

PRE-ECLAMPSIA – ACTUAL PROBLEM IN OBSTETRICS

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Abstract: *The etiology, diagnosis and treatment of pre-eclampsia are discussed. Also in the article modern aspects to forecasting, tactics and prevention of pregnant women with pre-eclampsia.*

Keywords: *pre-eclampsia, pregnancy, diagnostics, treatment.*

Аннотация: *В статье рассматриваются вопросы этиологии, современной диагностики и лечения преэклампсии. Также, в статье отражены современные аспекты к прогнозированию, тактике ведения и профилактике беременных с преэклампсией.*

Ключевые слова: *преэклампсия, беременность, диагностика, лечение.*

Pre-eclampsia (PE) is one of the most important problems in modern obstetrics, given its medical and socio-economic importance. Since the consequences of severe hypertensive disorders during pregnancy reduce the quality of life of women of reproductive age, and the frequency of violations of the physical, psychosomatic development of prematurely born children is quite high, this problem is significant both medically and socially [1–3]. The leading risk factors for the development of PE are called extragenital pathology (endocrinopathy, diseases of the cardiovascular system, kidneys), inflammation of the genital organs, and a burdened obstetric history. The main risk factors for the development of PE, identified from the anamnesis and clinically, are chronic kidney disease (58.6%), vascular pathology (51.7%), endocrine

pathology (38.0%), metabolic syndrome (24.0%), heart diseases (22.0%), diseases of the gastrointestinal tract (20.7%). Other risk factors for PE are maternal age over 35 years, obesity, and multiple pregnancies [4]. According to the World Health Organization, PE is the main cause of preterm birth, premature detachment of a normally located placenta, the development of placental insufficiency, intrauterine growth retardation, and the birth of children with low body weight. Complications of PE are hemorrhage and retinal detachment, acute renal failure, acute steatosis, HELLP syndrome, pulmonary edema, and stroke [4]. Until now, the etiology and pathogenesis of PE are not completely known, scientists around the world are trying to link together all the links, to determine the sequence and subordination of all the changes that occur in the body of a pregnant woman. Currently, the most priority is the placental theory of development, which explains the occurrence of PE as a result of pathological placentation, which in turn leads to placental ischemia with the further development of generalized vasospasm, endotheliosis and multiple organ failure. Among the many problems associated with PE and eclampsia, the problem of diagnosing, predicting and assessing the degree of severity occupies one of the most important places and is of great importance both for obstetrician-gynecologists and for doctors of related specialties. Reducing perinatal and maternal morbidity and mortality remains a major challenge for obstetricians and gynecologists. It is important to remember that even if PE is suspected, a pregnant woman must be urgently hospitalized for additional examination and diagnosis. When the diagnosis is confirmed, the state of the pregnant woman and the functional state of the fetus are assessed, and further management tactics depend on the gestational age and severity of the disease. The diagnosis of PE is established with a combination of arterial hypertension (systolic blood pressure - SBP ≥ 140 mm Hg and / or diastolic blood pressure - DBP ≥ 90 mm Hg), proteinuria (the presence of protein in the urine ≥ 0.3 g/l in a daily sample (24 hours) or in two samples taken with an interval of 6 hours; when using a test strip (protein in urine) - an indicator (\geq "1+") and generalized edema [4]. Peripheral edema is observed in 70–80% of cases during a physiological pregnancy, and therefore cannot be considered as

a diagnostic criterion for PE [4]. However, swelling of the face and hands often precedes the development of PE, and generalized, rapidly increasing edema, anasarca, fluid accumulation in the cavities are considered as one of the unfavorable prognostic criteria for severe PE. At the same time, PE without generalized edema is recognized as more dangerous for the mother and fetus than PE with edema.

Approaches to treatment

The basic drug in the treatment of preeclampsia and eclampsia is magnesium sulfate, administered at a concentration of 25%. Magnesia therapy should be carried out continuously at any stage of pregnancy, during childbirth and the postpartum period. Despite this, the use of magnesium sulfate is an inconclusive treatment for severe preeclampsia. Delivery is the only effective treatment for severe preeclampsia [5]. At the present stage, delivery through the natural birth canal in severe preeclampsia is becoming an alternative to operative delivery [5]. Also an important problem in preeclampsia is the determination of indications for emergency delivery and the gestational age at which complications for children will be minimal. In this regard, the opinions of scientists are divided. Some scientists advocate the tactics of early delivery in order to avoid complications on the part of the mother (eclampsia, placental abruption, HELLP syndrome, cerebral hemorrhage, acute renal failure, and others). Other scientists advocate the tactics of prolonging pregnancy in order to avoid complications from the fetus associated with its immaturity (respiratory distress syndrome, cerebral hemorrhage, necrotizing enterocolitis, and others). Changes in hemodynamics characteristic of preeclampsia under the influence of labor stress may acquire a progressive character, in particular, in women with a history of hypertensive disorders within a three-year period after childbirth, the following were found: hypertension (48.7%), myopia (18.7%), pyelonephritis (13.7%), violation of fat metabolism (6.2%), and only in 12.5% of cases the patients remained practically healthy.

Pre-eclampsia forecasting

To predict late postpartum complications in women who have undergone preeclampsia, indicators of central and cerebral hemodynamics obtained using the method of integral body rheography and rheoencephalographic study of cerebral blood flow are used. Currently, none of the methods for predicting preeclampsia can be recommended as a universal screening test to determine the risk of preeclampsia, because there are 40 theories of the etiology and pathogenesis of preeclampsia. Thus, among the many problems associated with preeclampsia and eclampsia, the problem of diagnosing, predicting and assessing the degree of severity occupies one of the most important places and is of great importance for both obstetrician-gynecologists and anesthesiologists-resuscitators. To reduce maternal mortality from preeclampsia and eclampsia, it is necessary to: take into account and identify risk factors for the development of preeclampsia, ensure proper monitoring of pregnant women with a risk group for preeclampsia, comply with the criteria for diagnosing preeclampsia when making a diagnosis, observe the principles of regionalization in preeclampsia, strict adherence to protocols when conducting magnesium and infusion therapy, compliance with delivery standards for preeclampsia and eclampsia, medical examination of women with extragenital diseases, their rehabilitation and treatment, integration of perinatal centers with multidisciplinary hospitals [5].

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