

The Role of Urogenital Infections in Pregnant Women with Rupture of Amniotic Fluid

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Abstract: The problem of infectious diseases during antenatal fetal death with the discharge of amniotic fluid is one of the most pressing problems in obstetrics. Infection of the fetus in the womb during prenatal rupture of amniotic fluid can lead to complications during pregnancy, childbirth, or the development of diseases in the postpartum period.

Keywords: premature rupture of amniotic fluid, fetal death, induction of labor.

Untimely rupture of amniotic fluid during premature and full-term pregnancy is considered the most important risk factor for the fetus and mother. Intrauterine infection of the fetus at the present stage is one of the most important problems in obstetrics and perinatology. The role of chlamydial, cytomegalovirus, and ureaplasma infections during pregnancy has sharply increased. Recently, in all countries there has been an increase in infectious pathology, which, on the one hand, is associated with the emergence of new, more informative diagnostic methods and, accordingly, with an increase in intravital infections detected; on the other hand, a true increase in the frequency of this pathology is not excluded [1,3,5]. Infection of the fetus in the womb during prenatal rupture of amniotic fluid can lead to complications during pregnancy, childbirth, or the development of disease in the newborn.

Stillbirth during preterm birth is observed 8-13 times more often than during full-term pregnancy, and premature live births account for up to 75% of early neonatal and child mortality. This is primarily due to the variety of medical and biological factors, including intrauterine infection, endocrinopathies and other psychological and socio-economic aspects in the lives of women. At the same time, the etiology of premature birth in 17-58% cannot be established. [2,8,9].

The initiation of antenatal fetal death in most cases is intrauterine infections, antenatal and premature rupture of membranes, accounting for 24% to 36% of all births [4,31-46]. DRPO is closely associated with perinatal infection, increasing by 10 times the risk of neonatal sepsis, high perinatal and infant mortality, as well as the risk of purulent-septic complications of the mother.

The tactics for managing pregnant women with this pathology are extremely variable and depend on the gestational age, on the amount of amniotic fluid that has been discharged, on the severity of the infectious process, on the severity of the infectious process, on the presence of extragenital pathology and complications of this pregnancy. Therefore, approaches to the management of antenatal fetal death complicated by DPO may differ not only in different countries, but also within the same city. In the countries of Western Europe, America, Japan, and recently in our country, the tactics of induction of labor complicated by DRPO are used. [7,3,10,12-22].

When choosing labor management tactics in case of antenatal fetal death (AFF), premature pregnancy with premature rupture of amniotic fluid (PROM) or with antepartum rupture of

amniotic fluid (APLR), it is necessary to constantly compare the risks of using expectant or active tactics, maternal risks - premature detachment of a normally located placenta (PONRP), chorioamnionitis, sepsis, postpartum uterine hypotension, fever and endometritis in the puerperal period, with the risks of choosing active expectant tactics (pre-induction, induction of labor) or with a scar on the uterus of active tactics (cesarean section - CS) [8 ,9,11]. Contraindications for choosing expectant management are chorioamnionitis; pregnancy complications requiring urgent delivery (severe preeclampsia, eclampsia, placental abruption, bleeding with placenta previa); decompensated conditions of the mother; Active tactics are also characterized by possible risks of developing complications: the need for labor induction, which can be complicated by hyperstimulation of the uterus, an increase in the frequency of CS, pain, and discomfort; development of maternal septic complications. However, the advantage of active tactics is the prevention of infection. It is necessary to take into account that the incidence of infection and CS increases in the case of labor induction after a 72-hour anhydrous interval [6,23-30].

Objective: To study obstetric outcomes in women with antenatal fetal death due to prenatal and premature rupture of membranes and labor management tactics.

Material and methods of research. To solve these problems, a comprehensive examination was carried out on 52 pregnant women whose births were complicated by DIOV at 37-40 weeks of gestation, who were admitted to the Bukhara Regional Perinatal Center during the period of 2017. Using anamnestic, clinical, laboratory and instrumental data, the course of pregnancy, childbirth, and the postpartum period was studied. The readiness of the birth canal was assessed using the Bishop scale. According to the National Standard for the management of patients with DIOV, after 18 hours of anhydrous interval, which is the basis for antibacterial therapy, in order to prevent purulent-septic complications in postpartum women, the birth canal of pregnant women is examined after 24 hours in the absence of labor in order to decide on the advisability of induction of labor. The nature of labor was monitored based on partograms. When managing labor complicated by prenatal rupture of amniotic fluid, it is necessary to monitor hemodynamic parameters, maintain an observation sheet, measure to-body every 4 hours, blood for leukocytosis once a day, a general blood test (coagulogram, C-reactive protein, leukocyte intoxication index, urine test, blood group and Rh-affiliation, analysis of vaginal discharge - smear, ultrasound of the uterus and fetus, cervicometry, general condition of the woman in labor. Given the high sensitivity of vaginal and cervical bacteria to ampicillin, the use of this antibacterial drug during childbirth immediately with premature rupture is indicated amniotic fluid.

