

## TERM PREGNANCY: PREVALENCE, ETIOLOGY AND PATHOGENESIS

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It is no secret that today, due to the daily increase in the number of children born after the due date, according to the recommendations of the International Federation of Gynecologists and Obstetricians (FIGO) and the American College of Obstetricians and Gynecologists (ACOG), a pregnancy lasting 42 weeks or more is considered to be a postterm pregnancy (PTG). In local obstetrics, a pregnancy lasting more than 287 days is considered to be postterm, which ends with a biologically premature birth [18, 22,24].

E.K.Aylamazyan, V.I.Kulakov, V.E.Radzinsky, G.M.Saveleva (2009) note that the experts of the Royal Society of Obstetricians and Gynecologists do not consider the description of the baby's condition when diagnosing an extended pregnancy, but rather the duration of pregnancy at 41 weeks is to be achieved [2,3,4]. Births in such pregnancies are delayed, and in most cases, the child born will have "signs of overmaturity". The concepts of "overdue" and "overmature" are often confused, because "overdue" is a calendar concept, and the concept of "overmaturity" is used to assess the physical status of the fetus and baby. If the duration of pregnancy is more than 42 weeks and no signs of menopause are detected, then it is possible to think about an extended pregnancy. It is known that a fetus can be born with signs of prematurity at a gestation period of less than 294 days [2,3,4,22,34,35].

Accurate determination of due dates is crucial for the diagnosis of preterm pregnancy (MPH), as there are often errors in determining the intended due date. Ultrasound diagnosis of early pregnancy to determine the intended term of delivery reduces the risk of errors in the diagnosis of term pregnancies from 12% to 3% [1,19, 23,28].

It should be noted that pregnant women in many countries do not have access to ultrasound screening, so the actual number of MMRs may be higher than officially recorded data.

As noted by A.N. Strizhakov et al. (2009), in modern obstetrics, a high-risk pregnancy is understood as a pregnancy in which the risk of morbidity or mortality of the mother, fetus, or infant before or after delivery exceeds 70% in the population [17, 18].



Extragenital pathologies account for up to 65% of the risk of adverse outcomes of the gestational process, fetoplacental insufficiency - 30.6%, gestosis - up to 20%, uterine scarring after cesarean section - 15.7%, late pregnancy - up to 10%, breech presentation - 3.5%, multiple pregnancy - 1.5-4.1%. The significance of these pathologies in the increase in perinatal morbidity (PM) and mortality has been examined over the past 10-15 years. Every year, about 50,000 children are born with disabilities in childhood [25].

The main diseases that cause disability (all disabled children, that is, about 400 thousand people) are diseases of the nervous system, mental disorders, behavioral disorders and congenital anomalies. 29 thousand disabled children with mental retardation aged 4 to 18 years live in boarding schools. A very important factor in the health status of children and their perinatal outcome is their dependence on medical and organizational conditions. In recent years, the significant decrease in (PO) is associated with the widespread introduction of ultrasound examination methods into clinical practice and, in connection with this, the timely diagnosis of various anomalies of fetal development and the determination of tactics for managing pregnant women [6,7, 31,32].

According to V.E. Radzinsky (2011), the decrease in the global incidence of PO in recent years has occurred due to the introduction of highly effective organizational measures and therapeutic and diagnostic technologies[13].

It consists of creating perinatal centers, equipping the bases with new equipment, developing perinatal diagnostics, expanding the indications for cesarean section in the interests of the fetus, widely using surfactant drugs and glucocorticoids in premature births, providing resuscitation and intensive care for infants, improving neonatal care methods, and introducing modern perinatal technologies. It is more correct to consider preterm labor as a pathological condition associated with the influence of various factors[13].

An etiological factor is transmitted infectious diseases in children (chicken pox, measles, rubella, etc.), infantilism, various extragenital diseases, menstrual disorders, endocrine diseases, mental trauma, gestosis, malposition of the fetus and fetal head, fetal pituitary-adrenal system. violation, there may be defects in the development of the fetus [13].

Some authors believe that MOT is associated with impaired mechanisms of labor. Also, abortions, inflammatory diseases of the internal genital organs, which cause changes in the neuromuscular system of the uterus, as well as



various endocrine diseases, are important in the development of overdue pregnancies [29,32].

