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TYPES OF AFFECTIVE TEMPERAMENT AMONG THE PATIENT WITH CARDIAC ISCHEMIAAFTERSTENTING OF THE CORONARY ARTERIES

AZATYAN N.G.

Department of Medical Psychology, YSMU

Corresponding author email: naira_gurgenovna@mail.ru

KEYWORDS:

affective temperament, stenting of the coronary arteries

INTRODUCTION. According to the official data of the Information-Analytical Center of the National Institute of Health of the Ministry of Health of the Republic of Armenia, the incidence of IB is also increasing in recent years in Armenia. Coronary artery stenting is a method of treating forms of coronary heart disease associated with constriction or occlusion of the heart arteries.[3] The affective type of temperament largely predetermines the level of vulnerability and a tendency to somatization of unresolved intra-psychic problems. Often affective types of temperament do not interfere with satisfactory social adaptation of the person, and the disadaptation arising in certain conditions is temporary and transient, however, the forms of emotional response of the person can influence the course of various diseases and the attitude of the patient towards their disease. The task of this study is to determine the relationship between the affective types of temperament and their effect on the postoperative period.

METHOD USED. We conducted our surveyamong 48 patients at NorkMarash Medical Centre in Yerevan, including 28 Male and 20 Female at the age of 41-65 years old. Weused the test TEMPS-A /A. Akiskal, K. AksikalThis questionnaire makes it possible to determine the following types of affective temperament: hypertensive, dysthymic, excitable, cyclothymic and anxious.{1}

RESULTS AND DISCUSSION. In our study, the following types of affective temperament were identified: hyperthymic type - 36%, dysthymic type - 45%, excitable type - 24%, cyclothymic type - 38% and anxiety type - 30%.

The results of this study make it possible to create a specific approach in the psychological work with patients, taking into account their emotional type of temperament. Based on the characteristics of each type, we offer the following recommendations for clinical psychologists and doctors when dealing with patients: hypertensive type - since this type is characterized by increased mood and thirst for activity, it is necessary to direct excessive activity to complex rehabilitation work; when working with patients with dysthymic manifestations, it is recommended to focus on positive factors and changes in negative perception of reality; Excitable type - work should be directed at controlling anger and accepting one's own aggression; for cyclotimic type it is recommended rational approach - to enable self-assessment of their mental state; when working with an anxious affective type of temperament, it is necessary to measure the level of manifestation and the type of anxiety with the help of psychological techniques, and accordingly to work to eliminate feelings of worry and anxiety.

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SEXUAL RISK BEHAVIOR AND ADVERSE CHILDHOOD EXPERIENCE

Introduction. Traumatic childhood experiences may have life-long consequences for person's medical, psychological, and sexual well-being. These experiences are hypothesized to compromise neurodevelopment and immune function, leading to an increased risk of various illnesses. Traumatic childhood experiences are also associated with a range of high risk behaviors including excessive use of alcohol, tobacco use, and criminal activity, early and unprotected sex.

However, these studies show a direct and consistent relationship between traumatic childhood experiences and general health, and there is no data that investigates the relationship to sexual disorders such as, for example, sexual desire disorder, vaginismus or erectile dysfunction, premature ejaculation, Although our preliminary clinical trials suggest Correlation between existing adverse childhood experiences and various sexual disorders.

Similar studies are aimed at emphasizing the role of risky behavior in the field of sexual and reproductive health and, consequently, the importance of developing health education programs and methodological guidelines for combating phenomena that threaten sexual and reproductive health.

Method Used. The Adverse Childhood Experiences (ACE) Questionnaires were used for this study. TheACE questionnaires were translated into Armenian language and were pre-tested among Armenian adult samples.

Special sexological history form confirmed in the Department of Sexology YSMU was used, and objective assessment of patients with sexual dysfunctionshas done.

Using structured interviews and self-report measures data were collected from 90 patients with sexual dysfunctions and 41 control volunteers. Patients were recruited from the Clinic of Sexology YSMU, whereas controls were recruited from the general population. Adverse Childhood was assessed using the Armenian translated version of the ACE questionnaire (Felitti et al., 1998). ACE questionnaire is 10 items retrospective self-report that assesses three primary domains: abuse, neglect and family dysfunctions.

