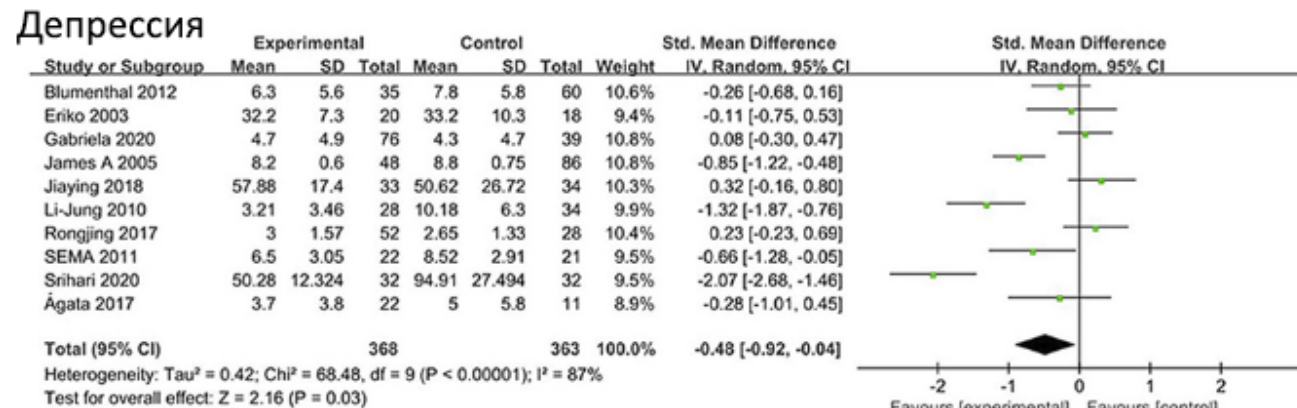
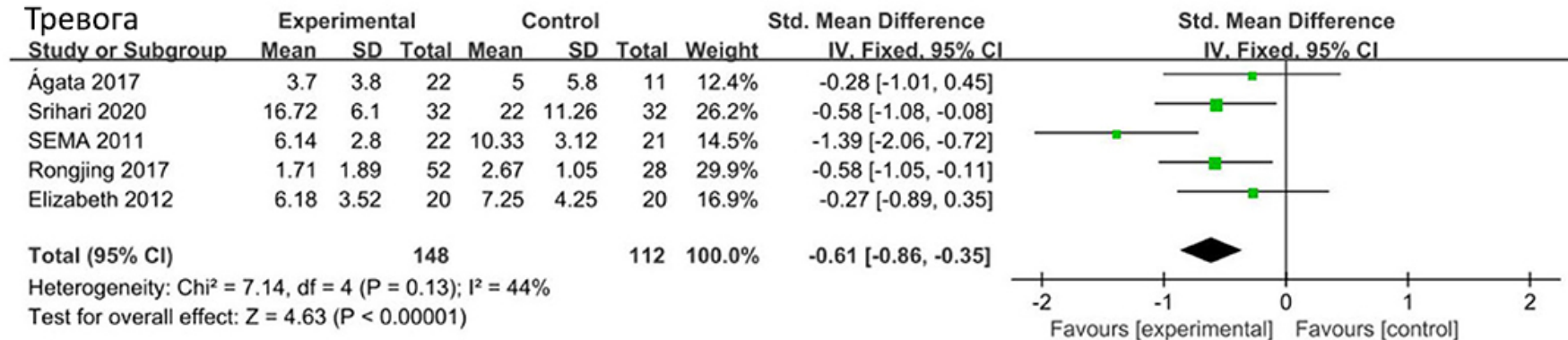
Наблюдательное исследование

Levis B, et al. Probability of major depression diagnostic classification using semi-structured versus fully structured diagnostic interviews. The British Journal of Psychiatry. 2018;212:377-385.

