INTERNATIONAL MULTIDISCIPLINARY JOURNAL FOR RESEARCH & DEVELOPMENT

SJIF 2019: 5.222 2020: 5.552 2021: 5.637 2022:5.479 2023:6.563 2024: 7,805

eISSN :2394-6334 https://www.ijmrd.in/index.php/imjrd Volume 11, issue 04 (2024)

PRE-ECLAMPSIA AND PREMATURE BIRTH

Yuldosheva Dilnoza Saidazim kizi

Assistant of the department of sciences in the field of therapy

Fergana Public Health Medical Institute

Abstract: A clinical analysis of 61 cases of pregnancy and childbirth was carried out: 26 hypertensive patients with clinical signs of preeclampsia and 35 normotensive women. It was found that patients with preeclampia are characterized by the following characteristics: history of preeclampsia (35.7% multiparous, p<0.05), high risk of surgical preterm birth (OR=38.0; 95% CI 13.7–105.7), a multiple increase in the risk of placental disorders in preeclampsia (OR=16.8; 95% CI 6.0–46.6).

Keywords: Preeclampsia, pregnancy, hypertension, childbirth.

INTRODUCTION

In the structure of maternal and perinatal mortality, preeclampsia and its complications throughout the history of obstetrics and to this day occupy a leading position in the world [1,2,3]. It is now known that preeclampsia is caused by impaired adaptation during pregnancy, when the mother's body cannot function normally under the conditions created by the fertilized egg itself, for example, secretion by the fetoplacental complex of hormones, immunomodulator proteins, angiogenesis factors, etc. Consequently, the initial pathomorphological substrate for preeclampsia develops in the early stages of pregnancy with an initial low adaptation reserve, which is present in women with systemic somatic pathology.

MATERIALS AND METHODS

The pathophysiology of maladaptation includes a process extended over time, its manifestations and results [4]. Moreover, with respect to preeclampsia, all these three components of maladjustment may have individual differences in the timing of the onset of clinical symptoms, the severity and rate of progression of the pathology, which determines its extent and outcome. The result of preeclampsia can be immediate and long-term complications. Hypertensive disorders present once during pregnancy have a high risk of cardiovascular diseases and their complications with a fatal outcome in the long term (OR 1.56; 95% CI 1.28–1.89; p<0.001). These data were shown by Australian researchers on a cohort of 31,656 patients who gave birth in a 10-year period (January 1980–December 1989), of whom 4,387 (14%) had hypertensive disorders during pregnancy, and according to national registries as of 2023 129 women died [2].

RESULTS AND DISCUSSION

Adaptive changes during pregnancy are dynamic and increasing in nature, therefore, the degree of disadaptation, and therefore the severity of preeclampsia, also increases. It follows that while pregnancy complicated by preeclampsia continues, preeclampsia cannot be cured; without treatment it progresses; the rate of progression is difficult to predict, but with proper treatment, stabilization of the condition and temporary improvement in the body's condition are possible. Pathophysiological treatment solves two main problems: firstly, to prevent eclampsia and its complications, and secondly, to prolong pregnancy for the birth of a mature fetus.

An analysis of the course of pregnancy and childbirth, the early neonatal period was carried out in 61 cases from among patients who gave birth in 2023.

INTERNATIONAL MULTIDISCIPLINARY JOURNAL FOR RESEARCH & DEVELOPMENT SJIF 2019: 5.222 2020: 5.552 2021: 5.637 2022:5.479 2023:6.563 2024: 7,805

eISSN :2394-6334 https://www.ijmrd.in/index.php/imjrd Volume 11, issue 04 (2024)

Gestational hypertension included elevated blood pressure (SBP >140 mm Hg, DBP >90 mm Hg), which first occurred during pregnancy after 20 weeks, without significant proteinuria, i.e. even in the presence of protein in urine with a concentration of less than 0.3 g in a daily volume. If the patient's blood pressure increased to the indicated values in the second half of pregnancy, after 20 weeks, or during childbirth and the postpartum period, accompanied by proteinuria with a protein content in the urine of >0.3 g per day, then this pathology was classified as preeclampsia (PE). In some cases, signs of preeclampsia developed against the background of previously existing chronic arterial hypertension (CAH). Signs of eclampsia are the appearance of seizures and/or coma in the presence of symptoms of preeclampsia.

The criteria for severe preeclampsia included:

- SBP $\geq 160 \text{ mm Hg}$, DBP $\geq 110 \text{ mm Hg}$,
- Proteinuria $\geq 3 \text{ g/}24 \text{ h}$,
- Central nervous system disorder (visual impairment, headache and other symptoms),
- Impaired renal function (oliguria <500 ml/day, increased creatinine levels),
- Liver dysfunction (increased activity of ALT, AST),
- Thrombocytopenia,
- Coagulopathy,
- Generalized edema,
- Fetal growth retardation, decompensation of chronic placental insufficiency.

The age of normotensive women and patients with hypertensive disorders did not differ and was 27 (23; 29) and 31.5 (27; 37) years, respectively. The proportion of primigravidas among hypertensive women was 1.6 times higher than in the comparison group - 46% and 28.6%, respectively. Of the multiparous women in the main group, 35.7% had a history of preeclampsia, while in the comparison group preeclampsia did not aggravate previous pregnancies ($\chi 2=5.0$, p<0.05). The reason for sending pregnant women of the main group to the hospital in 99% of cases was high blood pressure, with the exception of the case of high proteinuria detected during a routine visit of the patient to the antenatal clinic. When pregnant women of the main group were admitted to the hospital, the level of arterial hypertension averaged 160/101 mmHg, the level of proteinuria was 1.3 g/l. In the comparison group, the average blood pressure was 119/74 mmHg, there was no protein in the urine.

CONCLUSION

In practical obstetric care, when formulating a clinical diagnosis, one should use the international classification of hypertensive disorders in pregnant women, using modern terminology, criteria for diagnosis and assessment of severity. The identification of two degrees of severity of preeclampsia, moderate and severe, has clear clinical criteria, is convenient for the doctor and determines the strategy for managing the patient: with moderate preeclampsia, pregnancy can be continued subject to drug correction, with severe preeclampsia, termination of pregnancy is indicated. The absence of mild severity of preeclampsia is justified by the presence of symptoms of organ dysfunction.

REFERENCES

1. Obstetrics. Normal and problem pregnancies. Edited by Steven G. Gabbe, Jenifer R. Niebyl, Joe Leigh Sipson. – New York.: Churchill Livingstone Inc., 2016. – 1348 p.

INTERNATIONAL MULTIDISCIPLINARY JOURNAL FOR RESEARCH & DEVELOPMENT

SJIF 2019: 5.222 2020: 5.552 2021: 5.637 2022:5.479 2023:6.563 2024: 7,805 eISSN :2394-6334 https://www.ijmrd.in/index.php/imjrd Volume 11, issue 04 (2024)

2. Savelyeva G.M. Eclampsia in modern obstetrics / G.M. Savelyeva, R.I. Shalina, N.V. Kurtenok // Materials of the XI All-Russian Scientific Forum "Mother and Child", Moscow – 2010. – P. 211–212.

3. Radzinsky V.E. Obstetric aggression. – M.: Publishing house of the magazine Status praesens, 2011. – 688 p.

4. Pathophysiology // Edited by V.Yu. Shanina. – St. Petersburg: ELBI-SPb, 2015. – 639 p.

