Ministry of Health of the Republic of Uzbekistan

Bukhara Medical Institute named after Abu Ali ibn Sino

Department of Obstetrics and Gynecology

Educational-methodical complex on subject

obstetrics and gynecology

Knowledge branch:	**500000 Public health services and social security**
Training branch:	**510000 Public health services**
Training direction:	**5510100 Medical business**
	5111000 Vocational training

BUKHARA -2021

Ministry of health of the Republic of Uzbekistan

Bukhara medical institute named after Abu Ali ibn Sino

Department of obstetrics and gynecology

"APPROVED"

Rector of Bukhara medical institute

Doctor of Science _____ Teshaev Sh.J

"_____" _____ 2021 year

COLLECTION OF LECTURES

ON OBSTETRICS AND GYNECOLOGY

Bukhara-2021

Ministry of Health of the Republic of Uzbekistan

Bukhara Medical Institute named after Abu Ali ibn Sino

Department of Obstetrics and Gynecology

"APPROVED"

Prorector for Academic Affairs

t.f.d. professor____Jarilkasinova G.J.

"___" _____ 2021 year

EDUCATIONAL - METHODICAL COMPLEX ON SUBJECT OBSTETRICS AND GYNECOLOGY FOR STUDENTS OF 6th COURSE OF MEDICAL AND MEDICAL - PEDAGOGICAL FACULTIES.

The educational-methodical complex is compiled on the basis of the model program on obstetrics and gynecology for the students of the VI year of medical and medical-pedagogical faculties.

COMPOSITIONS:

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REVIEWS:

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The educational-methodical complex was discussed and approved in the central methodical council of Bukhara medical state institute

Protocol No - "-------" ---------- 201 y

The educational and methodical complex was discussed and approved by the Council of the Bukhara medical state institute **.** Protocol No. - "-------" ----------201 y

Secretary of the Council: docent Boltaev K.Zh.

Lecture 1: Physiological birth. Physiological postpartum period.

Lecture plan:

Generic pathways and fetus as an object of birth

Biomechanism of childbirth at folding positions of the fetus

Active management of the third stage of labor.

Determine the period of childbirth

The theoretical part

Childbirth - an unconditional reflex act aimed at the expulsion of the ovum from the uterus that reaches the fruit of vitality. It is now believed viability of the fetus for a period not less than 22 weeks gestation, weighing not less than 500 g, not less than 25 cm is considered the timeliness of deliveries in the period from 37 to 42 weeks of pregnancy. Birth after 42 weeks of pregnancy

is called late. Termination of pregnancy before 22 weeks is called abortion.
Onset of labor is preceded by the appearance of hook-called precursors of birth.
Harbingers of sorts - these are signs of the onset of their loved arising from 38 weeks of pregnancy before birth and manifested as a result of lowering the bottom of the uterus pressing pre ¬ lying part of the fetus to the entrance of the pelvis and reduce the amount of amniotic fluid, a discharge of "mucus plug", the lack of weight gain , increased excitability STI muscles of the uterus, etc.
In contrast to the precursors of birth preliminary limited to a few hours of pain-mi, immediately preceding the onset of labor, and should not impede the natural processes of life (sleep, diet, activity). Preliminary clinically pain occur for pregnant almost unnoticeably marked irregular painless contractions of the uterus, which are gradually becoming stronger and more persistent, and finally go into battle.
Preliminary pain correspond to the time of formation of the dominant clan and are accompanied by a biological "ripening" of the cervix. The cervix softens over-occupies a central position on the wire axis of the pelvis and drastically shortened. When pathological pain during the duration of the preliminary prolonged, uterine acquires a painful character, and the ripening of the cervix occurs.
Childbearing is divided into three periods:
- First - disclosure period (latent and active phase)
- Second - the period of the expulsion of the fetus (not evicted early and late phase casts out)
- The third - the sequence period.
At birth a pregnant woman in labor is called.
The first stage of labor - this is the part of labor, which begins with the appearance of contractions and ends with a complete disclosure of the uterine mouth.
Contractions - is the involuntary rhythmic contractions of the muscles of the uterus with at least one in 10 minutes. Contractions are characterized by four features: frequency, duration, strength and tenderness. In early labor contractions occur every 10 minutes, and further breaks are gradually reduced to 1-2 minutes.
Duration of contractions in early labor 10-15, in the middle of giving birth - 30-40. after delivery - 50-60 s. The contractions are weak, medium and strong strength. Soreness labor depends on the strength of the central nervous system and on the quality of the genera pregnant.

Figure cervical dilatation in nulliparous and multiparous.

Disclosure of uterine throat is due to a reduction (contraction), and of displaced relative to each other (retraction) of muscle fibers of the uterine body and stretching of the expansion (distraction) neck and the lower segment of the uterus. The lower segment of the uterus - a part pericervica; area of the body of the uterus, forming a clan ¬ howling channel in the first stage of labor as a result of processes of retraction and distraction. As the formation of the birth canal on the border of the upper and lower segments of the uterus is formed furrow, called the contraction ring. At the beginning of first-time mothers giving birth outer and inner mouth shut. Disclosure necks starts at the top. First revealed the inner mouth of the cervix and cervical canal. In the future, the cervix is still more shortened, and then fully anti-aliased, and only its outer mouth remains closed. Then, on the edges of external os gets thinner, and it begins to open up, as long as it does not happen complete disclosure. In this case, it is defined as a narrow rim in the birth canal, ¬ Call of formation of cavities merged together vagina and uterus. At the end of pregnancy in multiparous entire cervical canal to pass one or two fingers (as a result of its expansion in the previous birth). Therefore, anti-aliasing and the cervix throughout the first stage of labor is but at the same time ¬. Disclosure of uterine mouth is to fully open, which corresponds to 10 cm discharge of amniotic fluid should be at close to full opening of the uterine mouth. Rupture of membranes in the first stage of labor before the disclosure of 4-6 cm, and before regular labor is called premature.

During the first stage of labor identified two phases: latent - from onset of labor to the disclosure of the uterine mouth to 3-4 cm, active - from 4 cm to fully open. In turn, the active phase time of acceleration is isolated, and its maximum speed deceleration (decelerations). Rate of uterine mouth opening is an important indicator of the correct course of labors. The rate of cervical dilatation at the onset of labor (latent phase) is 0.35 cm / h in the active phase - 1.5-2 cm / h in nulliparous and 2-2.5 cm / h - multifarious.
Disclosure of uterine mouth from 8 to 10 cm (deceleration phase) passes more slowly - 1 -1.5 cm / h Meanwhile ¬ Py disclosure of uterine os dependent on contractility of the myometrium, Cervical resistance and combinations thereof. The duration of the first stage of labor in nulliparous an average of 10 to 14 hours, and multifarious - half the size.
In the first stage of labor, the doctor should monitor the overall health of mothers, the dynamics of labor and the heartbeat of the fetus.
The behavior of women in the first stage of labor should be active. It should to use techniques of anesthesia, which taught her classes on psycho preventive -ray preparation for childbirth. Acceptable attendance at childbirth husband and other relatives. Bed rest is recommended for stored the fetal bladder in cases of polyhydramnios, premature birth, breech presentation, we recommend taking food and liquids.

