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FEATURES OF A CURRENT PREGNANCY AND DELIVERY IN PREGNANT WOMEN WITH VARICOSE

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✓ ***Rezume,***

This article presents the research with varicose veins of the lower limbs and the pelvic veins during pregnancy. For identification of the etiologic factors for this disease in pregnant women, pregnant women were studied from 10 120 to 41 weeks of varicosity. Observations showed that varicose veins occur in more than residents of the city - 11%, while the residents of the village were sick less often - 7.8%. In pregnant women aged 25 - 30 years, the World Bank noted the occurrence of significantly more often - 55.2%, of the history has been revealed that varicose veins were observed either in the mother or the father, which suggests a genetic predisposition to varicose disease in patients with this pathology. In women with varicose veins are marked: the threat of termination of pregnancy (threat of premature birth) and chronic intrauterine fetal hypoxia, chronic phetoplacental insufficiency - in 2,5 times. Timely delivery was in 12 pregnant women with WB, representing 58.3%, in 17 (41.7%) completed delivery by caesarean section.

Keywords: varicose veins, etiology, pregnancy

ОСОБЕННОСТИ ТЕЧЕНИЕ БЕРЕМЕННОСТИ И РОДОВ У БЕРЕМЕННЫХ С ВАРИКОЗНОЙ БОЛЕЗНЬЮ

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✓ ***Резюме,***

В данной статье представлены исследования с варикозным расширением вен нижних конечностей и вен органов малого таза во время беременности. Для выявление этиологических факторов возникновения данной патологии у беременных, Было изучено 120 беременных от 10 до 41 недель с варикозной болезнью. Наблюдения показали, что варикозное расширение вен больше встречалось у жительниц города - 11%, тогда как жительницы села болели реже - 7,8 %. У беременных в возрасте 25 - 30 лет возникновение ВБ отмечалось достоверно чаще - 55,2%, из анамнеза было выявлено что, варикозная болезнь наблюдалось либо у матери, либо у отца, которое, свидетельствует о наследственной пред расположенности к варикозной болезни у пациенток с данной патологией. У женщин с варикозной болезнью отмечены: угроза прерывания беременности (угроза преждевременных родов) и хроническая внутриутробная гипоксия плода, хроническая фетоплацентарная недостаточность - в 2,5 раза. Своевременные роды были у 12 беременных с ВБ, что составляло 58,3%, у 17 (41,7 %) роды завершились путем кесарева сечения.

Ключевые слова: варикозная болезнь, этиология, беременность

VARIKOZ KASALLIGI BO'LGAN HOMILADOR AYOLLARDA TUG'RUQ VA HOMILADORLIK KECHISHINING O'ZIGA XOSLIGI.

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Ushbu maqolada homiladorlik davrida pastki mucha a'zolarining varikoz kengaymalari va chanoq a'zolarining varikozi bilan bog'liq tadqiqotlar keltirilgan. Ushbu patologiyaning homilador ayollarda paydo bo'lishining etiologik omillarini aniqlash uchun varikoz tomirlari bilan kasallangan 10 haftalikdan 41 haftagacha bo'lgan 120 ta homilador ayolda o'rganildi. Kuzatishlar shuni ko'rsatdiki, varikoz kasalligi shahar aholisi orasida ko'proq uchraydi - 11%, qishloq aholisi esa kamroq uchraydi - 7,8%. 25-30 yoshdagi homilador ayollarda varokoz kasalligining tez-tez uchrab turishi qayd etildi - 55,2%, anamnezda varikoz kasalligi onada yoki otada kuzatilganligi aniqlandi, bu esa ushbu kasallik bilan og'rigan bemorlarda varikoz kasalligiga irsiy moyilligini ko'rsatadi. Varikoz kengaygan tomirlari bo'lgan ayollarda uchradi: homiladorlikning tushish xavfi (erta tug'ilish xavfi) va homilaning surunkali gipoksiyasi, surunkali fetoplasentar yetishmovchilik - 2,5 baravar. Shu bilan birga tabbiy tug'ruq yo'llari bilan 12 ta ayol, bu 58,3% ni tashkil etdi, 17 ta ayolda (41,7%), kesar kesish yo'li bilan tug'ruq yakunlandi.