# Проект рекомендаций по ведению психических расстройств у пациентов с коронарной болезнью

Рекомендации по лечению	Класс
Рекомендуются физические нагрузки, которые предупреждают и улучшают контроль депрессии и тревоги, а также снижают риск сердечно-сосудистых событий у пациентов с коронарной болезнью	IB
Рекомендуется назначать антидепрессанты, предпочтительнее селективные ингибиторы обратного захвата серотонина, и/или когнитивно-поведенческую терапию для улучшения симптомов депрессии у пациентов с коронарной болезнью	IA
Лечение депрессии с помощью антидепрессантов или психотерапии может положительно повлиять на риск сердечно-сосудистых событий	IIaB
Для лечения депрессии и тревоги у пациентов с коронарной болезнью целесообразно использовать антидепрессанты, эффективность и безопасность которых проверена в надежных исследованиях (сертралин, циталопрам, эсциталопрам, мirtазапин)	IB
При назначении взаимодействие психотропных и кардиотропных препаратов, включая влияние на противотромботическую активность и интервал QT	IC
Психологическое лечение, включая когнитивно-поведенческую терапию, программы контроля стресса, совладающего поведения, может улучшить психическое состояние и облегчить отказ от курения	IIaB
Антидепрессанты эффективны для длительного контроля тревоги у пациентов с коронарной болезнью	IC
Транквилизаторы показаны для ситуационного или непродолжительного контроля тревоги у пациентов с коронарной болезнью	IC

# Влияние физических нагрузок на уровень тревоги и депрессии у пациентов с коронарной болезнью



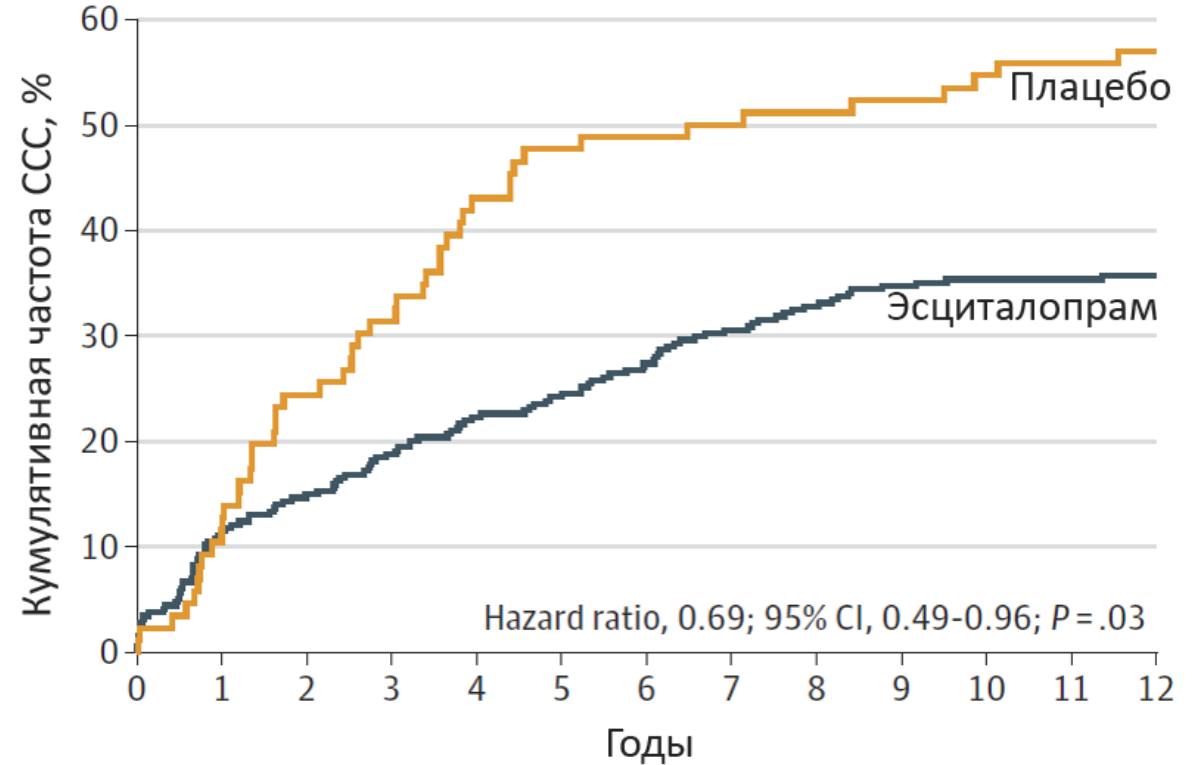
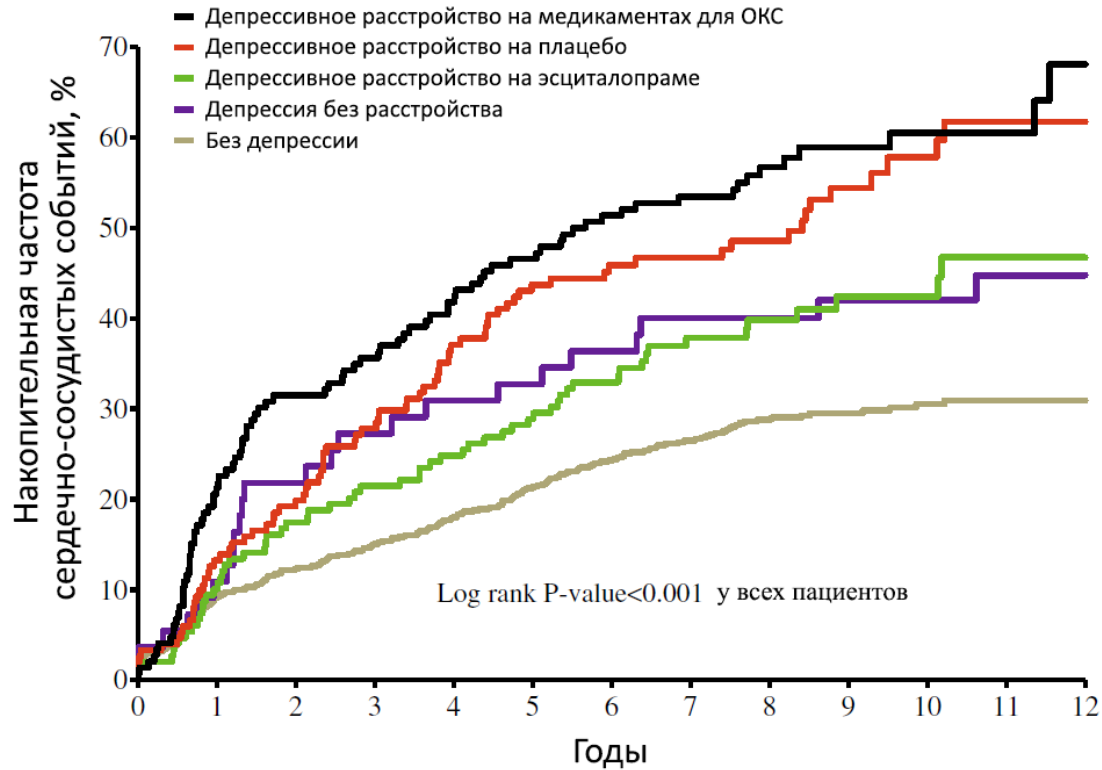
**Физические нагрузки, наряду со снижением сердечно-сосудистых рисков, могут уменьшить симптомы тревоги и депрессии у пациентов с коронарной болезнью**

