

OPTIMIZATION OF TREATMENT OF IRON DEFICIENCY ANEMIA IN THE POSTPARTUM PERIOD

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Key words: iron deficiency anemia, pregnancy, risk factors.

Annotation. The problem of IDA is faced by therapists and general practitioners, and not by an obstetrician-gynecologist and a hematologist. Therefore, their tasks include early detection, treatment and diagnostic programs for IDA in accordance with existing standards, as well as the justification and implementation of preventive programs taking into account patient risk factors.

ОПТИМИЗАЦИЯ ЛЕЧЕНИЯ ЖЕЛЕЗОДЕФИЦИТНОЙ АНЕМИИ В ПОСЛЕРОДОВОМ ПЕРИОДЕ

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Ключевые слова: железодефицитная анемия, период беременности, факторы риска.

Аннотация. С проблемой ЖДА сталкиваются терапевты и врачи общей практики, а не акушер-гинеколог и гематолог. Поэтому в их задачи входит раннее выявление, лечебно-диагностические программы ЖДА в соответствии с существующими стандартами, а также обоснование и реализация профилактических программ с учетом факторов риска пациентов.

Relevance of the topic. It is mentioned in a number of studies that therapists and general practitioners face the problem of ТТК, not obstetrician-gynecologist and hematologist. Therefore, their tasks include the creation of early detection, treatment and diagnostic programs of IDD in accordance with existing standards, and the justification and implementation of preventive programs taking into account the risk factors of patients [1,2,3]

Most recommendations indicate that the diagnosis of the disease by clinical manifestations and peripheral blood imaging is sufficient for the therapist and the UASh [5,6].

Trukhan D.I. According to the results of the researches of et al., a group of symptoms of the diseases that lead to it, "ie" causing IDD, are also observed - bleeding, gynecological diseases, gastrointestinal diseases, chronic hepatitis, cirrhosis of the liver, and alcoholism [7, 8]

If there is no age, ТТК in pregnant women is characterized by the fact that it passes without specific clinical manifestations for a long time, it is detected accidentally during preventive

examinations, for example, when referring to treatment institutions with unstable angina, respiratory failure, heart failure, and other atherosclerotic diseases [4,5,9]

The clinical manifestations of IDD in pregnant women are mainly manifested by the following, or in most studies and manuals, it is recommended to take them into account (in scientific works, in daily practice, in the planning of prevention and treatment programs): anemia syndrome (quick fatigue, pallor of the skin and mucous membranes, headache, circulation, hypothermic conditions, Hg and erythrocytes and color indicators are abnormally reduced), circulatory - hypoxic syndrome (hyositis, dysphagia, sub- and atrophic gastritis, abdominal pain, constipation, diarrhea, panting, tachycardia, anginal pains, muffled heart tone and presence of systolic noise in the area of the heart tip impulse, decrease of the T wave on the ECG; memory loss and difficulty concentrating, muscle weakness, urinary incontinence despite the normal urine analysis), sideropenic syndrome (stomach - by the intestinal system, skin - with changes in mucous membranes and nails) and secondary immunodeficiency syndrome (expressed by increased susceptibility to infectious-inflammatory diseases, accelerated recurrences) [9,11]

As etiological reasons and risk factors for IDD in pregnant women, various researchers confirm the following or note their exacerbation due to anemia: Breymann C. et al (2016) and Froessel B. et al. According to (2014), changes in the gastrointestinal system [8,12]

According to Derzsiova K. et al (2001) and Chrobak H. et al (2001) inappropriate quantification and selection of ferropreparations [15] Bozhinova S. et al. (2005) - gynecological diseases and Krochmalczy K. D. et al. (2005) to have other comorbidities [12,14]