Kalit so'zlar: varikoz kasalligi, etiologiya, homiladorlik

Relevance

Cardiovascular disease is currently the most significant health and social problem for the world's population: their prevalence, clinical course and effects largely determine the decline in the quality and duration of life of mankind [1, 5, 6]. In this evaluation Who Expert most common peripheral vascular disease is varicose veins [1, 10, 12]. Varicose disease (VD) represent one of the most common groups extragenital cardio - vascular system in pregnant and parturient women, according to various authors, in 30-50% of women [5, 16]. Varicose veins (VV) - is a systemic disease of the vascular venous system. This pathology is common among women that is exacerbated due to pregnancy, besides complicating pregnancy,

childbirth and the postpartum period, and leads to an increase in maternal morbidity and mortality [6, 14].

Clinical manifestations of varicose veins are atypical forms and blood overflow syndrome pelvic organs. By atypical localizations of varicose veins (VV) include the crotch area, external and internal sex organs. These forms are more common than is generally recognized [11,12]. The main cause of the syndrome is considered a valve failure ovarian vein reflux of blood, which causes a disturbance of function of the uterus and its appendages [2, 4].

In recent years, the subject of in-depth research was varicose pelvic veins (VPV). Today require clarification of the many issues related to the diagnosis and treatment of this disease, as this issue is relevant not only for phlebology, vascular surgeons, but also among obstetricians and gynecologists. Recent research proved that one of the common causes of chronic pelvic pain may be a venous congestion of the veins of the pelvis, which was detected in 1/3 patients [1, 5]. In the development of varicose veins plays an important role transferred pregnancy [5, 7, 13]. Pregnancy is one of the major risk factors for varicose [6, 7, 8, 14]. The main moments during this period are the increase in blood volume, compression gravid uterus lower hollow and retroperitoneal veins, a significant increase in intra-abdominal pressure during childbirth. However, the fact of appearance of the first signs of the disease in the first trimester of pregnancy, whereas when there occurs a sharp increase of circulating blood volume and increase uterine confirms the role of hormonal changes in the pathogenesis of varicosity.

High incidence varicosity in pregnancy and postpartum weight due to the increase of the circulating blood and the cardiac output [1,10], increased venous pressure and blood flow in the lower extremities, hormonal changes in the organism, changes in the microcirculation hemostasis [4]. Patients with varicose veins of the lower extremities is sufficiently high frequency (30%) of gestation, and postpartum complications.

Varicose veins of the lower extremities disease detected in 20-40% of pregnant women, which is 5.6% of the entire extragenital during pregnancy [1, 2, 6]. In 67.2% of patients scare varicose veins of the lower extremities, the first signs of the disease appear during pregnancy, and 10.9% - Pregnancy is an aggravating factor in the course of this disease. In cases where the varicose veins of the lower extremities develops during pregnancy, 12% of pregnant women it is diagnosed in the first trimester, confirming the connection to the changes in hormonal levels. In 87.9% of cases the disease is detected in the second trimester of gestation [3,5]. This is true especially for pregnant women and women in childbirth and the postpartum period. During pregnancy, the risk of thrombotic complications increases several times. In addition, venous thrombosis and pulmonary embolism during pregnancy and the postpartum period there are 5.5 times more likely than non-pregnant women, postpartum 3-6 times more often than during pregnancy [8, 14]. The frequency of thromboembolic complications in obstetrics varies from 0.6 to 5.0 per 1000 pregnant women [11]. When all the evidence of a causal connection in the development of thrombosis, is still not entirely clear reasons why this disease occurs in patients without any background diseases.

However, overweight adversely affects the condition of the veins. As well as during pregnancy, it can not be a full breath, necessary for normal venous outflow of blood from the legs and internal organs. [13] Obesity is a proven risk factor for varicose disease in women. According to studies, increased body mass index of above 27 kg / m 2 increases the risk of disease by 33% [5, 9], and a body mass index of above 35 kg / m2 is an independent risk factor for venous thromboembolism [8]. Lifestyle and activity is essential in the development and course of the disease. Violation of the outflow of blood from the lower extremities and pelvis related factors of gravity and the result of human bipedalism [9, 10, 13].

