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**DELIVERY IN PREGNANT WOMEN WITH FETAL
DISPROPORTION DURING CHILDBIRTH**

Resume: The article is an analytical review of domestic and foreign literature on the tactics of childbirth with a large fetus. Various aspects of this problem are considered, different points of view are compared. Arguments are given in favor of one or another tactic of labor management — planned caesarean section, induction of labor, wait-and-see tactics.

Key words: childbirth; large fetus; perinatal outcomes.

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**ПРОВЕДЕНИЕ РОДОВ У БЕРЕМЕННЫХ С ДИСПРОПОРЦИЕЙ
ПЛОДА ПРИ РОДАХ**

Резюме: Статья представляет собой аналитический обзор отечественной и зарубежной литературы по тактике ведения родов при крупном плоде. Рассмотрены различные аспекты этой проблемы, сопоставлены разные точки зрения. Приведены аргументы в пользу той или иной тактики ведения родов — планового кесарева сечения, индукции родов, выжидательной тактики.

Ключевые слова: роды; крупный плод; перинатальные исходы.

Relevance. Induction of labor (IR) is carried out in order to complete pregnancy as soon as possible in the presence of any pathology in the mother and / or fetus[1,7]. The aim of the IR is to prevent adverse maternal and

perinatal outcomes during childbirth through the natural birth canal (ERP) in clinical situations when the continuation of pregnancy and the expectation of spontaneous initiation of labor pose a higher risk than the procedure of labor initiation.

The frequency of IR in high-income countries is constantly increasing and amounts to 26% in Australia, 23.3% each in the UK and the USA [3,5]. In a well-planned prospective study, which has not lost its relevance today, it was found that when prolonging pregnancy for more than a certain period, the frequency of complications increases, such as stillbirth, macrosomia, the presence of meconium in amniotic fluid, hospitalization of a newborn in the intensive care unit [2]. IR is crucial for reducing the frequency and severity of complications for mother and fetus in high-risk pregnant women, primarily with hypertensive disorders and diabetes mellitus [3]. Thus, an IR performed at certain periods of pregnancy can improve perinatal outcomes.

At the same time, data on the effect of IR on the frequency of cesarean section (CS) in the world are very contradictory. Large observational studies have shown that IR increases the frequency of abdominal delivery. Thus, according to D.B. Ehrental et al. [4], when using IR in primiparous women with the location of the fetus in the head presentation, the frequency of CS was 1.87 times higher than in pregnant women without the use of IR — 25.5% versus 13.6%, respectively. However, in one of the recent systematic reviews, which included 37 randomized controlled trials, it was demonstrated that the risk of CS in IR in pregnant women with intact fetal membranes is significantly lower than with wait-and-see management tactics [5]. Also of interest are the data from the ARRIVE study, in which 6106 women demonstrated a decrease in the frequency of CS with IR at 39 weeks in primiparous women at low perinatal risk. in comparison with that with a wait-and-see management tactic (18.6% vs. 22.2%, respectively) [6].

In 2015, T.A. Nippita et al. [1] proposed a classification of pregnant women with indications for IR. The classification was created taking into account parity, gestational age, CS history, fetal presentation and the number of fetuses in order to assess the effectiveness of IR in a homogeneous group. We applied this classification in the GBUZ YAO "Regional Perinatal Center" (hereinafter referred to as the Perinatal Center), which is a level 3A hospital.

The objectives of the study are to evaluate the effectiveness of IR performed using the same methods in different groups, to determine the category of pregnant women with the best and worst response to IR, as well as to search for clinical and anamnestic factors of reducing the effectiveness of IR in certain groups of pregnant women.

Material and methods of research. A retrospective analysis of the birth histories of patients of the Department of Pregnancy Pathology of the Perinatal Center who underwent induction of labor activity according to the local protocol "Preparation of the cervix for childbirth and labor arousal", developed in 2023.

The results of the study. The distribution of patients into groups according to the classification of T.A. Nippita is shown in Table 1.

Indications for IR were: gestational diabetes mellitus (GSD) — 271 pregnant women (35.4%), hypertensive disorders — 204 (26.7%), the tendency to over—gestation — 103 (13.5%), fetal growth retardation syndrome (FDD) — 58 (7.6%), large fetus - 33 (4.3%), low and polyhydramnios — 31 (4.1%), multiple pregnancy — 18 (2.4%), obstetric cholestasis — 13 (1.7%), Rh conflict - 11 (1.4%), other indications — 22 (2.9%).

As can be seen from Table 1, the largest group consisted of repeat births in the period of 39-40 weeks. with head presentation of the fetus (group 5). At the same time, the frequency of CS in this group was one of the lowest — 6.6%. The highest frequency of CS was registered in group 8 (pregnant women with a history of CS and fetal head presentation) - 44.0%. However, this group is not numerous and in the structure of all patients with IR was only 6.5%.

In general, in IR, the frequency of CS was 15.5% (119 patients out of 765), while the frequency of abdominal delivery in the Perinatal Center for the same period of time (from 01.04.2018 to 31.12.2018) in patients not included in the study was 20.7% (531 out of 2565), which is significantly higher ($p=0.04$).