After full disclosure of the uterine mouth begins the **second stage of labor** - the period of Gnagno-which ends with the birth of the fetus. In the second period identified two phases: Early (not evicted) - full disclosure, the presenting part is omitted, but does not reach the bottom of the pelvis, there is no urge to dry heaving. Late (expulsion) - Full raskrytie5, presenting part of the fetus reaches the bottom of the pelvis, the woman begins to push. Characteristic of the period of exile is the appearance of any attempts - synchronous with the uterus reflex contractions of the abdominal muscles, the diaphragm and the pelvic floor. Attempts should start with finding the presenting part at the bottom of the bands small pelvis when the lower pole of the presenting part presses on the abdominal muscles and the pelvic floor. On this false appearance of any attempts to identify the beginning of the period of exile - they appear at the end of this period and help to overcome the presenting part of the narrowest part of small pelvis. Attempts repeat every 2-3 minutes and last for 50-60 seconds.
In the second stage of labor the doctor should carefully monitor the status of women in labor, the nature of labor, the heartbeat of the fetus (it should be auscultated after each attempts), promotion of the presenting part of the fetus, the character of discharge from the genital tract, hold receptions of "protecting the perineum"
The third stage of labor - the sequence - comes after the birth of the fetus and continues through the placenta. Its duration is an average of 10 to 15 minutes, but no more than 30 minutes. To date, the third stage of labor are actively using controlled cord traction with the first battle sequence, highlighting the active participation of women in labor with no consequences.
A woman called postpartum women in childbirth. Within 2 hours it should be in the delivery room under the supervision of a midwife, while continuing to maintain its activity. If all is well, women in childbirth transferred to the postpartum unit.
The set of movements made by the fruit as it passes through the pelvis and the soft parts of the birth canal, called the biomechanics of delivery. **The first point** - bending head (flexio capitis). Under the influence of intrauterine pressure, partly transmitted ¬ direct the spine to the head of the fetus, the cervical part of the spine is bent in such a ¬ time that chin close to the chest, back of the head is lowered. As you lower the back of the head small fontanelle is set below a large, approaching the pro ¬ water line of the pelvis

The second point biomechanism childbirth is a combination of translational ¬ relative motion of the head and its internal rotation.

The second point biomechanism childbirth begins after the head is bent over and getting up at the entrance to a small basin. Then head able to moderate flexion one of the sizes goes skew widest part of the pelvic cavity. Since the internal rotation ¬ mouth, in a narrow part of the pelvic cavity. As a result, the size of the head of the skew becomes a straight line. Turning ends when the head reaches the exit plane of idle once established as the head of the arrow-shaped seams in the direct output of the pelvis, begins **the third time** biomechanism birth - extension of the head. Between the symphysis pubis and the suboccipital fossa of the fetal head is formed fixation point around which the extension is the head. As a result, by extension therefore ¬ born crown, forehead, face and chin of the fetus.

Fixation point or fulcrum (punctum fixiim) is a point on the fetal head, which abuts against the lower edge of symphysis (and in some previa and coccyx tip) is then bending or unbending Birth and any part of the fruit.

Head born small oblique size equal to 9.5 cm and a circumference of 32 cm

Figure of perineum protection

After the birth of the head is an internal rotation of shoulders and outer rotation ¬ mouth head - the fourth time. Shoulders of the fetus produce internal rotation, as a result they are set out in the forward of the pelvis so that one shoulder (front) is located under the womb, while the other (back) paid to the coccyx. Born fetal head rotates back of his head to the left thigh of the mother (in the first position) or to the right (at the second position).
Between the anterior shoulder (in the deltoid muscle attachment to the humerus) and the lower edge of the symphysis, a new point of fixation. There is a bend of body to fetal thoracic and rear shoulder of birth and pens, and then easily given birth the rest of the body.
Biomechanism delivery at the front as the occipital previa is the most physiological and beneficial to both mother and fetus, as in this variant Biomechanism head passes through the plane of the pelvis and its smallest size is born ¬ authors.
In the delivery room or in the home immediately after the birth of a child is held first toilet newborn, which includes:
• treatment of the eye.
• Two-moment cut off the umbilical cord and umbilical handling balance.
• study anthropometric data-child weighing (minus the weight of the total weight of the diaper), the measurement centimeter ribbon growth child's head circumference (along brow to small fontanelle) and breast (the line passing through the nipple).

1. Partograph (organaizer) - is a graphical way to display the birth process:
- The progression of birth
-Disclosure cervix
- Promotion of the fetal head

- Labor-
the fetus and status of the mother

Partoprograph of WHO, 1988:Features and benefits

- Effective monitoring standard
- Early detection of unsatisfactory progress in labor
- Detection of pelvic disproportion-head before the symptoms of obstruction
- The timely adoption of a reasoned decision on the future tactics of birth
- The definition of the necessary interventions
- Simplicity, low cost, accessibility, visibility.

The basic principles of the partograph:

- Partograph used for doing basically t-he first stage of labor

- However, in the second stage of labor should continue to record indicators of the mother and fetus, as well as uterine contractions

- Partograph begins filled in the presence of
  - One or more contraction of uterus within 10 minutes of 20 seconds or more duration in the latent phase
  - Two or more ccontractions of uterus within 10 minutes of 20 seconds or more duration in active phase
  - Absence of complications requiring emergency care or deliveries
  - Partograph populated at the time of delivery, and not after their completion
  - During labor partograph should be in the delivery room
  - The completion and interpretation of the partograph should be a trained staff (doctor or midwife)
  - Keeping partograph will get terminated if there are developed complications requiring emergency delivery

  Advancing of the fetal head, determined by visual inspection:

  - Head over the entrance to the pelvis
  - The head of a large segment of the entrance to the pelvis
  - The head is palpated by the width of the 5 fingers on the top edge of the symphysis - 5/5
  - The head is palpated by the width of two fingers above the top edge of the symphysis - 2/5

  Amniotic fluid:

- Ts – a bag of waters, C – clear amniotic fluid, B – amniotic fluid stained with blood, M – meconium-stained amniotic fluid/

Configuration of fetal head:

- 0 – bones don't contact and connective tissues gets easy to define between the edges of skull
- + bones lightly touch each other
- ++ bones overlap
- +++ Bones significantly overlap

Conclusions:

- Simple, intuitive, easy-to-use and effective tool for monitoring the flow of labor and decision-making
- The use of the partograph significantly improved perinatal outcomes
- Partograph can be used effectively in the institutions of any level of care
- The effectiveness of the partograph is ensured compliance with the rules of use
- Partograph should be used for all kinds, i.e women as low-and high-risk

2. **Discussion** - is used in the discussion stage homework and determine the initial knowledge of the students.
Questions / Answers:
1. Periods of delivery
Childbearing is divided into three periods:
first - the period of disclosure,
second - a period of expulsion,
third - the sequence period.

