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Management of pregnant women with intra-uterine growth restriction in the condition of maternity welfare

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Ключові слова: преєклампсія, синдром затримки росту плоду, вагітність, жіноча консультація.

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Key words: preeclampsia, IUGR, pregnancy, maternity welfare.

Досліджено перебіг вагітності у жінок з синдромом затримки росту плоду. Відзначено високий рівень передчасних пологів у цієї групи жінок. У 63% випадків синдром затримки росту плоду розвивався на фоні тяжкої преєклампсії. Усі вагітні з синдромом затримки росту плоду мали супутню екстрагенітальну патологію, але жодна з них не отримувала профілактичні низькі дози аспірину.

Исследовано течения беременности и родов у женщин с синдромом задержки роста плода. Отмечен высокий уровень преждевременных родов в данной группе женщин. В 63% случаев синдромом задержки роста плода развился на фоне тяжелой преэклампсии. Все беременные с синдромом задержки роста плода имели сопутствующую экстрагенитальную патологию, но ни одна из них не получала профилактические низкие дозы аспирина.

Research of the duration of pregnancy and delivery at women with IUGR is carried out. High level of premature birth in the given group of women is noted. In 63% of cases IUGR has developed at women with severe preeclampsia. All pregnant women with IUGR had the the extragenital pathology. However any of women did not receive preventive low doses of aspirin.

Intrauterine growth restriction (IUGR), which is defined as the birth weight below the 10th percentile for gestational age[1]. IUGR is a serious anomaly in the antenatal period, responsible for many folds increase in the pregnancy wastage, neonatal morbidity and mortality as well as long term serious complications like dyslipidaemia, type 2 diabetes, atherosclerosis and premature death. It is the second cause of perinatal mortality after prematurity. Factors that contribute to IUGR are divided into several groups [2,3,4]. Maternal factors: high blood pressure, chronic kidney disease, advanced diabetes, heart or respiratory disease, malnutrition, anemia, infection, substance abuse, cigarette smoking. Factors involving the uterus and placenta: decreased blood flow in the uterus and placenta, preterm placental abruption, placenta previa, infection in the tissues around the fetus. Factors related to the fetus: multiple gestation, intrauterine infection, birth defects, chromosomal abnormality.

Our case control study was conducted in the field practice area of maternity welfare №5, in Zaporozhye. The field practice area covers a population of about 54 800 women, among them – 27 732 women of reproductive age. From December 2008 to December 2009, 1333 pregnant women were under medical supervision. All pregnant women had passed all necessary examinations according to the local guidelines. 48 pregnancies had been over by preterm deliveries (3,6%), mortinataly had taken place in 7 cases(5,2 ‰), early neonatal mortality had taken place in 5 cases(3,7 ‰), antenatal mortality-4 cases(3,7 ‰). 25 pregnant women had IUGR. 18 pregnancies had been complicated by the development of preeclampsia(7-severe preeclampsia, 11-moderate preeclampsia). We had made the analyses of all cases of IUGR and its management. There wasn't found any age factor that had influenced on the risk of IUGR. In 100% cases pregnant women with IUGR had extragenital pathology: 56% - cardiovascular diseases (essential hypertension-57%), 16%-chronic pyelonefritis,

and 42% – metabolic disorders. Symmetric IUGR had been in 20% of cases, asymmetric in 80%. 44% of pregnant women with IUGR had preeclampsia. Severe form had been in 63% of cases, the others had moderate preeclampsia. We had found out that rate of antepartum and intrapartum fetal distress that had led to cesarean delivery was 60%. Infants had low APGAR scores almost in 64%. Preterm delivery had taken place in 40% of cases, that is in 10 times as much than in observed population of the region. The main factors that led to the preterm delivery had been severe preeclampsia and antepartum fetal distress. Although all pregnant women with IUGR had been in high risk group for the development of that complication, none was prescribed low dose of aspirin and none wasn't informed about possibility of preventive treatment in the sanatorium-preventorium for pregnant women. In 12% of pregnancies with IUGR antenatal mortality had taken place, that is in 4 times as much than in observed population of the region.

Conclusions

1. IUGR remains a challenging problem for obstetricians. Most cases of IUGR in our region occur in pregnancies in which had developed severe preeclampsia; therefore, the clinician must be alert to the possibility of a growth disturbance in all pregnancies, specially at women with extragenital pathology.

2. The current therapeutic goals are to optimize the timing of delivery to minimize hypoxemia and maximize gestational age and maternal outcome.

3. It is very important for all obstetricians, who work at the female consulting center to remember about correct completion of the gravidograma form.

4. It is very important to inform pregnant women to pass nonmedical preventive treatment in the sanatorium-preventorium for pregnant women.

5. It is necessary to remember that there is only one way to decline in the rate of IUGR – usage of the low dose aspirin.

Literature

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