Метаанализ рандомизированных исследований (11 исследований, 771 пациент)

Wang L, Sun Y, Zhan J, et al. Effects of Exercise Therapy on Anxiety and Depression in Patients With Coronary Heart Disease: A Meta-Analysis of a Randomized Controlled Study. Front Cardiovasc Med. 2021 Oct 11;8:730155.



# Влияние депрессии на риск сердечно-сосудистых событий после острого коронарного синдрома



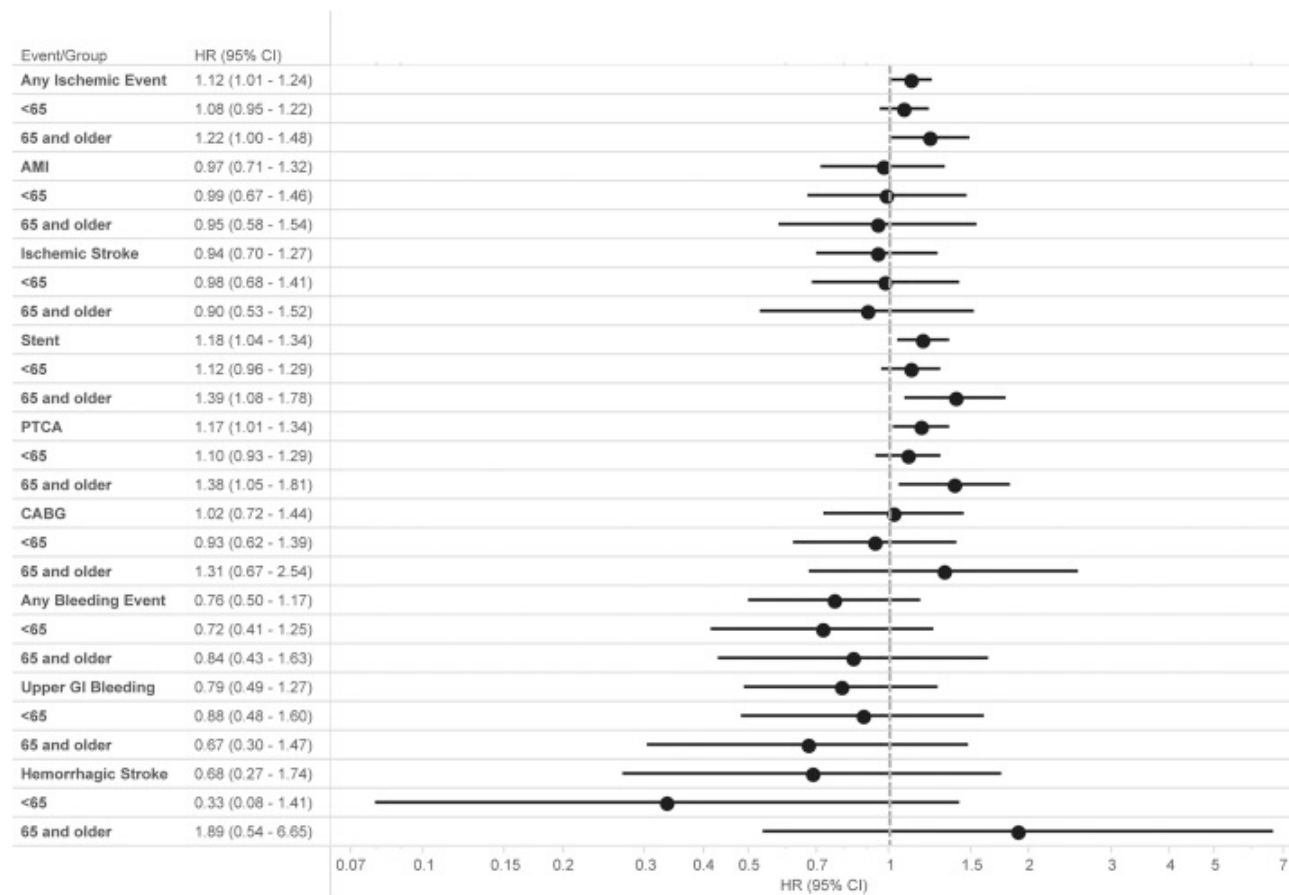
**Наличие депрессии, особенно депрессивного расстройства, повышает риск сердечно-сосудистых событий после ОКС, а лечение эсциталопрамом снижает риск**

## Рандомизированное исследование DEPACS

Kim J, et al. Effect of Escitalopram vs Placebo Treatment for Depression on Long-term Cardiac Outcomes in Patients With Acute Coronary Syndrome. A Randomized Clinical Trial. JAMA. 2018;320(4):350–358.

Kim JM, Stewart R, Kang HJ, et al. Long-term cardiac outcomes of depression screening, diagnosis and treatment in patients with acute coronary syndrome: the DEPACS study. Psychol Med. 2021;51(6):964-974.

