

СПИСОК ЛИТЕРАТУРЫ:

1. Аляви А.Л., Рахимова Д.А., Садыкова Г.А., Сабирджанова З.Т. Адаптационный потенциал эндотелий-зависимой вазодилатации у больных бронхиальной астмой // Материалы научно-практической конференции. - Харьков, 2011. - С. 8
2. Аляви А.Л., Д.А. Рахимова, Г.М. Касимова Нейрогуморальная активация при различных степенях ремоделирования правых отделов сердца у больных бронхиальной астмой и эффективность комплексных режимов лечения // Материалы научно-практической конференции. - Харьков, 2011. - С.7.
3. Гафнер Н.В., Ливерко И.В. Оценка вазодилатационных и адаптационных эффектов комплексной терапии больных БА // Актуальные вопросы фтизиатрии и пульмонологии в Узбекистане: // Сб. научных трудов. Ташкент, -2009. -С.93-96.
4. Долинина, Л.Ю. Качество жизни больных бронхиальной астмой и его динамика на фоне терапии комплексными гомеопатическими препаратами // Болезни органов дыхания. -2008. -№ 1. -С. 46-52.
5. Козина О.В., В.В. Андрушкевич, А.Э. Сазонов и др Клинико-биохимические аспекты развития обструкции бронхов при бронхиальной астме // Пульмонология. -2008. - №2. - С. 52-58.
6. Шахнис С.А., Омеляненко М.Г. Роль дисфункции эндотелия, гипоксии в формировании легочной гипертензии у больных бронхиальной астмой // Пульмонология. -2008. -№2. -С. 38-41.
7. Овчаренко С.И. Влияние психосоматических соотношений и расстройств личности на динамику контроля течения бронхиальной астмы // Пульмонология. -2009. - № 3. - С. 82-88.
8. De Man F.S, Handoko ML, van Ballegoij JJ, Schalij I, Bogaards SJ, Postmus PE, van der Velden J, Westerhof N, Paulus WJ, Vonk-Noordegraaf A. Bisoprolol delays progression towards right heart failure in experimental pulmonary hypertension // Circ. Heart Fail. -2012. -Vol. 5(1). - P. 97-105.
9. Sanz J, Garc?a-Alvarez A, Fern?andez-Friera L, Nair A, Mirelis JG, Sawit ST, Pinney S, Fuster F. Right ventriculo-arterial coupling in pulmonary hypertension: a magnetic resonance study // Heart. -2012. -Vol. 98(3). - P.238-243.

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EXODUS OF PREMATURE BIRTH

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✓ Resume,

The problem of preterm birth, is one of the first places in practical obstetrics, as they determine the level of perinatal mortality and morbidity. Premature babies account for 60-70% of early neonatal mortality and 65-75% of infant mortality. Stillbirth in preterm birth is 8-13 times higher than in timely delivery.

Key words: premature race, perinatal risk.

MUDDATDAN OLDINGI TUG'RUQ NATIJALARI

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Buxoro davlat tibbiyot instituti.

✓ Resume,

Muddatdan oldin tug'ilish muammosi, perinatal o'lim va kasallanish darajasini aniqlaganligi sababli, amaliy akusherlikda birinchi o'rinlardan birini egallaydi. Muddatdan oldin tug'ilgan chaqaloqlar 60-70% erta neonatal o'lim va 65-75% chaqaloq o'limini tashkil qiladi.

Kalit so'zlar: erta tug'ruq, perinatal xavf.

ИСХОДЫ ПРЕЖДЕВРЕМЕННЫХ РОДОВ

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✓ Резюме,

Проблема преждевременных родов, занимает одно из первых мест, в практическом акушерстве, так как именно они определяют уровень перинатальной смертности и заболеваемости. На долю недоношенных детей приходится 60-70% ранней неонатальной смертности и 65-75% детской смертности. Мертворождаемость при преждевременных родах в 8-13 раз выше, чем при своевременных родах

Ключевые слова: преждевременным род, перинатальный риск.

