



Prevention of reproductive losses in women with genital tract infections

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ABSTRACT

The article discusses the complications of pregnancy in women with sexually transmitted infections, including the risk of miscarriage, miscarriage, preterm birth and their impact on pregnancy. The problem of protecting the health of mother and child is considered as the most important component of health care, which is of paramount importance for the formation of a healthy generation of people from the earliest period of their life. Among the most important problems of practical obstetrics, one of the first places is occupied by miscarriage. The frequency of miscarriage is 10-25% of all pregnancies, 5-10% – preterm birth. Premature babies account for over 50% of stillbirths, 70-80% of early neonatal deaths, and 60-70% of infant mortality. Premature babies die 30-35 times more often than full-term babies, and perinatal mortality in miscarriage is 30-40 times higher than in term births. Thus, miscarriage does not lose its relevance in modern obstetrics. Miscarriage – spontaneous termination of pregnancy at various times from conception to 37 weeks, is considered from the 1st day of the last menstruation to 259 days from this date. According to the World Health Organization, preterm births are defined as births between 22 and 37 completed weeks of gestation, counting from the first day of the last menstrual period, with a fetal weight of 500 g or more. The most common causes of miscarriage are: genital infections, endocrine disorders of the reproductive system; erased forms of adrenal dysfunction; damage to the receptor apparatus of the endometrium, clinically manifested as an inferior luteal phase (NLF); chronic endometritis with persistence of opportunistic microorganisms and/or viruses; isthmio-cervical insufficiency (ICN);

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malformations of the uterus; intrauterine synechia; antiphospholipid syndrome and other autoimmune disorders.

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Жинсий йўллар инфекцияси мавжуд бўлган аёлларда репродуктив йўқотишлар профилактикаси

АННОТАЦИЯ

Калит сўзлар:

аборт,
генитал инфекция,
эрта туғилиш,
тактика,
олдини олиш.

Мақолада жинсий йўллар инфекцияси мавжуд аёлларда ҳомила тушиш хавфи, эрта туғруқ ва уларнинг ҳомиладорлик жараёнига таъсири муҳокама қилинади. Она ва бола саломатлиги муаммоси соғлиқни сақлашнинг энг муҳим таркибий қисми сифатида қаралади, бу эса инсон ҳаётининг дастлабки даврида соғлом авлодни шакллантиришда муҳим аҳамиятга эга. Амалий акушерликнинг энг муҳим муаммолари орасида биринчи ўринлардан бири ҳомиладорликдир. Ҳомиладорликнинг тушиши барча ҳомиладорликларнинг 10-25% ни, эрта туғилишнинг 5-10% ни ташкил қилади. Эрта туғилган чақалоқлар ўлик туғилишнинг 50% дан ортиғини, эрта неонатал ўлимнинг 70-80% ва чақалоқлар ўлимининг 60-70% ни ташкил қилади. Эрта туғилган болалар тўлиқ туғилганларга қараганда 30-35 баравар тез-тез ўлишади ва абортда перинатал ўлим тўлиқ туғилганларга қараганда 30-40 баравар юқори. Шундай қилиб, аборт замонавий акушерликда ўз аҳамиятини йўқотмайди. Аборт – ҳомиладорликнинг концепциядан бошлаб 37 ҳафтагача бўлган турли босқичларида ўз-ўзидан тугаши, охири ҳайзнинг 1-кунидан бошлаб шу кундан бошлаб 259 кунгача ҳисобланади. Жаҳон соғлиқни сақлаш ташкилоти маълумотларига кўра, эрта туғилиш ҳомиладорликнинг 22 дан 37 ҳафтагача тугалланган, охири ҳайзнинг биринчи кунидан бошлаб, ҳомила оғирлиги 500 г ва ундан ортиқ бўлган туғилиш деб таърифланади. Абортнинг энг кўп учрайдиган сабаблари: жинсий йўл билан юқадиган инфекциялар, репродуктив тизимнинг эндокрин касалликлари; адренал дисфункциянинг ўчирилган шакллари; пастки лутеал фаза (ЛЛП) сифатида клиник жиҳатдан намоён бўлган эндометриал рецепторлари аппарати шикастланиши; оппортунистик микроорганизмлар ва / ёки вирусларнинг давом этиши билан сурункали эндометрит; истмик-цервикал этишмовчилик (ИЦЕ); бачадоннинг малформацияси; интраутерин синехия; антифосфолипид синдроми ва бошқа аутоиммун касалликлар.

