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## APPROACHES TO SECONDARY PREVENTION AND REHABILITATION OF STROKE

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Tserebrovascular diseases are one of the most common causes of disability and death among the population. A stroke often leaves severe consequences in the form of movement, speech and other disorders, significantly crippling patients. The main goal of rehabilitation of stroke patients is to restore their physical, psychological and professional activity, independence in everyday life.

- One of the main tasks of rehabilitation is to restore movement, walking and self-service in the paretic limbs. 100 (81.2%) of post - stroke survivors experienced movement disorders (including severe— 27 (22.3%) movement disorders, by the end of the first year movement disorders (Hemi-and less monoparesis) were recorded in 61 (49.7%), compared to 14 (11.5%) of patients survived by that time (including severe ones).. These numbers indicate a great prospect for restoring damaged motor functions.

A set of measures to reduce muscle spasticity, which will help prevent the development of contractures.

Patients were examined for spastic limb conditions on the Ashworth scale before starting the above treatments. The resulting score on the modified Ashworth scale of spasticity in the limbs averaged 8 points.

Thus, in the rehabilitation process, many in the group of patients had a degree of need for others.

Thus, navigation TMS, referring to anatomical structures, made it possible to accurately determine the localization of cortical images of motor functions in a given patient; to determine the stimulation force (CHMP limit) necessary and sufficient to excite a group of neurons of a certain depth. As a result, in accordance with the maximum amplitude of chmp, a point corresponding to the basal primary Sox (M1) was chosen and reserved for further rhythmic stimulation.

The second stage consisted of TMSs of the selected point with a frequency of 10 Hz, with a magnetic field intensity of 70% (80% of the response limit). Each stimulation session consists of 10 series of 2 seconds, the break between the series was 58 sec. 200 stimuli were performed in one session. Stimulation was carried out daily for 10 days. The total number of incentives according to the course of treatment is 2000.

In the course of the study, patients were divided into 2 groups in order to carry out rehabilitation measures. According to this 1 guru rehabilitation standard treatment,





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botulotoxin, TMS method  $N=65$  and 2 Guru rehabilitation standard treatment(after treatment) was made up of  $n=59$  patients.

Results on amsh up to treatment without the TMS method showed  $8.1 \pm 2.1$  points, and changes in dynamics after treatment with TMS and botulotoxin showed  $3.1 \pm 1.6$  points. The severity of pain on the vash scale showed  $7.0 \pm 2.5$  points up to treatment in 1 guru patients,  $3 \pm 1.5$  points after treatment,  $6.0 \pm 1.9$  points up to treatment in 2 Guru patients,  $8 \pm 2.1$  points after treatment. According to the results of the degree of extensibility of the patient in the study group to daily life, 1 group of patients received a pre-treatment estimate of  $75.5 \pm 2.9$  points, while  $88 \pm 2.4$  points after treatment. In 2 Guruh patients who had suffered a stroke, the pre-treatment extirpation rate showed  $73.5 \pm 3$  points, followed by  $72 \pm 3$  points after treatment.

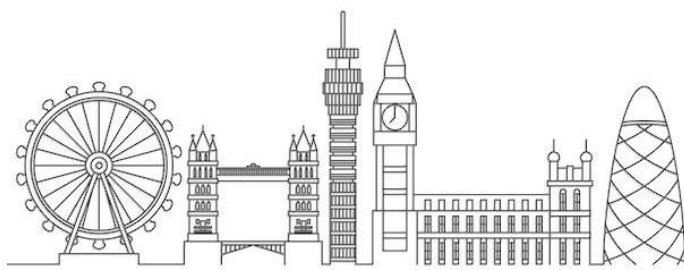
To reduce muscle tone, positional treatment and a number of special exercises and techniques are used. A distinctive feature of posisia treatment, unlike the initial period of the disease, is the duration of fixation of the paretic limbs in the position of maximum distance from each other from the spastic muscle attachment points: removable plaster longets or orthoses are applied 2-3 times a day for 2-4 hours, and with significant spasticity, they are left overnight.

Special gymnastic techniques for relaxing muscles include light squatting of the limbs, "positivity" and rocking movements, rolling the palm surface of the arms and legs along a rotating roller, stretching the spastic muscles. Below are some exercises using the relaxation technique.

Conclusion: in conclusion, we want to highlight a few more important points. In the secondary prevention of stroke, the impact Sox of doctors are very important and responsible. If neurologists, primary care physicians, general practitioners, as well as all doctors who have come into contact with stroke patients in one way or another act on a competent and collegial basis, then the likelihood of repeated acute cerebral circulatory disorders is significantly reduced. In this guide, we have focused on the contributions of the doctor.

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