# Сочетанный прием СИОЗС и клопидогрела

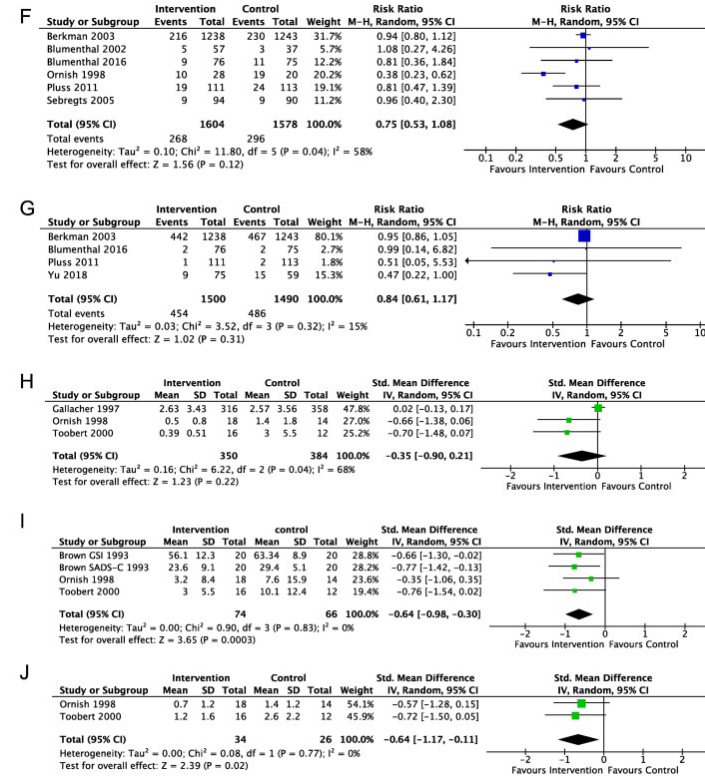
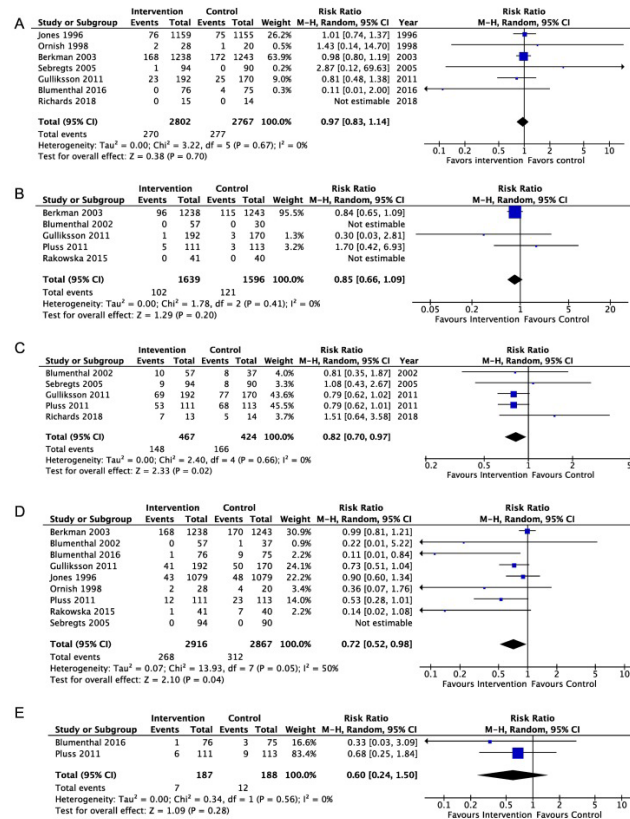


**Лечение СИОЗС, ингибирующими СУР2С19 (флувоксамин, флуоксетин), может снизить эффект клопидогрела и повысить частоту ишемических событий (+12%), особенно у пациентов ≥65 лет**

## Наблюдательное исследование

Bykov K, et al. Impact of an Interaction Between Clopidogrel and Selective Serotonin Reuptake Inhibitors. Am J Card. 2017;119(4):651-657.

# Психотерапевтическое лечение коронарной болезни



Психологическое лечение на основе когнитивно-поведенческой и позитивной психологической терапии снижает риск сердечно-сосудистых событий, инфаркта миокарда и стенокардии у пациентов с коронарной болезнью

Метаанализ рандомизированных исследований (25 исследований, 8119 пациентов)

Magán I, et al. Efficacy of psychological interventions on clinical outcomes of coronary artery disease: Systematic review and meta-analysis. Journal of Psychosomatic Research. 2022;153:110710.



A scenic landscape featuring a calm lake in the foreground, a forested mountain range in the middle ground, and a large pine tree on the left side. The sky is overcast and grey. The text is overlaid on the right side of the image.

# The 19th Congress of the Asian College of Psychosomatic Medicine

Irkutsk, Russia, August 23–24, 2022