Results And Discussion. More than three-fourth of the sample reported experiencing at least one adverse childhood experience, and nearly 30% of the patient group and 15% of the control volunteers reported experiencing at least four adverse childhood experiences. In both groups, women reported experiencing more adverse childhood experiences than males. The number of categories of adverse childhood exposures showed a graded relationship to the presence of sexual dysfunction such as vaginismus, dyspareunia, female sexual interest/arousal disorders, and erectile disorders.

Conclusion. To the best of our knowledge, this is the first study to examine the prevalence and characteristics of adverse childhood experiences in the Republic of Armenia. Preliminary findings suggest that adverse childhood experiences are more common among people with sexual dysfunctions than the general population. Theoretical and policy implications are discussed.

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Azatyan R.E.

Department of Sexopathology, YSMU

Corresponding author email: r_azatyan@sexology.am

Keywords:

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KOMITAS SYNDROME: THREE CASE ANALYSIS

GASPARYAN KH.V.

Department of Medical Psychology, YSMU

Corresponding author email: kvgaspar@yahoo.com

INTRODUCTION. In these theses we are discussing the issue of the Armenian Genocide related traumatic reactions. After brief discussion of two other cases associated with manmade and natural disasters- earthquake and war in Artsakh, we are comparing it with Komtas reaction after Genocide.

METHOD USED. We used case studies as a research methodthrough reports of past studies, allows the exploration and understanding of complex issues.

SignificantlyKomitas himself was a victim of the mass deportations and Genocide. According to Armenian Diaspora representatives in France, whenever Komitaswas visited, he did not speak with the Armenian people, but easily communicated with others in French. He never spoke of his family or of his friends. He was withdrawn, isolated, mute and irritable, and his mental state was not improved by the time he was hospitalized in Villejuif. It was known that Komitas dismissed his friends (Kuyumjian, 2015).

The Sumgait massacres in February 1988, in Azerbaijan reopened old wounds not yet healed, while the earthquake of December 1988 seemed to repeat the 1915 total terror perpetrated the time by Nature itself. The other clinical cases mentioned before, are indicating that there are parallels in symptoms, similar with the way Komitas had reacted to the trauma he endured and in reviewing these cases, we see what we refer to as a "Komitas Syndrome" (Gasparyan & Saroyan).

The two boys of above-mentioned cases were suddenly faced with overwhelming, shattering occurrences. The common connection between Komitas and the two mentioned cases is that their poly-traumatization experiences changed their idea of world, their way of functioning, and their perception of the people around them. They discovered and experienced hostility, with symptoms of a Komitas Syndrome due to their multi-trauma experiences.

CONCLUSION. The central point of a Komitas Syndrome is that one's traumatic experience is unbearable, so the person will defend to save the Self. This person ignores the parts of their identity that help to rehabilitate the traumatic memories and suffering. A similar account of this process of unspoken traumas left unelaborated by words, unassimilated and becoming unthinkable was described by Schutzenberger (2009), and Kalsched (2007), who looked at the inner world of traumatized people. Trauma is about the split of those developmental transitions that make life easy to live. He views this as a spiritual problem as well a psychological one and provides a compelling insight into how an inner self-care system tries to save the personal spirit. Finally, we are proposing a new term in Trauma psychology- Komitas syndrome.

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KEYWORDS:
Armenian Genocide, trauma, Komitas syndrome

SOCIAL-PSYCHOLOGICAL ADAPTATION OF STUDENTS OF DIFFERENT COUNTRIES IN HIGHER EDUCATION INSTITUTIONS

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Ghazaryan G.H., Babayan L.A.

Department of Medical Psychology, YSMU

Corresponding author email: kgy@rambler.ru

Introduction. This article presents the benefits of first-year students' effective adaptation to higher education institutions, especially those who obtain higher education in foreign countries.

The research team consists of 60 first-year students. Three different groups are formed, each of them consists of 20 first-year students. The first group includes 20 local Armenian students, the second group includes 20 foreign students studying in Russian, the third group includes 20 foreign students studying in English.

Method Used. The survey was conducted at the Yerevan State Medical University after Heratsi. The age of the students was 17-21 years old. During the survey, we used Kettle's personal questionnaire (which reveals 16 factors of character), K. Rogers and R. Diamond's Diagnostic Methodology of Social-Psychological Adaptation as well as the first-year student's questionnaire [1].