Despite evidence of active interest from experts in various fields to the problem of varicose veins in pregnant women, in recent times, there are still many unresolved issues in the study of this disease, which is maintained sufficiently high frequency. Some of them are associated with a variety of clinical forms of the disease, while others - with the possibilities of diagnostic methods, and others - with the choice of treatment. Lack of awareness of surgeons, gynecologists and other physicians leads to the preservation of the frequency of diagnostic errors and, consequently, inadequate conduct of medical tactics. The lack of a uniform treatment strategy with varicose veins is an incentive for further study of this pathology as a phlebology and doctors of other specialties. [5, 12, 14].

Purpose of the study. Identify the causes of varicose veins in pregnant women, study the effectiveness of a differentiated approach to the management of pregnancy and childbirth in women with varicose veins.

Material and methods

To achieve the objectives we were prospectively examined in terms of 10-41 weeks of pregnancy, childbirth and the immediate postpartum period 120 patients with varicose disease (VD), living in the city of Bukhara and Bukhara region. All pregnant women surveyed were divided into 3 groups:

Group I - the main group consisted of 75 pregnant women with varicose veins of the lower extremities.

II comparison group - made up of 45 patients with varicose veins of the pelvic organs (VPV).

The control group consisted of 30 patients with non-complicated pregnancy and childbirth.

In accordance with aim of and research objectives it developed studies program providing event clinical statistical analysis, complex biochemical and ultrasound, a mathematical treatment of the results. Profile has been compiled, which were made to the following items: passport number, age, constitutional findings, heredity (presence of venous disease and its complications in relatives), time detection and duration of varicose veins, the operation mode transferred extragenital and gynecological diseases. All pregnant women take into account the peculiarities of pregnancy, childbirth, the postpartum period, while the onset of clinical manifestations of varicose veins, depending on the duration of pregnancy. Pregnant examination began with a survey, inspection of the feet, lower abdomen daylight first into a standing position, and then laying. All pregnant women with varicose veins were counseled vascular surgeon.

Results and discussion. All subjects were matched for age, parity, physical and obstetric and gynecological history.

From history it followed that varicose veins, namely varicose observed either in the mother veins of the lower

extremities, either the father or close relatives of both sexes. So 43.3% of patients with varicose veins that may have formed during pregnancy or after delivery, marked hereditary predisposition to this disease. The studies of history among the 1 and 2 groups of pregnant women we have found that the VV has developed during pregnancy 89.3%, subsequent pregnancy intensifies the degree of varicose veins. Most of the World bank is mainly developed at the 3 and 4 of the pregnancy.

Analysis of the data revealed that the varicose veins of the lower limbs, typical of the women of reproductive age. So pregnant women aged 25 - 30 years of the emergence of the world bank noted significantly more often - 55.2%, and in patients older than 35 years, these complications occurred in 10 times more likely than 20-year-olds. Distribution of pregnant women with the VV by age are shown in Figure 1.1.

