

THE INTRODUCTION OF PREGNANT WOMEN WITH CORONAVIRUS COVID-19

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Mankind has faced an unprecedented level of war on a global scale, in which our common enemy is the new coronavirus. At the same time, our hospitals have become a battlefield, and our medical staff – soldiers [5].

The main condition for the victory of mankind in this battle is to provide medical personnel with the necessary resources and to create technical knowledge and tools that will allow them to share experiences [2]. To do this, we need to be confident that the virus on the battlefield of the hospital is not us, but we will defeat the virus. According to the World Health Organization (WHO), viral diseases continue to emerge and are a serious problem for public health. In the last 20 years, several viral epidemics have been recorded, for example, coronavirus (SARS-CoV) with Acute Respiratory Syndrome in 2002-2003 years, as well as H1N1 grippi in 2009. In addition, in 2012 Year in Saudi Arabia, the coronavirus of Respiratory Syndrome (MERS-CoV) was also detected [1, 4].

For the first time, the respiratory coronavirus (COVID -19), which has spread in the city of Wuhan, the largest capital of the province of Hubei in China, and now manifests itself as a pandemic in countries around the world, was reported to the WHO Chinese office on December 31, 2019. Since the causative agent of the disease was not clear, these cases were described as " pneumonia with an unknown etiology." A program for Disease Control and Prevention was developed in the Chinese Center and local hospitals, and as a result of inspections it was found that the etiology of this disease is a virus belonging to the coronavirus family. On February 11, 2020, who General Director Tedros A.G. announced the appearance of this new coronavirus is "coronavirus-2019" (COVID-19). Since this virus is very contagious, it soon became a pandemic in global quantities [2, 6].

According to the American doctor Obstetricians and Gynecologists, until now, the indicator of pregnant women among those infected with the COVID -19 virus is not high. However, the gripp noted that there is a high risk of infection from the COVID -19 virus, such as upper respiratory infections. It is known that during pregnancy, the female body undergoes various changes, which in its place causes a decrease in the immune system [1, 5]. This in turn leads to the fact that various infections badly affect both the pregnant woman and the fetus. In pregnancy, respiratory viral infections, such as gripp, cause premature births and the birth of low-weight babies. In addition, high

fever, manifested as a result of viral infections, leads to the development of congenital defects in the fetus.

Despite the fact that pregnant women are more prone to a viral disease, it has already been known that changes in the immune system during pregnancy can be associated with more serious symptoms [3, 4]. By COVID -19, serious symptoms such as pneumonia, respiratory failure are widely described in the elderly, followed by immunosuppression and in patients with long-term diseases such as diabetes, cancer and chronic lung disease. Similar symptoms can also occur in pregnant women due to the appearance of several changes in the immune system, which means that it is necessary to immediately identify and treat the risk group.

During the pandemic of 2002–2003, 12 pregnant women became infected with the SARS-CoV virus. 7 pregnancies were in the first trimester and 4 (57%) fetal deaths. In the II-III trimester, 2 women had delayed fetal development (40%) and 5 had premature births (80%). Three women died during pregnancy. When 11 pregnant women were tested for MERS-CoV, 91% had adverse events, 6 had a neonatal condition, and 3 had infant deaths (27%) [2, 6]. The development of respiratory failure during pregnancy has led to premature termination of pregnancy. It is noteworthy that the 2019-CoV virus also causes such high pathogenic complications as the SARS-CoV and MERS-CoV viruses, indicating a high risk that this infection will lead to drift complications in pregnancy. Coronavirus infection can be caused by both a pregnant woman and a fetus [1, 2].

Clinical manifestations of viral infections occur individually for each pregnant woman. According to data from Australia, it found a significant increase in the incidence of diseases in later stages of pregnancy. Other types of coronavirus infections (SARS, MERS) are considered to be a high-risk condition for pregnant women, especially in the last trimester of pregnancy, this risk increases. Recently in one study it was stated that the cause of premature termination of pregnancy due to the medical condition of a pregnant woman.

Effects on pregnancy

Currently, there is no evidence of an increased risk of pregnancy or premature termination due to COVID-19. However, in an article published on March 26, to date, coronavirus antibodies have been detected in the blood of 3 infants born to a pregnant woman infected with COVID-19, but the virus itself has not been detected in the umbilical cord blood. According to WHO, 3 April 2020 year, however, in the RF, it was announced the birth of the first baby infected with COVID -19. There is also currently only one case in which a woman with severe COVID -19 disease was sent to the hospital for 34 weeks, was born in an emergency for an unborn child and was admitted to the intensive care unit with an acute respiratory syndrome requiring urgent medical care [6].

There is currently no evidence of a teratogenic virus. But according to the latest data, there is a possibility of vertical transmission of the virus, but the ratio of pregnancy and the value of the newborn still need to be determined.