Based on the research, we can draw the following conclusions: the adaptation process of the first-year student is largely determined by the relationship between the student, the lecturer and the fellow students. These relationships develop students' skills that allow them to manage their activities, contribute to self-expression, personal and professional growth. The main principles of effective relationships between student and lecturer, as well as fellow students, include dialogue, active perception, self-disclosure, formation of value-semantic orientation and development of responsibility.

Results And Discussion. Self-control enables the effectiveness of the adaptation process, to control their own emotions and behavior easily. Communication, as a result of which students are more involved in the higher education institution's learning process, which ensures the adaptation process. The factor of awareness of the first-year students contributes to their adaptation. The more the student is informed about the education system, the sooner and more effectively the process of adaptation will be. Emotional Intelligence is of great importance in this regard, since a student, who is entering a completely new environment and is completely self-confident, believes in his strength and can express himself, manage his own emotions, understand and accept other people's feelings and emotions, can quickly adapt to any new environment [2,3].

Conclusion. To ensure effective adaptation process we suggest conducting surveys in first year:

- Related to students' expectations and issues, using it to organize further work with students,
- Organize psychological trainings, especially for foreign students, who are from other cultures, far from their homes,
- Involve them in the work of the Student Council, as team work also contributes to the adaptation process,
- Organize various events by presenting traditions and customs of foreign students.

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Keywords:
foreign students, adaptation, interpersonal communication, emotional intelligence.

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ABOUT NECESSITY OF CHANGES IN THE SCALE OF VECTOR DETERMINATION OF THE SEXUAL CONSTITUTION

GRIGORYAN A.D.,
SAHAKYAN S.A.

Department of Sexopathology, YSMU

Corresponding author email: a.d.grigoryan@gmail.com

KEYWORDS:
sexual constitution, acceleration, sexologist

NTRODUCTION. In the diagnostic and therapeutic practice of a sexologist, the mandatory correlation of the intensity of the sexological manifestations of the subjects with their age, if carried out without taking into account the individual characteristics of the patient's sexual organization, or his sexual constitution, cannot be considered sufficient.

Sexual constitution is a set of stable biological properties that are formed under the influence of hereditary factors and developmental conditions in the prenatal period and early ontogeny; it limits the range of individual needs at a certain level of sexual activity and characterizes the individual resistance to pathogenic factors that have selectivity to the sexual sphere.

METHOD USED. Acceleration is the accelerated development of a living organism. The average age of the onset of the first menstruation in Norwegian girls, which in 1850 was 17 years, by the middle of the XX century approached 13.75 years, and at the end of the XX century was already 13 years old. [1].. V.G. Sidamon-Eristavi, the data received by her comparing on the age of appearance of secondary sexual characteristics in boys in the early 70's with the corresponding data of B.S. Solovyeva, noted the earlier appearance of all the traits studied in the 1.5 -9 months [3].

The age of the first ejaculation and the beginning of masturbation among servicemen depending on the age: 13.3-19% of servicemen of different age groups note that they started to masturbate from the age of 10-12, 45.5-52.4% - from 13-15, and 17.0-29.7% - from 16-18 years [2].

RESULTS AND DISCUSSION. For the diagnosis of sexual disorders use the scale of vector definition of the sexual constitution, developed and tested for men G.S. Vasilchenko and for women I.L. Botneva.

Numerous studies indicate a decrease in the age of the oigarche (first ejaculation) and the age of menarche (the first menstruation) for approximately 1 year. Today, there's a need to revise the relevant indicators.

Proceeding from the above, we propose to make changes in the 2nd point of the scale of the vector definition of the sexual constitution for men (the age of the first ejaculation): namely: reduce the indicators for 1 year. Also, we propose to make changes in the 1stpoint of the scale of the vector definition of the sexual constitution for women (the age of the first menstruation), namely: to reduce the indicators for 1 year.