Results and discussion: The average age of the observed women was 26.5 years. In all women, pregnancy occurred against the background of extragenital diseases, and in most cases a combination of several of them. Anemia of mild and moderate severity (73.1%), thyroid disease (32.7%) and varicose veins (25%) predominated. Every third woman (32.7%) suffered infectious diseases during this pregnancy, mainly in the form of acute respiratory infections (ARI), exacerbation of chronic sinusitis, cystitis, and pyelonephritis. In 17.3% of pregnant women, episodes of ARI were repeated many times during pregnancy. Among the gynecological diseases suffered, the most frequently diagnosed were chronic endometritis, viral infections of herpetic and ureaplasmosis in combination with chlamydia (54%), and colpitis of various etiologies, vaginal dysbiosis (44.6%). All women with prenatal rupture of amniotic fluid underwent a vaginal examination using speculum to identify the nature of the discharge, the color of the amniotic fluid, and the degree of dilation of the cervix. It was revealed that at the onset of labor, in 61.6% of the examined pregnant women, the parameters of dilatation, length, consistency, position of the cervix and the condition of the presenting part of the fetus had scores of up to 5, which was assessed as "immature cervix." And in 38.4% of women, the birth canal was assessed as a "mature cervix." Accordingly, further management tactics were chosen according to the protocol of the maternity complex. In pregnant women with an "immature" cervix and signs of colpitis, induction of labor with mifepristone 200 mg, 1 tablet, is proposed after the informed consent of the pregnant woman and relatives. The birth canal is re-evaluated after 12 hours to

determine the need to continue induction. In pregnant women with a “mature” cervix, childbirth was carried out with expectant tactics: Convince the woman that there is a possibility of spontaneous birth of the fetus within 24 - 48 hours without complications. With the consent of the family, the woman is under the supervision of a gynecologist, waiting for the spontaneous onset of labor (up to 24 hours), a coagulogram and platelet count, progesterone and estriol levels are analyzed. If within 24-48 hours the number of platelets has decreased or spontaneous labor has not occurred, it is necessary to discuss active management tactics in favor of prostaglandins. In case of critical conditions threatening the life of a woman (PONRP stage 2, severe preeclampsia, eclampsia, scar failure), severe obstetric pathology, immaturity of the cervix and the absence of conditions for urgent delivery, a council of doctors decided on the issue of surgical delivery.

It is important to distinguish between the goals of preinduction and induction of labor. Pre-induction of labor (“ripening” of the cervix, cervicalripening) is the preparation of the cervix for childbirth by methods that are insufficient for independent induction of labor. Induction of labor (labor induction) is an intervention aimed at initiating labor before spontaneous onset in order to achieve vaginal delivery. Induction of labor is also called artificially induced labor according to maternal or fetal indications, as well as combined indications (premature, timely, delayed) [11,17]. According to the recommendations of foreign literature, with PROM in a gestational age of more than 34 weeks if there is a risk of developing AIS (amniotic infection syndrome), delivery should be carried out by induction of labor; in the absence of labor for 4-6 hours, active induction of labor should be performed [2,3,11]. In case of PROM before 37 weeks of pregnancy, antibiotic therapy was prescribed immediately. In gestational age of more than 37 weeks, in the absence of signs of AIS, the use of antibiotics was started 18 hours after DRPO. If spontaneous labor does not occur within 8 to 12 hours of PROM with AGP, active tactics are indicated—labor induction. The prophylactic use of antibiotics for premature rupture of membranes is also justified. [13,18].

For the purpose of pre-induction of labor, prostaglandins are used: Glandin 3 mg or dinoprostone (Pge2) pervaginum gel; The initial dose is 2 mg for primiparous women with an immature cervix, 1 mg for multiparous women. If regular labor has not begun, a second dose of dinoprostone 1 or 2 mg can be administered after 6 hours. The maximum dose of dinoprostone over a 12-hour period is 4 mg for primiparous women with an “immature” cervix, 3 mg for all others women.

