



## EFFECTIVENESS OF CARE IN PREGNANCIES WITH THREATENED ABORTION: COMPLIANCE WITH CLINICAL GUIDELINES

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### ABSTRACT

*To evaluate the efficacy of diagnostic and therapeutic interventions provided to pregnant women facing the threat of miscarriage, a retrospective review was conducted involving 150 cases of patients with gestational age up to 22 weeks who underwent inpatient treatment in gynecological departments of Volgograd. All women had been diagnosed with "Threatened abortion" according to ICD-10 classification (code O20.0). The analysis revealed that one in three patients (n = 51; 34%) did not receive the full range of diagnostic procedures outlined in clinical guidelines, including pelvic ultrasound in the first trimester and cervicometry in the second trimester. The most frequent issues were related to inappropriate therapeutic strategies. Polypharmacy was identified in 110 cases (73.3%), where patients were prescribed 6 to 10 different medications. Moreover, in 92 women (61.3%), the prescribed drugs were not listed in the official medical care protocols for this condition. Among these patients, 60 (40%) required rehospitalization due to recurrent symptoms, and in 17 cases (28.3%) the pregnancy could not be sustained.*

## ЭФФЕКТИВНОСТЬ ВЕДЕНИЯ БЕРЕМЕННЫХ С УГРОЗОЙ ПРЕРЫВАНИЯ: АНАЛИЗ СОБЛЮДЕНИЯ КЛИНИЧЕСКИХ РЕКОМЕНДАЦИЙ

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### ABSTRACT

*С целью оценки результативности лечебно-диагностических мероприятий, проводимых при угрозе прерывания беременности, был выполнен*



*Угроза прерывания беременности, потери репродуктивного потенциала, лечебно-диагностические подходы, клинические рекомендации.*

*ретроспективный разбор медицинской документации 150 женщин с гестационным сроком до 22 недель, проходивших стационарное лечение в гинекологических отделениях города Волгограда с диагнозом "угроза выкидыша" (код по МКБ-10 — O20.0). Установлено, что у каждой третьей пациентки ( $n = 51$ ; 34%) не были проведены диагностические процедуры, предусмотренные клиническими стандартами: УЗИ органов малого таза в I триместре и цервикометрия во II триместре. Наиболее частыми нарушениями были ошибки при выборе медикаментозной терапии. У 110 женщин (73,3%) отмечено назначение одновременно от 6 до 10 лекарственных средств, что соответствует признакам полипрагмазии. Кроме того, у 92 беременных (61,3%) были назначены препараты, не рекомендованные действующими стандартами оказания помощи при данной патологии. Повторная госпитализация потребовалась 60 пациенткам (40%), при этом у 17 из них (28,3%) беременность сохранить не удалось.*

**Introduction.** Despite certain positive trends in recent years, the demographic situation in Russia remains extremely tense [1, 3, 13]. According to official statistics, 53% of the Russian population are women. The reproductive age is generally defined as the period from 15 to 49 years, and 45.7% of women fall within this range. However, the actual number of women capable of reproduction is significantly lower, as many are entering reproductive age with serious somatic health issues. Consequently, a marked improvement in the demographic situation is unlikely [2, 7, 10, 12]. Under such conditions, preserving each desired pregnancy becomes a matter of fundamental importance [14, 17, 18, 20].

At the same time, miscarriage rates, according to various sources, range from 10% to 20%, amounting to 19.1 per 100 live births. Spontaneous abortions constitute the majority of reproductive losses (65.3%), and their incidence is not declining: while in 2001 the miscarriage rate was 4.21 per 1,000 women of reproductive age, by 2010 it had increased to 4.63 [11, 16]. In contemporary obstetrics, reproductive losses remain one of the most pressing concerns [8, 9, 15, 19].

