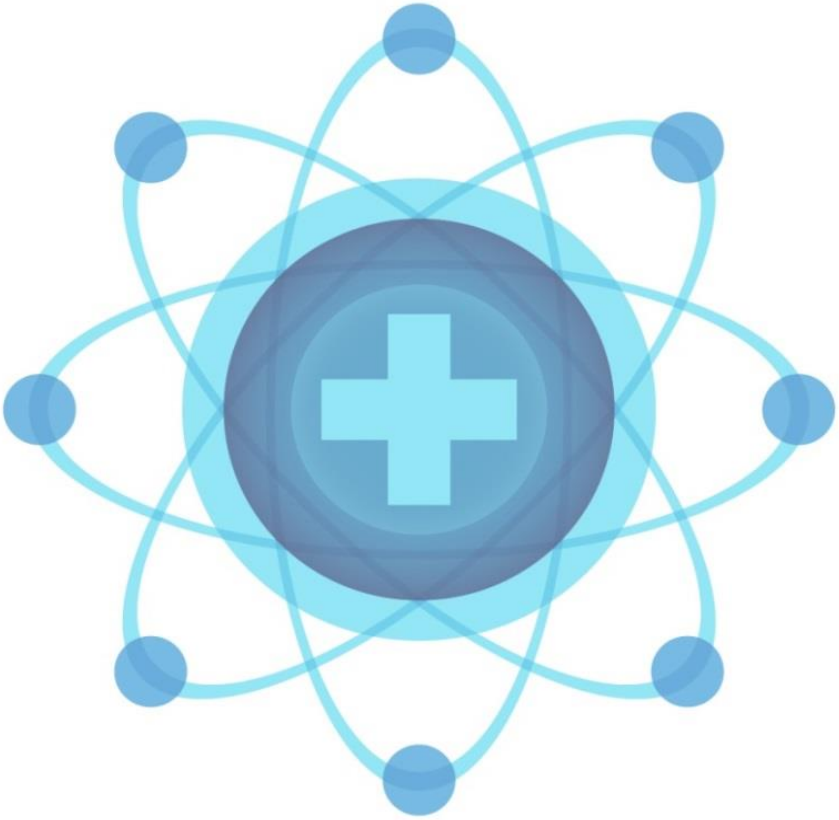

INTERNATIONAL MEDICAL SCIENTIFIC JOURNAL

ART OF MEDICINE

Founder and Publisher **Pascual Izquierdo-Egea / North American Academic Publishing Platforms**

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11931 Barlow Pl Philadelphia, PA 19116, USA +1 (929) 266-0862

Available at https://www.bookwire.com/

ISBN: 978-0-578-26510-0

10.5281/zenodo.6563380

THE PROBLEM OF PREVALENCE OF DIFFUSE LIVER DISEASES (REVIEW)

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Abstract: Diffuse liver diseases, including fatty hepatosis, chronic hepatitis, including viral etiology, cirrhosis of the liver remain one of the central problems for public health throughout the world. In the world there are about 2,000 million people infected with the hepatitis B virus, of which more than 350 million are chronically infected and from 500,000 to 700,000 people. die annually from hepatitis B virus infection. About 130-170 million people. are chronically infected with the hepatitis C virus, and it is estimated that more than 350,000 people die each year from hepatitis C-related liver disease. As one of the strategic directions for the treatment of viral hepatitis, WHO considers it important to expand access to health care, systematic monitoring and combating drug resistance.