Kortekaas J.C., Bruinsma A, Keulen J.K.J (2019) reviewed the management of late pregnancy in obstetric care settings[30,33].

Since there is no consensus on the optimal management of late-term pregnancies (LTG) ( $\geq 41.0$  weeks), the authors studied different strategies for managing LTG in the Netherlands to determine the extent of these differences and the extent of these differences. In the Netherlands, maternity care is provided by independent midwifery teams (provided by obstetricians) and by hospital-based midwives and obstetricians (provided by obstetricians). In the event of complications during pregnancy and childbirth or an increased risk of adverse perinatal and/or maternal outcomes, women receiving midwifery care are referred to a midwife for advice/monitoring and/or admission, if necessary. Risk stratification is carried out by midwives under the guidance of the midwife to ensure the most appropriate care for mother and child. This risk selection is based on the Midwifery Guidelines (MDG-VIL) and regional collaboration agreements. The Midwifery Guidelines are based on national Dutch documents and are based on current evidence and/or consensus, and they describe a national agreement between midwives, gynecologists and pediatricians on the care needed for women with specific conditions or risks of complications. Regional collaboration between midwifery and midwifery care is formed in the "Motherhood Care Network" (MCN, in Dutch VSV), a regional partnership between midwifery departments and all midwifery practitioners, where local protocols are developed based on national and international guidelines. Local protocols and agreements may vary between different MSAs. MMR is defined as a pregnancy with a gestational age  $\geq 42.0$  weeks. LMR is defined as a pregnancy between 41.0 and 41.6 weeks[32, 33, 34].

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The number of complications in the mother and fetus increases in the case of MH. Over the past 7 years, the number of MH cases among women living in Dushanbe has ranged from 3.9 to 0.83%. MH lasts 10-14 days longer than physiological and ends with the birth of a premature baby.

Studies show that after the implementation of national standards for labor induction, the number of late deliveries and complications associated with them decreases. Among women undergoing late deliveries, both are first pregnancies. The course of labor and pregnancy in women undergoing late deliveries is characterized by a high number of complications, which are  $6.7 \pm 2.09\%$  and  $70.8 \pm 2.16\%$ , respectively, 382 (72%) women gave birth vaginally, and 77 (15%) women underwent cesarean section. Despite the trend towards a decrease in the number of late deliveries after the implementation of national standards for labor induction, the obstetric and perinatal outcomes of late deliveries are noteworthy [17, 33].

The common consequences of OBGYN include fetal macrosomia, complicated labor, birth trauma, and an increased number of cesarean deliveries. The course of OBGYN is characterized by a high rate of complications (gestosis, anemia, hypoxia, and fetal asphyxia), as well as complications during labor (premature rupture of membranes, labor force abnormalities, clinical narrow pelvis, hypotonic hemorrhage, fetal hypoxia and asphyxia, and fetal birth trauma) [15, 17, 33, 34].



The American Association of Obstetricians and Gynecologists regulates the use of induced labor only in cases where the risk of labor resolution is low for the mother and the fetus in relation to prolongation of labor [35]. According to the National Statistics Centers of America and Canada, the percentage of induced births in North America is more than 20%. In the Russian Federation, this indicator varies from 5% to 18% [26].

Pregnancy complications (gestosis, fetoplacental insufficiency, immunological incompatibility according to the Rh factor, late pregnancy), especially large fetuses with anatomically narrow pelvis of the pregnant woman, and extragenital diseases of women have an adverse effect on the health of the mother and baby, in connection with which, in order to ensure safe motherhood and the birth of a live, healthy child, in many cases it is necessary to solve the issue of the need to solve the problem of MOT. One of the possible ways to solve this problem is induced labor [19,21].

The most common complications of pregnancy include chronic fetal hypoxia, gestational anemia, and gestational diabetes mellitus. The course of labor is often complicated by failure to break the amniotic fluid in a timely manner, labor abnormalities, and the increased use of abdominal surgery to manage labor. Infants are characterized by a higher birth weight and a lower Apgar score at birth. MOH is associated with a high risk of both maternal and perinatal complications. Induction of labor after 41 weeks of gestation is necessary to prevent these complications. Methods for diagnosing MOH and determining the appropriate cohort of women for induction of labor remain controversial to this day [12].