The following are confirmed by foreign researchers as the leading risk factors in the population of pregnant women with IDD, that is, with their search and detection as a leading task: chronic blood loss of various locations (excessive menstruation, dysfunctional uterine bleeding), gastrointestinal bleeding (reflux - esophagitis, erosive-ulcer diseases of the stomach, Crohn's disease, ulcerative colitis, helminthosis, diverticulitis, hemorrhagic cystitis), nosebleeds, bleeding due to kidney diseases (glomerulonephritis, urolithiasis, tumors), bleeding gums, endometriosis and bleeding in pulmonary hemosiderosis, increased need for iron, alimentary deficiency (insufficient intake of iron with food), iron absorption disorders (in enteritis, malabsorption syndrome, after resection of digestive organs, taking drugs that have a negative effect on iron absorption and iron transport disorders) [5, 9]

In the case of modern obstetrics and gynecology, for example, TTK, transition to a completely new model of the organization of medicine, in our opinion, there is an urge and an urgent need. This process has been started in other specialties and significant results have been achieved. For example, in the last ten years, the rate of cardiovascular risk from arterial hypertension has decreased by 45% as a result of using this model of medicine [8,10].

This direction is "4P" medicine, which proposes 4 main principles: PREDICT, PREVENT, PERSONALIZE and PARTICIPATE [9].

Its main goal is to identify the disease before its clinical manifestation, to develop comprehensive preventive measures and appropriate use of treatment tools. Modern medicine/obstetrics and gynecology, in its traditional sense, works with the manifestations of the disease (primary or chronic diseases), while "4P" medicine focuses on risk factors and causes of diseases. aimed at determining the problem, developing methods for their elimination.

In order to introduce "4P" medicine in obstetrics and gynecology, first of all, it is necessary to increase epidemiological studies on a large scale [14]

Serov V. N. And so on. (2006), Chilova R. A. etc. (2017) and Tarasova I. S. (2011) emphasized the importance of pathogenesis-based treatment and prevention in women of childbearing age and children and adolescents with IDD problems. It has been reliably confirmed that the cases of iron deficiency in children and women of childbearing age and pregnant women have started to increase with an epidemic tone due to the fact that preventive and predictive medical direction did not take place early in clinical practice. These data are also confirmed in WHO reports [8,10]. In particular, according to these data, more than 2 billion people in the world, most of whom are women and children, have TTK. In Europe and Russia, IDD is detected with a prevalence of 12% in women of childbearing age, while occult iron deficiency is reported at a frequency of 50%, and children are more affected than adults [11,12].

According to WHO data, 3 groups of population are recognized as the most vulnerable population to anemia: preschool children (0-5 years old), pregnant women, women of childbearing age (15-50 years old) [13].

Stuklov N. I. et al., Konovodova E. N. b.q. and Napalkov D. A. and b. Q. (2012) analyzed the epidemiological situation of anemia, iron deficiency and iron deficiency anemia in women in Russia.

In the Russian Federation, the problem of anemia among the population has intensified for several years and is expressed as follows:

- 1) 20 39.9 percent of the population is sick with anemia;
- 2) in children of preschool age - it is recorded with a frequency of 26.5%;
- 3) IDD in pregnant women is confirmed by the prevalence rate of 20.8%;
- 4) in women of childbearing age, the frequency of detection of this disease is 19.8 percent. In the conditions of Russia, the issue of reducing the global risk of disease and death from it has become extremely urgent in almost all groups of the population, and mainly in women of childbearing age, adolescents, children and pregnant women [15].

On June 29, 1921, as part of the Plenum of the Board of Obstetricians and Gynecologists of Russia, the expert council on the condition of iron deficiency in pregnant women discussed the issues of the high prevalence of this disease, as well as issues of timely diagnosis and treatment in women/pregnant women, problems of complications, resolutions were adopted and proposals were formulated.

The panel of experts analyzed the epidemiological situation and the panel noted that the prevalence of prelatent and latent iron deficiency reached 32% in women. All women of childbearing age are iron deficient and are always at risk of developing iron deficiency anemia. Another consideration emphasized in the Council's conclusion is that it should be taken into account when planning and implementing primary, secondary and tertiary prevention in TYOA and pregnant women.

Accordingly, menarche - premature menstrual cycle always leads to blood loss and, in appropriate cases, loss of micronutrients, such as iron, and bulk ferrotherapy - prevention needs to be changed.

