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DIABETES MELLITUS WITH TYPE 2, DIABETIC PERIPHERAL SLEEP DISORDERS IN PATIENTS WHO ARE COMPLICATED BY A PAINFUL FORM OF NEUROPATHY

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Annotation: This article examined the sleep quality of patients with diabetes mellitus 2 Type (QD 2 Type), which is complicated by the painful form of diabetic polyneuropathy (DPN). 50-80% of patients with chronic pain experience sleep disorders,while the severity of sleep disorders depends on the strength of the pain. Sleep disorders and neuropathic pain are interrelated and should be treated at the same time. One of the factors that affect sleep in order to improve sleep - the treatment of the painful form of DPN leads patients to improve the quality of sleep and, alternatively, the quality of life of them. The relationship between neuropathic pain and sleep disorders is twofold.Neuropathic pain patients develop sleep disorders with large extimol, and these sleep disorders in turn lead to increased pain. A positive relationship has been found between pain sensitivity and sleep disorders. Pain tolerance has been found to decrease in patients with chronic pain and insomnia. In our examination, 120 people received ogrigan patients with 2 types of QD. The duration of QD was 3 to 12 years, with those examined averaging 56.6±9.8 years of age, of which 79 (65.8%) were women and 41 (34.2%)were men. In contrast, the control group received 20 non-QD patients, of whom 5 (25%) had AG, with an average age of 55.9±7.5 years. Patients were classified into two groups with sleep quality disorders and no sleep quality disorders.
100% of patients with QD type 2, complicated by the painful form of DPN, were found to have varying levels of sleep quality disorders. In this case, the most reported complaints of patients in Group 1 were “feeling of post-waking fatigue from night sleep”, this complaint was reported by 100% of patients, while only 45% of patients in Group 2 accounted for patients. Other complaints that determined the quality of sleep in patients also dominated Group 1 patients. This in turn reaffirmed that the painful form of DPN QD 2 has an effect on the quality of sleep of different patients.
Keywords: Diabetes Mellitus Type 2, diabetic neuropathy, peripheral neuropathy,neuropathic pain, sleep disorders, sleep quality, neuropathy and pain, pain and sleep.

Currently, the most common complications of QD, peripheral and vegetative nerve
it is a group of clinical syndromes that are accompanied by the jarochatalization of their system. Usually known as various forms of neuropathy, diffuse and foci of the nervous system
injury-causing syndromes occur in almost half of patients with QD .
The most common form of diabetic peripheral neuropathy (DPN), a painful form of polyneuropathy or neuropathic pain, is characterized.
Painful DPN can be acute and chronic. Of the DPN painful type
for its chronic form, with periods of undulating, remission and aggravation of pain
it is characteristic that the course and painful syndrome lasts more than 3 months. For neuropathic pain, the daily rhythm of symptoms is characteristic: it intensifies until late and at night. Symptomatics, on the other hand, can be varied: aching, acute pain, stinging pain, painful rubbing, vein pulling. Along with the symptoms indicated in most cases, sensitivity disorders or lack of sensitivity and decreased or absent reflexes are observed.

The painless species, however, slowly develops sensomotor insufficiency, accompanied by minimal symptomatics in which no pain is present. Typical complaints, on the other hand, are associated with rubbing of the legs and a decrease in sensitivity.In the objective view, it is found that there is a decrease in the variety of sensitivity and whether the reflexes are rasay or not.

Nerve fiber damage other complications of QD in some cases

it occurs even before its development and may be the first clinical sign of carbohydrate metabolism disorders. Pathological changes in the nerves develop as early as the stage of violation of glucose tolerance, and damage to non-myelinated nerve fibers occurs much earlier than in myelinated nerve fibers, which leads to an increase in the number of disability, Hatto death.

Glycemic attention in a modern approach to the treatment of diabetic neuropathy

it will focus on improving control, improving the lifestyle and reducing neuropathic pain. The optimal therapeutic approach in patients with QD involves a change in mood, with an emphasis on parchesis and physical training with optimal control of lipids and arterial blood pressure. Glycemic control with a target indicator of HbA1c < 6% increases mortality in QD patients, with little effect on diabetic neuropathy, for which reason this indicator is not recommended as a treatment standard. As part of a broader approach to good glycemic control,treatment with an individual approach is the optimal choice for QD li patients.

