

УДК 617.008.002

CRITERIA FOR RUPTURE OF AMNIOTIC FLUID IN WOMEN OF REPRODUCTIVE AGE

Khatamova Matluba Tilavovna
Bukhara State Medical Institute.

City of Bukhara. The Republic of Uzbekistan.

Department of Obstetrics and Gynecology

Sharopova Gulnigor Kuntug'mish qizi

Bukhara State Medical Institute.

City of Bukhara. The Republic of Uzbekistan.

Department of Obstetrics and Gynecology

Summary. The combination of prenatal amniotic fluid and infectious diseases is a serious problem in modern obstetrics. The causes of prenatal rupture of amniotic fluid, despite numerous studies, have not been definitively established, although infection is considered to be the leading factor in this complication.

Key words: full term, induction of labor, prenatal rupture of amniotic fluid

Relevance. Prenatal rupture of amniotic fluid (DIOV) is a serious problem of modern obstetrics. Amniotic fluid, or amniotic fluid, being a biologically active medium surrounding the fetus throughout pregnancy, performs a variety of functions, ensuring the normal functioning of the mother-placenta-fetus system [5] According to [7], childbirth against the background of prenatal rupture of fetal membranes often accompanied by anomalies of labor, hypotonic and atonic bleeding, high rates of trauma to the soft tissues of the birth canal.

The causes of prenatal rupture of amniotic fluid, despite numerous studies, have not been definitively established, although infection is considered to be the leading factor in this complication. [8] .Daneshmand et al. (2002) concluded that morpho-functional, physiological and biochemical changes in the genital tract during pregnancy lead to the fact that the vaginal microflora becomes more homogeneous, with a pronounced dominance of lactobacteria, which reduces the likelihood contamination of the fetus conditionally pathogenic microorganisms during its passage through the birth canal. But childbirth leads to significant changes in the qualitative and quantitative composition of the vaginal microflora. The number of non-spore-forming Gram-negative strict anaerobes (mainly bacteroids), Escherichia increases significantly, and the levels of lactobacilli and bifidobacteria are reduced. Violations of the normal vaginal microflora contribute to the development of such an infectious complication as endometritis. One of the mechanisms for maintaining a normal

microflora of the vagina is associated with the formation of lactobacilli during their metabolism of lactic acid and other organic acids that maintain a low pH in the vaginal environment. Acidification of various media during the growth of lactobacilli inhibits the proliferation of such conditionally pathogenic microorganisms as candida, peptostreptokokk, bacteroids, gardnerelle and other bacteria released from the vagina of women with dysbiotic disorders. Gram-negative obligate - anaerobic bacteria, some of their types, have pathogenic properties: the cell wall contains lipopolysaccharide, which is an inducer of IL-8, the main cytokine that triggers the inflammatory process. They are capable of producing succinic acid, inhibiting the migration of polymorphonuclear neutrophils and their phagocytic ability. Consequently, this increases the possibility of infection of the fetus and mother. [8]

Prenatal rupture of amniotic fluid and the inhaling of an anhydrous period more often leads to complications of labor (rapid and rapid delivery, weakness and discoordination of the contractile activity of the uterus), which aggravates the fetus and in some cases requires operative delivery [2]

The frequency of prenatal rupture of the membranes varies widely: from 5 to 19.8% of cases in full-term pregnancy [4] Births in this case do not always end favorably for the fetus and mother. Childbirth and the postpartum period can have: the risk of developing purulent-septic complications in the mother, anomalies of labor and intrauterine infection of the fetus. In addition, labor induction may be ineffective, which leads to an increase in the frequency of surgical interventions [1]

The purpose of our study was to study the role of infection in the DIOV to reduce obstetric and perinatal complications and the development of rational tactics of labor management in the prenatal discharge of amniotic fluid.

Material and research methods. To solve the tasks, a comprehensive survey of 72 pregnancies was carried out, the delivery of which was complicated with HI in the period of 37-40 weeks of gestation, received in the Bukhara regional perinatal center for the period of 2017. With the help of anamnestic, clinical, laboratory and instrumental data, we studied the course of pregnancy, labor, the postpartum period, the condition of the fetus and the newborn. The readiness of the birth canal was evaluated on the Bishop scale. According to the National Standard for the Management of Patients with DIOV, antibacterial therapy was carried out after 18 hours of anhydrous period in order to prevent purulent-septic complications in puerperas. The birth canal of women in childbirth DIAV examined after 24 hours in the absence of labor activity in order to decide on the feasibility of induction of labor. The nature of labor activity was controlled on the basis of maintaining partographs. Conducted: monitoring of hemodynamic parameters, maintaining a sheet of observation, measuring the body every 4 hours, laboratory monitoring of leukocytes 1 time per day, urinalysis, analysis of vaginal discharges. Ultrasound of the uterus and fetus,

cervicometry, monitoring of rhythm and heart rate fetus and the general condition of the woman in labor. Given the high sensitivity to ampicillin of the vaginal and cervical bacteria, this antibacterial drug was used according to the protocol. The condition of the fetus was assessed by ultrasound and cardiotocography (CTG), and the condition of the newborn at birth was measured on the Apgar scale. Fetal monitoring during labor was performed with the “Corometrics 170” apparatus.