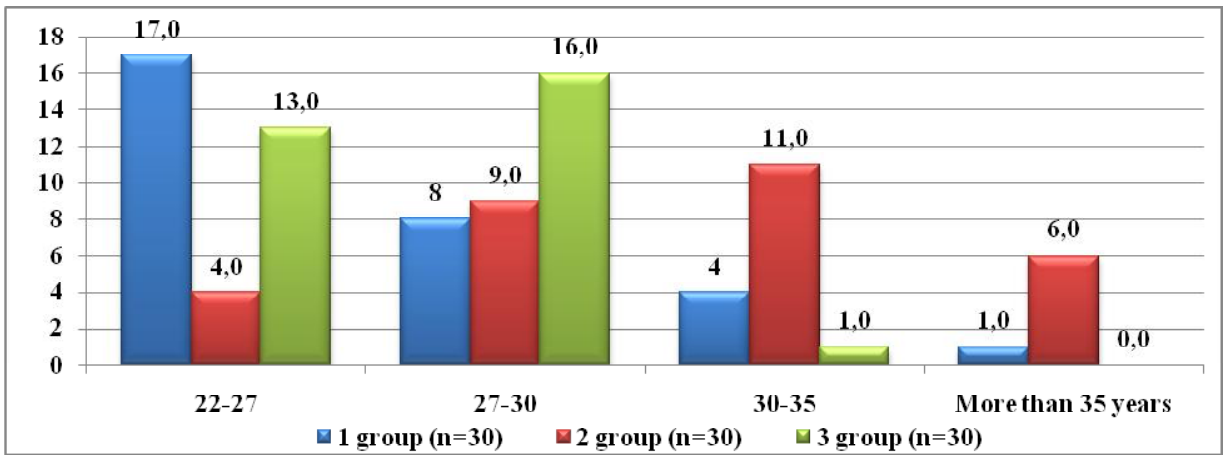


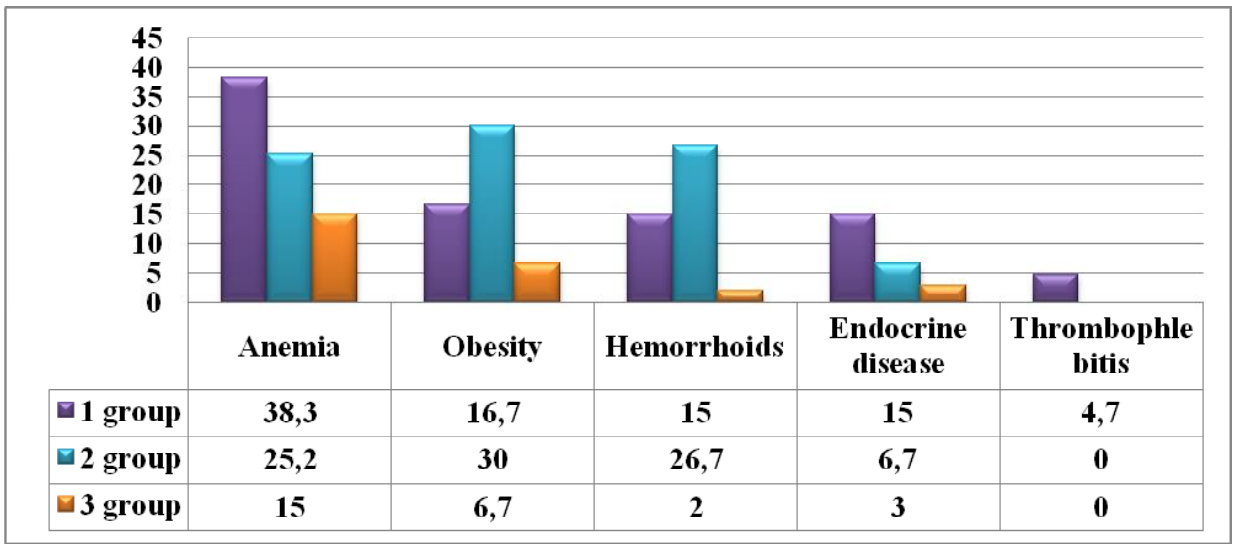
Fig. 1. Distribution of pregnant women with VV by age.

It was found that the majority of pregnant women with the World Bank were aged from 20 to 35 years and averaged 29.5 in the main group 1.4 and 26.6 in the comparison group 0,9let. Patients in the control group were also active in the reproductive age from 20 to 31 years old. Pregnant women in the group with pelvic veins age was not significantly different compared with the control group ($p > 0.05$) and amounted to 26, 6 0.9 years and 27,1 ± 0,6 years, respectively.

From history we surveyed pregnant was burdened by various extragenital diseases. Analysis of somatic diseases of women surveyed is presented in Fig. 2. The most frequently occurred anemia 38.3% of all pregnant women suffering from varicose veins, obesity among group 1 was 16.7%, the number of pregnant women with varicose 2 groups obesity occurs in 30% of women.

Also as a result of studies found that pregnant women in comparison hemorrhoids met more often than in group I group (26.7%).

From the literature it is known that the venous pressure in the lower extremities is increased twice during pregnancy. In addition, the increased blood flow to the uterus contributes to overload the pelvic veins and improve venous pressure in the lower extremities, which is accompanied by an extension of the superficial veins. Perhaps, in this case, the combination of pregnancy and obesity with increased venous pressure even more, which contributed to the progression of varicose veins. It should be noted with obesity thromboses occur in 2 times more often than at normal body weight. Availability hypercholesterolemia, hyperglycemia, hypolipoproteinemia blood chromogenic potential rises at which platelets more sensitive to the action of aggregating factors.



	Anemia	Obesity	Hemorrhoids	Endocrine disease	Thrombophlebitis
1 group	38,3	16,7	15	15	4,7
2 group	25,2	30	26,7	6,7	0
3 group	15	6,7	2	3	0

Fig. 2 Somatic diseases among treatment groups

Body weight before pregnancy in pregnant women with varicose veins were significantly lower ($p < 0.01$) than in the group of clinical comparison and was 62.3 ± 2.54 and 71.57 kg ± 3.53 kg, respectively. The first pregnancy was dominated by changes in one limb, multiparous observed bilateral veins of lower extremities.

