



## To Study the Prevalence of Neurological Diseases in the Primary Health Care System

Rasulova Nilufar <sup>1</sup>, Aminova Asalya <sup>2</sup>

<sup>1</sup> Docent of the Department of Public Health, Healthcare Management of the Tashkent Pediatric medical institute (Uzbekistan)

<sup>2</sup> 4th year students of the Medical and Pedagogical faculty of the Tashkent Pediatric medical institute (Uzbekistan)

**Abstract:** Chronic kidney disease (CKD) is a global public health problem that is often undiagnosed and untreated. CKD is a "silent" disease and remains unnoticed because it cannot be "felt". However, it affects many more people than we can imagine: 1 in 10 adults in the world has some form of kidney damage. However, up to 90% of those with CKD remain undetected. High blood pressure and diabetes are the main causes of CKD. Diabetes is projected to increase by 70% by 2025. Therefore, early detection and prevention of the progression of CKD in people with very high cardiovascular risk are extremely important tasks and goals for general practitioners/family doctors (GP/CB). CKD is a progressive irreversible decrease in glomerular filtration rate (GFR). Unfortunately, most chronic nephropathies lack specific treatment, and they steadily progress to end-stage renal failure (ESRD). Progressive loss of renal function is common in kidney failure, regardless of the underlying cause of kidney disease.

**Keywords:** Chronic kidney disease (CKD), End-stage renal failure (ESRD), Nephrological diseases.

**Introductions:** The kidney is able to adapt to damage due to adaptive hyper filtration – an increase in filtration in the remaining normal nephrons. As a result, patients with mild renal insufficiency often have normal or almost normal serum creatinine concentrations. Adaptive hyper filtration, although initially useful, apparently leads to long-term damage to the glomeruli of the remaining nephrons, which is manifested by proteinuria and progressive renal failure. This process seems to be responsible for the development of kidney failure in those whose initial disease is either inactive or cured. The cost of severe renal failure and renal replacement therapy is enormous. Thus, early diagnosis and optimal treatment of CKD pose many problems for primary health care, helping to maintain health and quality of life among the population at risk. According to the position statement "Kidney disease: Improving global outcomes" (KD: IGO), the use of the term "disease" in CKD is consistent with:

1. the need for action to improve outcomes through prevention, detection, evaluation and treatment
2. providing communication for public, physician and patient education programs
3. general use its use in other conditions determined by results and laboratory tests, such as hypertension, diabetes and hyperlipidemia.

## Strong> Classification of CKD

CKD is classified according to severity, diagnosis, treatment and prognosis.<sup>9</sup> The five-stage classification is based on structural and functional criteria regardless of the cause and taking into account dialysis and transplantation. The suffix "T" is used for all transplant recipients with any GFR level, and "D" for dialysis for patients with stage 5 CKD receiving dialysis.

Clinical evaluation of CKD should include finding out the cause of the disease. However, it is not possible to determine the cause of the disease in all cases. In addition, renal function usually decreases with age, and the exact level of decline at this age, which should be considered pathological, is unknown. KD Statement: IGO considers GFR less than 60 ml/min to be a pathology at any age. Cross-sectional studies report a slow decrease in GFR after the fourth decade of life  $-0.75 \text{ ml/min}/(1.73 \text{ m}^2) \text{ /year}$ . These changes are slow, but in the presence of other diseases, such as diabetes, hypertension and heart disease, the kidneys become vulnerable to failure. Very few causes of chronic kidney failure are completely curable. There is often no need to conduct extensive tests to find the cause, especially when the symptoms of kidney failure are already present. However, in order to determine the stage and features of the underlying disease, dispensary monitoring of patients and a thorough diagnostic examination are necessary. Diabetes is one of the most common causes of kidney failure after glomerulonephritis in many countries. The main groups of diseases leading to end-stage renal failure are glomerulonephritis, diabetic nephropathy, hypertension, chronic pyelonephritis and polycystic kidney disease. In different countries, the proportions of these diseases as causes of renal failure vary: for example, glomerulonephritis accounts for 22-24% of patients with renal replacement therapy (RRT) in Estonia, Germany, Poland or Finland, but only 11-12% in France, Italy or England. Diabetic nephropathy patients account for 12% of HRT patients in Italy, 22% in Estonia, 24% in Finland and Poland, 23% in Germany, 12% in England, 30% in Japan and 37% in the USA.

Nephrotoxic agents such as non-steroidal anti-inflammatory drugs (NSAIDs), antibiotics, iodine-containing contrast agents and chemotherapeutic drugs are common causes of AKI, and the link is often quite clear given the short time interval between dose administration and changes in kidney function. The contribution of nephrotoxic agents to the development of CKD, such as proton pump inhibitors, is more difficult to determine, since the onset of the disease is more insidious. The pathophysiology of chronic nephrotoxicity varies from interstitial inflammation to damage to the tubules and glomeruli. It is also important that alternative remedies are often used in high-income countries and may play an underestimated role in the development of both AKI and CKD. Both the public and healthcare professionals should be aware of the risks of nephrotoxicity of drugs and alternative remedies, as well as the potential interactions between them, so that their use as a CKD prevention strategy can be minimized or optimized. . Calls for better regulation of alternative remedies are needed to improve product standardization and develop proper understanding and warning regarding potential toxicity.

### Conclusion:

1. Health care systems should guarantee the population's access to primary health care with referral to secondary health care, if necessary.
2. Primary health care should play a leading role in the implementation of CKD screening programs in at-risk groups, and health systems should provide resources for this.
3. Primary health care is ideal for primary and secondary prevention of CKD. It is important to understand that CKD significantly increases the overall cardiovascular risk; therefore, its preliminary

Prevention of CKD is possible, but requires a broad and holistic approach — from proper management and achievement of Sustainable Development Goals to ensuring healthy pregnancies for a good start in life — and access to appropriate screening for early detection and treatment of risk factors for CKD, as well as early CKD. In some countries, the management of traditional risk factors has improved, but even in developed countries, significant gaps remain in the provision of assistance,

especially with regard to early detection of risk (for example, detection and monitoring of albuminuria) and the elimination of these risks, especially in disadvantaged health sectors. population size. Non-traditional risk factors remain undervalued in many settings. Addressing these gaps will require multifaceted engagement with stakeholders, including the development and implementation of strong public health measures to prevent CKD risk factors, especially diabetes, hypertension and obesity; patient rights protection and awareness-raising tools; and the promotion of self-management programs. It is also necessary to develop a strong primary health care capacity to implement targeted screening, early diagnosis and early treatment strategies.

### Used literature

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