2. The duration of labor in first-and multiparous

The duration of labor in nulliparous is 11,5-14,5 hours, including - first stage of labor - 9-12 hours, the second - up to 2 hours. The duration of labor in bipara - 8,5-11,5 hours, including the first stage of labor lasts 8-11 hours, second - to 1 hour. The third stage of labor in nulliparous as well as multifarious actively conducted.

3. Biomechanism delivery at the front as the occipital previa (a demonstration on models or phantom)

The first point - bending head (flexio capitis). Under the influence of intrauterine pressure, partly transmitted ¬ direct the spine to the head of the fetus, the cervical part of the spine is bent, chin close to the chest, back of the head is lowered. As you lower the back of the head small fontanelle is set below a large, approaching the pro ¬ water line of the pelvis

The second point biomechanism childbirth is an internal rotation of the head. It begins after the head was bent and inserted into the entrance to the pelvis. Then the head is in a state of moderate flexion in one of the oblique size goes wide part of the pelvic cavity from the internal rotation ¬ mouth. In the narrowest part of the pelvic cavity head ends rotational movement. As a result, the size of the head of the skew becomes a straight line. Turning ends when the head reaches the exit of the pelvis

The third point biomechanism birth - extension of the head. Between the symphysis pubis and the suboccipital fossa of the fetal head is formed fixation point around which the extension is the head. As a result, by extension therefore ¬ born crown, forehead, face and chin of the fetus. The head is born small oblique size equal to 9.5 cm and a circumference of 32cm, it is appropriate. After the birth of the head is an internal rotation of shoulders and outer rotation ¬ mouth head - the fourth time. Shoulders of the fetus produce internal rotation, as a result ¬ Tate they are set out in the forward of the pelvis so that one shoulder (front) is located under the womb, while the other (back) paid to the coccyx. Born fetal head rotates back of his head to the left thigh of the mother (in the first position) or to the right (at the second position). Between the anterior shoulder (in the deltoid muscle attachment to the humerus) and the lower edge of the symphysis, a new point of fixation. Bending that occurs of fetal body in the thoracic and the birth and rear shoulder of the handle, and then easily given birth ¬ rest of the body.

4. What are the ways of the placenta

A) central (by Schultze) - placenta begins from the center to form retro placental hematoma. In this case, no external bleeding, hematoma retro placental born with afterbirth and placenta - its fruit surface.

B) boundary (by Duncan) - separation of the placenta begins to edge retro placental hematoma is formed. From the very beginning of branch starts bleeding from the genital tract, the placenta is born of its parent surface.

5. What happens when blood loss physiological delivery?

Blood loss on the average is 150-200 ml. The upper limit of the permissible scope of physiological blood loss - 0.5% of body weight, or 5 ml per 1 kg.

6. How often should be conducted outside midwifery research in the I stage of labor?

Outside midwifery, research in the period of disclosure should be done repeatedly and systematically. Recording of medical records shall be made not less than every 2 hours.

7. What should I look for when external OB exam?

To: - the shape of the uterus, its consistency in and out of battle, fundal height and condition of the contraction of the ring;

- The strength and duration of contractions (with the hand placed on the fundus of the uterus), the degree of relaxation of uterine contractions is (by palpation);

- Standing height of the contraction of the ring;

- Position, position, look and fetal presentation and the attitude of the presenting part to the entrance of the pelvis (methods of Leopold-Levitsky), and - on the clinical correlation between the size of the head and pelvis (sign Vasta).

8. What is the heart rate of the fetus?

It normally is 100-180 beats per minute. Increased heart rate, as well as its slowing is signs of fetal hypoxia.

9. When there is a discharge of amniotic fluid?

Discharge of amniotic fluid should be at close to full opening of the uterine mouth. Rupture of membranes in the first stage of labor prior to the disclosure of 6-7 cm, and before regular labor is called premature.

Lecture number 2: Complicated pregnancy.

Lecture plan:

1. Absolute and relative indications for operative paralysis

2. Peculiarities of tactics of conducting pregnancy and childbirth, methods that determine the anatomical and functional state of the uterus

3. Methods of rehabilitation in the postpartum period and features of contraception in women with a scar on the uterus.

4. Causes contributing to the development of an improper position and presentation of the fetus.

5. The main clinical symptoms, differential diagnosis, complications.

6. Stages of first aid in case of emergency conditions associated with this pathology.

The theoretical part

C-section -obstetric surgery intended for delivery through laparotomy incision and uterine wall, when giving birth vaginally for whatever reason are not possible or are accompanied by complications for the mother and the fetus.

All indications for caesarean section is divided into absolute and relative by both the mother and the fetus.

Absolute indications for caesarean section.

Absolute indications include a group of causes:

-(III)—(IV)the degree of narrowing of the pelvis;

-Tumor and cicatricial changes to birth the fruit;

-Complete placenta previa or incomplete bleeding her fetus;

-Premature detachment normally situated placenta (in the absence of rapid vaginal birth);

-Eclampsia during pregnancy or the first stage of labor; lack of quick delivery pregnant with severe gestosis therapy, very hard, the appearance of renal deficiency baked;

-Threatening uterine rupture;

-Incorrect position of the fetus;

-Disability wall of the uterus (after cesarean section in the past, myomectomy, uterine perforation, etc.);

Incorrect insertion of the presentation and the fetal head (brow, perednetemennoe, asinklitic, high standing seam directly arrow, etc.);

-The presentation and cord prolapsed with live fruit; the severe form of heavy late toxicoses of pregnant with no conditions for immediate delivery through the birth canal, and (most);

-Uterine inertia forces with inefficiency therapy;

-Progressive course and extra genital diseases in decomposition condition (idiopathic hypertension, diseases of the cardio-vascular system, etc.) that require an urgent delivery and there are no facilities for it through most of the major birth canal;

-Deformations and fractures of the pelvis;

-Genitourinary and gastro-sexual fistulas in history;

-Threatening and began tearing the uterus;

Varicose veins-expressed in the external genital organs;

-Numerous combined testimony (large fruit for breech presentation in nulliparous age, etc.).

Relative indications for caesarean section.