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CORRELATION BETWEEN SEXUAL DYSFUNCTIONS AND PSYCHIATRIC SYMPTOMS

Introduction: Nowadays in sexual health medicine prevails a multidimensional approach in diagnosing and treatment of sexual dysfunctions (SD). Despite of the development of multidimensional approach in diagnosing and treatment of sexual dysfunction which is included bio-psycho-socio-cultural approach, the psychiatric evaluation is usually eliminated during the primary visit. A review of recent literature highlights the correlation between dysfunction and a decreased quality of life in people with psychiatric comorbidity, and explores several aspects impacting care, from following the patient to pharmacological and non-pharmacological treatments. Always Sexual dysfunctions (SD) have been shown to be prevalent, but under-diagnosed and undertreated because of communication barriers between patients and physicians. Causes of sexual problems are often difficult to differentiate. Psychiatric diseases may increase the risk of SD, and SD may further exacerbate psychiatric problems, suggesting a bi-directional relationship.This is imperative for any consideration of human sexuality. It is obvious and common for the Sexologist, in a process of diagnoses sexual dysfunction to meet patients with some psychic symptoms which are not so dominant and usually not undergo into the psychiatric diagnoses. After the period of dynamic observation we have found out that these patients were under the psychiatric control. That's why we mentioned to check the prevalence of psychic signs and symptomswhich could possible lead to development of psychic end neurotic disorders.

The aim of this study to define the subclinical signs and symptoms in primary sexological patients for the more beneficial treatment.

Method Used. It was conducted dynamic observation of 60 male patients with just sexological problems. Among them were 10% sexual desire disorders, 40% sexual arousal disorders, 30% Orgasmic disorders, 20% mixed conditions according to the DSM IV. Diagnoses were proved by using primary special sexological interviewing, physical examination included uro-genital tests of prostate and psychiatric evaluation.

Results And Discussion. 24% of all patients after some period of time have been referred to psychiatrists. 8% of patients have psychotic disorders and they have been hospitalized to psychiatric clinic. 16% of them have been in psychiatric outpatients' clinic with prevalence of different neurotic and borderline disorders.

Leading sexological symptoms may be conducted or combined with subclinical psychiatric signs and symptoms. Primary arousal disorders complain of insufficient erection usually combined with neurotic sings, and desire disorders combined withsub depressive components.

Conclusion. During primary sexological examination it is necessary to take attention on the psychic symptoms and signs. Effective treatment of sexual dysfunction frequently involves combination of elements from psychotherapy, and behavioral along with pharmacotherapeutic intervention, if needed. The persistence of psychiatric problems has significant negative impact on patient's satisfaction and adherence with the treatment, quality of life and partnership.

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Hakobyan A.E.,
Azatyan R.E.

Department of Sexopathology, YSMU

Corresponding author email: hakobyan.aram@yahoo.com

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MINI-MENTAL STATE EXAMINATION (MMSE) FOR THE DETECTION OF DEMENTIA IN CLINICALLY UNEVALUATED PEOPLE AGED 60 YEARS AND OVER IN NEUROLOGY PRACTICE

KHACHATRYAN L.R.,
HAKOBYAN A.V.,
MANVELYAN H.M.

Department of Neurology, YSMU

Corresponding author email: doctorkhachatryan@yahoo.com

INTRODUCTION. Alzheimer's disease (AD) is a chronic neurodegenerative disease that usually starts slowly and worsens over time. It is the cause of 60% to 70% of cases of dementia [1].Although the number of cases will triple by 2050, cognitive impairment goes unrecognized in over half of affected patients [2]. This study was conducted to investigate prevalence and impact of education, gender, and place of residence (city or village) on cognitive impairment of a target group.

METHOD USED. We piloted a cognitive screening initiative using the MMSE, which was administered to neurology patients aged ≥ 60 years without a history of cognitive disorder, who was visiting outpatient neurology clinic. The total score for the MMSE ranges from 0 to 30; scores ≥ 24 indicate basically no cognitive impairment; scores 18-23 point out mild cognitive impairment and scores≤17 provesevere cognitive impairment [3].

