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FEATURES OF THE COURSE AND MANAGEMENT OF PREGNANCY AND CHILDBIRTH WITH BREECH PRESENTATION

Resume: Pregnancy is one of the few physiological conditions that require a long-term and radical restructuring of functional systems due to the need to maintain homeostasis at a new, energetically higher level. In response to pregnancy, physiological adaptive changes occur in the woman's body, which affect all organs and systems and contribute to the proper development of the fetus, the preparation of the woman's body for childbirth and feeding the newborn.

Pregnancy is considered as a state of adaptation of a woman's body to the manifestations of hormonal activity of the fetoplacental system. In this regard, it is of interest to study the peculiarities of the course of pregnancy and the outcomes of childbirth, as well as the state of the fetoplacental complex depending on the sex of the fetus.

One of the fundamental reasons leading to a complicated course of pregnancy and childbirth is a violation of cellular regulation processes due to changes in the production and functioning of growth factors that ensure the growth, development of the placenta and the formation of its vascular system.

Growth factors, being biologically active compounds, play an important role in reproductive processes, intercellular interaction, stimulating or inhibiting the division and differentiation of various cells, as well as the processes of angiogenesis.

Keywords: pregnancy, breech presentation, pregnancy course.

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ОСОБЕННОСТИ ТЕЧЕНИЯ И ВЕДЕНИЯ БЕРЕМЕННОСТИ И РОДОВ ПРИ ЯГОДИЧНОМ ПРЕДЛЕЖАНИИ

Резюме: Беременность - одно из немногих физиологических состояний, требующих долговременной и кардинальной перестройки функциональных систем в связи с необходимостью поддержания гомеостаза на новом, энергетически более высоком уровне. В ответ на беременность в организме женщины происходят физиологические адаптационные изменения, которые касаются всех органов и систем и способствуют правильному развитию плода, подготовке организма женщины к родам и кормлению новорожденного.

Беременность рассматривают как состояние адаптации организма женщины к проявлениям гормональной активности фетоплацентарной системы. В связи с этим вызывает интерес изучение особенностей течения беременности и исходов родов, а также состояние фетоплацентарного комплекса в зависимости от пола плода.

Одной из основополагающих причин, приводящих к осложненному течению беременности и родов, является нарушение процессов клеточной регуляции, обусловленное изменением продукции и функционированием факторов роста, обеспечивающих рост, развитие плаценты и формирование ее сосудистой системы.

Факторы роста, являясь биологически активными соединениями, играют важную роль в репродуктивных процессах, межклеточном взаимодействии, стимулируя или ингибируя деление и дифференцировку различных клеток, а также процессы ангиогенеза.

Ключевая слова: беременность, ягодичная предлежания, течения беременность.

Relevance. Management of pregnant women with pelvic presentation of the fetus is an important and complex obstetric problem. Pelvic presentation of the fetus is observed in about 3-4% of births, while perinatal mortality is 24.3-25.4%[4,6].

It is important to note that such an unfavorable perinatal outcome is observed even with the exclusion of factors such as prematurity and congenital anomalies, which is due to a number of complications characteristic of childbirth in pelvic presentation [5].

Children born in pelvic presentation are much more likely to need intensive treatment. Thus, according to research by Albrechtsen S. (1997), 8.8% of these children born through the natural birth canal need intensive monitoring and treatment. They have lesions of the central nervous system 10 times more often than children born in the head presentation [1,7].

Even with careful selection of patients for vaginal delivery, asphyxia, acidosis, birth trauma are much more often diagnosed in their children, and artificial ventilation of the lungs becomes necessary. At the same time, one in three women (34%), however, due to the complications that have developed during childbirth, there is a need for abdominal delivery [6].

In order to reduce the frequency of complications with pelvic presentation of the fetus, many gymnastic complexes have been developed. However, their effectiveness depends on many factors, as a result of which corrective gymnastics has been questioned in recent years[2,5].

Insufficient effectiveness of methods of antenatal correction, high levels of perinatal morbidity and mortality during delivery through the natural birth canal determine an extremely high frequency of cesarean section with pelvic presentation, currently reaching 70-80%.

The high frequency of cesarean section with pelvic presentation of the fetus is currently one of the determining factors of the ever - increasing frequency of abdominal delivery . In general, in the structure of indications for cesarean section, the share of pelvic presentation of the fetus accounts for from 9.6% to 23.4%[3.8].

At the same time, an increase in the frequency of abdominal delivery leads to increased morbidity of the mother. The mortality rate of women with cesarean section performed for pelvic presentation of the fetus is 0.1-0.15%, while the total maternal mortality on average is 0.02-0.03%.

Currently, the close attention of obstetricians and gynecologists is attracted by the possibility of correcting the pelvic presentation of the fetus by external preventive rotation on the head. However, there is no clear evidence of the absence of a negative effect of this method on perinatal outcomes, many practitioners, including in the CIS countries, prefer abdominal delivery.