To relative grounds include a situation where there is a possibility of delivery by natural means, but the risk of complications for the mother and/or the child exceeds the risk of complications of abdominal delivery.

Common **relative** indications:

-scar at the womb after preceding operations;

-pelvic fetal position;

-extra genital diseases in which the breech vaginal birth is increased risk to women's health (myopia with Dystrophic changes in the fundus, epilepsy, posttraumatic ènce falopatiâ, etc.);
-premature rupture of membranes;
-anomalies birth (uterine inertia forces);
-presence of obstetrical history (infertility, habitual miscarriage);
-age over 30 years 1st labor;
-over term pregnancy;
-diabetes mellitus and large fruit;
-anatomically narrow hips p & I degree, especially in combination with other unfavorable factors (elderly women, pelvic presentation etc.); facial previa; multiple uterine fibroids; diseases of the central nervous system; fetal hypoxia; malformations of the uterus; by combining different evidence.
Early caesarean section is shown by:
-preterm rupture of membranes or premature development of labor activity and presence of intrauterine fetus development delays(II)—(III)degree;
-moderately expressed hypoxia according to CTG combined fetal development delay(II)—(III)degree.
-(II)degree of hemodynamic abnormalities in mother-placenta-fetus with bilateral uterine blood flow in the arteries of the violation and the presence of notches on the spectrogram dichotic.
-Indications for emergency delivery in the presence of fetoplacental insufficiency, as well as support the development of the fetus during pregnancy more than 32 weeks are:
-Detection of signs of pronounced hypoxia according to CTG (antenatal spontaneous emergence late decelerations, deceleration in oxitocin test);
-Critical state fruit-placental blood flow Doppler ultrasound data (lack of diastolic or retrograde blood flow in the umbilical artery);
-The emergence and progression of clinical (rhythm or heart rate with the development of bradycardia, low tones) and/or cardiografic (late decelerations) signs of fetal hypoxia in childbirth (in the absence of the conditions for rapid vaginal birth);
-Drop loop of umbilical cord with cephalic presentation;
-The lateral position of the second fetus from the twins.
Delivery by caesarean section routinely are pregnant in the following clinical situations:
-Delay of the development of the fetus or cause doplerometric symptoms over term blood circulation in its centralization of pregnancy (fetal aorta in a 8.0 and JDO in Middle cerebral artery is less than 2.8);
-Pelvic presentation or lateral position of the fetus;
-Combination(I)-(II)degree of hemodynamic abnormalities in mother-placenta-foetus, early signs of fetal hypoxia with other obstetrical pathology (large fruit, age 30 years older than 1st labor, weighed down by obstetric history, etc.);
-Early signs of fetoplacental insufficiency Progression (worsening of CTG, JDO or signs of increasing centralization of blood circulation in doplerometric research), despite ongoing treatment.
However, the increase in the number of operations cesarean VA section leads to an increase in the number of women having a scar on the uterus, and is accompanied by increased risk of complications in the postoperative period. Therefore, it is important to consider the conditions and contraindicated of the IDB to caesarean section.
Conditions for caesarean section are: a viable fetus, the classification of the qualification of the surgeon, a woman's consent to the operation.
It should be remembered that a scar on the uterus is uterine rupture in perspective (asymptomatic or minor symptoms).
Abdominal pain, lower back pain, across the abdomen, in the region. the scar, on the abdominal wall, the unclear localization during physical exercise, even minor, especially not peel

spazmolitikami, analgesics should be interpreted as a threat of uterine rupture of rubcu, not the threat of miscarriage.
In term pregnancy in women with scar at the womb long preliminary period should also be considered as threatening uterine rupture.
At the same time, under the guise of threatening preterm birth in late pregnancy may show clinical failure of the scar on the uterus and thereby threatening uterine rupture. The positive effect of the therapy aimed at preserving the pregnancy (Tocolytic, sedatives), and no local pain in the scar on the uterus, and ultrasound data (evidence about the full lower segment) and cardiotocography (indicating the absence of acute fetal hypoxia) confirm the diagnosis of premature delivery. Persistent local pain in the scar on the uterus, thinning and acoustic heterogeneity ehoplotnost regions (detected at ultrasound of the lower segment of the uterus), and the signs of the deterioration of the fetus (according to CTG) is called the failure of the uterine scar - or rather, to a threatening rupture of the uterus. In these cases, the required emergency abdominal delivery.To develop tactics of pregnancy and delivery method of choice for women with scar at the womb has an important meaning of NOE, the assessment of the condition of the uterus, which is carried out using a transabdominal and transvaginal ultrasonography in pregnancy.
Ehografic criteria for full healing of the lower uterine segment are:
-U-shaped it with a thickness of not less than 4-5 mm;
-Normal èhogennic′ of the lower segment, similar to the one in the other divisions of the uterus;
-Small areas of low sound transfer on the background of normal acoustic density.
The **èhografic** featured **the insolvent** transverse scar we include:
-Cans-or conical form of the lower segment of the uterus;
-The thickness of the lower segment of less than 3 mm;
-Local thinning of the lower segment of less than 3 mm in the background of normal thickness (4-5 mm);
-Enhanced acoustic density throughout the area of the former.
Many complications that arise in gestational period give reason to treat the scar on the uterus like a disease "after the uterus, cervical incompetence".
Complications during gestation: the threat of termination of pregnancy, placental insufficiency, SZRP, PONRP, wrong position of fetal, perinatal complications, the risk of uterine rupture, uterine rupture of rubcu, coma, lethality.
Complications in childbirth: birth anomalies, bleeding (PONRP, hypotension, etc), perinatal complications, the risk of uterine rupture, uterine rupture of rubcu, coma, lethality.
Recommandations to abdominal′nomu delivery are: intrauterine fetal death or being, incompatible with the existence of intrauterine (Glu-bokaya prematurity, very pronounced degree of hypoxia and fetal malnutrition, foetal malformations, incompatible with life), acute infectious-inflammatory diseases
Criteria for the selection of women with scar at the womb to conduct **spontaneous deliveries** are:
-one c-sections in history, made a cut in the lower uterine segment to a non-repeating (transient) condition: fetal hypoxia, birth abnormalities, pelvic presentation and abnormal position of the fetus, placenta previa and Abruptio, heavy forms hypertensive States;
-No new evidence during this pregnancy to the birth of samoproizvol′;
-satisfactory condition of the mother and fetus.
previa-head sole fruit;
-a full lower cervical segment (clinical and ultrasound data);
-a woman's consent to conduct spontaneous deliveries.
-favourable currents of this pregnancy with no sign of the threat her interruption, signs of fetoplacental insufficiency of gipoksičeskom syndrome of fetus and its placenta location, wasting away, the alleged "scar" on the uterus;
-the biological maturity of the cervix 4th degree;

-preservation of the principle of "triple downward gradient between the divisions, including the lower segment of the uterus; with the start of labour;
-establishing the correct position of the fetus and members head location at the entrance of the pelvis, or centered above the pelvis in the preparatory period for childbirth.
Conservative management of women with scar at the womb is possible only in large hospitals equipped with obstetric enough (or perinatal centres), with 24-hour supervision of highly qualified obstetricians and gynaecologists who endorsed full ext of assistance (including hysterectomy).