Keywords: Liver, hyperinsulinemia, obesity, hypertriglyceridemia

Relevance

Chronic diffuse liver disease is one of the most urgent problems in modern gastroenterology. The prevalence of this pathology is increasing, especially among people of working age. However, the analysis of the research results allows us to conclude that the real prevalence of diffuse liver diseases in the world has not been fully studied, so further research is needed. In practice, the most significant metabolic lesions are non-alcoholic fatty liver disease (NAFLD) and alcohol-induced liver lesions, in the pathogenesis of which the leading role belongs to the accumulation of lipids in the hepatocyte and increased lipid peroxidation, leading to the development of necrosis. Non-alcoholic fatty liver disease is an independent nosological entity, divided into two stages: fatty hepatosis (steatosis) of the liver and non-alcoholic hepatitis. Since hepatic steatosis is a very common condition that in most cases does not determine the patient's prognosis, from the point of view of the clinician, it is advisable to focus on the stage of non-alcoholic steatohepatitis (NASH). The etiological factors of NASH can also be divided into two groups. The first are endogenous and exogenous xenobiotics (eg drugs, toxins). Second, congenital or acquired metabolic disorders. Risk factors for the development of NASH include starvation, rapid weight loss, exclusion of protein intake, malabsorption syndrome of any origin, interintestinal anastomoses, anemia, parenteral nutrition, intestinal bacterial overgrowth, and a number of endocrinological disorders. However, much more often NASH is detected in diabetes mellitus, obesity (especially visceral) and hyperlipidemia. Congenital metabolic diseases of the liver include familial hepatosteatosis, glycogen storage diseases, Wilson-Konovalov disease, etc. The majority of those suffering from NASH are women over 50 years of age. For most cases of NASH, the presence of vivid symptoms is not typical, asthenia and a feeling of heaviness in the right hypochondrium are less common. When diagnosing, the echoscopic syndrome comes first - "diffuse changes in the liver", less often a change in blood biochemical parameters (transaminases, alkaline phosphatase). In addition, an important place in the development of metabolic liver damage belongs to alcohol.

10.5281/zenodo.6563380
The frequency and degree of hepatic pathology when taking alcohol depends on the individual sensitivity of the organism, as well as on the dose of alcohol and the duration of its intake. The biochemical effects of alcohol as a direct hepetotoxic agent are reduced to a violation of the redox potential of the cell, the accumulation of free radicals that cause inflammation and tissue damage, hypoxia and the development of pronounced metabolic disorders in hepatocytes and other cells of the body. To recognize alcoholic liver disease (ALD), it is very important to know how long and how much alcohol has been taken. There are no physical signs pathognomonic for APP. Among the laboratory signs, first of all, attention is paid to an increase in transaminases and gammaglutamine transpeptidase. In an ultrasound examination, as a rule, the conclusion includes the syndrome "diffuse changes in the liver", hepatomegaly (an increase in the size of the liver). Among laboratory signs, first of all, attention is paid to an increase in transaminases and gammaglutamine transpeptidase. Ultrasound examination, as a rule, in the conclusion appears syndrome "diffuse changes in the liver", hepatomegaly (enlargement of the liver). Among laboratory signs, first of all, attention is paid to an increase in transaminases and gammaglutamine transpeptidase. Ultrasound examination, as a rule, in the conclusion appears syndrome "diffuse changes in the liver", hepatomegaly (enlargement of the liver).

Purpose of the study:to study the problem of the prevalence of diffuse liver diseases.

Research results:

Currently, diffuse liver diseases (DLD) among the pathologies of the gastrointestinal tract occupy one of the leading places [1, 2, 7, 13, 14]. This is largely due to the severity of the course and the high incidence of these diseases. Etiological factors that can lead to the development of these pathological conditions can be very diverse [1,2,5]. Among them, the leading place is occupied by viral hepatitis and alcohol abuse [3,4]. The proportion of viral hepatitis C (CVH C) in the overall structure of chronic hepatitis in 2013 was 79%. According to a number of authors, there is currently a steady increase in the incidence of chronic hepatitis C [8]. In 2005, this figure was 32.0 per 100 thousand, and in 2013 the incidence was 39.26 per 100 thousand of the population. At the same time, half of all registered cases of hepatitis C morbidity occur in persons under 40 years of age [6,7,11]. An important feature of the hepatitis C virus is its heterogeneity. There are several HCV genotypes: 1a, 1c, 2c, 3a [7,9,10]. The problems associated with viral hepatitis C infection remain obvious: a long asymptomatic course, a high incidence of chronic forms, manifestation in the late stages. Hepatitis C infection is the main cause of liver cirrhosis and hepatocellular carcinoma in economically developed countries [15]. The incidence of viral hepatitis B (CVB B) is at a high level. Approximately one third of the world's population has markers of a past infection with the hepatitis B virus, and 350 million people have markers of a current chronic infection [8,13,14]. This virus is highly resistant in the external environment. According to official statistics, in 2012 in the Russian Federation, hepatitis B was detected in 5,952 donors of blood and other biological substrates, 16,513 pregnant women, and 915 children born to