The purpose of the study. To develop optimal tactics of pregnancy and childbirth with pelvic presentation of the fetus to reduce perinatal morbidity and mortality.

Materials and methods of research. 90 women with the physiological course of pregnancy who made up the first clinical group were examined, including 23 women with male fetuses, 17 with female fetuses, and 45 women with placental insufficiency and fetal growth retardation included in the second clinical group.

Results and discussion. Stratification of the surveyed women by age indicated that the most numerous groups were pregnant women aged 26-30 and 31-35 years. In clinical group I, the average age of women pregnant with female fetuses was 24.87 ± 0.52 years, and pregnant women with male fetuses -25.21 ± 0.31 years. In the II clinical group, the average age of women pregnant with female fetuses was 26.87 ± 0.63 years, and pregnant women with male fetuses - 27.21 ± 0.33 years. The menstrual function of pregnant women was assessed by

such parameters as the age of menarche, the time of establishing a regular cycle, the duration of menstruation, the amount of blood lost, complaints. The average age of the onset of menstruation in women of the first group was 13.12 ± 1.23 years, and the second - 12.78 ± 1.54 years. In both groups, the onset of menarche occurred mainly at the age of 11-14 years. The average duration of the menstrual cycle in group I was 28.8 ± 1.4 days, in group II was 30.6± 1.6 days. The regularity of the menstrual cycle was observed in the overwhelming number of patients and averaged 27-30 days.

The majority of the examined patients in all groups had a history of one or more pregnancies. In group I, there were 98 (52.4%) pre-pregnant and 89 (47.6%) repeat-pregnant women with female fetuses, and 117 (87.2%) pre-pregnant and 86 (42.4%) repeat-pregnant patients with male fetuses. In group II, there were 62 (36.7%) first-time pregnancies with female fetuses, 107 (63.3%) second-time pregnancies; the number of first-time pregnancies with male fetuses was 90 women (51.2%), 86 women (48.9%) second-time pregnancies.

According to the somatic state, the age of onset of menarche and the parity of childbirth, the groups were comparable. At the same time, there were no significant differences in the frequency of occurrence of the alternative sex of the fetus, depending on the age of women, the nature of menstrual function, and the parity of childbirth.

One of the most severe complications that occur against the background of placental insufficiency is preeclampsia (PE), in the development of which many factors are involved, some of which contribute to the development of the complication, others are directly related to its occurrence [1, 3]. There are certain differences between the frequency of detection and the severity of the course of preeclampsia in women, depending on the factor "fetal sex". Mothers with female fetuses had mild and moderate preeclampsia (10.1% and 8.2%, respectively). At the same time, in pregnant women with female fetuses against the background of moderate PE, there was an increase in the expression of

SEFR by 3.6 times (206.2 pg/ml), compared with its physiological course (SEFR-A - 56.5 pg/ml). When determining ET-1 in women with PE, there was also an increase in its production by 1.3 times (0.5 pg/ml) compared to the control values (0.4 pg/ml). In pregnant women with PE, the determination of FRP showed a sharp decrease in its concentration by 2.0 times (47.3 pg/ml) relative to the data obtained during physiological pregnancy (92.4 pg/ml).

When analyzing the indicators of Doppler examination in pregnant women with placental insufficiency in the case of the male fetus, more pronounced violations of uteroplacental and fetoplacental blood flow were revealed compared to the female fetus (violation of uteroplacental blood flow with preserved fetoplacental hemodynamics or violation of fetoplacental blood flow with preserved uteroplacental blood flow). A similar relationship was established when analyzing ultrasound patterns: in mothers with male fetuses, pregnancy was complicated by placental hypoplasia in 8.5% of cases, which is 1.6 times more than in mothers with female fetuses. Premature maturation of the placenta was also 1.3 times more common in mothers with male fetuses.

The change in the amount of amniotic fluid was characteristic in the case of both fetal sex variants. However, in mothers with male fetuses, pregnancy was complicated by water scarcity in 11.4%, polyhydramnios in 9.0% of cases, which is 1.5 times more than in mothers with female fetuses.

Conclusion. The results obtained in the course of the conducted studies also indicate that during the physiological course of pregnancy in the II and III trimesters there are certain differences in the absolute levels of the studied polypeptides. In pregnant women with female fetuses at all stages, both physiological and complicated pregnancy, more pronounced production of vascular-endothelial factors and some cytokines was recorded, which indicates the features of anatomical and functional "request" from the utero-placental-fetal complex and differences in the formation of the immune response in pregnant women with this type of sexual dimorphism. An important role in the revealed

dynamics of the studied bioactive polypeptides, apparently, is played by differences in the immune-hormonal control of the "mother-placenta-fetus" system, determined by the alternative sex of the fetus.

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