Results. A total of 99 patients (66 women, 33 men) underwent MMSE screening. The average patient age was 70.9 yrs old.The mean MMSE score for this population was 24.82.The self-declared educational level was primary school or no education for 23 patients.In female population (n=66) 69.69% (n= 46) had no cognitive impairment, 21.21 % (n=14) – with mild cognitive impairment, and 9.09% (n=6) – with severe cognitive impairment. In males (n=33) 87.87% (n= 29) had no cognitive impairment, 9.09% (n=3) – with mild cognitive impairment, and 3.03% (n=1) - with severe cognitive impairment. In the "primary school or no education" group (n=23) 56.52% (n=13) of patients showed no cognitive impairment, 30.43% (n=7) - mild cognitive impairment, and 13.04 % (n=3) - severe cognitive impairment. In the group of patients with secondary education (n=49)75.51 %(n=37) of patients showed no cognitive impairment, 16.32% (n=8) - mild cognitive impairment, and 8.16% (n=4) - severe cognitive impairment. In patients with university education (n= 26) 88.46 % (n=23) of patients no cognitive impairment, 7.69% (n=2) - with mild cognitive impairment, and 3.84% (n=1) - with severe cognitive impairment. In the patients from rural areas (n=38) 78.94% (n=30) showed no cognitive impairment, 13.15 % (n=5) - with mild cognitive impairment, and 5.26% (n= 2) – with severe cognitive impairment. Regarding patients from urban areas (n=56) no cognitive impairment has been registered in 78.57% (n=44), mild cognitive impairment – in 16.07% (n= 9), and severe cognitive impairment – in 5.35% (n=3) of cases. Estimating the relationship between age and MMSE score was found no strong relation (correlation coefficient=0.283).

Discussion And Conclusion. This investigation evaluated the prevalence of cognitive impairment in older people. The test score increased with the degree of educational background.Gender was significantly related to the MMSE score, women had lower MMSE scores at all educational levels. The current analyses also demonstrate no significant differences in cognitive impairment among older adults in urban areas compared with those in rural areas.

This investigation has several limitations, most important of which is the small sample size. Further studies comparing MMSE with other brief instruments for detection of cognitive impairment would be helpful.

KEYWORDS:
older adults, Alzheimer's disease, dementia, Mini-Mental State Examination

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HYPERACTIVE SEXUALITY AMONG WOMEN IN DEPRESSIVE MOOD STATES

Introduction. Negative emotional states such asdepression were most often associated with decreased sexual interest and arousal. However, there is some evidence that depressed mood may be the reason for hyperactive sexuality. This hyperactivity is mostly considered as problematic sexual behavior taking into account its common features as impaired control and the continuation of such behavior despite adverse consequences. It was assumed that early sexual arousal and pleasure are the reason of eroticized child that are further pursued by an adult person in his non adaptive behavioral patterns. The purpose of this study was to examine the predictive power of some sexual characteristics as determinants of hyperactive sexuality in depressive mood states among women who applied to sexual health clinic.

Method Used. This was a descriptive, case series study. Four models of Ordinal logistic regression were run. As dependent variables reflecting hyperactive sexuality two concepts were separated. One is Sexual libido meaning general sexual appetite and the second is Sexual intercourse desire as a more specific behavioral motivation. As independent variables we examined the effect of the following sexual characteristics-intercourse desire, subjective arousal, orgasm, pregnancy desire, masturbation practice and age of erotic awakening.

Results And Discussion. More frequent and High level of sexual libido is more probable in cases where there is never or a few times experienced subjective arousal during sexual activity. Sexual intercourse desire doesn't predict sexual libido level. Frequent and high level of sexual intercourse desire is more probable when there is frequent and strong subjective arousal during sexual activity. Finally, we found that earlier erotic awaking heightens sexual libido level.

Conclusions. The high level of sexual activity in depressive mood states among clinical women with sexual complaints is more probable when there is low level of subjective arousal during intercourse and when erotic awakening occurs before puberty. Thus, we can presume that paradoxical relationship between negative mood and sex might be somehow associated with a history of early erotization of a child. This process of early erotic awakening and lately sex being used as a coping strategy, however, is not determined by any resulting sexual arousal or pleasure, but might be associated with an early awareness of a higher consciousness that is able to alleviate depression. Acquired inappropriate sexual scripts leading to problematic hypersexuality create a habit of paradoxical sexual activity in depressive mood states conditioned by the reward of finding, albeit temporarily, strong sense of self that brings alleviation from the depressive mood.