Introduction

The problem of preterm birth, is one of the first places in practical obstetrics, as they determine the level of perinatal mortality and morbidity. Premature babies account for 60-70% of early neonatal mortality and 65-75% of infant mortality [1, 2, 3]. Stillbirth in preterm birth is 8-13 times higher than in timely delivery [4, 5]. Children born weighing less than 1500 g, 200 times more often die newborns and, if they survive, 10 times more often have neurological and somatic complications than children born weighing over 2500 g [6, 7]. Criteria of vitality of the fetus:

term - 22 weeks or more, body weight - 500 g or more.

The perinatal mortality statistics, in accordance with WHO recommendations, include all cases of birth of a fetus and newborn with a body weight of 500 g or more (or, if the body weight at birth is unknown, body length is 25 cm or more or a gestation period of 22 weeks and more) "In this regard, issues of timely diagnosis of the causes and the development of optimal tactics for pregnancy and preterm birth are becoming particularly acute. The problem of preterm birth has always had great social significance. Contrary to the efforts of scientific and practical obstetrics, the frequency of preterm birth does

not tend to decrease. The birth of a premature baby, especially with extremely low body mass (EBMT) and very low body mass (ONMT), is a psychological burden for family members and their associates, a social burden for society [11,12]. The problem is associated with the high cost of nursing these children, the high frequency of disability.

The choice of method of delivery for preterm birth is sometimes a difficult task. According to the literature, only about 25% of pregnant women with a gestational age of 28-37 weeks are delivered through the birth canal. This group, as a rule, consists of premature birth without obstetric complications or extragenital pathology. In 75% of cases of preterm labor, delivery occurs by cesarean section [8, 9, 10].

Purpose of the study

The aim of the work was to study the perinatal outcomes of preterm labor depending on the method of delivery.

Materials and methods

For the period 2017-2018 On the basis of the Bukhara Maternity Complex No. 1, a retrospective analysis of 129 histories of preterm birth was performed at gestational periods ranging from 22 to 37 weeks. For analysis, the indicated cases of preterm birth were divided into four groups, according to the classification of preterm birth, based on the gestational age of the newborn:

The 1st group - from 22 to 28 weeks (27 weeks 6 days) - newborns with EBMT, up to 1000 g, the prognosis is extremely unfavorable, high rates of perinatal mortality and morbidity - 19 (15.3%) births;

Group 2 - 28-30 weeks 6 days - ONMT, up to 1500 g, where the birth outcome for the fetus is more favorable - 28 (22.1%) births;

Group 3 - 31-33 weeks; 6 days - moderate prematurity - 34 (26.2%) births;

Group 4 - 34-36 weeks 6 days - 48 (37.1%) deliveries.

Research results

The age of the patients examined by us ranged from 18 to 35 years, the average age was 26 ± 1.5 years, no significant differences in age were observed in all groups. A clinical and statistical analysis of the state of somatic and reproductive health of the examined patients showed that, in general, the groups are comparable in the main parameters analyzed. In the somatic status of patients, chronic hypertension should be noted, which was significantly more common in the 1st and 2nd groups (20.3% and 19.4%, respectively), compared to the 3rd and 4th groups - 4.9% and 3.6%, respectively ($p < 0.05$). Chronic pyelonephritis was significantly more common in the 1st and 2nd groups (20.3% and 18.4%) of observations, in comparison with the 3rd and 4th groups (10.3% and 9.1%) of observations ($p < 0.05$). The nature of the menstrual function in all patients had no significant violations. It is noteworthy that among gynecological diseases, the carrier of a viral infection in the 1st and 2nd groups (20.3% and 17.9%) of cases was encountered with great frequency, compared to the 3rd and 4th groups (15.3% and 13.1%), respectively. Chronic endometritis in the 1st and 2nd groups was significantly more frequent

(23.2% and 19.4% of cases) in comparison with the 3rd and 4th groups (10.6% and 8.8% of cases) accordingly ($p < 0.05$), which also indicates adverse factors for pregnancy planning and is a high risk factor for carrying a pregnancy. Studying parity in the studied groups, it was established that the multiplying patients in the 1st group - 9 (7.6%), in the 2nd group 17 (15.3%), in the 3rd group - 26 (19.7%) , in the 4th group - 38 (29.9%), respectively.

