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MORPHOLOGICAL CHANGES IN THE PLACENTA IN WOMEN WITH FETAL GROWTH RETARDATION SYNDROME

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Abstract: This article presents the results of ultrasound placentography and dopplerometry examination of the placenta of women with fetal growth retardation syndrome (IUGR). In the prospective stage, a total of 90 pregnant women aged 21-38 were subjected to tekhshuruv. Clinical-laboratory and instrumental examinations (general blood analysis, blood clotting system analysis, ultrasound and dipplerometry) have been performed to assess changes in their fetoplasentar system. The core group was made up of 60 patients at risk of becoming oxen. The control group consisted of 30 relatively healthy pregnancies. In the main group of women, vascular resistance in dopplerometry was higher compared to the control group in the uterine artery as well as in the arteries of the umbilical system. But these rates were lower in the central cerebral artery in the main group compared to the control group.

Keywords: fetal growth retardation syndrome, ultrasound, dopplerometry, fetoplasentar insufficiency

Fetal growth retardation syndrome (IUGR) refers to the fact that the body weight of the fetus does not correspond to the average body weight for this period of pregnancy. The main number of newborns with IUGR occurs in Asia; followed by Africa and Latin America.[12]. M. and yu. According to Ismatova (2017), a retrospective and prospective analysis in 2014 at the Perinatal Center in Bukhara found that 73 women had IUGRS(5.1%) among 3,476 emergency births. [10]. Recent advances in medicine have identified (but not fully studied) the etiology and pathogenesis of this complication of the perinatal period. The causes that lead to fetal growth retardation syndrome are divided into several groups: mother, fetus, placenta and others occur in 35-40% of cases with maternal pathologies, such as: gestational hypertension, preeclampsia, heart disease, diabetes, as well as women with a low socioeconomic level have a high risk. [4,6, 8].

The most common cause of impaired fetal development is placental insufficiency. The uteroplacental blood flow, necessary for the optimal supply of nutrients and oxygen to the growing organism, reaches the intercalated space along the spiral arteries. Histological and morphological changes in these arteries are closely related to the stage of trophoblast invasion [1,2]. It is believed that uteroplacental insufficiency is caused by placental anomalies, or rather disorders that occur during the stage of

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trophoblast invasion. Inadequate invasion leads to a certain number of vascular events, including the absence of vasodilation of the placenta blood vessels, causing placental ischemia. [14,18].

A total of 90 pregnant women with gestational age of 24-38 weeks were examined. All women examined were divided into the following groups:

Group I-the main group, 60 women were introduced, whose gestation period was observed in the development of IUGR during the examination

Group II-control group, which included 30 pregnancies with relatively healthy gestation periods during the examination.

The median age of pregnant women in the primary group was 26.78 ±4.81 years (changed from 16 to 25 years), while the control group was 26.20 ± 5.01 years (changed from 19 to 41 years) (r <0.05).

All groups were dominated by first-time pregnant and first-time births: 16 (26.7%) and 11 (18.3%) in the main group, 10 (33.3%) and 10 (33.3%) in the control group, respectively.

In the main groups, the presence of calcinates in the placenta was observed in 21 (35%) cases. In this, Grade I was consistent with its term of placenta maturation in all existing observations, Grade III was inconsistent with its term in existing observed pregnancies-half of all cases, its early "aging" was noted, while Grade II– 5 (71%) was inconsistent with its term in observations, with 11 (26.2%) cases of early "aging" and 3 (60%) cases of

When an Individual analysis was carried out, 75% of observations in a small group containing Grade III IUGR noted changes in placental thickness, placental cysts, premature ejaculation, and "aging", as well as a coherence of exographic signs such as calcinosis. For 36 pregnant women (73.5%) from Sub-Group II, the combination of early maturation and signs such as "aging", calcinosis and the location of the placenta below became characteristic. In 2/3 pregnant women in the I-subgroup, changes in placental thickness, premature "aging" and calcinosis Harmony were established.

In the small groups being analyzed, the ultrasonic identities of the placenta are shown in Figure 1.

The presence of calcinates in the placenta in the main groups is 32 (35.6%)

observed in position. There is an I-level in that IUGR available at all

in observations, the rate of placental maturation was consistent with its term, in pregnancies where Grade III was observed, half of all cases did not match its term, its premature "aging" was noted, while in Grade II– present IUGR-5 (71%) observations did not match its term, with 11 (26.2%) cases of premature "aging" and 3 (60%) cases – of morphofunctional immaturity.