Neuropathic pain causes sleep disorders in patients and sleep disorders own

in turn, it can be from the causes of increased pain. From this it can be said that when treating neuropathic pain, at some point it will also be necessary to improve sleep. Currently, patients are leaving with regard to the use of both pain-reducing and sleep-improving drugs. Anticonvulsants such as Pregabalin and gabapentin improve neuropathic pain and comorbid has a good effect on sleep disorders. Opioids and antidepressants reduce pain but do not affect sleep. 50-80% of patients with chronic pain experience sleep disorders, while the severity of sleep disorders depends on the strength of the pain . Sleep disorders and neuropathic pain are interrelated and should be treated at the same time. Despite the fact that improving sleep reduces pain, the main focus in the treatment of modern day is on reducing pain .

The relationship between neuropathic pain and sleep disorders is twofold .

Neuropathic pain patients develop sleep disorders with large extimol, and these sleep disorders in turn lead to increased pain. A positive relationship has been found between pain sensitivity and sleep disorders. Pain tolerance has been found to decrease in patients with chronic pain and insomnia . For example, the clinical evaluation process for neuropathic pain after spinal cord injury should also include sleep quality assessment.

The stages of diabetic peripheral neuropathy of QD are listed in the table below.

Table 1.

Classification of DPNs by weight level

DPN level	Characteristic
Stage 0 (DPN"-")	DPN has no clinical and electrophysiological symptoms
Stage 1, subclinical (DPN1	DPN has no objective neurological signs and symptoms. EMG and when 2 changes are detected in the quantitative autonomous examination.
Stage 2, clinical (DPN2)	Complaints specific to DPN. Sensitivity, malaise, autonomic disorders, bending muscles of the leg have signs of weakness or not can be (the patient cannot stand on the heel).
Stage 3, heavy (DPN3	Cocktail activities lead to disruption and/or social adaptability incoming neuropathy.

The body's response to neuropathic pain relieving drugs is to

predictability in the selection and recording of medicines for doctors

challenges [9]. Antidepressants in the treatment of neuropathic pain,

anticonvulsants, tramadol, opioids and other analgesics are used [9]. The Special Interest Group on Neuropathic Pain (NeuPSIG) of the International Association for the Study of Pain (IASP) conducted a double-blind study meta analysis and systematic review of neuropathic pain management. The results of the study suggest a review of NeuPSIG recommendations for neuropathic pain pharmacotherapy (tricyclic antidepressants, inhibitors of serotonin and norepinephrine reuptake, first-line agents such as pregabalin and

gabapentin, and second-line agents such as the less recommended lidocaine, caspaisin, and tramadol).
New anticonvulsant agents such as Pregabalin and gabapentin relieve neuropathic pain
relieving, as well as comorbid has a good effect on sleep disorders. Patients who received gabapentin or pregabalin for the cause of neuropathic pain had improved sleep length and sleep saturation, in addition to improved deep sleep, improved depression and anxiety, which were claimed by patients. Anticonvulsants such as oxcarbazepine, lamotrigine,gabapentin, and pregabalin can be used in second line treatment sieve such as baclofen (myorelaxant and antispastic agent).Carbamazepim(anticonvulsant) has been proposed as the first line treatment for Trigeminal neuralgia [10]. The benefits of pregabalin,gabapentin, venlafaxine, duolexetine, tricyclic antidepressants, and opioids have been demonstrated in the pain of diabetic neuropathy.
Opioids must be applied with extensibility to reduce pain, but cannot be used in sleep disorders. In addition, sleep breathing disorders such as central sleep apnea developed when opioids were administered.

Research objective:

A study of sleep quality in patients with diabetes mellitus 2 type, with complications with diabetic peripheral neuropathyanigic painful type.

Conclusions:

1. Dpnning in patients in Groups 1 and 2 with Type 2 diabetes mellitus
the subclinical stage was found in 56.9% and 60.9%, the clinical stage - 25.8% and 39.1% of patients, respectively. Thus, in patients with Type 2 diabetes, a subclinical stage of DPN is often identified.
2. The main risk factor for the development of DPN is hyperglycemia and dyslipidemia
is. At the same time, the amount of HbA1c in both groups is 37 and 39% higher in mosrawish compared to the control group. Levels of bad lipids such as PZLP in the blood are also high at 43 and 45%, respectively.
3. Sleep in 100% of patients with Type 2 diabetes with complications of DPN
impairment of quality has been found. This is countered by the Pittsburgh survey finding that the average sleep Rate Index For Group 1 patients was 10.89±0.77 points (r0.05), while in Group 2 the index was 4.92±0.77 points. This is another confirmation that the DPN sore form in the uz queue has an effect on the quality of sleep in 2 different patients with QD.

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