From obstetric history, it was revealed that all patients had a high percentage of uterine curettage (two or more) in history: in the 2nd group in 42.4%, in the 3rd group in 37.1%, in the 4th group in 36 , 2% and in the 1st group in 30.7% of patients. Perinatal losses due to a premature birth in the history of patients in the 1st and 2nd groups were significantly more frequent. The course of this pregnancy was complicated by an acute respiratory viral infection (ARVI) with a rise in body temperature above 37.5°C significantly more often in the 1st group compared to other groups: in the 1st group - in 10 (8.9%) patients ($p < 0.05$), in the 2nd in 6 (4.6%), in the 3rd in 8 (5.2%), in the 4th in 8 (1.7%), respectively. The threat of miscarriage was significantly more common in the 3rd and 4th groups in 23 (21.4%) and 34 (32.2%) patients, respectively, compared with the 1st and 2nd groups in 14 (21%) and 14 (30.4%) patients, respectively ($p < 0.05$), that is, starting from the first trimester of pregnancy, the patients examined by us had factors leading to a complication of the course of pregnancy. The results of our research are supported by literature data, where the threat of abortion is a frequent complication of the course of pregnancy ending in preterm labor and ranges from 38.9% to 43.8% [1, 4, 6]. One of the most dangerous complications of pregnancy is preeclampsia, eclampsia. Pre-eclampsia was significantly more frequently observed in the 4th group - in 19 (28.3%) patients, compared with the 2nd (2-0.9%), the 3rd (5-3.3%) and the 1st (2-2.9%) groups ($p < 0.005$), which, apparently, is more associated with the timing of gestation. Placental insufficiency prevailed in the 2nd group and amounted to 39.4%, while in the 1st group it was 14.7%, in the 3rd group - 12.2% and in the 4th group - 4, 8%, respectively ($p < 0.005$). Summarizing the analysis of the course of this pregnancy, we came to the conclusion that the risk factor for preterm labor is SARS with a rise in body temperature in the first trimester, the threat of termination of pregnancy, especially in the first trimester, multiple pregnancy and placental insufficiency. Further research was aimed at studying the course of labor and, accordingly, analyzing the outcome of labor for newborns in the respective groups depending on the method of delivery. Delivery through the birth canal was carried out in 1-to the 16th group (14.5%), in the 2nd group in 25 (23.4%), in the 3rd group in 10 (17.1%) patients, in the 4th group in 45 (44, 2%), respectively. In the 3rd group, delivery through the natural birth canal was significantly inferior to the abdominal delivery. An analysis of the duration of delivery through the birth canal showed that in the 1st, 2nd and 4th groups, there was a rapid birth up to 4 hours in 27.3 %, 24.1% and 19.6% of multiparous patients, respectively. In this connection, the average duration of labor in these groups is significantly less and was 6 hours 42 ± 12 minutes than in the 3rd group, in which the average duration of labor was 9 hours and 15 ± 6 minutes, there were no quick births. In all groups, with a prolonged anhydrous period of 12 hours or more, antibacterial therapy was carried out, before which,

