1. Основываясь на данные исследования, можно сделать вывод, что в настоящее время наблюдается высокая частота гестационных осложнений у ВИЧ-инфицированных женщин, что с учетом уровня пороговой вирусной нагрузки и объема АРВ-терапии (антиретровирусная терапия) определяет дальнейший акушерский и перинатальный прогноз.

2. Тактика ведения беременности и родов при ВИЧ-инфекции, профилактика гестационных и перинатальных осложнений остаются дискутабельными, требуют дальнейшего изучения и разработки рациональных технологий, диспансеризации беременных и тактики родоразрешения.

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ТАКТИКА ВВЕДЕНИЕ И ИНДҮКЦИЯ РОДОВ Ү ЖЕНЩИН С ОТХОЖДЕНИЕМ ОКОЛОПЛОДНЫХ ВОД ПРИ РАЗЛИЧНЫХ ИНФЕКЦИЯХ

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TACTICS OF INTRODUCTION AND INDUCTION OF LABOR IN WOMEN WITH PREMATURE RUPTURE OF MEMBRANE ASSOCIATED WITH VARIOUS INFECTIONS

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Annotation. The problem of induction of labor in pregnant women with preterm discharge of amniotic fluid and chorioamnionitis is becoming more serious. Infection of the fetus in the uterus during prenatal discharge of amniotic fluid can lead to complications of pregnancy, childbirth or the development of the disease in the newborn.

Key words: premature rupture of membrane, full-term pregnancy, induction of labor, sepsis

Аннотация. Проблема индукции родов с инфекционными заболеваниями при отхождениях околоплодных вод является одной из самых актуальных проблем в акушерстве. Инфицирование плода в утробе матери при дородовом излитие околоплодных вод может приводить к осложнениям течения беременности, родов или развитию септических заболеваний в послеродовом периоде.

Ключевые слова: преждевременное излитие околоплодных вод, беременность, индукция родов, сепсис

Among the problems of modern obstetrics, premature and prenatal rupture of amniotic fluid takes one of the first places, as it determines the high level of perinatal and infant morbidity and mortality [1,2,3]. 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, infections have been detected, on the other hand, a true increase in the frequency of this pathology is not excluded [4,5,6]. Infection of the fetus in the womb during prenatal rupture of amniotic fluid can lead to complications during pregnancy, childbirth or the development of the disease in the newborn [7,8,9].

The tactics of managing pregnant women with this pathology is extremely variable, and depends on the gestational age, on the amount of amniotic fluid that has

flowed out, 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 [10, 11, 12].

Objective - To study labor outcomes and methods of induction in women with antenatal and premature rupture of membranes and management of labor.

Material and methods of research

To solve the set tasks, a comprehensive examination was carried out of 52 pregnant women whose childbirth was complicated with PROM at 37-40 weeks of gestation, who were admitted to the Bykhara city and perinatal center for the period 2017-2018. With the help of 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 according to the Bishop scale. According to the National Standard of Management of Patients after 18 hours of anhydrous interval, which is the basis for antibiotic therapy, in order to prevent purulent-septic complications in puerperas and the birth canal of pregnant women, examined after 24 hours in the absence of labor in order to resolve the issue of the appropriateness of induction of labor ... The nature of labor was monitored on the basis of partograms. In the management of childbirth, complicated by prenatal rupture of amniotic fluid, it is necessary to control hemodynamic parameters, maintain a checklist, measure t-body every 4 hours, blood for leukocytosis 1 time per day, complete blood count (coagulogram, C-reactive protein, leukocyte intoxication index, urine analysis, blood group and Rh-accessory, analysis of vaginal discharge - smear, infectious of the uterus and fetus, cervicometry, general condition of the woman in labor and amniotic fluid.

Results and their discussion

The average age of the observed women was 26.5 years. In all women, pregnancy proceeded against the background of extragenital diseases, and in most cases a combination of several of them. Mild and moderate anemia (73.1%), thyroid disease (32.7%) and varicose veins (25%) prevailed. 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, pyelonephritis. In 17.3% of pregnant women, ARI episodes were repeated many times during pregnancy. Among the transferred gynecological diseases, chronic endometritis, viral infections of herpetic and ureaplasmosis in combination with chlamydia 54% and colpitis of various etiology, vaginal dysbiosis, which amounted to 44.6%, were most often diagnosed. All women with prenatal rupture of amniotic fluid underwent vaginal examination using mirrors in order to identify the nature of the discharge, the color of the amniotic fluid, the degree of cervical dilatation. 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 state of the presenting part of the fetus had points up to 5, which was assessed as "immature cervix". And in 38.4% of women, the birth canal was assessed as “mature cervix”. Accordingly, the tactics of further management were chosen according to the protocol of the maternity complex. In pregnant women with "immature" cervix and detection of signs of colpitis, induction

of labor with mifepristone 200 mg 1 tablet was proposed after the informed consent of the pregnant woman and relatives. The birth canal was reevaluated at 12 hours to clarify the need for continuation of the induction. In pregnant women with a "mature" cervix, childbirth was carried out with expectant tactics: To convince women that there is a possibility of spontaneous birth of a 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), an analysis of the coagulogram and the number of platelets, the level of progesterone and estriol is performed. If, within 24-48 hours, the number of platelets has decreased or spontaneous labor has not occurred, it is necessary to discuss an active management tactics in the use of prostaglandins. In critical conditions that threaten a woman's life (severe preeclampsia, eclampsia, rupture of the ribs), severe obstetric pathology, with immaturity of the cervix and the absence of conditions for urgent delivery, the conscience of doctors resolved the issue of operative delivery.

Thus, the question of management tactics in the presence of a rib on the uterus with PROM unresolved, multicenter studies require continuation, which will allow analyzing the outcomes of childbirth depending on the duration of pregnancy, the duration of the anhydrous interval, the body's reaction women on PROM, the presence of concomitant obstetric and extragenital pathology, the woman's age, obstetric history and the individual choice of the method of induction.

Conclusion.

1 Clinical and anamnestic risk factors for complicated PROM are a history of endometritis, pathological growth of conditionally pathogenic cervico-vaginal microflora, chlamydia, nonspecific colpitis and bacterial vaginosis. The presence of infections (primarily herpetic and ureaplasmosis) negatively affects the course of pregnancy and childbirth. After 18 hours of anhydrous interval, the tactics of labor should be conservative - expectant up to 24-48 hours against the background of antibiotic therapy, if labor does not occur on its own, it is necessary to start induction of labor with antiprogestins and prostaglandins. In the presence of vaginal infections, the recommended antiprogestin fepristone 200 mg peros is recommended for induction. Induction of labor with ribs on the uterus is the activation of uterine contractility with the onset of labor, while successful induction is natural delivery, or operative delivery within 24-48 hours.

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