

FETOPLACENTAL INSUFFICIENCY WITH HYPOTENSION IN PREGNANT WOMEN

Khudoyarova Dildora Rakhimovna
Abdullaeva Shakhnoza Uktamovna

¹ Department of Obstetrics and Gynecology №1 Samarkand State Medical University, Samarkand, Uzbekistan

² Department of Obstetrics and Gynecology №1 Samarkand State Medical University, Samarkand, Uzbekistan

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Annotation: Despite the intensive development of obstetrics and perinatal medicine, placental insufficiency remains the leading cause of high morbidity and mortality in children, not only in the perinatal period, but also at subsequent stages of child development. So, according to various authors, in more than 30% of cases, signs of maladaptation of the newborn in the early neonatal period are detected, lesions of the central nervous system are observed in almost half of the children. The study of placental insufficiency has not lost its relevance for many years and continues to be a priority in modern obstetrics and perinatology.

Keywords: hypotension in pregnant women, hypotensive conditions, fetoplacental insufficiency (FPI), hemodynamics, intrauterine growth retardation.

The frequency of arterial hypotension in pregnant women varies widely, ranging from 6.2% to 32.4%. It is not always possible to identify the cause and unambiguously determine the mechanisms of development of this pathology. Among the many causes of arterial hypotension in pregnant women are adrenal dysfunction, neurological disorders, vegetative pathology, disruption of the central mechanisms of blood circulation regulation, prolonged physical inactivity, malnutrition, and much more. In addition, the development of hypotension in pregnant women is explained by the inhibition of ovarian function, the influence of the placenta, the action of prostaglandins, the immune response to placental and fetal antigens, resulting in a reduced or increased release of a number of biological substances that affect vascular tone.

Currently, hypotension is isolated, which occurred before pregnancy, and first occurred during this pregnancy. The severity of arterial hypotension should be assessed according to the following criteria: the severity of tachycardia, the presence and frequency of vegetovascular crises, the presence and severity of pain, exercise tolerance.

Arterial hypotension leads to an increase in the frequency and severity of complications during pregnancy and childbirth, adversely affects the condition of the fetus and newborn. In pregnant women with arterial hypotension, complications such as early toxicosis (from 6.1% to 38.4%), preeclampsia (in 18.9% - 34.7%), the threat of abortion (12.4% - 43.1%), preterm birth (6.2% - 20.1%). One of the frequent complications of pregnancy is fetoplacental insufficiency, the early onset and severity of which is aggravated by arterial hypotension.

With arterial hypotension, various pathologies during childbirth occur much more often, which is manifested by untimely rupture of amniotic fluid (from 19.8% to 50.6%) and anomalies in labor activity (8.4% - 25.6%). Pregnant women with arterial hypotension are characterized by a long period of labor precursors, a slow rate of development of labor activity and a protracted course of labor. There is a tendency to develop various forms of discoordinated labor activity. Pregnant women and women in labor with arterial hypotension tolerate blood loss worse, which in a number of cases (9.8-28.1%) is increased in them.

The cause of obstetric bleeding is not only the pathology of the contractile activity of the uterus, but also violations of the blood coagulation system. A high number of complications in childbirth in pregnant women and women in labor with arterial hypotension causes a large number of surgical interventions, which, in turn, creates conditions for the development of postpartum complications, mainly due to the development of postpartum inflammatory diseases. In puerperas with arterial hypotension, postpartum diseases occur 2 times more often than in puerperas with normal blood pressure.

At the initial stage of development of placental insufficiency, the listed clinical signs may be mild or absent. In this regard, the methods of laboratory and instrumental dynamic monitoring of the state of the fetoplacental complex in the high-risk group for the development of fetoplacental insufficiency are of great importance. The dominant position in the clinical picture may be occupied by signs of the underlying disease or complication in which fetoplacental insufficiency has developed. The severity of fetoplacental insufficiency and violations of compensatory-adaptive mechanisms are directly dependent on the severity of the underlying disease and the duration of its course. The most severe course of placental insufficiency acquires when pathological signs appear during pregnancy up to 30 weeks and earlier. Thus, the most complete information about the form, nature, severity of fetoplacental insufficiency and the severity of

compensatory-adaptive reactions can be obtained from complex dynamic diagnostics.

Sonographic examination includes placentography. This determines the localization of the placenta, the thickness of the placenta, the distance of the placenta from the internal os, the correspondence of the degree of maturity of the placenta to the gestational age, pathological inclusions in the structure of the placenta, the location of the placenta in relation to myomatous nodes or a scar on the uterus. In the course of the study, an assessment is made of the volume of amniotic fluid, the structure of the umbilical cord and the location of the loops of the umbilical cord.

Dopplerography is a highly informative, relatively simple and safe diagnostic method that can be used for comprehensive dynamic monitoring of the state of blood circulation in the mother-placenta-fetus system after 18-19 weeks of pregnancy, since by this time the second wave of cytotrophoblast invasion is completed. The nature of hemodynamics in the arteries of the umbilical cord makes it possible to judge the state of the fetoplacental blood flow and microcirculation in the fetal part of the placenta. To diagnose violations of uteroplacental blood flow, studies are carried out in the uterine arteries from both sides.

An important component of a comprehensive assessment of the fetal condition is cardiotocography (CTG), which is a method of functional assessment of the fetal condition based on recording the frequency of its heartbeats and their changes depending on uterine contractions, the action of external stimuli or the activity of the fetus itself. CTG significantly expands the possibilities of antenatal diagnosis, allowing you to resolve issues of rational tactics for managing pregnancy.

The final tactics of managing the patient should be developed not only on the basis of an assessment of individual indicators of the state of the fetoplacental complex, but also taking into account the individual characteristics of a particular clinical observation (the duration and complications of pregnancy, concomitant somatic pathology, the results of an additional comprehensive examination, the state and readiness of the body for childbirth, etc.).

Conclusions. Thus, arterial hypotension is one of the leading problems of modern obstetrics, which determines the high level of complications among pregnant women, women in labor and puerperas. In domestic and foreign literature, there are a large number of works on the etiology and pathogenesis of arterial hypotension, and complications associated with it. This pathology can lead to a

delay in intrauterine development of the fetus due to a decrease in uteroplacental blood flow. In pregnant women suffering from arterial hypotension, spontaneous abortion occurs 3-5 times more often at different times. The results of fundamental research conducted in recent years have shown that the formation of intrauterine suffering is laid in the early stages of pregnancy, when the ill-being of the woman's body, the state of the endo- and myometrium cause defective formation of the embryo, fetus and extrauterine structures: amniotic fluid, umbilical cord, placenta, placental bed. Currently, there is practically no information in the literature on the state of the fetoplacental complex (PFC) in pregnant women with symptomatic arterial hypotension.

The most complete information about the form, nature, severity of fetoplacental insufficiency and the severity of compensatory-adaptive reactions can be obtained from complex dynamic diagnostics.

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