Профилактика репродуктивных потерь у женщин с инфекциями генитального тракта

АННОТАЦИЯ

Ключевые слова:

невынашивание
беременности,
генитальная инфекция,
преждевременные роды,
тактика,
профилактика.

В статье рассматриваются осложнения беременности у женщин с инфекциями, передающимися половым путем, включая риск невынашивания, преждевременных родов и их влияние на течение беременности. Проблема охраны здоровья матери и ребенка является важнейшей составляющей здравоохранения, поскольку имеет первостепенное значение для формирования здорового поколения с самого раннего периода жизни. Среди основных проблем акушерской практики одно из первых мест занимает невынашивание беременности. Частота случаев невынашивания составляет 10-25% всех беременностей, а преждевременные роды составляют 5-10%.

На долю недоношенных детей приходится более 50% случаев мертворождения, 70-80% ранней неонатальной смертности и 60-70% младенческой смертности. Недоношенные дети умирают в 30-35 раз чаще, чем доношенные, а перинатальная смертность при невынашивании в 30-40 раз выше, чем при своевременных родах. Таким образом, проблема невынашивания беременности остается актуальной в современном акушерстве.

Выкидышем считается самопроизвольное прерывание беременности на сроке до 37 недель, начиная с первого дня последней менструации (или до 259 дней от этой даты). По данным Всемирной организации здравоохранения, преждевременные роды определяются как роды, происходящие между 22 и 37 полными неделями беременности, при весе плода 500 г и более.

К основным причинам невынашивания беременности относятся: половые инфекции, эндокринные нарушения репродуктивной системы, скрытые формы дисфункции надпочечников, нарушения рецепторного аппарата эндометрия (например, недостаточность лютеиновой фазы), хронический эндометрит с персистенцией условно-патогенных микроорганизмов и/или вирусов, истмико-цервикальная недостаточность, а также пороки развития матки, внутриматочные синехии, антифосфолипидный синдром и другие аутоиммунные заболевания.

INTRODUCTION

Chlamydia, mycoplasmosis, ureaplasmosis, gardnerellosis, cytomegalovirus and herpes virus) has become of particular importance in obstetric and gynecological practice. It can cause infertility, and when pregnancy occurs, it can cause miscarriage; with the progression of pregnancy, it can cause congenital malformations of the fetus and