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Nersisyan N.R.,
Hakobyan A.E.,
Sahakyan S.

Department of Sexopathology, YSMU

Corresponding author email:
narine.nersisyan@sexology.am

Keywords:

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THE ROLE OF METABOLIC SYNDROME IN THE GENESIS OF ERECTILE DYSFUNCTION

SHAHRAMANYAN V.A.

Department of Sexopathology, YSMU

Corresponding author email: v.shahramanyan@gmail.com

INTRODUCTION. In recent years the so called metabolic syndrome, which is a complex of related disorders based on insulin resistance, i.e. insulin sensitivity, carbohydrate, lipid, purine metabolism, abdominal obesity, is paid more and more attention to in literature. For males, in compare with females, the deposition of adipose tissue is the central character. The greatest accumulation occurs in the abdomeninside,predominantly abdominally or visceral.

Testosterone stimulates the adrenergic receptors predominated in visceral adipose tissue, while the estrogen / progesterone – mainly theadrereceptors of subcutaneous fat. Visceral adipose tissue has a high metabolic activity, aimed at the synthesis of triglycerides and the release of large amounts of fatty acids.

METHOD USED. Hypogonadism, andropause is the state, caused by the decreased production of sex hormones or violation of their actions. The obvious relationship between the lack of function of the gonads and the development of obesity is proved.

Male congenital hypogonadism is also accompanied by obesity. However, obesity can exist without hypogonadism. Therefore, it is necessary to distinguish the hypogonadism obesity as the prime cause of obesity and hypogonadism caused by obesity.

Males have an inverse relationship between BMI and free testosterone. Free testosterone concentration is inversely related to the amount of visceral fat and the insulin resistance. It is proved that it was preceded by a decline in testosterone secretion and possibly contributes to visceral obesity.

RESULTS AND DISCUSSION. The correction of hypogonadism with androgens for males with obesity leads to a decrease in BMI by reducing the amount of visceral fat, a decrease in insulin resistance and reduction in diastolic blood pressure,thelipid profile improvement. Aromatase of excess adipose tissue (preadipodit) mainly converts androgens-testosterone, and androstendion into estrogens, which suppress secretion of gonadotropin-like releasing hormone and LH, which is manifested by the decreasing of testosterone secretion by Leydig cells, i.e. secondary hypogonadism. Low testosterone is an independent risk factor for the development of visceral obesity. Hypogonadism with obesity is an important factor in the maintenance and the progression of obesity.

For males with abdominal obesitythe testosterone level and gonadotropin-releasing hormone decrease,immune-reactive insulin level increase, the development of tolerance to carbohydrates and dyslipidemia, coronary heart disease and hypertension, and consequentlythe development of hypogonadism is observed.

CONCLUSIONS. In case of PDE-5 inhibitors an inefficient therapyof erectile dysfunction (ED) in metabolic syndrome is caused bythe lack of androgens in the body and the existence of neuropathy. The lack of androgens may be mainly caused by the overweight, hypogonadism and andropause. Reducing the level of testosterone can be the reason of libido lose.

Treatment of the ED in combination with androgen insufficiency and obesity must begin with obesity therapy, and then switching to the scheme of therapy PDE-5 inhibitors and androgens.

KEYWORDS:

metabolic syndrome, erectile dysfunction.

APPROACHES IN STARTING LEVODOPA TREATMENT FOR PARKINSON'S DISEASE IN ARMENIA

Introduction. It is well-known that long treatment with levodopa leads to delayed motor complications such as motor fluctuations and dyskinesias. One of the strategies to prevent this problem is to delay start of levodopa treatment, that could be reached by using dopamine agonists as a fist-line medication, especially for patients under 65 years old. The aim of this study was to establish time of starting levodopa treatment in relation to age of Parkinson disease (PD) patients.

Method Used. The sample was collected from patients, referred to Movement Disorders Clinic. Diagnosis was redefined using UK PDS Brain Bank diagnostic criteria. Patients taking levodopa were divided into two groups: Group 1 (G1) - under 65 years old, Group 2 (G2) - 65 and above. Presence of motor fluctuations and dyskinesia was assessed during interview.