The frequency of gynecological disorders in patients who entered the study, varied (Table. 1).

Table 1

Gynecological diseases in the studied groups

Disease	The core group (n = 75)		The control group (n = 45)		The control group (n = 30)	
	abs.	%	abs.	%	abs.	%
Spontaneous miscarriage	9	12 ± 6,20	5	11.1 ± 3.4 **	3	10 ± 6,3
Therapeutic abortion	11	14.6 ± 4.1 *	6	13.3 ± 3.9	5	16.7 ± 2.7
Endocevicits	15	20 ± 3,40	9	20 ± 6,2 **	3	13.3 ± 4.1
Chronic metritis	19	25.3 ± 3.4 *	12	26.6 ± 2.6	2	6.7 ± 2.1
Chronic salpingoofarits	14	18.6 ± 4.70	9	20 ± 2,6	1	10 ± 6,3

* R?0,05- reliable difference between the core group and the comparison group; ** R?0,05-reliable difference between the comparison group and the control group; R?0,05- about the difference between the authentic core group and the control group

Number of spontaneous abortions in pregnant women with varicose veins of small pelvis, compared with the control group, and pregnant with varicose veins of the lower limbs was significantly lower ($p < 0.05$). Similar data were obtained by analyzing the history of healthy patients and pregnant women in both groups with varicose veins of small pelvis for guidance on non-developing and ectopic pregnancy. Among pregnant I Group 9 patients suffered spontaneous abortions (12%), artificial abortion history made in 11 pregnant women (14.6%). In pregnant women with varicose veins pelvis (VVP) a history of 5 (11.1%) were pregnant spontaneous miscarriage, abortion and 2 had a history of female 12.7%, more than 3 miscarriages - 6.7%, respectively. These indicators studies have shown that varicose disease often develops during early onset of sexual activity, carried over abortion, inflammatory diseases of the uterus and appendages, short (1 year) intervals between pregnancies.

Pregnant reproductive function was evaluated based on the number of pregnancies in the history and outcomes.

Table 2

Indicators parity of pregnancy and childbirth in the study groups

Indicators parity of pregnancy and childbirth	Group number of patients (%)		
	Group I (n = 75)	Group II (n = 45)	The control group (n = 30)
First pregnant	23 (30.6%)	13 (28.8%)	6 (20%)
Second pregnant	39 (35%)	25 (39.6%)	19 (63.3%)
Anamnesis in pregnancies 4 or more	16 (14.2%)	4 (6.35%)	2 (6.67%)
Primiparous	14 (18.6%)	17 (37.7%)	6 (20%)
Multiparous	36 (48%)	23 (51.1%)	12 (40%)
Multiparous, 4 and more	9 (12%)	2 (4.4%)	0

* R?0,05- reliable difference between the core group and the comparison group; ** R?0,05-reliable difference between the comparison group and the control group; R?0,05- about the difference between the authentic core group and the control group

As seen from Table. 2 during obstetrical examination pregnant following results were obtained in groups. In all 3 treatment groups most patients were and multiparous. Multiparous (4 generaand more) in agroup was varicose veins of the legs 9 (12%) of pregnant women in the comparison group - 2 (4.4%) and was not in the control group. In addition in all groups were sufficiently pregnant first pregnancy and childbirth first, respectively in the main group - 23 (30.6%) and 14 (18.6%) in the control group - 13 (28.8%) and 17 (37.7%) in group VV - 6 (20%) and 6 (20%)

Estimates of the reproductive function of pregnant women ranged in groups. The data obtained are presented in Table. 3.

All history in healthy pregnant women were 115 pregnancies in women with varicose disease - 263 patients with isolated pelvic veins - 195. On average, one patient had pregnancy 1,7 ± 1,1, 3,1 ± 1, 5 pregnancies, pregnancy 2.15 ± 1.2, respectively, in groups. Parity in women with isolated varicose veins of the legs was higher, which proves the connection of this disease with subsequent pregnancies. Number of spontaneous abortions in patients with varicose veins of small pelvis, compared with the control group and with varicose veins was significantly lower ($p < 0.05$). Similar data were obtained by analyzing the history of healthy patients and pregnant women in both groups with varicose veins for guidance on non-developing and ectopic pregnancy.