Efforts to optimize medical care and reduce reproductive losses are reflected in the Russian Ministry of Health Order No. 572n dated 01.11.2012 "On Approval of the Procedure for the Provision of Medical Care in the Field of Obstetrics and Gynecology (Except for the Use of Assisted Reproductive Technologies)" and in the Clinical Guidelines "Miscarriage in Early Pregnancy: Diagnosis and Management Tactics" dated 07.06.2016, No. 15-4/10/2-3482 [4, 5, 6].

Recurrent pregnancy loss (RPL) is defined differently across international medical communities. According to the European Society of Human Reproduction and Embryology (ESHRE), RPL refers to three successive pregnancy losses, whether or not they were visualized



through imaging. Meanwhile, the American Society for Reproductive Medicine (ASRM) defines this condition as two or more confirmed clinical pregnancy losses, identified via ultrasound or histopathology, without the requirement of consecutive occurrence. In the Russian medical context, most experts consider two miscarriages sufficient to initiate a full reproductive assessment prior to attempting conception again.

The main recognized contributors to RPL include structural uterine abnormalities, antiphospholipid antibody syndrome, disruptions in hormonal or metabolic balance, and chromosomal anomalies. Additionally, several less universally accepted factors are often discussed, such as chronic endometritis, inherited forms of thrombophilia, luteal phase insufficiency, and excessive DNA fragmentation in sperm.

Although targeted therapies based on underlying causes—such as surgical intervention for uterine malformations or antithrombotic treatment in antiphospholipid syndrome—have led to improved pregnancy outcomes, a substantial proportion of cases (estimated at nearly 50%) remain idiopathic. These are typically treated using empirical strategies, including hormonal support with progesterone, anticoagulant medications, and, in some instances, immunomodulatory agents [3].

**The aim of the research:** To assess the effectiveness of diagnostic and therapeutic measures in providing medical care to pregnant women with a threatened abortion.

**Materials and Methods.** A retrospective analysis was conducted on the medical records of 150 pregnant women up to 22 weeks of gestation who received inpatient treatment in gynecological departments of Volgograd with a diagnosis of "Threatened Abortion" (ICD-10 code: O20.0). The study evaluated the diagnostic effectiveness and compliance of therapeutic interventions with regulatory and clinical standards. Data analyzed included medical history, physical examination findings, laboratory and instrumental diagnostics, and consultations with related specialists, which allowed for diagnostic verification.

Therapy was assessed based on its justification and conformity with the Ministry of Health's clinical guidelines and prescribing instructions. The validity of hospitalization, length of stay in the gynecological ward, frequency of readmissions, and pregnancy outcomes were also analyzed. Statistical analysis was performed using Statistica 6.0 (StatSoft Inc., USA).

**Results and Discussion.** Clinical and expert analysis showed that the average age of hospitalized patients was  $32.7 \pm 0.82$  years. A history of inflammatory pelvic diseases was recorded in 116 (77.3%) cases and menstrual irregularities in 44 (29.3%) patients. Extragenital comorbidities included urinary tract diseases in 61 (40.7%) women, liver and biliary tract disorders in 48 (32.0%), and metabolic syndrome in 38 (25.3%).

Analysis of the medical records revealed deficiencies in the confirmation of the "Threatened Abortion" diagnosis. According to current protocols, the diagnosis should be based on the detection of a retrochorionic hematoma on ultrasound in the first trimester or cervical shortening during second-trimester cervicometry. Complaints of abdominal pain and mucous vaginal discharge, in the absence of these findings, are not sufficient grounds for the diagnosis.

A third of the patients ( $n = 51$ ; 34%) did not receive a full set of diagnostic procedures (first-trimester pelvic ultrasound or second-trimester cervicometry). This diagnostic gap may result in either underestimating abortion risk or initiating unjustified pharmacological treatment. Errors in therapeutic management were primarily due to polypharmacy. A total of



110 (73.3%) patients received 6–10 medications, with no documented medical board justification. Drugs not included in the standard of care—such as valerian, 5% glucose, 5% ascorbic acid, etamsylate, and aminocaproic acid—were prescribed in 92 (61.3%) cases. For example, unproven hemostatic agents like aminocaproic acid and etamsylate were used, despite official guidelines recommending tranexamic acid at a daily dose of up to 1,500 mg. Only 58 (38.7%) women received hemostatic therapy in line with the guidelines, and bleeding typically ceased by days 3–4 of treatment.