Diagnostics of the scar in the out-patient stage:

Visit pregnant women in turn.(I)half of 1 times in 2 weeks, in(II)– 1 time per week.

ULTRASOUND in Dynamics: the I-II trimester 1, III – 3 times.

To èhografičeskim scar at the womb insolvency during pregnancy include thinning of the lower segment of the scar (less than 0, 3 cm), a significant number of acoustically dense inclusions, indirectly indicating the presence of scar tissue, reshaping the lower segment in the form of niches.

To determine the usefulness of the uterine muscles in the area of the former incision should take into account the objective data obtained by palpation. To do this, pushing aside a skin scar the uterus, pal′piruût when the incision the previous operation. In response to palpation, the uterus is usually reduced. If a scar, then it is not defined and the uterus is uniformly reduced. With nepolnocennom rumen connective tissue is reduced and not pal′piruûŝie fingers feel the deepening (notch) in the uterus.

CTG in Dynamics: from 24 weeks.

Date of hospitalization for women with scar at the womb:

-up to 12 weeks, to assess the condition of the SCAR and to address the issue of pregnancy prolongirovani.
-In 24-26, 30-34 weeks. for the treatment of fetal hypoxia, ÈGZ and attendant complications during gestation.

In a 38-37 weeks for the birth, and when in the rumen nepolnocennom 35-36 weeks.

For delivery, pregnant with scar at the womb State of pitaliziruûtsâ in obstetrical hospitals in 37-38 weeks gestation, where they conducted a full survey of the General and special maternity, childbirth timing TBC, valued the fetoplacental system (using ultrasonic fetometrii, placentografii and dopplerometričeskogo study of blood flow in the umbilical artery and the uterine arteries) and is determined by the estimated weight of the fetus, an assessment of the status of the scar on the uterus (clinically and èhografičeski), be sure to include the data history.

In order to improve the outcomes of repeated Caesarean section for fetal surgery is very significant in the timing, close to childbirth: 39-40 weeks. The transformation of prior years ' arrears, to avoid the risk of uterine rupture is most often coming with the start of labor activity, repeated abdominal delivery were at 38 weeks. The children were born with a birth weight of full-term, but often with gratitude, Kami morfofunkcional′noj immaturity, that in some cases led to the development of respiratory distress syndrome.

Management of pregnancy in women with scar at the womb:

(I)term:
(a) medical-conservative) mode;
b) General recreational activities;
in the laboratory and instrumental examination);
g) treatment of concomitant ÈGZ;
d) treatment complications during gestation;
e) programming follow-up.
(II)term:
(a) medical-conservative) mode;
b) General recreational activities;
in laborotorno)-instrumental examination;

g) treatment of concomitant ÈGZ;
d) treatment complications during gestation;
e) programming follow-up.
(III)term:
(a) medical-conservative) mode;
b) General recreational activities;
in laborotorno)-instrumental examination;
g) treatment of concomitant ÈGZ;
d) treatment complications during gestation;
e) programming of prenatal hospitalization with the traditional preparation for childbirth and with the assessment test readiness indicators.

Concept and types of inappropriate regulations and presentations.

A situation in which the longitudinal axis of the fruit forms a sharp corner or right angle with the longitudinal axis of the mother in the absence of the presenting part.

Causes of the wrong position and fetus.

Excessive fetal movement: when polyhydramnios, gipotrofičnom or nedonošennom fruit, multiple pregnancy, the muscles of the anterior abdominal wall skin flabbiness multiparous. Limited mobility: Fetal malovodii, big fruit, there, you have uterine fibroids, uterine cavity strain, increased uterine tonus, threat of termination of pregnancy. Obstacle vstavleniû head: placenta previa, narrow hips, the presence of uterine fibroids in the lower segment. Abnormalities of the uterus: the uterus dvurogaâ septum, the septum. Fetal anomalies: hydrocephaly, anencephaly.

Diagnosis and incorrect presentations.

-Belly shape: oval or cross-kosooval′naâ; -low standing of seafloor of the uterus; the absence of the presenting part;
-pelvic palpation, head end in the side sections of the uterus fetal heartbeat heard;-in the navel area;-lack of the presenting part of the vaginal examination, and when izlitii amniotic fluid when you can define study vaginal shoulder, handle the umbilical cord, ribs or spine of the fruit; ULTRASOUND study).
--Prevention of constipation; It is recommended for pregnant women to lie on her side, and at the same position on the side of Kos a major part of the fruit;
-admission to 35 weeks;

Complications of pregnancy and childbirth in the wrong position and fetus fetus.

-premature birth by prenatal observing the amniotic fluid in the absence of the belt is tight, may be accompanied by Syncope: small parts (knobs, feet, hinges of the umbilical cord),
-infection of the fetus,
-running lateral position, which threatens to fetal hypoxia, when continuing cuts the uterus may at first, then pererastâženie, and uterine rupture.

Prevention activities:

-polupostel′nyj mode;
-prophylaxis of constipation;
-It is recommended to pregnant women lying on the side of the position, and when the situation on the side of Kos a major part of the fruit;
-admission to 35 weeks;
-combined fetal rotation on foot;
-the best method of delivery is by caesarean section;

Tactics of fetal pelvic presentation in redležanii..

. Pelvic presentation requires an expectant observation.
From 29-30 weeks are recommended: gymnastic exercises (pregnant lies on the right and left side perevoračivaâs′, every 10 minutes, repeat 3-4 times a day).

INCORRECT POSITION OF THE FETUS.

A situation in which the longitudinal axis of the fruit forms a sharp corner or right angle with the longitudinal axis of the mother in the absence of the presenting part.

1. Excessive fetal movement: when polyhydramnios, gipotrofičnom or nedonošennom, plural pregnancy the foetus (the second fetus), the muscles of the anterior abdominal wall skin flabbiness multiparous.
2. limited mobility of the fetus: malovodii, big fruit, there, you have uterine fibroids, uterine cavity strain, increased uterine tone under the threat of termination of pregnancy.
3. Obstacle vstavleniû head: preležanie placenta, narrow hips, the presence of uterine fibroids in the lower segment.
4. abnormalities of the uterus: the uterus dvurogaâ septum, the septum.
5. fetal Anomalies: hydrocephaly, anencephaly.

