Profilaktik tibbiyot va salomatlik – Профилактическая медицина и здоровье – Preventive Medicine and Health
Journal home page:
https://inscience.uz/index.php/preventive-medicine

Prevention of reproductive loses in women with genital tract infections

Kamola NASRIDDINOVA[1], Oltinoy YAKUBOVA[2]

Andijan State Medical Institute

ARTICLE INFO

Article history:
Received August 2024
Received in revised form
10 September 2024
Accepted 25 September 2024
Available online
15 October 2024

Keywords:
high-risk pregnancy,
miscarriage,
genital infection,
preterm delivery,
management,
prevention.

ABSTRACT

The article discusses the complications of pregnancy in women with sexually transmitted infections, including the risk of miscarriage, premature birth and their impact on pregnancy. The problem of protecting the health of mother and child is considered 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. One of the most important problems of practical obstetrics is miscarriage. The frequency of miscarriages is 10-25% of all pregnancies, 5–10% – premature births. Premature babies account for over 50% of stillbirths, 70-80% of early neonatal deaths, and 60–70% of infant mortality. Preterm babies are 30–35 times more likely to die than full-term babies and perinatal mortality is 30–40 times higher for miscarriages than for term births. Thus, miscarriage is not losing 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 menstrual period to 259 days after 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 inferior luteal phase (NLF); chronic endometritis with persistence of opportunistic microorganisms and/or viruses; isthmic cervical insufficiency (ICN); uterine malformations; intrauterine synechia; antiphospholipid syndrome and other autoimmune disorders.

DOI: https://doi.org/10.47689/2181-3663-vol3-iss5-pp77-81

[1] Department of Obstetrics and Gynecology №2, Andijan State Medical Institute. E-mail: www.kamolka-91@mail.ru
[2] Department of Obstetrics and Gynecology, Traumatology and Orthopedics, Neurosurgery and Sports Medicine of FAT, ASMI Andijan, Uzbekistan. E-mail: www.oltinoy62@mail.ru

Profilaktik tibbiyot va salomlatlik – Профилактическая медицина и здоровье – Preventive Medicine and Health
Issue – 3 № 5 (2024) / ISSN 2181-3663

Жинсий йўллар инфекцияси мавжуд бўлган аёлларда репродуктив йўқотишлар профилактикаси

Калит сўзлар:
аборт,
генитал инфекция,
эрта туғилиш,
тактика,
олдини олиш.

АННОТАЦИЯ

Мақолада жинсий йўллар инфекцияси мавжуд аёлларда хомила тушиш хавфи, эрта туғруқ ва уларнинг ҳомиладорлик жараёнига таъсири муҳокама қилинади. Она ва бола саломатлиги муаммоси согғлиқни сақлашнинг энг муҳим таркибий қисми сифатида қаралади, бу эса инсон ҳаётининг дастлабки давриданоқ согғлом авлодни шакллантиришда муҳим аҳамиятга эга. Амалий акушерликнинг энг муҳим муаммолари орасида биринчи ўринлардан бири ҳомиладорликдир. Ҳомиладорликнинг тушиши барча ҳомиладорликларнинг 10–25% ни, эрта тугғилишнинг 5–10% ни ташкил қилади. Эрта тугғилган чақалоқлар ўлик тугғилишнинг 50% дан ортигғини, 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 концепсиядан бошлаб 37 ҳафтагача бўлган турли босқичларида ўз-ўзидан тугаши, охирги ҳайзнинг 1-кунидан бошлаб шу кундан бошлаб 259 кунгача ҳисобланади. Жаҳон соғлиқни сақлаш ташкилоти маълумотларига кўра, эрта туғилиш ҳомиладорликнинг 22 дан 37 ҳафтагача тугалланган, охирги ҳайзнинг биринчи кунидан бошлаб, ҳомила оғирлиги 500 г ва ундан ортиқ бўлган тугилиш 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 автоиммун касалликлар.