neuropsychiatric diseases in newborns. Infection of the genital tract does not leave behind stable immunity; in pregnant women, they occur in a chronic or latent form, without causing much concern [1, 2, 3, 4, 7]. Infection of the genital tract is the cause of a wide range of antenatal pathologies: infectious diseases of the fetus, fetoplacental insufficiency, stillbirth, miscarriage, fetal growth retardation and anomalies in its development. Along with the acute course of infection in the fetus and newborn, a long-term persistence of the pathogen can be observed with the formation of a latent, slow-moving chronic infectious process. Infectious pathology of the fetus is often hidden behind such diagnoses as intrauterine hypoxia, asphyxia, intracranial trauma of the newborn. In many countries, more than 70-80% of the population becomes infected with HSV-1 (HSV-1) during childhood. This to some extent protects against infection with HSV-2 type (HSV-2), traditionally considered the causative agent of genital herpes. Serological studies show that 15-70% of the population have antibodies to HSV-1 and approximately 20% of the population to HSV-2 [2, 4, 8]. Intrauterine infection in the first trimester of pregnancy may result in spontaneous miscarriage. There are cases of congenital herpes, manifested by microphthalmia, choreoretinitis and microcephaly [1, 3, 6, 7]. *Ureaplasma urealyticum*, a member of the *Mycoplasmataceae* family, is often part of the vaginal microflora. This microorganism has been found in fetal membranes during preterm birth and has also been isolated from the lung tissue of newborns who died of pneumonitis. [6, 7, 8]. *Mycoplasma genitalium* causes a spectrum of diseases similar to chlamydial infection (cervicitis, inflammatory diseases of the internal genital organs, non-gonococcal urethritis) [6, 7, 8]. Cytomegalovirus belongs to the herpesvirus family and therefore is capable of causing a latent current infection. The frequency is 1 in 200 pregnant women. In 40% of cases, intrauterine infection of the fetus occurs. The main symptoms of intrauterine cytomegalovirus infection include microcephaly, blindness and deafness, pneumonitis, choreoretinitis, brain calcifications and IUGR [1, 6, 7, 8]. Once in the human body, the cytomegalovirus multiplies and is released from it for weeks, months (when an adult is infected) and even years (when a child is infected). Penetrating into lymphocytes, it remains in the human body throughout his life and therefore can be transmitted through blood transfusion or organ transplantation. From time to time, reactivation of the virus occurs, accompanied by its release from the host body through the genitourinary or respiratory tract. [1, 2, 5, 6, 8]. Infection of the genital tract does not leave behind stable immunity; in pregnant women, they occur in a chronic or latent form, without causing much concern.

The purpose of the work: to assess the impact of genital tract infections on the reproductive function of women.

MATERIAL AND METHODS OF RESEARCH

We analyzed 50 case histories of women admitted to the gynecological department of the maternity hospital No. 2 in Andijan with a threat of abortion in 2022. All women, along with clinical, laboratory and instrumental research methods, underwent a comprehensive bacteriological examination of secretions from the genital tract. The study was carried out using microbiological research methods to determine the type of flora.

RESULTS OF OWN RESEARCH

By age, patients were distributed as follows: under 20 years old – 7, from 21 to 30 years old – 34, from 31 to 35 years old – 9 women. The gestational age at admission was up to 16 weeks in 40 women, from 17 to 20 weeks and more – in 10. Of the

50 patients admitted, 10 were primigravid, the remaining 40 were re-pregnant: 18 of them had one abortion in history, 12 had 2 -3, 10-more than 3 abortions. 14 women had a history of spontaneous miscarriages, 17 had given birth in the past and 3 were operated on for ectopic pregnancy, 37 had gynecological diseases in the past: 16 women had chronic adnexitis, 14 women had cervical erosion, chronic gonorrhea in 2, and one had violation of the menstrual cycle, another one had isthmic-cervical insufficiency, which required the imposition of a circular suture on the cervix during pregnancy. A burdened somatic history was detected in 14 women: 12 women had chronic pyelonephritis, 2 women had chronic hypertension. The observed pregnancy in all proceeded with the phenomena of threatened miscarriage. During examination for urogenital infection, chlamydia was found in 7 women, gardnerellosis in 7, trichomoniasis in 6, mycoplasmosis in 4, ureaplasmosis in 7, cytomegalovirusinfection was detected in 3 women and herpes virus in 2 women. Bacteriological examination revealed streptococcus, enterococcus in 3 women and E. coli in 3 women; candidiasis was detected in 9 patients. Mixed infection was noted in 11 examined pregnant women: gardnerellosis and streptococcosis, gardnerellosis and chlamydia, etc. Of the 50 women hospitalized because of the threat of abortion, only 11 did not have infectious inflammatory diseases. In the hospital, patients received conservation therapy: no-spa, papaverine suppositories, aevit, hormone therapy with duphaston or utrozhestan, as well as, if indicated, antibiotic therapy. Of the 50 patients, 48 were discharged with a progressive pregnancy, 2 women had a spontaneous miscarriage.

CONCLUSION

Thus, infections of the genital tract have a significant impact on the course of both present and subsequent pregnancies. Therefore, the prevention and treatment of genital tract infections in the preconception program improves the outcomes of both pregnancy and childbirth.

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