DIAGNOSTICS.

-Belly shape: oval or cross-kosooval′naâ;
-low standing of seafloor of the uterus;
-absence of the presenting part;
-pelvic palpation, head end in the side sections of the uterus;
-fetal heartbeat should be heard in the area of the navel;
-absence of the presenting part of the vaginal examination, and when izlitii amniotic fluid when you can define study vaginal shoulder, handle the umbilical cord, ribs or spine of the fruit;
-Ultrasound study.

PREGNANCY AND CHILDBIRTH.

Often when you cross the pregnancy without complications, sometimes with increased mobility is not a stable position of the fetus.
The most common complications of prematurity with prenatal observing the flow of amniotic fluid in the absence of the belt is tight. Premature rupture of water may be accompanied by Syncope: small parts (knobs, feet, hinges of the umbilical cord), infection of the fetus.
Premature rupture of waters from intensively reduction uterus, limiting the mobility of the fetus is called a running situation. Fetal hypoxia, which may face when continuing cuts the uterus may be at first, then pererastâženie, and uterine rupture.

MANAGEMENT OF PREGNANCY AND CHILDBIRTH.

-polupostel′nyj mode;
-prophylaxis of constipation;
-It is recommended to pregnant women lying on the side of the position, and when the situation on the side of Kos a major part of the fruit;
-admission to 35 weeks;
-combined fetal rotation on foot;
-the best method of delivery is by caesarean section;
-If a woman comes in the second stage of labour with a live fetus small mass motility can be saved of the combined rotation of the fetus on the foot;
-If you have an infection on the background of a long period when anhydrous live fruit shown caesarean section, the removal of the uterus, the drainage of the abdominal cavity;
-When running a transverse position of the fetus and the dead foetus is èmbriotomiâ.

BUTTOCK PRESENTATIONS.

Divided into purely buttock (pointing to the entrance of the pelvis, and legs âgodički stretched along the body) and mixed the buttock (together with âgodičkami to the door of the small pelvis turned legs of the fetus).
Maternal factors: abnormalities of the uterus, uterine tumors, narrow hips, lowering or raising the tone of womb in mnogorožavših, scar at the womb after operation.
Fruit: prematurity, multiple pregnancy, intrauterine growth, fetal abnormalities, abnormal fetal členoraspoloženie.
Placental factors: placenta previa, its location in the DNA or the angles of the uterus, malovodie or abounding in water.

DIAGNOSTICS.

Exterior obstetrical examinations (Leopold Levytskyy techniques):

-detects the first reception of a rounded, dense, ballotiruûŝej heads; the bottom of the uterus is higher than with cephalic presentation.
-second trick determines the backrest of the fruit;
-third taking over the entrance or at the entrance of the predležaŝaâ in large part determines the pelvis, soft consistency, unable to stand as candidates;
-the fourth trick is predležaŝaâ the part that most often until the end of pregnancy is not pressed to the door of the small pelvis.
The heartbeat of the fetus is being heard above the navel.
When the vaginal Vault through the forward study has major mâgkovatoj predležaŝaâ consistency of the fetus.
ULTRASOUND Diagnostics.
When fetal electrocardiography želudočkovyj complex turned downwards, not upwards, as with cephalic presentation.

PREGNANCY AND CHILDBIRTH.

Most pregnancies complicated by: threat of interruption of pregnancy with signs of cervical incompetence, incompetence of the first half of pregnancy toxemia, hypertensive disorders, anaemia, obvitiem fetal umbilical cord, malovodiem.
The genera is characterized by a large number of complications. In the first period more often early or premature rupture of water because the pelvis is not fitted firmly to distinguish descent not channel water into the front and back of each scene and tension membranes.
However, observing the flow of water could drop small pieces of fruit or umbilical cord.
There is often weakness generic activities, disclosure of the cervix occurs long pelvic end remains over the entrance of the pelvic cavity. Births become protracted because the largest part of the fruit is a head-final is born. First descent is a channel, the end of the pelvic less voluminous and cannot disclose the birth canal for more careful passing shoulder and head. Therefore, at the time of entry into the pelvis shoulder girdle may occur zaprokidyvanie pens and unbending heads that threaten fetal hypoxia and loss.
When passing through the pelvis to the upper half of the body is the squeeze of umbilical cord and the duration of that period more than 3-5 minutes, there is severe fetal hypoxia.
May vkolačivanie the buttocks of the fetus in the pelvis, which is a sign of the mother's pelvis dimensions inconsistencies of the fruit. Another serious complication – rotate the fetus back posteriorly when the Chin is fixed beneath the lobkovym Ingens, unbent head: danger of hypoxia, fetal and maternal trauma.
Breech presentation during childbirth injuries are often caused by the mother's tears: the cervix, vagina and perineum.
Often there is a transition from purely a breech position in mixed, which expands the indications for caesarean section.

MANAGEMENT OF PREGNANCY AND CHILDBIRTH.

Pelvic presentation requires an expectant observation.
From 29-30 weeks are recommended: gymnastic exercises (pregnant lies on the right and left side perevoračivaâs′, every 10 minutes for repeat 3-4 times, 3 times a day).
You can carry out the external routine rotation of the fruit.
Tactics of delivery should be determined before taking into account: Fetal weight, an extension of the head, the evaluation of the fetal heart, utero-placental and fruit-placental blood circulation, the mother's pelvis, cervical maturity.
Delivery may be:
-spontaneous vaginal delivery and the start of vaginal birth;
-rodovozbuždenie at or before the time of the birth;
-delivery by elective caesarean section as planned.
In the first stage of labour with a view to preventing premature izlitiâ amniotic fluid lying-in woman should observe bed rest, lying on its side which faces the back of the fetus. Immediately after izlitiâ amniotic fluid to vaginal examination to exclude cord prolapse loops.

The genera predležaniii, breech requires continuous monitoring of fetal heart activity and uterine contraction. What would change if options to expand the indications for caesarean section.

When the established regular birth (uterine opening Zev 3-4 cm.) shows the introduction: pain medications and remedies, the case of epidural anesthesia, which contributes to the regulation of labour; rapid disclosure of the cervix; relaxation of pelvic floor muscles in the second stage of labour. Required activities for the prevention of fetal hypoxia 2-4 ml. 1% solution sigetina, 50-100 mg, kocarboksilaza 10-20 ml of 40% glucose, oxygen inhalation moistened.

The presence of meconium for breech presentation is not a sign of hypoxia.

In the second stage of labour recommended ET introduction of uterotonic (oxytocin), and by the end of the second period to prevent acute cervical injected 1, 0ml. 0.1% solution of atropine, or 2 ml 2% solution papaverina etc.

During her powers should rest the soles of the feet, hips and hands pressed to his stomach to amplify the powers and reduce the angle of the pelvis.