Profilaktik tibbiyot va salomlatlik – Профилактическая медицина и здоровье – Preventive Medicine and Health
Issue – 3 № 5 (2024) / ISSN 2181-3663

Профилактика репродуктивных потерь у женщин с инфекциями генитального тракта

Ключевые слова:
не вынашивание беременности,
генитальная инфекция,
преждевременные роды,
тактика,
профилактика.

АННОТАЦИЯ

В статье рассматриваются осложнения беременности у женщин с инфекциями, передающимися половым путем, в том числе риск невынашивания беременности, преждевременных родов и их влияние на течение беременности. Проблема охраны здоровья матери и ребенка рассматривается как важнейшая составляющая охраны здоровья, имеющая первостепенное значение для формирования здорового поколения людей с самого раннего периода их жизни. Среди важнейших проблем практического акушерства одно из первых мест занимает невынашивание беременности. Частота невынашивания беременности составляет 10–25% всех беременностей, 5–10% – преждевременных родов. На долю недоношенных детей приходится более 50% мертворождений, 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 беременности в 30–40 раз выше, чем при рождении в срок. Таким образом, невынашивание беременности не теряет своей актуальности в современном акушерстве. Выкидыш – самопроизвольное прерывание беременности на различных сроках от зачатия до 37 недель, считается с 1-го дня последней менструации до 259 дней от этой даты. По данным Всемирной организации здравоохранения, преждевременными родами считаются роды в период между 22 и 37 полными неделями беременности, считая с первого дня последней менструации, с массой плода 500 г и более. Наиболее частыми причинами невынашивания беременности являются: половые инфекции, эндокринные нарушения репродуктивной системы; стертые формы нарушения функции надпочечников; поражение рецепторного аппарата эндометрия, клинически проявляющееся в виде нижней лютеиновой фазы (НЛФ); хронический эндометрит с персистенцией условно-патогенных микроорганизмов и/или вирусов; истмико-цервикальная недостаточность (ИЦН); пороки развития матки; внутриматочные синехии; антифосфолипидный синдром и другие аутоиммунные заболевания.

INTRODUCTION

Chlamydia, mycoplasmosis, ureaplasmosis, gardnerellosis, cytomegalovirus, and herpes virus have 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, and 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]. Ureaplasmaurealyticum, a member of the Mycoplasmataceae family, is often part of the vaginal microflora. This microorganism has been found in fetal membranes duringpreterm 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 is 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, and 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, and 2 women had chronic hypertension. The observed pregnancy in all proceeded with the phenomena of threatened miscarriage. During an 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, and 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.

REFERENCES:

1. Campbell S T., Lisa K., eds. Obstetrics from ten teachers: Per. from English. 17th ed. M., 2004. 464 p.

2. Radzinsky V.E., Orazmuradov A.A. Early pregnancy. M., 2005.

3. Sidelnikova V.M. Habitual pregnancy loss / V.M. Sidelnikov. M.: TriadKh, 2000. 304 p.

4. American College of Obstetricians and Gynecologists. Management of recurrent early pregnancy loss. ACOG practice bulletin no. 24 / American College of Obstetricians and Gynecologists. Washington DC, 2001.

5. Azam AZ, Vial Y, Fawer CL, et al: Prenatal diagnosis of congenital cytomegalovirus infection. obstetGynecol 97:443, 2001

6. Baud D, Greub G: Intracellular bacteria and adverse pregnancy outcomes. Clinic Microbiol Infect 17:1312, 2011

7. Bricker L., Farquharson RG Types of pregnancy loss in recurrent miscarriage: implications for research and clinical practice // Hum. reproduction. 2002 Vol. 17, No. 5. P. 1345-1350.

8. Coonrod DV, Jack BW, Boggess KA, et al: The clinical content of preconception care: infectious diseases in concept care. Am J ObstetGynecol 199(6 Suppl 2): S290, 2008.