

Conclusions:

1. There is increasing evidence suggests that erectile dysfunction is primarily avascular disease and may be a marker for cardiovascular disease, and depending on the degree of erectile dysfunction can appreciate the progression of pathology CV
2. Patients with erectile dysfunction should be carefully examined, to exclude other major disorders suffering patient which clinically not yet occurred.
3. Exclusion of risk factors and lifestyle changes can improve sexual function and also prevent installation of early CV disease.

Key-words: Erectile Dysfunction(ED), Cardio-Vascular Disease(CVD), Endothelial Dysfunction.

CARDIAC AUTONOMIC NEUROPATHY IN DIABETES

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Introduction: Cardiovascular form of diabetic autonomic neuropathy (CDAN) is represented by sympathetic (accelerative) and/or parasympathetic (inhibitive) influence upon cardiovascular system induced by prolonged action of elevated glycemia. CDAN perturbs cotidian usual activity, decreases life quality, increases mortality level and also it occupies an imposing part of healthcare service costs[2]. According to different studies, CDAN prevalence variates between 16,8 - 25,3% in diabetes type 1 and 22,1 - 34,3% in type 2. [3]

CDAN manifestations such as decrease in effort toleration level and silent ischemia, determine an unfavourable prognosis, as a result myocardial infarction develops 50% more frequently in CDAN diabetics versus non-CDAN (Valensi J. 2001). Prolonged QTc interval, being an independent predictive factor of cardiovascular mortality, is associated with a high risk of developing malignant ventricular arrhythmias and sudden death.

Prompt diagnosis and chronic complications screening of diabetes have a positive impact upon therapeutic efficiency, life quality improvement and decrease in mortality level.

Objectives: Frequency determination of cardiovascular form of diabetic autonomic neuropathy depending on type of diabetes, its duration in concordation with clinical and paraclinical data.

Materials and methods: There have been examined 72 patients (18 with type 1 diabetes and 54 with type 2) through clinical (examination, inquiry) and paraclinical (Ewing tests, QTc interval, sinus rhythm variability, circadian index) methods. This patients were divided, according to diabetes duration, into 3 groups – A(0-5years), B(5-10years) and C(>10years).

Results: In group of patients with type 1 diabetes, CDAN incidence - 22,2% (4 pts). Group A: 6 pts., with average duration of diabetes $2,4 \pm 3,2$ years – there wasn't any data of CDAN. Group B: 8 pts., average duration $9,4 \pm 1,6$ years, signs of CDAN were determined in 2 pts (25%). In group C: 4 pts., average duration $17,5 \pm 6,2$ years – 2 pts (50%).

In group of patients with type 2 diabetes, CDAN incidence - 29,6% (16 pts). Group A: 17 pts., average duration $2,89 \pm 1,62$ years – CDAN data in 17%. Group B: 21 pts., average duration $10,32 \pm 1,5$ years, CDAN in 43% cases. In group C: 16 pts., average duration $17,56 \pm 4,8$ years, CDAN signs in 25% cases.

Conclusions: In type 1 diabetes first signs appear after a diabetic evolution of over 5 years with subsequent incidence elevation directly proportional to diabetes duration. In type 2 diabetes CDAN mani-

festations may be present during primary diagnosis, determining an insignificant increase in incidence during evolution.

All patients with type 1 diabetes with diabetic duration over 5 years and patients with type 2 diabetes during diagnosis – require evaluation against CDAN.

Clinical manifestations of DAN may significantly affect patients life, however it continues to be frequently misdiagnosed [1]. Application of functional tests, ECG, inquiry and Holter-ECG monitoring distinguish precocious signs of CDAN much before suggestive clinical manifestations.

Key words: diabetic autonomic neuropathy, Ewing tests, QTc interval