material for bacteriological examination was collected from the cervical canal. According to the results of bacteriological research, conditionally pathogenic microflora was sown most often: *Escherichia coli* - 18.4%, *Staphylococcus aureus* - 12.6%, *Enterobacter* spp. - 5.0%, *Enterococcus* spp. - 4.6%. We drew parallels between the duration of the anhydrous period, the results of bacteriological seeding, and the development of chorioamnionitis. In the 1st group, chorioamnionitis was diagnosed in 30.6%, in the 2nd group in 18.9%, in the 3rd group in 14.3%, in the 4th group in 3.4% of patients. The highest percentage of complications in the form of chorioamnionitis was observed in the 1st group in 30.6% of patients. In this group, the largest percentage (28.8%) of patients with positive bacteriological findings was observed. The smallest percentage of complications in the form of chorioamnionitis occurred in the 4th group (5.4%) of cases, in this group a positive result of bacteriological seeding was observed in 3.1% of patients. Thus, the development of chorioamnionitis directly depends on the microflora of the birth canal and the duration of the anhydrous period. The leading principle for preterm labor is their careful management. Births through the birth canal in such cases against the backdrop of epidural anesthesia. The method of choice for anesthesia for preterm labor was epidural anesthesia in all studied groups: in the 1st group - in 3 (2.5%), in the 2nd - in 3 (2.5%), in the 3rd - in 24 (10.8%), in the 4th, in 3 (2.5%) patients. If possible, we carried out prevention of the syndrome of respiratory disorders (SDR) with dexamethasone in short and long courses at the rate of 24 mg of the drug per course. In the 1st group, the prevention of SDR was carried out in 11 (13.2%) cases, in the 2nd group in 15 (15.2%), in the 3rd group in 19 (20.1%) and in the 4th group in 17 (16.6%) cases. By the number of cases, the prevention of fetal SDR was more often carried out in the 4th group. The lack of prevention of SDR of the fetus is explained by the time from admission to delivery, from 40 minutes to 6-8 hours, when it was necessary to deliver on an emergency basis or a gestation period of more than 34-36 weeks. After delivery, we evaluated the condition of the premature baby on the Apgar scale. The increased frequency of inhibition of vital functions in a newborn baby correlates with a low assessment of the state at birth. An important predictive value is the assessment of the child's condition 5 min after birth; if it remains low, the prognosis is poor. Adaptation of the cardiovascular system to extrauterine life occurs simultaneously with the adaptation of the lungs. In the 1st group, the average Apgar score was in the first minute 3.4 ± 1.6 points, in the fifth minute 4.1 ± 1.3 points. In the 2nd group, the average Apgar score was in the first minute 5.2 ± 1.8 points, in the fifth minute 6.1 ± 1.5 points. In the 3rd and 4th groups on the 1st minute 6.6 ± 1.4 points; 7.1 ± 1.6 points, on the 5th minute 7.5 ± 1.3 points; 8.0 ± 1.1 points, respectively. Comparing the incidence of cesarean section and perinatal outcomes, it was noted that the assessment of the condition of newborns on the Apgar scale is higher for abdominal delivery. According to the results of the analysis, in the 1st group there were no particular differences in the assessment of the condition of the newborns, depending on the method of delivery.

In the 2nd and 3rd groups, delivery by cesarean section increased the Apgar score on newborns (6.3 ± 1.3 points; 6.9 ± 1.4 points; 6.7 ± 1.5 points; 7.2 ± 1.7 points, respectively) in comparison with delivery through the

birth canal (5.1 ± 1.1 points; 5.3 ± 1.2 points; 6.1 ± 1.2 points; 6.5 ± 1.4 points respectively). In the 4th group, Apgar score was higher in newborns delivered via the birth canal (7.1 ± 1.1 points; 8.2 ± 1.3 points) compared with patients given by a cesarean section (6.3 ± 1.3 points; 6.9 ± 1.4 points). The results obtained by us correspond to the data of the literature [1]. Newborns of the 1st group had an average birth weight of 721 ± 103 g, in the 2nd group - 1120 ± 218 g, in the 3rd group - 1670 ± 170 g, in the 4th group - 2300 ± 170 g.

The most serious complication of labor for a premature baby is birth trauma, which occurs seven times more often in preterm labor than in timely delivery [12]. The following features of premature newborns predispose to birth trauma: a relatively large head, mainly due to the cranial skull, soft bones of the skull and open seams and springs, including lateral springs [13]. The cerebral vessels have a subependymal germinal layer located above the head and body of the caudate nucleus, it becomes thinner after the 30th week of gestation and disappears almost completely by the 36th week.

This area is the source of most cases of intraventricular hemorrhage in premature babies [14]. Analysis of perinatal outcomes in the studied groups once again indicates a direct dependence on the period of gestation and the method of delivery. According to the data obtained, in the period of 22-27 weeks of gestation (group 1) there was a high percentage of perinatal mortality in 31 (44.5%) cases. Out of the 1st group, 17 (40.4%) of newborns were transferred to the second stage of nursing. In terms of 28-30 weeks (group 2), perinatal outcomes are optimistic, and a direct dependence on the delivery method by cesarean section was noted; there were no cases of perinatal losses in this group.