Results and discussion: The average age of the observed women was 26.5 years. In all women, pregnancy proceeded against the background of extragenital diseases, and in most cases a combination of several of them. Anemia of mild to moderate severity (72.2%), thyroid disease (33.3%) and varicose veins (25%) prevailed. Every third woman (32%) suffered infectious diseases during this pregnancy mainly in the form of ARI, exacerbation of chronic sinusitis, cystitis, pyelonephritis. In 16.7% of pregnant patients, ARI episodes repeated many times during pregnancy. Among transferred gynecological diseases, colpitis of various etiology was most often diagnosed, which amounted to 43%. 72.2% of women in the history indicated a history of inflammatory diseases of the genital tract. This was mainly manifested in the form of yeast, trichomonas and banal colpitis, endometritis and adnexitis. 19.4% of women were treated for cervicitis and cervical erosion. According to previous analyzes of vaginal smears in 43% of women had 3 and 4 degrees of purity of vaginal smears.

In all women with prenatal rupture of amniotic fluid, a vaginal examination was performed to assess the maturity of the cervix on the Bishop scale. Evaluation was carried out on 5 criteria. It was revealed that 61.1% of the examined pregnant women had disclosure parameters, length, consistency, position of the cervix and condition of the presenting part fetuses had scores of up to 5, which was rated as an “immature neck”. And in 38.9% of women, the birth canal was assessed as a “mature neck”.

Accordingly, the tactics of further reference was chosen according to the OPT protocol. In pregnant women with an “immature” neck, induction of labor with Glandin E 2, 3 mg, 1 tablet, intravaginally, after the informed consent of the pregnant woman and relatives, was proposed. A conversation was conducted about possible complications of labor induction. During induction, fetal heartbeats and uterine activity were monitored. The birth canal is overvalued after 8 hours to clarify the need to continue induction. Pregnant women with a “mature” neck gave birth to expectant tactics before playing a regular labor activity or a council of doctors resolved the issue of oxytocin stimulation. 58.3% of pregnant births through the birth canal. Newborns born to mothers with DIOV were rated on an Apgar scale by an average of 6 points.

Thus, studies have shown that in the majority of women in labor with prenatal rupture of the fetal membranes, the readiness of the cervix was assessed to 5 points, which meant “unpreparedness” of the birth canal for childbirth. Of this number, 58.3% of women in labor underwent labor induction after the informed consent of the woman

in labor and her relatives. 22.2% of the parturient women had relative or absolute contraindications to labor induction and family stimulation. The remaining 19.4% of the parturient women refused to give birth, which as a further delivery tactic was chosen for a cesarean section. The study of the postpartum period showed that 26.4% of women had such complications as a lohiometer and a hematometer, manifested in the form of subinvolution of the uterus, with sound clinical data and ultrasound. In 18.1% of women, secondary wound healing of the soft birth canal was observed. In 2.8% of women, the postpartum period showed signs of exacerbation of chronic inflammatory diseases of the genital tract.

Conclusion: The prolonged anhydrous period is a factor in increasing infection, which leads to an increase in obstetric and perinatal pathology, an increase in the incidence of newborns and puerperas in the postpartum period, an increase in dissemination of the birth canal of the common and conditionally pathogenic flora and an increase in the imbalance of the vaginal ecosystem. These data dictate the need for antibacterial drugs in women with DIOV. The appointment of antibacterial therapy after 18 hours of anhydrous period prevents the development of purulent-inflammatory processes in the mother and fetus, causes colonization resistance and is not a contraindication to operative delivery by cesarean section.

Bibliography:

1. Varfolomeev D.I., Handel M.G. Features of uterine contractile activity in case of premature rupture of amniotic fluid in primiparous. // midwife. Igin 1984. - № 7. - S.ZZZ - 35.
2. Gurtovoy B.L., Kulakov V.I., Voropaeva S.D. The use of antibiotics in obstetrics and gynecology. Moscow, 2004.
3. "Tibbiotdayangikun" magazine №2, page 292-295, 2019. Res.Uzbekistan. M.T.Hotamova, I.I.Tosheva. "Aspects of the management of labor at antenatal discharge of amniotic fluid."
4. "Tibbiotdayangikun" magazine №2, page 345-349, 2019. Res.Uzbekistan. Khatamova MT, "PECULIARITIES OF IMMUNE-HORMONAL INDICATORS OF THE POST-FERRIN PERIOD"
5. "Tibbiotdayangikun" magazine №2, page 316-319, 2019, Res.Uzbekistan. Sh.Zh.Shukurlaeva, M.T.Hotamova. "Criteria for diagnosis after the birth of septic condition and methods of hemostasis"
6. Extremely prolonged premature rupture of membranes / Amici C. [et al.] // Minerva Ginecol. - 2017. - Vol. 49. -P. 509-514.
7. «Tibbiotdayangikun» №3 magazine page 275-278, 2019, Res.Uzbekistan. Khatamova MT, Soliyeva NK, "CURRENT FEATURES OF CHRONIC PYELONEPHRITIS IN WOMEN OF FETURAL AGE".
8. Kamysnikov V.S. Clinical laboratory tests from A to Z and their diagnostic profiles. // Moscow, 2005.
9. Kondratieva E.N. Pathogenesis, diagnosis and prevention of complicated course of pregnancy and childbirth in the pathology of the amniotic medium: author. dis. MD: 14.00.01 E.N. Kondratieff. Moscow, 1999-36 p