All patients received progestogen support with either micronized progesterone or dydrogesterone, as recommended. However, in 38 (25.3%) cases, dydrogesterone was prescribed at 10 mg 3–4 times daily without the initial 40 mg loading dose outlined in the drug's instructions. The administration route of micronized progesterone was not specified in 27 (18%) cases.

Folic acid prescriptions in 64 (42.7%) records listed the number of tablets (e.g., "1 tablet daily") without specifying the dosage, despite wide variability in available tablet strengths (1, 5, 260, 280, or 400 mcg). Discharge summaries in some cases lacked dosage and duration recommendations for continued progestogen therapy.

Readmission was required in 60 (40%) patients. Among these, pregnancy could not be preserved in 17 (28.3%) cases.

**Conclusions.** Pregnancy outcomes are largely influenced by a woman's somatic and reproductive health. The study showed that 133 women had complex obstetric histories and chronic somatic conditions. Genital tract inflammation (77.3%) and urinary tract diseases (40.7%) were most common. A high proportion of patients were overweight, which is consistent with global evidence linking metabolic disorders to pregnancy loss.

Accurate diagnosis of "Threatened Abortion" must be based strictly on clinical and instrumental criteria such as vaginal bleeding and retrochorionic hematoma (first trimester) or cervical shortening (second trimester). The absence of proper documentation and diagnostic justification in 34% of records indicates poor compliance with regulatory standards and insufficient adherence to clinical guidelines. Lack of diagnostic confirmation and unjustified medication use reflect a trend toward polypharmacy. Obstetricians must prioritize adherence to prescribing standards and restrict treatment to medications approved for use in obstetrics. The high rate of rehospitalization (40%) and miscarriage in 28.3% of these cases underscores the need for improved quality of care and guideline adherence.

Although miscarriage remains a complex medico-social challenge, current evidence-based protocols offer clear diagnostic and treatment pathways. Regulatory guidance must serve as a foundation for clinical decision-making, ensuring both optimal care and legal protection for practitioners.

## References:

1. Radzinskiy V. E., Dimitrova V. I., Maiskova I. Yu. Moscow, GEOTAR-Media Publ., 2018. – 1088 p.
2. Savelyeva G. M., Sukhikh G. T., Serov V. N., Radzinsky V. E. Obstetrics: a national guide. Moscow, GEOTAR-Media Publ., 2009. – 1196 p.