In the 3rd and 4th groups there was one case of perinatal loss due to the following obstetric complications (1 case - decompensation of placental insufficiency, 1 case - PONRP, bleeding). All other newborns of the 3rd group were transferred to the second stage of nursing in the premature wards. In the 4th group, 302 (59.4%) of newborns were discharged home. Transfer of newborns to the second stage of nursing was carried out mainly in the 1st group on the 7th day, in the 2nd, 3rd, 4th groups for 3-4 days.

The structure of the pathoanatomical diagnosis in the 1st group prevailed: severe asphyxia - 47.7%, lung atelectasis - 20.4%, lung distelectasis - 19.4%, equally often multiple petechial hemorrhages, congenital generalized infection - productive portal hepatitis, small focal productive pneumonia, grade II - IV intraventricular hemorrhages - 20.7%. In the 2nd and 4th groups there was no perinatal loss, in the 3rd group - 1 (0.6%) case of perinatal loss due to grade II intraventricular hemorrhage in combination with congenital heart disease (hypoplasia of the left heart).

Findings:

1. Modern obstetric tactics with the threat of abortion, aimed at prolonging pregnancy under the control of the functional state of the fetus, makes it possible to conduct a full course of prevention of SDR, thereby allowing to improve the perinatal outcome of preterm birth. However, we noticed that in the 1st group, the prevention of SDR by dexamethasone did not have the expected effect on the perinatal outcome, most likely this is due to the deep

prematurity of the fruit. 2. The method of choice of delivery for preterm labor in pregnant women of high perinatal risk should be prompt delivery, since it significantly reduces the rate of perinatal mortality. However, in the gestation period from 22 to 28 weeks, cesarean section, as shown by our results, does not increase the viability of the newborn. In the period of gestation from 29 weeks to 34 weeks, a more careful delivery method should be considered a cesarean section, based on the perinatal risk. After 34 weeks, the operative delivery method does not affect the perinatal outcome. In the structure of indications for operative delivery, there were those indications that are equally common in the general population and were not determined by the period of gestation. The method of choice of delivery in gestation after 34 weeks is birth through the birth canal. 3. The risk of preterm birth is determined in accordance with the risk strategy in obstetrics and perinatology. Our analysis was determined on the basis of biomedical risk factors for preterm labor.

LITERATURE / REFERENCES:

1. Aylamazyan E.K. Obstetrics. National leadership. /M.: GEOTAR-Media, 2014. 1200 p.
2. Artymuk N.V., Elizarova N.N. Features of the morphology of the placenta and the condition of newborns in women with premature rupture of the fetal membranes during a premature pregnancy 2016. №1 (27). P.48-52.
3. Glukhovets BI, Glukhovets N.G. Pathology of the placenta. /SPb.: Graal, 2002. 448 p.
4. Kalashnikov S.A., Sichinava L.G., Povarova A.A., Korshikova P.N. Multiple fertility: risk factors of pregnancy termination in the II trimester. // Vestnik RUDN. Medicine series. 2009. №6. P.385-392.
5. Milovanov A.P. Pathology of the mother-placenta-fetus system: a guide for physicians. /M: Medicine, 1999. 448c.
6. Nedoseykina MS, Mishin A.V., Baranovskaya E.I. Features of the morphological structure of the sequence in women with preterm labor // Problems of health and ecology. 2012. №4 (34). Pp. 79-83.
7. Prokhorov V.S., Pavlov N.G. Perinatal outcomes with multiple fetuses // Journal of Obstetrics and Female Diseases. 2010. №3. Pp.54-59.
8. Puchkov GF, Domoratskaya T.L., Chuchko V.A. Features of the study of the corpses of newborns in forensic medicine. /Teaching manual. Minsk, 2001. 31 p.
9. Radzinsky V.E. Obstetric aggression, v. 2.0. /M.: Status Praesens magazine, 2017. 872 p.
10. Fatkullin F.I. Selection of the method of operative delivery for preterm labor // Kazan Medical Journal. 2008. T. 89. No. 5. P. 610-613.
11. Enkin M., Keirs M., Renfrey M., Neilson D. Guidelines for effective assistance in pregnancy and childbirth. /SPb.: Petropis, 2003. 455 p.
12. Penava D, Natale R. An association of chorionicity with preterm twin birth. // J. Obstet Gynaecol Can. 2004; 26 (6): 571- 574.

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