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NEW MEASURES FOR EARLY DIAGNOSIS AND TREATMENT OF SPONTANEOUS MISCARRIAGE

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Resume : This article is devoted to the statistics of spontaneous miscarriage on the territory of Uzbekistan , the most common causes, clinical signs , as well as modern measures of diagnostic correction , treatment and Prevention , written based on the clinical standard of the Republic of Uzbekistan (compiled on the recommendation of the World Health Organization).

Key words: spontaneous fetal fall , fetal fall risk, road abortion , abnormal baby fall , uncertain fetal location ,extra-uterine fetal , Anembryony .

НОВЫЕ МЕРЫ РАННЕЙ ДИАГНОСТИКИ И ЛЕЧЕНИЯ САМОПРОИЗВОЛЬНОГО ВЫКИДЫША

Резюме : Данная статья посвящена статистике , наиболее частым причинам, клиническим признакам самопроизвольного выкидыша на территории Узбекистана , а также современным мерам диагностики , лечения и профилактики и написана на основе клинического стандарта Республики Узбекистан (составлен по рекомендации Всемирной организации здравоохранения).

Ключевые слова: Самопроизвольный выкидыш, Угрожающий выкидыш Выкидыш в ходу ,Неполный выкидыш ,Неразвивающаяся беременность Беременность неясной (неизвестной) локализации ,Внематочная беременность ,Анэмбриония .

O’Z –O’ZIDAN XOMILA TUSHISHI BARVAQT DIAGNOSTIKASI VA DAVOLASHNING YANGI CHORA TADBIRLARI

Rezume : Ushbu maqola O’zbekiston hududida xomila o’z –o’zidan tushish statistikasi , eng ko’p uchraydigan sabablari, klinik belgilari shuningdek , tashxis qoyish , davolash va oldini olishning zamonaviy chora tadbirlariga bag’ishlangan bo’lib , O’zbekiston Respublikasi klinik standartiga asoslangan holda yozilgan (Jahon sog’liqni saqlash tashkiloti tavsiyasi asosida tuzilgan).

Kalit so’zlar :O’z-o’zidan xomila tushishi , xomila tushish xavfi, yo’ldagi abort , noto’liq bola tushishi , Homilaning noaniq joylashuvi ,Bachadondan tashqari xomiladorlik , Anembrioniya .

Introduction: spontaneous abortion (miscarriage) — spontaneous termination of pregnancy until the fetus reaches the period of vital pregnancy [1,2].

According to the WHO definition, miscarriage is the spontaneous expulsion or extraction of an embryo (fetus) up to 500 g, which corresponds to the gestational age of less than 22 weeks of gestation.

Epidemiology:

spontaneous miscarriage is the most common complication of pregnancy. Its frequency is 10-15% of all clinically diagnosed pregnancies. About 80% of abortions occur before 12 weeks of pregnancy.

From time to time, in the composition of early miscarriage, a third of pregnancy is stopped by the type of anembryony up to 8 weeks (there is no embryo). Repeated miscarriage is less common. The usual miscarriage affects about 1-2% of women, if determined to be three consecutive pregnancies up to 22 weeks after the last menstruation [4,6] .

Fall on your own:

1) During Pregnancy:

b) early – spontaneous abortion up to the full 13 weeks of pregnancy (in the 1st trimester);

c) late-spontaneous termination of pregnancy from 13 to 22 weeks.

2) by stages of development: dangerous fall;

down the road;

incomplete descent;

full fall;

(termination of embryonic/fetal development) – underdeveloped pregnancy.

Diagnostics

Assessment and diagnosis of the patient's condition is carried out on the basis of complaints analysis, Anamnesis, physical examination and additional clinical studies. Ultrasound examination should be done as soon as possible, if necessary, urgently. In all cases, a preliminary assessment of the parameters of hemodynamics is necessary.

At different stages of pregnancy, the following clinical manifestations are characteristic: dangerous miscarriage-pain in the lower abdomen and lumbar region, bleeding from the genital tract. The strain of the uterus increases, the body of the uterus coincides with the period of pregnancy, the cervix (CU) is not shortened, closed. An ultrasound examination records the CU of the embryo (from 5-6 weeks of pregnancy or CTR≥7 mm) /fetus. The following obstetric complications must be ruled out: the arrival or low placement of the chorion (placenta) in front, bleeding from the second branch of the uterus with its malformation, the death of one fetal egg during multiple pregnancies .

Fall on the road-the body of the uterus, as a rule, less than the expected duration of pregnancy, a regular contraction of myometry is detected, and amniotic fluid can flow. The inner and outer throat are open, the cervical canal extends along its entire length, the elements of the ovary are located in the cervical canal or partially in the vagina.

Incomplete miscarriage-pregnancy is over, but the elements of the ovary are detected in the uterine cavity. A complete contraction of the uterus and the lack of closure of its cavity leads to bleeding. Infected miscarriage is the end of pregnancy, fever, chills, restlessness, pain in the lower abdomen, blood, sometimes purulent discharge from the genital tract.