3. Selikhova, M. S. Non-developing pregnancy: How to avoid losses in the future? / M. S. Selikhova, G. V. Dmitrienko, O. A. Kuznetsova, S. V. Vdovin // *Vestnik novykh meditsinskikh tekhnologii*. – 2012. – T. 19, No 2. – P. 303–305.
4. Sidelnikova V. M. Podgotovki i vedenie beremennosti u zhenshchiny s habitual'nom nevyushcheniyem [Preparation and management of pregnancy in women with habitual miscarriage]. Moscow, MEDpress-inform Publ., 2011. – 219 p.
5. Sinchikhin S. P., Stepanyan L. V., Mamiev O. B. Novye podkhody v lechebnoy taktike pri nerazvivayushchey beremennosti [New approaches in medical tactics for non-developing pregnancy] / S. P. Sinchikhin, L. V. Stepanyan, O. B. Mamiev // *Voprosy gynecology, obstetrics and perinatology*. – 2012. – № 4. – P. 20–26.
6. American College of Obstetricians and Gynecologists. Early Pregnancy Loss. ACOG Practice Bulletin No. 200. // *Obstet Gynecol*. — 2018. — Vol. 132(5). — P. e197–e207.
7. Jauniaux E., Bhide A. Prenatal ultrasound diagnosis and outcome of first-trimester intrauterine hematomas. // *Am J Obstet Gynecol*. — 2019. — Vol. 220(1). — P. 1–10.
8. Kh, Kobilova Z., and Zubaydulloeva Z. Kh. "FEATURES OF HEART RHYTHM DISORDERS AT DIFFERENT STAGES OF GESTATION." *Talqin va tadqiqotlar ilmiy-uslubiy jurnali* 2.54 (2024): 272-277.
9. Khudoyarova D. R., Kh K. Z., Kh Z. Z. ARRHYTHMIAS IN PREGNANCY: TACTICS OF PATIENT MANAGEMENT // *Eurasian Journal of Medical and Natural Sciences*. – 2024. – T. 4. – № 9. – C. 119-123.
10. Larsen E.C., Christiansen O.B., Kolte A.M., Macklon N. New insights into mechanisms behind miscarriage. // *BMC Medicine*. — 2013. — Vol. 11. — P. 154.
11. Practice Committee of the American Society for Reproductive Medicine. Evaluation and treatment of recurrent pregnancy loss: a committee opinion. // *Fertility and Sterility*. — 2012. — Vol. 98(5). — P. 1103–1111.
12. Rakhimovna K. D., Khamzaevna K. Z. CARDIAC ARRHYTHMIAS IN PREGNANT WOMEN: A COMPREHENSIVE REVIEW // *Eurasian Journal of Medical and Natural Sciences*. – 2024. – T. 5. – № 1. – C. 35-39.
13. Triche E.W., Hossain N., Paidas M.J. Placental abruption and adverse perinatal outcomes. // *Clin Obstet Gynecol*. — 2022. — Vol. 65(1). — P. 76–85.
14. Баринов В.С., Адамян Л.В., Сухих Г.Т. Акушерство. Национальное руководство. — М.: ГЭОТАР-Медиа, 2020. — 1088 с.
15. Кобилова З. Х., Худоярова Д. Р. СОВРЕМЕННЫЙ ВЗГЛЯД НА ИДИОПАТИЧЕСКИЕ НАРУШЕНИЯ РИТМА СЕРДЦА В РАЗЛИЧНЫЕ СРОКИ ГЕСТАЦИИ // *Eurasian Journal of Medical and Natural Sciences*. – 2024. – T. 5. – № 1. – C. 50-55.
16. Краснопольский В.И., Аляева Е.А., Белокриницкая Т.Е. Невынашивание беременности. — М.: МЕДпресс-информ, 2021. — 304 с.
17. Кулаков В.И., Курцер М.А., Мартюшова Е.Ф. Невынашивание беременности: современный взгляд на проблему. // *Вопросы гинекологии, акушерства и перинатологии*. — 2021. — Т. 20, №3. — С. 14–20.
18. Шопулов Ш., Абсаматов Ш., Холдоров И. ГИПЕРАКТИВНОСТЬ ДЕТРУЗОРА: СОВРЕМЕННЫЕ ВОЗМОЖНОСТИ ТЕРАПИИ // *Евразийский журнал медицинских и естественных наук*. – 2022. – T. 2. – № 6. – С. 409-411.



19. Шопулотова З. А., Худоярова Д. Р. ХРОНИЧЕСКИЙ ПИЕЛОНЕФРИТ И БЕРЕМЕННОСТЬ: ВЛИЯНИЕ КОМОРБИДНОСТИ И ЕГО ПРОЯВЛЕНИЯ //ЖУРНАЛ РЕПРОДУКТИВНОГО ЗДОРОВЬЯ И УРО-НЕФРОЛОГИЧЕСКИХ ИССЛЕДОВАНИЙ. – 2023. – Т. 4. – №. 4.

20. Шопулотова З. СРАВНИТЕЛЬНЫЙ АНАЛИЗ КЛИНИЧЕСКИХ СЛУЧАЕВ ОБОСТРЕНИЯ ХРОНИЧЕСКОГО ПИЕЛОНЕФРИТА У БЕРЕМЕННЫХ //Международный вестник медицинских наук и клинических исследований. – 2023. – Т. 3. – No 8. – С. 22-25.