In 2016, a case-control study of 216 birth histories and developmental histories of infants was conducted based on the data of the maternity hospital of TTYo hospital named after M.A. Podgorbunsky in 2016 in order to study the characteristics of pregnancy and childbirth in induced labor [9, 10, 15, 12].

The main group consisted of 108 women with induced labor and their babies, and the control group consisted of 108 women with spontaneous labor and their babies. The effectiveness of various methods of labor induction, the onset of labor, its duration, the level of blood loss during labor, anomalies in labor activity, and the health status of the baby were assessed. Indications for labor induction, exacerbation of somatic pathologies - 42 (32.1%); preeclampsia resistant to conservative treatment - 33 (27.2%); premature rupture of



membranes and the absence of permanent labor activity in pregnant women ending at term - 16 (11.3%), and MOH - 27 (22.9%) women [19,20].

Before induction of labor, the degree of cervical ripening was assessed using the E.H. Bishop scale [27]. The pelvic axis, length and consistency of the cervix, the opening of the external os, and the position of the cervix relative to the location of the fetal head were determined.

When assessed according to the E.H. Bishop scale, a cervix with a score of up to 6 was considered "immature", 6-8 points – "sufficiently immature", and more than 8 points – "mature". "Immature" cervix was observed in 10 pregnant women (9.6%), "sufficiently immature" – in 27 (26.0%) and "mature" – in 69 (65.4%) pregnant women [27].

Before deciding on the need for and conduct of induction of labor, the condition of the fetus was also assessed (ultrasound, cardiotocography, Dopplerometry), the correspondence of the fetal head and pelvic dimensions, the gestational age was determined, and the informed consent of the pregnant woman to induce labor using appropriate methods was obtained. The following data were obtained based on the results of ultrasound, cardiotocography, and Dopplerometry: According to the results of ultrasound, 10 (9.2%) women had low placentation during pregnancy, 12 (11.1%) had impaired amniotic fluid volume, and 29 (26.8%) had borderline cardiac activity abnormalities according to cardiotocography. Dopplerometry did not reveal any abnormalities in uteroplacental and fetal-placental blood flow. The authors note that induced labor increases blood loss, the number of labor anomalies, birth canal injuries, and the length of time the baby stays in the hospital. The effectiveness of the induced labor method depends on the "ripening" of the cervix, the period of pregnancy, and the condition of the fetus[27, 30,33].

The women's somatic and obstetric-gynecological anamnesis data, physical examination data, instrumental examination data (assessment of the quantity and quality of amniotic fluid; assessment of the degree of placental maturity; assessment of cervical maturity), as well as complications during pregnancy and childbirth were taken into account. Cardiotocography to assess the condition of the fetus; data from screening examinations of pregnant women, including ultrasound photometry with assessment of fetal maturity signs, were taken into account. In infants, the neonatologist's body weight, body length, and Apgar scores at 1 and 5 minutes were taken into account; signs of maturity were determined; according to the conducted studies, the average age of women in



late pregnancy was 32-36 years. First-time births under the age of 30 accounted for 28%, first-time births after the age of 30 for 48%, and repeated births for 24%. When examining the somatic anamnesis, chronic diseases were detected in 19 women (76%). Of these, urinary tract infections (chronic pyelonephritis, cystitis) were noted in 12 women (63.1%), obesity in 9 women (47.3%), chronic cholecystitis in 9 women (47.3%), autoimmune thyrotoxicosis in 2 women (10.5%). In 12 women (48%), childbirth was complicated. Among complicated childbirths, premature rupture of the fetal membranes was detected in 5 women (41.6%), and perineal and vaginal tears in 7 women (58.3%). Cesarean section was performed in 13 women (52%). The most common reasons for surgical intervention were fetal size and fetal hypoxia [8,33].