Table 3

Characteristics of the reproductive function of women surveyed

Groups	number		abortions		birth			developing pregnancy	Ectopic pregnancy
			artificial	spontaneous	premature	urgent	Caesarian		
The core group (pregnant with varicose veins of the legs)	75	abs	11	9	6	48	21	5	-
		%	14.7 *	12	8*	64 *	28	6.7	-
Comparative group (pregnant with varicose veins of the pelvic organs)	45	abs	5	6	2	30	13	2	1
		%	11.1	13.4	4.5	66.7	28.8	4.5	2.2
Control group	30	abs	3	5	-	29	1	1	-
		%	10	16.7	-	97	3.4	3.4	-

* R?0,05- reliable difference between the core group and the comparison group; ** R?0,05-reliable difference between the comparison group and the control group; R?0,05- about the difference between the authentic core group and the control group

Previous pregnancy in healthy pregnant women only 3.4% resulted in premature birth. It should be noted that in the group of pregnant varicose veins of the lower extremities number of preterm births was two times higher than in healthy women group (P <0.05).

Urgent delivery ended previous pregnancies in the group with VD 64% and in patients with varicose veins of small pelvis 66.7%. The number of fixed-term parity surveyed pregnant women with varicose statistically significant differences compared with healthy women who had not.

Anamnesis revealed that for I trimester pregnancy primigravidas 78.6%, 81.2% in re-pregnant main group proceeded without complications in clinical comparison group of 90% and 85%, respectively. In the P-trimester pregnancy was without complications in patients with varicose vein disease in 75% and 66.2% in the clinical comparison of 80%. Third trimester of pregnancy characterized by progressive course of varicose disease in primiparous (37.5%), more frequently diagnosed with chronic placental insufficiency, fetal distress. At 25.5% and 27.8% of primiparous multiparous noted progressive course of varicose veins.

Morbidity pregnancy identified and preterm delivery, premature rupture of membranes, fetal hypoxia. Our research has shown that the varicose veins of the lower limb disease is often accompanied by the veins of the uterus and basically had no clinical symptoms, and only 13.4% of pregnant women have noted constant aching pain in the abdomen and lower back. With the combination of varicose veins of the lower extremities and varicose veins of the uterus revealed venous insufficiency symptoms that occur mainly after 20 weeks of gestation. Were the following symptoms of venous insufficiency: a feeling of heaviness in the legs (79.0%), paresthesia (67.7%), convulsion (45.2%), pruritus (25.8%). Moreover, the first symptoms of venous insufficiency appeared on one of the limbs,

Table 4

The course of pregnancy in the examined groups

Indicators	group I n = 75		group II n = 45		Group III (control) n = 30	
	Abs.	%	Abs.	%	Abs.	%
Interruption Threat in II thrimester III Plus	11	14.7	5	11.1	2	6.7
	7	9.3	9	20	4	13.3
Early toxicosis	3	4	2	4.4	1	3.34
Preeclampsia	4	5.34	3	6.7	0	
FPN	1	1.34	2	4.4	0	
SZVRP	1	1.34	3	6.7	0	
breech presentation	3	4	2	4.4	1	3.34
perenashivanie	0		1	2.2	0	
polyhydramnios	6	8	4	8.9	1	3.34

* R?0,05- reliable difference between the core group and the comparison group; ** R?0,05-reliable difference between the comparison group and the control group; R?0,05- about the difference between the authentic core group and the control group

During pregnancy in women with varicose disease is characterized by a significant percentage of complications. In the first trimester of pregnancy has evolved from early toxicities in 23.1%. Joining toxemia of pregnancy in women with varicose veins is evidence of early occurrence immunoconflict situation, which is consistent with the concept Savelyev V.S. (2002), an autoimmune, autoagressive genesis of this disease.

During pregnancy, 12.3% with the World Bank complicated phenomena threatening miscarriage in the first trimester. In the second trimester in 11.1% of patients in status of threatened abortion persisted despite ongoing therapy in the hospital. In the group of pregnant women with WB complications occur far more frequently than in the control. The threat of termination of pregnancy can be attributed to a complicated obstetric history and as a confirmation of a hormonal imbalance in the placental system.