It is understandable that in most observations there is a harmony of several exographic characters. When an Individual analysis was carried out, 75% of

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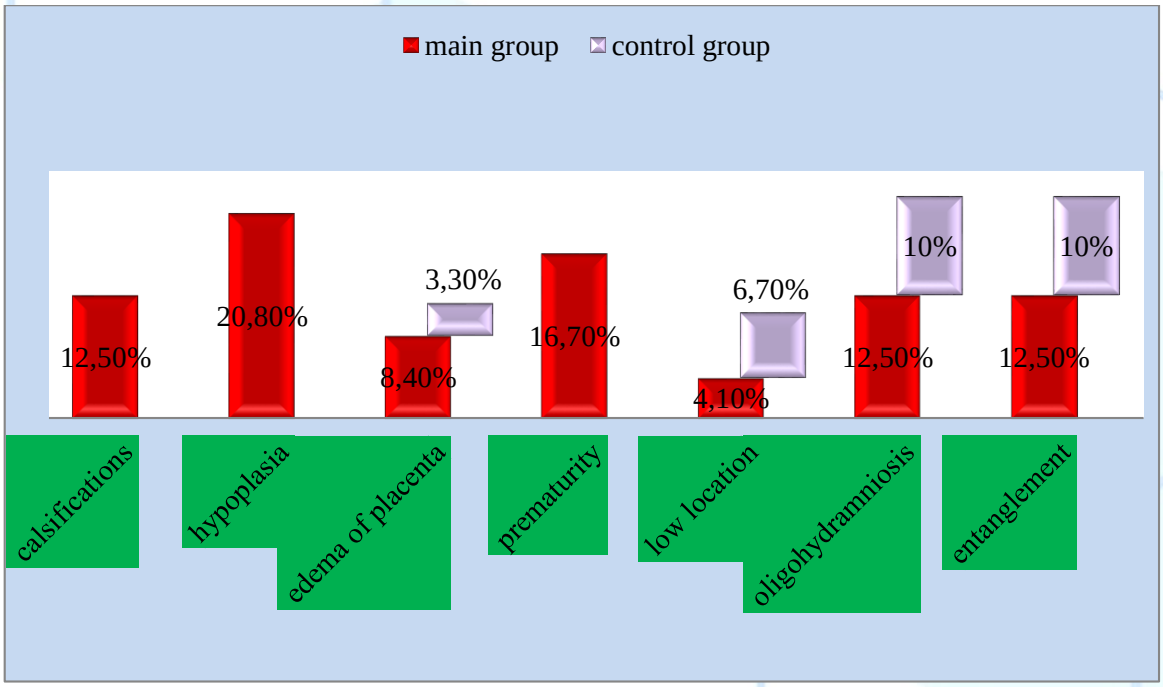
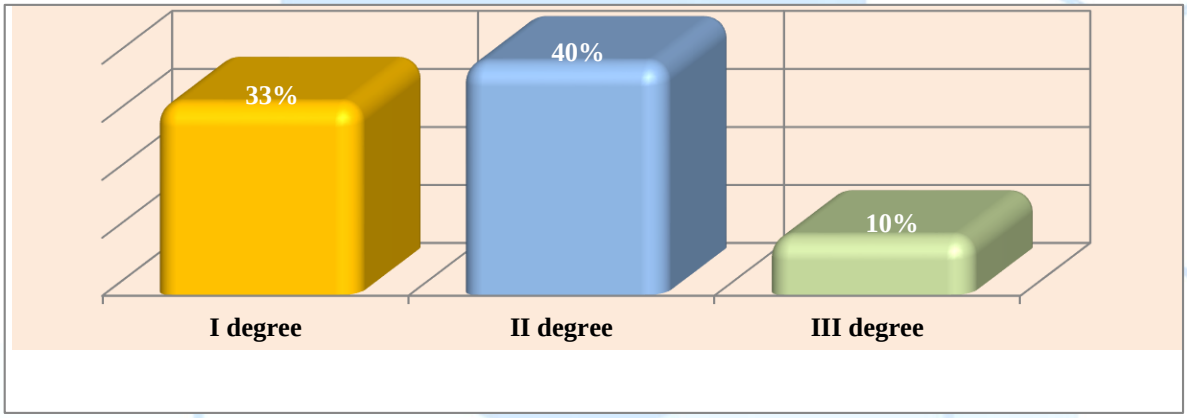
observations in a small group containing Grade III IUGR noted changes in placental thickness, placental cysts, premature ejaculation, and "aging", as well as a coherence of exographic signs such as calcinosis. For 36 pregnant women (73.5%) from Sub-Group II, the combination of early maturation and signs such as "aging", calcinosis and the location of the placenta below became characteristic. In 2/3 pregnant women in the I-subgroup, changes in placental thickness, premature "aging" and calcinosis Harmony were established .



Nevertheless, it is evident that the most significant exographic signs for Grade II-III IUGR are the calculation of placental thickness. Thus, at expressed levels of IUGR, the thin placenta was found 1.4 times more often than in subgroups II and I. As for the thickening of placental dimensions, they were found to be 2.3-2.5 times higher in Grade II – III IUGR than in I and control groups. This may be due to peculiarities in the formation of placentar compensatory mechanisms.



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Thus, placentar insufficiency in more than 2/3 patients in the main group was observed with the development of hypotrophy in the form of symmetry or asymmetry in fetuses. The analysis carried out shows that the results of exographic diagnostics do not always allow antenatal conclusions with a high degree of reliability about the severity of placentar insufficiency in pregnant women who have an esophagus.

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