Ultrasound examination of pregnant women revealed a decrease in placental thickness and the presence of petrifications in 36% of women, and an amniotic fluid index < 70 mm in 19.2% of women. Early neonatal period hypoxia was observed in 15 infants (60%), moderate asphyxia in 44%, intrauterine infections in 16%, and nephrohematoma in 4 infants (16%). Analysis of the distribution of body weight of infants showed that 4 (16%) infants had a body weight of 2501-3000 g., 9 (36%) infants - 3001-3500 g., 12 (48%) infants - 3501-4000 g. The Apgar score was used to assess the condition of infants at birth. Infants born after term (IT) had the highest Apgar scores, indicating severe to moderate hypoxia[10,33].

Symptoms of menopause (Clifford's syndrome) - 22 (88), decreased turgor - 19 (86.3), density of the bones of the skull (tightness and narrowness of the sutures) 17 (77.2%), subcutaneous fat cells and skin folds deficiency was observed in 11 (50%) infants.

These studies have confirmed the influence of gestational age on the course of labor and the period of infancy. As a result, factors leading to premature birth include the age of the pregnant woman over 30, and mainly women giving birth for the first time, chronic diseases of an infectious and non-infectious nature, impaired lipid metabolism, thyroid diseases (thyroid gland diseases), spontaneous abortions and miscarriages, irregular menstrual cycles, dystrophic changes in the placenta, and low amniotic fluid.

Recent studies have shown that the problem of premature birth is becoming one of the most urgent problems in modern obstetrics and neonatology. It is characterized by the late development of labor activity. The final diagnosis of premature birth can be made only after birth, when the baby shows signs of



premature birth. Usually, premature birth occurs on the basis of gestosis, the threat of termination of pregnancy, feto-placental insufficiency.

Postterm pregnancy is a high risk factor for clinical manifestations of perinatal lesions of the MAT, fetal and infant distress syndrome. The number of complications such as rupture of amniotic fluid before delivery, labor activity, and bleeding is high in preterm infants. This, in turn, increases the risk of surgical intervention. The majority of surgical interventions in preterm infants are performed urgently. It is also noted that compared to children born at term, preterm infants stay in the maternity hospital longer.

One of the main places in the structure of perinatal morbidity and mortality in the newborn is occupied by pathologies of respiratory function during labor, manifested by two main distress syndromes - respiratory failure and aspiration of amniotic fluid. The newborn is not only a risk factor in terms of the risk of impaired adaptation mechanisms of the newborn, but also one of the causes of infection of the nosocomial flora in terms of the increased frequency of surgical delivery for the mother [14].

A number of studies have shown that the use of ultrasound examinations in the antenatal period allows you to diagnose the vast majority of anomalies in the development of the MAT, face, cardiovascular system, lungs, gastrointestinal system, kidneys and urinary tract, genitals, musculoskeletal system. The accuracy of diagnosing anatomical manifestations of fetal developmental anomalies using ultrasound is 92%, with the optimal period for their detection being 20-24 weeks. Due to modern achievements in neonatal care and the introduction of high-tech methods of surgical care, it is necessary to timely detect about 40-50% of congenital malformations [12,16].

The literature, which covers the results of numerous studies, shows that the source of differences in adult health is traced back to childhood. According to scientists, the foundation of human physical and mental health is laid during prenatal phylogenesis and ontogenesis. The health of the child is closely related to the health of the mother. In part, this is due to hereditary predisposition to certain diseases, developmental disorders in the womb, and the poor quality of care that a mother suffering from severe and/or chronic diseases can provide to her child. For example, maternal smoking, medical abortions, respiratory infections during pregnancy, anemia, and the risk of termination of pregnancy are biologically significant risk factors for the formation of ARVI and other health disorders in the child in the future [20,21].



In recent years, MH has become a serious problem in obstetrics, as all authors consider it a high-risk condition for infants, especially the fetus, and mothers due to the relatively high number of long-term and short-term complications in the child and the high risk of birth injuries [10,11,13,15,18,20,33,34].

Methods for diagnosing late pregnancy and determining the appropriate contingent of women for induction of labor, developing preventive measures to prevent it, developing a hygienic analysis of the state of maternal health, prevention of diseases, and the development of a procedure for assessing their causes remain controversial to this day. Finding a solution to this problem is one of the urgent problems of modern clinical and preventive medicine.

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