Untimely rupture of the amniotic fluid of pregnant women with varicose observed in two times higher than in the control group, and was 13.3% and 8.8% respectively. The most common complication of childbirth was the weakness of labor 7 (9.3%).

Table 5

Features of a current delivery in the examined groups (M ë m)

disease entities	group I n = 75		group II n = 45		Group III (control) n = 30	
	Abs.	%	Abs.	%	Abs.	%
Untimely dischurch / n water	10	13.3	4	8.8	2	6.7
Clinical disparity	5	6.7	4	8.8	1	3.34
PONRP	2	2.7	1	2.2	-	
Bleeding in the early period after birth	6	8	5	11.1	-	3.34
Injury of soft birth canal	9	12	6	13.3	1	3.34
Pathological, prelimenarny preiod	7	9.3	2	4.4	2	6.7

* R?0,05- reliable difference between the core group and the comparison group; ** R?0,05-reliable difference between the comparison group and the control group; R?0,05- about the difference between the authentic core group and the control group

Pathological progress of labor increases the number of bleeding. According to the results of our investigations blood loss of over 400 ml in successive period was observed in the group I and group II in 2 (6.7%) and 7 (23.3%) beremennih with WB, respectively, which greatly exceeds that of healthy women (3.34%). In all cases, hypotonic bleeding produced Manual entry into the uterine cavity.

The outcome of pregnancy and childbirth is a set of quality indicators, reflecting, primarily, the level of assistance provided to the pregnant woman, at the same time, the perinatal outcomes are closely linked to the health of the mother, which determines the degree of adaptation of her body for pregnancy and severity of acceding to the above, complications. As the analysis of the flow of gestation, birth outcomes and postpartum period in 120 patients, vascular disorders in complicated pregnancy were directly or indirectly cause major complications and their future consequences for both the mother and the fetus. Timely delivery occurred in 12 pregnant women with WB, which was 58.3%. In 17 (41.7%) of these births were completed by caesarean section.

Spontaneous labor ended in 167 pregnancies (87%) of women operative delivery by cesarean section - in 25 (13.2%). The number of preterm delivery was significantly higher ($p < 0.05$, compared with control group) among patients with complicated pregnancy and isolated varicose pelvic veins (9.3% and 4.4%), respectively.

Pregnancy in all women in the control group completed delivery in term of 37-41 weeks. The average term of delivery was 39,12 ± 0,95 weeks.

TABLE 6

Indications section Cesar in the examined groups

Nosology	group I n = 75		group II n = 45		group III (control) n = 30	
	Abs.	%	Abs.	%	Abs.	%
PONRP	4	5.3	1	2.3	-	
Pelvic-head disproportion	5	6.7	2	4.5	1	3.34
Breech presentation	3	4	3	6.7	1	3.34
Fetal distress	2	2.7	3	6.7	-	
Severe pre-eclampsia	7	9.3	4	8.9	-	

* R?0,05- reliable difference between the core group and the comparison group; ** R?0,05-reliable difference between the comparison group and the control group; R?0,05- about the difference between the authentic core group and the control group

The main indications for abdominal delivery in the study group were acute fetal hypoxia 2 (2.7%). In the comparison group indications for cesarean section were as follows: fetal distress 3 (6.7%), breech 3 (6.7%).Pelvic-head disproportion (unsatisfactory progress of delivery) were detected in all groups, more often in patients with varicose veins of small pelvis (19.2%). Premature detachment of normally situated placenta was also observed in the study and the comparison group, which was significantly higher ($p < 0.05$), compared with a group of healthy women) in postpartum women with pelvic venous ectasia and placental insufficiency.

Postpartum women in the control group was uneventful. The absence of pathological changes, the normal uterine involution, confirmed by ultrasound picture of the pelvic organs were observed in 27 women in the control group. In 2 (6.7%) showed signs of uterine puerperal sub involution in 1 (3.3%) - hemometra 4-5 day puerperal children were discharged home.

Most postpartum women groups varicose veins of the lower extremities postpartum period was uneventful. In 4 cases (5.3%) during the early postpartum endometritis complicated by development with an increase in body temperature to 37,5-38,0 ° C. Ultrasound examination had confirmed signs endometritis extension of the uterine cavity, the presence of gas in it, fibrin infiltration myometrium. In 1 (1.3%) patient was identified hemometra. 42 (56%) patients in this group of 4-5 hours were discharged home.