Clinical course and diagnosis during pregnancy

Any viral infection during pregnancy is an additional risk. Gripp, herpes, and sitomegalovirus and other viral infections produce many complications especially in the early stages of pregnancy. Organogenesis, during the period of development of organs and tissues, a viral infection can quickly affect the embryo, causing various complications: early miscarriage, the development of the fetus, premature birth or premature withdrawal of papaya water and similar complications. These complications can also be observed in cases of damage to the coronavirus, but we do not know for sure, but we know that there is a risk of serious consequences.

So far, it has not been proven that the virus passes through the fetoplacental barrier in a pregnant woman infected with the coronavirus, as a pregnant woman with the disease was found to be free of the virus when examined for amniotic fluid, umbilical cord, placenta, and breast milk after delivery.

Clinical course of coronavirus infection during pregnancy is characterized by a slow development of symptoms (hyperactivity) or rapid transition to severe degree. Perhaps, for this reason, it is possible to go with increased body temperature, massive bleeding and acute respiratory failure, with the addition of septic processes, mainly during childbirth or after childbirth, to compensate for clinical symptoms in pregnant women affected by coronavirus up to now.

Dangerous groups in which severe course of the disease is observed include: pregnant women, women with especially in the third decade, postpartum women, children and adults (less than two years and older than 65 years), overweight patients and patients with chronic diseases (lung disease, bronchial asthma, chronic bronchitis, cardiovascular disease, diabetes diabetes, etc.).

The tactics of etiotropic treatment of women who have an infection of COVID-19 during pregnancy and lactation have not yet been developed. The drug Ribavirin and recombinant interferon beta-1b can not be used during pregnancy. However, as an etiotropic therapy, antiviral drugs can be prescribed taking into account the effectiveness of the drug against the new coronavirus, taking into account the vital indications. In other cases, their safety should be taken into account during pregnancy and during breastfeeding. Prescribe Lopinavir + ritonavir is possible if the expected benefit for the mother is greater than the potential risk for the fetus: 400 mg lopinavir + 100 mg ritonavir is prescribed in the form of tablets every 12 hours for 14 days. If oral administration is not possible, the drugs (400 mg lopinavir+100 mg ritonavir) are injected through the nasogastric tube in the form of a suspension every 12 hours (5 ml) for 14 days.

Treatment should be started as early as possible, which will ensure a faster recovery. For pregnant women with a severe or progressive type of disease, antiviral drugs should be prescribed, even if they have passed much earlier than the day the disease began. When prescribing antiviral drugs to nursing mothers, the decision to continue breastfeeding depends on the condition of the mother. Pathogenetic and symptomatic treatment. The first choice is antipyretic drug paracetamol, which is prescribed 500 - 1000 mg 4 times a day (no more than 4 g per day).

For pregnant women: who recommends antenatal corticosteroid therapy. This is because there is a risk of premature pregnancy from 24 weeks to 34 weeks.

But if the mother does not have any signs of infection, it is recommended during childbirth and as a support for a newborn.

In addition, if symptoms of a mild degree of COVID-19 infection are observed in women, when the clinical advantage of corticosteroid for the fetus is higher than the danger for the mother. In this case, it is necessary to talk in detail about the benefit and harm between the fetus and the infantile baby with the pregnant woman, and to come to a clear conclusion, taking into account the desire to please the woman and her family, as well as the availability of health resources.

Obstetric tactics in several aspects: the patient's condition, the state of the fetus and the period of pregnancy. Up to 12 weeks in severe and moderate-weight diseases depends. Pregnancy with a high risk of prenatal complications, it is recommended to stop pregnancy after the treatment of infectious jaundice. If the patient refuses to stop pregnancy, a biopsy of chorionic fibers is necessary to identify chromosomal abnormalities in the fetus.

The period of exacerbation of the disease can be attributed to the death of mothers and numerous complications: aggravation of the underlying disease and its complications, the development of respiratory failure, the appearance of obstetric bleeding, postpartum death, and purulent-septic complications after childbirth.

However, if it is not possible to eliminate hypoxia in progressive respiratory failure using pulmonary artificial ventilation, early delivery by cesarean section with all necessary precautions in case of refractory septic shock for the benefit of the mother with alveolar lung tumor and vital signs will be. It is preferable to give birth in the natural way, under the monitoring of the condition of the mother and fetus, if there is a development of spontaneous complications, when the disease is in the outbreaks and the risk of pneumonia is high.

This should include complete analgesia, detoxification, antibacterial and antiviral therapy, and respiratory support.

In the second period, it is necessary to limit the tension of the pregnant woman to prevent respiratory and cardiovascular failure. If it is necessary to accelerate labor, there will be instructions to remove the fetus by vacuum-extraction by placing two

obstetric clamps. Cesarean section is performed if there is an absolute obstetric indication and the pregnant woman dies (to save the fetal life). In severe cases, regional methods of anesthesia in the background of respiratory support in the absence of signs of polyorgan failure (up to 2 points on the SOFA scale) are used in the provision of anesthetic care for caesarean section, total intravenous anesthesia using artificial lung ventilation when signs of polyorgan deficiency are evident.

All patients undergo bleeding profilactics regardless of the time of pregnancy. In all cases, the issue of time and method of delivery is decided individually.

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