On physical examination - tachycardia, tachypnea, deformation of the muscles of the anterior abdominal wall; on bimanual vaginal examination-painful, soft consistency of the uterus, enlarged cervical canal. If left untreated, the infection can be generalized.

Underdeveloped pregnancy-the death of an embryo or fetus up to 22 weeks of pregnancy, in the absence of the expression of conception products from the uterine cavity. The diagnosis is made using ultrasound.

Anamnesis

Anamnesis should have the following questions:

the nature of the menstrual cycle and the date of the last menstruation.

Previous pregnancy, their results, especially the presence of pregnancy.

Gynecological diseases and operations.

If auxiliary reproductive technologies have been used, indicate the type and date.

Conclusion of the ultrasound examination (if done).

Signs of early pregnancy. the presence of symptoms associated with:

- vaginal bleeding (time, degree and weight);
- pain (lower abdomen / cramping / back pain);
- syncope states with changes in body position;
- vomiting;
- separation of fertilization products (fetal egg elements) from the genital tract.

Physical examination.

The physical examination should carry out basic examinations:

general condition assessment,

thermometry,

heart rate measurement,

measure breathing rate,

blood pressure.

Abdominal wall palpation and percussion should be performed to detect pain, tension (dementia), symptoms of abdominal irritation, bloating, the presence of free fluid in the abdominal cavity [7].

To assess the condition of the vaginal part of the BB, the intensity of bleeding, the presence of the ovary in the vaginal parts, it is recommended to carry out a BB examination in mirrors. When examining the BB, the source and size of bleeding, the presence of conception products in the cervical canal (if possible, it must be removed and sent for histological examination), prolapse of the fetal bladder, as well as the state of the BB Anatomy, external pharynx and cervical canal are assessed. Confirmed by an ultrasound examination, the risk of uterine pregnancy and miscarriage is high (hematoma, excessive bleeding from the genital tract, increased uterine tone), which can be determined by a definitive examination [10] .

If it is not possible to perform a blood test to determine pregnancy, it is recommended to check serum HChG (human chorionic gonodotropin ,free B-subunit) or perform a quality urine test for HChG .

To exclude ectopic pregnancy and determine the development of pregnancy, it is recommended to re-check serum HChG (free B-subunit) levels after 48 hours during an uncertain (uncertain) localized pregnancy. Re-examination is carried out at the first barrier (HChG) at the repeated barrier (HChG 2) to calculate the ratio to the level of HChG (HChG 1). This calculation makes it possible to determine the tactics of diagnosis and taking boorish [17,74]:

This study is relevant regardless of whether the patient has contraception, sterilization or lack of sexual activity, regardless of the onset of the last menstruation. The method can also be used as a predictive tool. [8]

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- If the HChG level ≥1000 IU/ml, hcg2/OXG1 \ u003e is taken in the ratio of 0.8 – ultrasound of the uterus and appendages is recommended to determine the location of the ovary.

* With an HChG ratio of 2 / HChG 1 ≥2 the prognosis of pregnancy is favorable.

- In the HChG relation2 / HChG 1 <0.5 observation must be stopped.

* With HChG ratio 2/HChG 1 = 0.5-0.7 ultrasound should be stopped, but HChG levels should be continued to be checked to ≤100 IU / ml, depending on the initial level of HChG.

If the HChG 2/HChG 1 ratio does not decrease and bleeding and pain complaints persist, diagnostic laparoscopy may be performed to diagnose.

Fetal drop-to diagnose fever, chills, in the presence of complaints of purulent discharge from the genital tract, it is recommended to check the level of C-reactive protein in the blood serum .

For Rh-negative patients, as well as pregnant women from a sexual partner belonging to Rh-positive or unknown blood RH, it is recommended to identify antibodies to the antigens of the Rh system during this pregnancy.

If pregnancy persists, a molecular biological examination of the mucous membranes of the female genitals is recommended for pathogens of sexually transmitted infections (STIs): Neisseria gonorrhoeae, Trichomonas vaginalis, Chlamydia trachomatis, Mycoplasma genitalium. If an early rupture of the fetal bladder was suspected in the 2nd trimester of pregnancy, a test for the detection of amniotic fluid should be carried out when conducting a cervical examination in mirrors.

Instrumental verification methods.

Transvaginal scanning (TVS) performed by an experienced specialist is the "gold standard". If TVS is not available, a transabdominal scan (TAS) can be used, but this method has less diagnostic confidence than TVs to detect complications in the early stages of pregnancy.

The patient should be explained the procedure and indications for ultrasound [4]. Pregnancy in a viable uterus-the fetal bladder settles normally , the fetus is visible , and its heart rate is determined .

Survival uncertain pregnancy

– Option 1-the fetal egg is usually located, the average internal diameter of the ovary is 20 mm, the embryo is not depicted;

Option 2-the fetal egg is located normally, the embryo is 7 mm, the fetal heart rate is not described.

Repeated ultrasound of the uterus and appendages after 7-10 days is recommended to confirm a developing pregnancy.