Under VPV clinical and echographic signs endometritis met in 7 (15.6%) cases, hemometra - 2 (4.4%), the symptoms of uterine subinvolution - 3 (6.7%). uterine dimensions while exceeding standards envisaged for this period postpartum period more than every fourth patient, the width of the uterine cavity - in each of the sixth. In 3 (6.7%) puerperal complicated phlebitis postpartum uterine veins.

Determined sharp pain, and pelvic wall region appendages fervescence to 37,5-38,5 °C, changes in the clinical analysis of blood and hemostasiogram. On ultrasonic examination conducted at 3-5 hours, determined signs uterine sub involution which detected the mismatch uterine size at SPL provided for this period postpartum period, and visualized by enhanced uterine veins recorded low amplitude retrograde blood flow, features vessels. Ultrasound picture of the pelvic organs confirmed the clinical signs of phlebitis uterine veins.

Thus, heaviest during the postpartum period was observed in postpartum women in the groups with varicose veins of the pelvis. The main criterion for a successful outcome of gestation period and birth is the condition of the newborn, depending on the impact of pre- and intrapartum risk factors and complications during pregnancy and childbirth. Integrated assessment of newborns (1-5 days) were used Apgar score.

All spontaneous labor in a group of healthy pregnant women are over the birth of live full-term infants with Apgar scores in the first minute 7 points or more for 5 minutes - 8-10 points. The average weight of newborns was 3468 ± 425 grams.

The growth of infants ranged from 49 to 58 cm, and averaged 52,1 ± 2,34 sm. The early neonatal period was uneventful, all the children in the control group were discharged home in satisfactory condition at 4-5 days after birth.

Hypoxic syndrome fetuses detected in 16.2% of the main group, versus 3.0% in the control group. In the study group of 75 children were born. The satisfactory condition with Apgar scores in the first minute of 8- 9 points were born 62 (82.7%) children. In 11 (14.6%) children at birth is marked hypoxic syndrome (Apgar score of 7 points) and 2 (2.6%) were born in a grave condition score at birth in the first minute less than 6 points. The frequency of hypoxic syndrome in newborns of pregnant women with varicose veins may be explained by the fact that at the time of delivery at the duration of contraction of the uterus is the failure of the compensatory-adaptive reaction against the backdrop of the uterine arteries spasm, difficulty of venous outflow and change blood rheology.

The average weight of term infants from pregnant women with varicose veins of the legs exceeded weight and healthy newborns was 3650.0 ± 0.54 g, the mean length of 51.3 ± 0.7 cm. In this group 25 (33.3%) children born with a weight 3800.0 In the comparison group, 45 live born full-term infants. Average weight infants was 3435,5 ± 0,52g and the average length of 50.7 ± 0.3 cm.

From the study of other authors known that the clinical manifestation of chronic placental insufficiency is small for gestational. According to our data the mass of the newborn, even those who were born with hypoxic syndrome was higher than that of mothers of children who do not suffer from varicose disease. Perhaps this is due to the fact that in the placenta in pregnant women with this pathology has allowed the preservation of good vascularization, to carry out compensatory reactions at the tissue level, and contributed to the birth of viable children whose weight corresponds to the gestational age, even when burdened by pregnancy.

Conclusions:

1. The developing varicose disease in women increases with each subsequent pregnancy: when the first 1.3%, while the second, 7.6% of women, with 31.7% of the third and fourth at 34.3% of women that coincide with the opinions of other authors. Our observations showed that varicose veins suffer the residents of the city - 11%, while the residents of the village are sick less often - 7.8%.

2. In addition, varicose veins most often develop in the early onset of sexual activity, carried over abortion, inflammatory diseases of the uterus and appendages, short (1 year) intervals between pregnancies.

3. In the studies of history was revealed that varicose veins were observed either in the mother or the father, or in close relatives of both sexes, which suggests a genetic predisposition to varicose disease in patients with this pathology.

4. During pregnancy in women with varicose veins are marked: the threat of termination of pregnancy (threat

of premature birth) and chronic intrauterine fetal hypoxia, chronic fetoplacental insufficiency - in 2,5 times.

5. Pregnant with varicose pathology joint must be provided with observation obstetricians gynecologists Phlebology (or vascular surgeons), which should be continued and, after delivery, to not omissions progression of pathological conditions and early prevention of thromboembolic disorders.

A conflict of interest is not notified

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