A debatable issue is the possibility of pre-induction of labor with antigestagens (mifepristone) with DRPO during AGP with the onset of admission to the hospital in women with uterine scars. On the one hand, the rationale for the use of mifepristone is the presence of contraindications for the use of prostaglandin E, prepilidil gel, kelp: vaginal dysbiosis, the presence of intrauterine infection, polyhydramnios, oligohydramnios, fetal hypoxia. On the other hand, the evidence base on the safety of the use of mifepristone in case of antenatal fetal death was carried out on the basis of the Department of Obstetrics and Gynecology in Bukhara from 2012 to the present day. where pregnancies were terminated at different stages of gestation. However, women with uterine scars in the absence of labor and discharge of amniotic fluid with induction of labor with mifepristone 200-400 mg without effectiveness ended up with a cesarean section with indications of failure of the uterine scar. Nevertheless, the existing significant experience in the use of mifepristone as a pre-induction of labor, its proven effectiveness allows us to expect in the near future the appearance of scientific and practical information on its use of pre-induction of labor in women with uterine scars during antenatal death of a fetus with PROM, o comparing the risk of its use with expectant or surgical tactics.

In the Bukhara city maternity hospital, an ultrasound assessment of the cervix and lower segment of the uterus is performed to assess the dynamics of the biological transformation of the cervix. Transvaginal and transperineal access was used (PHILIPSHD11 device with a 5-7 MHz sensor, ToshibaAplioMX with a transperineal 3.5 MHz and transvaginal 6.0 MHz sensor) to evaluate the

diameter of the internal pharynx; thickness of the anterior wall of the lower segment of the uterus; posterior angle of the cervix; Doppler indicators of cervical blood flow and contractile activity of the uterus and the duration of fetal death (color and energy Doppler mapping). Also, when assessing the dynamics of the movement of the fetal head along the birth canal during labor, the distance between the fetal head and the perineum was assessed using ultrasound and transperineal access, which also minimized the need for vaginal examination. Transabdominal access allows you to determine the type of presentation and position of the fetus. During ultrasound, the following data is assessed: the length of the cervix is measured along a line drawn through the center of the cervical canal (anechoic or hypoechoic space) from the vaginal part of the decidual plate (ultrasonic internal os) to the base of the ultrasonic external os; internal throat diameter; thickness of the anterior wall of the lower segment of the uterus; posterior angle of the cervix; Doppler indicators of cervical blood flow (color and energy Doppler mapping). Also, when assessing the dynamics of the movement of the fetal head along the birth canal during labor, the distance between the fetal head and the perineum was assessed using ultrasound and transperineal access, which also minimized the need for vaginal examination. When the pregnancy period is from 28 to 34 weeks, expectant active tactics are considered a priority, the purpose of which is to prevent the development of clinically and histologically significant chorioamnionitis. In case of an increase in the risk of developing chorioamnionitis (an increase in leukocytosis by more than 15-20% from the initial level, neutrophils and especially C-reactive protein) and the presence of negative dynamics in the functional state of the mother-placenta-fetus system (decreased amniotic fluid index, decreased cranial index, negative dynamics during Doppler measurements in the middle cerebral artery of the fetus) expectant management should be abandoned. They choose either active expectant tactics (pre-induction of labor), or active - induction of labor (oxytocin for a "mature" cervix and conditions for quick and gentle delivery) or surgical delivery by cesarean section for scars on the uterus. The tactics of pregnancy management and the method of delivery are always discussed jointly by councils of obstetricians and gynecologists.

When pregnancy is prolonged and pathogenic flora discharged from the cervical canal is re-identified in a clinically significant titer during a cultural study, antibiotic therapy is resumed (second generation cephalosporins, metronidazole); wait-and-see tactics are abandoned.

Thus, the issue of tactics for managing antenatal fetal death in the presence of a scar on the uterus with PROM and DRPO remains not fully resolved; multicenter studies that will allow us to analyze birth outcomes depending on the gestational age and the duration of the water-free interval require continued , the reaction of the woman's body to PROM, the presence of concomitant obstetric and extragenital pathology, the woman's age, obstetric history and individual choice of induction method.

Conclusions.

Clinical and anamnestic risk factors for AGP complicated by DRPO are a history of endometritis, pathological growth of opportunistic cervicovaginal microflora, chlamydia, nonspecific colpitis and bacterial vaginosis. The presence of infections (primarily herpes and ureaplasmosis) negatively affects the course of pregnancy and childbirth. After 18 hours of anhydrous interval, labor management tactics should be conservative - expectant up to 24-48 hours against the background of antibacterial therapy; if labor does not occur on its own, it is necessary to begin induction of labor with antiprogestins and prostaglandins. In the presence of vaginal infections, the antiprogestin mifepristone 200 mg per os is recommended for induction. Induction of labor with uterine scars with antenatal fetal death is the activation of uterine contractility with the onset of labor, while successful induction means natural delivery within 24-48 hours.

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