Differential diagnostics:

Diagnosis	**Examinations for conducting a comparative diagnosis**	**Clinical trials**	**Exceptional cases in diagnosis**
Pregnancy beyond the uterus	Symptoms: delay in menstruation, pain in the lower abdomen and the arrival of bloody detachment from the genital tract. Positive HCG test	Bimanual vaginal examination: the uterus is at the moment lower than the corresponding position in the course of pregnancy ,the detection of a derivative with a pasty consistency in the area of the uterine appendages.	Ultrasound: there is no fetal egg in the uterine cavity, the embryo outside the uterine cavity can be seen, free fluid in the abdominal cavity can be detected.
Menstrual cycle disorder	Symptoms: delay in menstruation, bloody discharge from the genital tract	In mirrors and bimanual examination: the uterus is of normal size, the cervix is closed	The HCG test is negative. Ultrasound: fetal egg not detected.

Treatment:

Nomedicamentosis - methods of treatment due to the increased unnecessary discomfort of the patient, it is not recommended to use the therapeutic and protective regimen, which includes bed rest, in clinical practice. Currently, there is no clear data on whether adhering to bed rest can prevent the loss of pregnancy.

At the same time, the abandonment of physical activity and sex life in the home environment makes it possible to create the necessary conditions for prolonging a vital pregnancy. In the first trimester of pregnancy, the tactic of waiting in threatening and initiated Falls is possible, when there is no clinically significant (moderate, severe) uterine bleeding, signs of infection, excessive pain syndrome, hemodynamic disorders.

Medicamentosis-treatments drug therapy possible in two different options, depending on the purpose:

1.Continuing pregnancy (risk of miscarriage or initiated abortion)

2.Medicamentous abortion (in undeveloped fetal)

Progestogen therapy when the fetus is at risk of miscarriage reduces the risk of miscarriage relative to the placebo and is considered safe.

The safety profile of micronized progesterone and didrogesterone at recommended doses in early pregnancy is favorable: increased incidence of adverse events by the pregnant woman and fetus, lack of therapy/placebo, or lack of evidence when comparing these drugs directly [3,9,10].

On the recommendation of NICE (2021), progesterone is recommended for patients with TX with a history of 1 or more pregnancies in early pregnancy. To relieve pain in order to reduce spasms of smooth muscles, a patient with SM may be advised to prescribe antispasmodic agents (drotaverin) according to the instructions for the drug.

The onset of miscarriage is an indication for admission to the Department of gynecology.

A pregnant patient is advised to prescribe tranexanic acid according to the scheme in accordance with the instructions for the drug to stop bleeding if there is a lot of bleeding from the vagina.

A patient who is pregnant in a hospital is advised to prescribe antibiotic therapy with broad-spectrum drugs to treat the infectious and inflammatory process. Misoprostol may be recommended for 600 mcg peroral or 400 mcg sublingual administration of incomplete fetal descent at HT < 14 weeks.

To empty the uterine cavity, it is preferable to appoint mifepristone, followed by misoprostol, with an underdeveloped pregnancy for HT< 14 weeks with intact fetal bladder and closed CU.

To stop pain syndrome and achieve an anti-inflammatory effect, it is recommended to prescribe non-steroidal anti-inflammatory drugs to patients with medical interruptions of an underdeveloped pregnancy.

Antibiotic prophylaxis is recommended for patients with incomplete pregnancy or underdeveloped pregnancy who are undergoing surgical treatment to prevent infectious and inflammatory complications.

To reduce the volume of blood loss, it is recommended to prescribe 5 ME of oxytocin intravenously or intramuscularly after surgical removal of the ovary. Surgical treatment serves as a method of choice for incomplete fall and associated bleeding, as well as infected fall. This allows you to remove the remnants of chorial or placenta tissue, stop bleeding, evacuate the tissue affected by the inflammatory process with an infected fall.

Surgery may also be preferred in the presence of comorbidities (severe anemia, ongoing bleeding, hemodynamic disorders, etc.) [2].

Vacuum aspiration is preferred compared to curettage of the uterine cavity, as it is characterized by less injury, less blood loss, less intensity of pain and shorter duration of the procedure. Curettage of the uterine cavity is performed only when vacuum aspiration is not possible [10]. It is recommended to use general anesthetics (mainly intravenous anesthetics) to provide adequate anesthesia in the surgical treatment of underdeveloped pregnancy, incomplete miscarriage, and infected fall.

Prevention :

Patients should be informed about the need to see a doctor in time when pain in the lower abdomen and bloody discharge from the genital tract appears during pregnancy.

Organization of medical care instructions for hospitalization include:

dangerous fall;

falling on the road accompanied by bleeding;

incomplete fall accompanied by bleeding;

infected fall;

bleeding from the genital tract,

accompanied by unstable hemodynamics.

Before surgical treatment (vacuum aspiration, uterine curettage), it is necessary to obtain informed consent of the patient to the planned size of the operation.

Before the operation with the patient, the following issues should be discussed:

what the next operation will include;

purpose of operation: taking into account the advantages and potential risks of the method.

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