Results And Discussion. A total of 70 PD patients aged 42-85 (M=63.4 years) of which 34 were females (48.6%) participated in the study. Thirty nine patients (55.7%) were treated with levodopa at the time of visit. Mean age of levodopa treated patients was 62.3 years and non-levodopa treated – 64.6 years. Twenty two patients (56.4%) were included in G1, with mean disease duration 6.7 years and mean age of starting levodopa treatment 51.6 years. Seventeen patients (43.6%) were included in G2 with mean disease duration 8 years and mean age of starting levodopa treatment 65.3 years. Levodopa was prescribed in average in 2 years after disease onset in G1 and in 2.8 years – in G2. Motor fluctuations occurred in 16 (72.7%) patients in G1 and in 7 (47.1%) patients in G2. Eight (36.4%) patients suffered from dyskinesias in G1 and 5 (29.4%) - in G2.

Conclusion. Our results show that among Armenian neurologists the age of PD patient is not an important criterion for starting levodopa treatment. This leads to early development of motor fluctuations and dyskinesias. This gap needs to be addressed in future.

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Tavadyan Z.D.[1,2],
Amroyan H.R.[1],
Yeghyan L.K.[1],
Bakunts H.H.[1]

1Chair of Angioneurology, Faculty of Postgraduate Education, YSMU
2 "Somnus" Sleep and Movement Disorders Clinic

Corresponding author email: zdtavadyan@gmail.com

Keywords:
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PSYCHOTHERAPEUTIC CORRECTION OF SEXUAL DISHARMONY DURING ANDROGEN DEFICIENCY

ZAKARYAN M.H.

Department of Sexopathology, YSMU

Corresponding author email: v.shahramanyan@gmail.com

INTRODUCTION. It's presented the system of psychotherapeutic correction of sexual disharmony. It's described new system of psychotherapeutic correction of sexual disharmony, when men are suffering from neuroses and sexual dysfunction.

Some of the symptoms of androgen deficiency include: reduced sexual desire, hot flushes and sweating, breast development (gynaecomastia), lethargy and fatigue, depression, reduced muscle mass and strength, increased body fat, particularly around the abdomen, weaker erections and orgasms, reduced amount of ejaculate, loss of body hair, reduced bone mass, therefore increased risk of osteoporosis.

Psychotherapeutic correction of sexual disharmony is a system of correcting measures including individual, couple and group psychotherapy methods.

We have modified and adapted the system of psychotherapeutic correction of sexual disharmony for married couples in which males had androgen deficiency and sexual dysfunction.

The development of sexual disharmony of married couples in cases when male suffers from androgen deficiency and sexual dysfunction is dependent not only on sexual function loss caused by main pathology, but also on psychological, sociopsychological and sexual behavioral adaptation.

During differentiated psychotherapeutic correction procedure one must consider clinical form of the androgen deficiency, specific manifestations and personal qualities of the patient.

The psychological correction of patients with androgen deficiency is directed at emotional state normalization, hyper-irritability and affective reactions control, decrease of general and psychic tones.

METHOD USED. During psychotherapeutic correction procedures we used these common psychotherapeutic methods: hypnosesuggestion, emotional-volitional training, rational psychotherapy, autogenic training, sexual behavioral training.

Emotional-volitional trainings were executed by A.T. Filatov method.

Hypnosesuggestion was directed at neurotic process remission and sexual function normalization.

RESULTS AND DISCUSSION. Psychotherapeutic correction of sexual health problems of men with androgen deficiency has a lot of distinctive features. First, it must be directed both at neurotic condition elimination and at sexual function normalization. Second, correction must involve the spouse of the patient also considering their interpersonal relationship. Third, it's important to consider the causes and conditions of personalization disturbance for both spouses.

Listed combination of the methods and techniques of psychotherapeutic correction with consideration of all the components of sexual harmony and their features gave the opportunity of having maximum results.

We examined the results of correction procedure after each treatment, as well as during revisiting and scheduled visits (1-2 times a year) of treated patients.

We emphasize that the effectivity of psychotherapeutic correction of sexual disharmony not always coincide with effectivity of androgen deficiency treatment.

So, the therapeutic correction of sexual disharmony during androgen deficiency is an optimal method which should be utilized altogether with different techniques and modifications.

KEYWORDS:

androgen deficiency, psychotherapy sexual disorder

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