Delivery in breech presentation there are 4 phases: 1. the birth of a fetus to the navel; 2. the birth of a fetus from the navel to the lower edge of the blades; 3. birth of the shoulder girdle and handles; 4. birth of the head.

Indications for caesarean section.

During pregnancy: perenašivanie, lack of birth, abnormalities of the genitals anatomically narrow hips, HVGP, fruit weight is 3600 more or less 2000, unbending, heads hem primiparae, age of the adverse outcome, previous birth, infertility in anamnesis.

During childbirth: birth anomaly, fetal hypoxia, loss of loops the cord or small pieces of fruit, unbending head.

RAZGIBATEL′NYE FETUS.

There are three degrees of extension wedges heads:

1. Perednegolovnoe previa is a leading point of big spring, the diameter of a large segment of 12 cm.
2. the place of the presentation is the leading point of the nadbrov′e, a large segment of 13 cm.
3. Facial previa is a leading point of the Chin, a large segment of 9.5 cm.

Abounding in water, abounding in water, the aborted fetus, reducing uterine tone, large fruit, narrow hips, placenta previa, uterine and fetal abnormalities (tumors, neck cord entanglement).

PEREDNEGOLOVNOE PREVIA.

DIAGNOSTICS.

For exterior obstetrical survey of higher standing of seafloor uterus, when measuring the direct head size is 12 cm. and more.

ULTRASOUND Diagnostics.

When vaginal birth study found wired dot – big spring, the sagittal suture in the plane of the entrance of the pelvis is in cross sometimes in Koos.

After the birth of a fetus in the birth of large tumor bulging Fontanelle (tower head).

TACTICS OF.

At term, nekrupnom fruit size pelvis normal childbirth and lead.

With the full opening of the conformity assessment of the fetal head size of the pelvis of the mother.

Surgical delivery is shown at: perenašivanii fruit large, narrow, pervorodâŝej, taze an old weakness generic activities.

In the second period when the weakness of labour, fetal hypoxia in the front of the pelvic cavity is shown by means of the delivery of obstetric forceps.

In posledovom and for the prevention of postpartum haemorrhage injected substances that reduce the uterus.

THE PLACE OF THE PRESENTATION.

For exterior obstetrical survey of high standing of seafloor of the uterus, the angle between the head and the back of the fetus. Heartbeat heard better from the side of the chest.
When vaginal delivery study finds the frontal part of the head, forehead seam ending palpated on the one hand with the other great perenosicej rodničkom.
After birth, fetal birth is on the forehead swelling (piramidnaâ head).
ULTRASOUND Diagnostics.

At term, at normal size pelvis deliveries are impossible, since the head is moving its biggest how generic the size with the development of clinically narrow pelvis.
If you place a previa hospitalization to determine the causes of frontal presentation and delivery tactics.
For preterm amniotic fluid izlitii cesarean section.
If a caesarean is missed, the mother was at the front of the pelvic cavity, you must exclude the risk of uterine rupture, monitor the status of the fetus, avoid prolonged standing heads in one plane, to prevent fetal hypoxia, with long period-anhydrous antibacterial therapy.
Late fetal birth, signs of hypoxia require immediate delivery, application of obstetric forceps or plodorazrušaûŝie operation even with live fruit.

TRANSVERSE FACIAL.

For exterior obstetrical survey definition of deepening between the head and the back of the fetus, the lack of convexity of the back. The heartbeat is most clearly heard from the side of the chest.
When vaginal study identifies part of a fruit facial: Chin, brow bones, nose, mouth with hard lumps of gum. The foetal position is determined by the Chin.

If you require hospitalization previa facial to determine the causes of frontal presentation and delivery tactics.
Creating a protective regime for the prevention and treatment of premature izlitiâ amniotic fluid.
When the personal presentation, at normal size and pelvic nekrupnom fruit deliveries more often end favorably. Follow labour and palpitation of the fruit.
In the first period to ensure continued as rear view front view if you have genera vaginal birth is not possible.

Indications for caesarean section: fetal hypoxia, loss of loops the cord or small parts of the fetus, the development of clinically narrow pelvis, large fruit, perenašivanie, old Primiparous, front view of personal presentation, the weakness of labour.
In the case of a secondary weakness of labour, fetal hypoxia in the front of the pelvic cavity (there is no way to extract the fetus by Cesarean section), to save the life of the pregnant woman is plodorazrušaûŝaâ surgery, even if the fetus is alive.

Lecture number 3: Headache. Vision. Epilepsy. Loss of consciousness. Increase in A / D. Hypertensive conditions during pregnancy and childbirth.

Lecture plan:

Assess the condition of a pregnant woman with hypertensive disorder;

Emergency treatment for severe preeclampsia and eclampsia;

To assess the intrauterine state of the fetus (listening to the fetal heartbeat, VDM, PVP);

Identify further tactics for managing pregnancy;

Conduct counseling on the selection of contraceptives in the postpartum period.

Theoretical part

Hypertensive state in pregnancy and childbirth.

Classification:

I. Chronic arterial hypertension (CAH) (hypertension before 20 weeks).

II. Hypertension induced by pregnancy (GiB).

• GiB without proteinuria is a landmark in diastolic blood pressure

• Ease of pre-eclampsia

• Severe pre-eclampsia

• Eclampsia

III. Chronic hypertension with preeclampsia or eclampsia layer these areas using

In the hypertensive disorders diastolic BP (DBP) is an indicator for policy-making management of pregnancy and childbirth.

• DBP shows peripheral resistance and does not vary depending on the emotional state of women

• If diastolic blood pressure of 90 mm Hg or increased in two consecutive measurements at intervals of 4 hours, then it's Hypertension!

• If hypertension develops after 20 weeks, during childbirth or within 48 hours after birth is a pregnancy-induced hypertension.

• If diastolic blood pressure 90 - 100 mm Hg 20 weeks + proteinuria and 2 (1 g / L) - Chronic hypertension with mild preeclampsia merger.

I. Speaking of the **CAG** have in mind that the diagnosis is usually carried out pregnancies, and is conducted in an outpatient setting. If necessary treatment and complications EGZ gestation in a hospital.

• The most common chronic arterial hypertension is:

- Primary (90-95%) or essential

- In other cases it represented a secondary or symptomatic hypertension.

• If there is insufficient data to differentiate between CAH and flexible, then the following criteria for CAH:

- Hypertension occurs before 20 weeks of pregnancy

- Hypertension persists for more than 6 weeks after birth in the absence of treatment

- Recurrent hypertension in every pregnancy should be considered as chronic hypertension.

Error diagnostics. About 40% of pregnant women suffering from hypertension.There is a significant reduction in blood pressure in early pregnancy to increase it in the third trimester, so it is likely setting misdiagnosis of hypertension of pregnancy, and in the presence of proteinuria and minimalnoyf diagnosis of preeclampsia.