We did not establish a significant difference in the frequency of CS between groups 1, 2, 3, which included primiparous women with one fetus in head presentation at gestation from 37 to ≥ 41 weeks. In repeat-bearing women with one fetus in the head presentation, the frequency of CS in terms of 37-38 weeks. (group 4) and 39-40 weeks. (Group 5) was exactly the same and accounted for 6.6%, and at 41 weeks. and more (group 6) — 2.4%, which, however, has no statistically significant difference from the 4th and 5th groups ($p = 0.66$ and $p=0.47$, respectively).

When comparing the frequency of COP in the groups of first- and second-term pregnancies with the same gestation period, a significantly lower frequency of COP in second-term pregnancies was established, starting at 39 weeks. and more (2nd and 5th groups — $p = 0.004$; 3rd and 6th groups — $p= 0.049$). In terms of 37-38 weeks. there was no significant difference in the frequency of CS between the first and second-generation (groups 1 and 4) ($p= 0.16$).

We compared the frequency of CS in groups 1, 2, 3 (primiparous in terms from 37 to ≥ 41 weeks. with head presentation of the fetus) and in groups 4, 5, 6 (repeat births in terms from 37 to ≥ 41 weeks. with head presentation of the fetus) depending on the maturity of the cervix at the time of the onset of labor.

T. Nakano et al. [8] showed that in 44% of age-related (35 years and older) primiparous women, an attempt at full-term pregnancy ends unsuccessfully and childbirth ends with an emergency COP.

The main risk factors for an unsuccessful IR attempt and emergency CS in this study were hypertensive disorder and immature cervix.

In the group of premature births with head presentation of the fetus (group 7), the frequency of CS was 28.3%. In general, in the Perinatal Center, the

frequency of CS in preterm labor with head presentation of the fetus in recent years is 23.8–26%, regardless of whether they are spontaneous or induced, and regardless of the presence of CS in the anamnesis [9]. Thus, the use of IR in premature pregnancy, according to our data, is not associated with an increase in the frequency of CS in preterm labor.

In patients with a history of CS (group 8), the proportion of CS in IR was only 44%, whereas, according to our previous study [9], among all pregnant women with a history of CS and fetal head presentation, the frequency of abdominal delivery was 63.6%. Of course, with IR, there is a more careful selection of pregnant women for independent childbirth, which is why the lower frequency of CS in IR is associated. However, in our opinion, despite this, the group of pregnant women with a history of CS and IR remains a reserve for reducing the frequency of CS in the clinic, since, according to the American Society of Obstetricians and Gynecologists (ACOG), in the case of a decision on vaginal delivery in pregnant women with a history of CS, the frequency of successful childbirth is at least 60-80% [10].

The main indication for CS in the process of conducting IR in case of its failure was the dystocia of labor, including the inefficiency of labor excitation, primary or secondary weakness of labor activity, discoordination of labor activity. Of course, with a history of CS, a scar on the uterus is a deterrent to the use of adequate therapy for labor anomalies, primarily oxytocin infusion. Every 4th case of CS in IR is performed according to the indication "fetal distress". It should be noted that during the IR, cardiotocography (continuous CTG monitoring) was performed in patients with CS in the anamnesis, which contributed to the timely registration of signs of intrauterine fetal suffering. In addition, when decelerations appeared in a pregnant woman and a woman in labor with a scar on the uterus, the decision on abdominal delivery was made faster and more often than in a similar situation in a woman without a history of CS. This is due to the fact that fetal distress is the initial symptom of the

divergence of the uterus along the scar. At the same time, no cases of uterine scar divergence (uterine rupture) were recorded in the analysis.

The diagnosis of chorioamnionitis as an indication for CS was registered in only one pregnant woman. This diagnosis is made in accordance with the federal clinical guidelines "Septic complications in obstetrics", approved on 06.02.2017. Chorioamnionitis developed against the background of an anhydrous interval of 7 hours in the presence of *Escherichia coli* in the results of bacteriological examination from the cervical canal.

A higher frequency of CS in IR in repeat births is a reserve for reducing the frequency of CS in our clinic, including induced labor. The frequency of severe asphyxia of a newborn with IR was 5.4%, without IR — 6.5% ($p=0.94$). Perinatal mortality in IR has not been recorded. The frequency of severe asphyxia in both groups did not significantly differ, which indicates the absence of a significant effect of IR on the fetal condition. It is also important to emphasize that there was no perinatal mortality with the use of IR in all the study groups.

The use of IR in the Perinatal Center should be considered effective, because, firstly, with IR, the frequency of CS was lower than without IR, and secondly, the frequency of severe asphyxia with IR was comparable to that without IR.

Conclusion. According to our data, the factors that increase the effectiveness of IR should be considered repeated childbirth, fetal head presentation, gestation period of more than 38 weeks, multiple pregnancies, as well as the absence of CS in the anamnesis. The most frequently successful IR was recorded in pregnant women with multiple pregnancies.

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