If the losses exceed the consumption capacity, iron deficiency is formed. Then, if iron metabolism is not balanced and the iron element is not replenished, iron deficiency anemia, especially in pregnant women, becomes more severe and develops [12,14].

Therefore, during pregnancy, during and after childbirth, it is necessary to continue planned active ferrotherapy - prevention together with microelements. For example, clinical-epidemiological, prophylactic and pharmacocontrol issues become more relevant in pregnant women with iron deficiency.

In this process, epidemiological studies have a special place in identifying and solving IDA problems.

LITERATURE:

1. American College of Obstetricians and Gynecologists. ACOG Practice Bulletin No, 95: anemia in pregnancy // *Obstet. Gynecol.* – 2018. – Vol. 112. – P. 201 – 205.
2. Brabin B.J., Hakimi M., Pelletier D. An analysis of anaemia and pregnancy related maternal mortality // *J. Nutr.* – 2021. – Vol. 131. – P. 604 – 612.
3. Cappellini M.D., Musallam K.M., Taher A.T. Iron deficieng anaemia revisited // *J. intern. Med.* – 2020. – Vol. 287. - № 2. P. – 153 – 168. Doi: <https://doi.org/10.1111/joim.13004>.
4. Corwin E.J., Myrray – Koib L.E., Beard J.L. Low hemoglobin level is arisk factor for postpartum depression // *J. Nutr.* 2020. – Vol. 133. - № 12. – P. 4139 – 4140.
5. Enns R.A., Hookey L., Annstrong D., Bamstein C.N. et al. Clinical practice guidelines for the use of video capsule endoscopy // *Gastroenterology.* 2017. – Vol. 152. – P. 496 – 512. Doi.<https://doi.org/10.1053/j.gastro.2016.12.032>.

6. Emberson J., Whincup P., Morris R. et al Evaluating the impact of population and highrisk strategies for the primary prevention of cardiovascular disease // *Eur Heart S.* - 2004; 25: 484 – 91.
7. Froessler B., Colligwood S., Hodyi N.A., Dekker G. intravenous ferric carboxymaltose for anaemia in pregnancy // *BMC Pregnancy Childbirth.* – 2014, 14: 114.
8. Fico Working Group on Best Practice in. Maternal – Fetal Medicine // *int.J. Gynecol. Obstet.* – 2015. – Vol. 128. P. 80 – 81.
9. Ferguson M.T., Dennis A.T. Defining peri – operative anaemia in pregnant women – challenging the status quo // *Anesthesia.* – 2019. – Vol. 74. - № 2. – P. 237 – 243.
10. Goddard A. F., James M. N., McIntyre A. S. et al. Guidelines for the management of iron deficiency anaemia//*Gut.* 2011 – Vol. 60 – P . 1309 – 1313. Doi. [https:// doi. Org/10 II 36/gut.](https://doi.org/10.1136/gut.2010.228874) – 2010. 228874.
11. Guralnik J.M., Eisenstaedi R.S., Ferrucel L. et al. Prevalence of anemia in persons 65 years and older in the United States, evidence for a high rate of unexplained anemia // *Blood.* – 2004; 104(8): 2263 – 7. DOI: 10. 1182 // *blood* – 2014 – 05 – 1812.
12. Goddard A.F., James M.W., McIntyre A.S., Scott B.B. Guidelines for the management of iron deficiency anaemia // *Gut.* 2011. – Vol. 60. – P. 1309 – 1313. Doi:[https://doi.org/10.1136/gut.](https://doi.org/10.1136/gut.2010.228874) – 2010.228874.
13. Ginsburg R. O`Connor A. Epigenetics and personalized medicine: foundations and applications. *Translat. Res.* 2019; 154(6): 463 – 70.
14. Harom K, Nilsen R.J. Iron supplementation in pregnancy – evidence and controwersies // *Acta obstet. Gynecol. Scand.* – 2021. – Vol. 80. - № - 8. P. 683 – 685.