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mothers infected with the hepatitis B virus [12]. The data of many publications show that the end stages of progressive chronic hepatitis B are the cause of 5-10% of currently performed liver transplantation [8]. Alcohol is also an important factor leading to severe damage to the liver parenchyma. In the Russian Federation, according to statistics, approximately 2% of men and 1% of women aged 18 to 60 suffer from alcoholism [10, 14]. At the same time, almost a third of the male population of working age systematically consumes alcohol in doses dangerous to health. It has also been established that the share of alcoholic disease among all diffuse liver diseases accounts for approximately 24%. According to the latest international recommendations of hepatologists, the hepatotoxic dose of alcohol should be considered to be the use of more than 24 g of pure ethanol per day for at least 5 years for men and 12 g / day for women, which corresponds to 76 and 38 ml of vodka (strength 40%) and 253 ml and 127 ml of dry wine (strength 12%), respectively [15]. At the same time, there is an increase in the number of mixed alcoholic-viral liver lesions, the toxic effects of alcohol and such etiological factors as type 2 diabetes, obesity, hyperlipidemia. It is customary to distinguish the following forms of alcoholic liver disease: alcoholic steatosis (fatty hepatosis), acute alcoholic steatohepatitis, chronic alcoholic steatohepatitis (ASH), alcoholic cirrhosis of the liver [3,7,12]. The concept of "non-alcoholic fatty liver disease" (NAFLD) includes two main forms of this disease: fatty degeneration of the liver, non-alcoholic steatohepatitis [3,5]. NAFLD is currently considered as a liver lesion occurring within the framework of the metabolic syndrome, which also includes abdominal-visceral obesity, type 2 diabetes mellitus, arterial hypertension, atherosclerosis, coronary heart disease, polycystic ovary disease, etc. [3, 5, 9] . In North America, Europe, Japan, the prevalence of this disease reaches 10-40%. At the same time, there is also a steady increase in the incidence of this pathology around the world [1,5,14]. The course of NAFLD has a relatively benign, stable, non-progressive course. According to the literature, only 20% of these patients develop liver cirrhosis (LC) within 20 years [10, 15]. Only in some patients, cirrhosis develops early (within 10 years) [11]. However, 30-40% of patients with NAFLD have liver fibrosis at initial examination; in 10-15%, the formation of false lobules is observed. The pathogenetic basis for the development of NAFLD is the phenomenon of insulin resistance [3,8,9]. It is characterized by a decrease in the sensitivity of tissue receptors to endogenous insulin, even if it is produced in large quantities [13,14,15]. A decrease in the sensitivity of body tissues to insulin and a violation of the supply of glucose to cells is accompanied, in turn, by an increase in the rate of lipolysis in adipose tissue and the concentration of free fatty acids in the blood serum. Hyperinsulinemia also reduces the rate of beta-oxidation of free fatty acids (FFA) and increases the synthesis of very low density lipoproteins (VLDL). In turn, all these factors contribute to the formation of fatty degeneration of hepatocytes [11,12,13,15]. Cirrhotic restructuring of the liver is the final and most severe form of HDZVP. This pathology is currently an urgent problem in healthcare systems around the world [1, 3, 8]. Mortality from this nosological unit is high (in some countries it ranks 3rd-4th) [6, 8]. The leading role in the development of liver cirrhosis is given to chronic viral infection, in

10.5281/zenodo.6563380
particular viral hepatitis C. Thus, in 2013, the proportion of liver cirrhosis that develops as a result of chronic HCV infection increased to 30.3%. Currently, despite all the variety of etiological factors involved in the development of diffuse liver diseases, the scientific community is actively discussing the issue of participation in these processes, regardless of the form of diffuse diseases, and the microcirculatory link [8,10]. Moreover, this manifests itself both in the form of rheological disorders (disorders in the blood coagulation system, changes in the protein composition of the blood) caused by damage to the hepatic parenchyma, and in the form of damage to the capillaries of the circulatory system [10, 11, 12].

Findings

The creation of a technological model of outpatient care for patients with chronic diffuse liver diseases, the danger of which is due to the predominant asymptomaticity in the early stages of development and a tendency to progression, is an urgent task of scientific and practical medicine. As a result of the progression of the pathological process, successive stages of fibrosis are formed, often accompanied by the formation of liver cirrhosis and the risk of developing hepatocellular carcinoma. A high degree of liver fibrosis is considered as the main reliable factor for an unfavorable outcome of the disease. The level of fibrosis before and after therapy serves as a criterion for the effectiveness of treatment.

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