Pregnant women with CAH is VOPom on an outpatient basis:

• Encourage extra rest

• Lower blood pressure reduces renal and placental perfusion. BP should be reduced nenizhe level available to the women before pregnancy.

• If a woman taking antihypertensive medications before pregnancy, continue!

• If diastolic blood pressure 110 mm Hg and more and SBP 160 and assign more antihypertensive medications

• If proteinuria is detected, it is joined preeclampsia, and lead, depending on the degree of pre-eclampsia.

• Monitor growth and fetal

• If no complications - in time rodorazreshite

• If \ b fetus <100 or> 180 bpm. per minute - disstres fruit!

• If severe IUGR fetus showed an early delivery

• Determination of gestational age in late pregnancy by ultrasound is notfull-time!

II. **Hypertension induced by pregnancy**. (GiB) is considered high blood pressure after 20 weeks (except for hydatidiform mole).Increased blood pressure during pregnancy is considered to be an adaptive response of the body that occurs in response to inadequate perfusion of different parts of the vascular bed of pregnant and vital organs.

SPM is a weekly observation on an outpatient basis, measurements of blood pressure and proteinuria in the urine study.

The criterion of hypertension during pregnancy:

- Increase in diastolic blood pressure above 90 mm Hg
- Increase in systolic blood pressure above 140 mm Hg
- The true increase in blood pressure can be seen at the base of at least 2-fold pressure for 4 hours.

Factors "at risk" for development GiB

1. Pregnancy
2. Signs point to the lack of an increase in intravascular volume (hypovolemia possible)
3. The absence of a physiological reduction in diastolic blood pressure in the second trimester of pregnancy
4. Increased systolic blood pressure by 30 mmHg from baseline, but did not reach 140 mm Hg (conventional)
5. Increase in diastolic blood pressure by 15 mmHg from baseline, but does not reach 90 mm Hg
6. Intrauterine growth restriction.

II.A. Hypertension without proteinuria, hypertension pregnancy (gestational hypertension)

Pathophysiology

High blood pressure, first noted in the second half of pregnancy, is a response to increased peripheral resistance of blood vessels.Such a reaction is usually an adaptive response aimed at maintaining adequate blood perfusion of vital organs and parts (brain, liver, kidneys, etc.), as a pregnant woman and fetus.

It is obvious that lowering blood pressure with antihypertensive drugs may lead to violation of these divisions and perfusion, including the further deterioration of the fetus.

Of pregnant women with GiB an outpatient basis.

During the initial identification of hypertensive disorders of GPs collects history, during the hearing of complaints reveals any signs of eating disorders of cerebral circulation, examines urine to determine proteinuria.

GP confirming the diagnosis GiB conducts a conversation with the pregnant woman and her relatives about possible complications. Recommends measuring blood pressure 2 times a day and write a weekly examination of urine for proteinuria.GP explains the prognosis of patients with GiB subject of work and rest, good nutrition, and compliance while reducing physical and mental stress is good.But with the progression of hypertensive disorders in the home and occurrences of headaches, nausea, vomiting, blurred vision, pain in the epigastrium - call an ambulance or go to the hospital Blajan.

Prevention:

1. Restricting food intake kallarozha, fluid and salt does not prevent the progression of hypertensive disorders and may be harmful to the fetus.
2. Not shown a positive effect of aspirin, calcium and other medications to prevent hypertensive disorders
3. Identifying women at risk and provide them with timely assistance is an important factor in the treatment and prevention of seizures GiB. Women included in this group are under control and must clearly explain when and under what circumstances should seek medical attention.Education relatives is an important factor in identifying the progression of GiB and timely admission to hospital.

Events organized at the antenatal clinic:

1. measurement of blood pressure, urine (proteinuria) and fetal once a week;
2. in cases of elevated BP as being in the mild pre-eclampsia;
3. If signs of lagging behind the growth of the fetus or impairment of urgent hospitalization to assist or premature delivery;

4. mandatory counseling for women and families about danger signs severe pre-eclampsia and eclampsia;
5. if all the indicators the study showed no pathological changes in delivery vaginally.

III.B. Arterial hypertension with proteinuria, preeclampsia

Pathophysiology

Kompesatorno-adaptive reaction of the body to improve perfusion of the pregnant vital organs and the fetus. This is an adaptation that accompanies the hypertensive:

• Generalized vasospasm, leading to increased peripheral vascular resistance and consequent reduction in perfusion of vital organs (brain, liver, kidney, placenta), which in turn leads to a decrease in:

- Placental perfusion and may lead to growth retardation and fetal
is a major cause of perinatal morbidity and
mortality. Reduced uteroplacental blood flow by 50-60%
occurs 3-4 weeks before the hypertension becomes
apparent.

- Decreased renal blood flow and glomerular filtration rate is the reason:

1. Glomeruli and hypoxia, as a consequence - proteinuria, water retention and edema development
2. Increase in plasma Occupational uric acid, creatinine and urea (in severe cases).
3. Gemokontsetratsiya as a result of increased vascular permeability with a decrease in intravascular fluid (hypovolemia) and signs of extravascular growth.

• Damage to the vascular endothelium (due to peroxidation products as a result of reaction to a fruit tissue) is:

- Stimulation of the coagulation mechanisms, reflected in increased platelet aggregation.
- Violation of production and decay of prostacyclin / thromboxane - prostaglandins having opposite effects on vascular tone and platelet aggregation.

Pre-eclampsia - a hypertension + proteinuria in the second half of pregnancy.On the recommendation of WHO pre-eclampsia is divided into two forms:

By gravity:
• Light
• severe

For gestational age:
• full-term (> or = 36 weeks gestation)
• prematurity (<36 weeks gestation)

III. **Light pre-eclampsia** - a double-marked rise in diastolic blood pressure above 90 mm Hg to 110 mm Hg within 4 hours after 20 weeks of gestation with proteinuria over 0.3 g/l to 1 g/l

Management of mild preeklapsii

If <37 weeks - if the symptoms are not modified or normal state, the woman is observed twice a week on an outpatient basis:

• Pregnant measure blood pressure twice a day and takes her record;
• GP watches twice a week, or by treatment (blood pressure checks, urine for proteinuria, reflexes and fetal);
• Mandatory counseling for women and families about danger signs severe pre-eclampsia and eclampsia;
• Encourage extra rest a pregnant woman;
• encourage compliance with a balanced diet;
• reducing physical and mental stress;
• If the outpatient surveillance woman can not, send her to the hospital;

• When gestation 34 weeks and fetal weight less than 2000 g to prevent the SDR in the newborn. For the prevention of the SDR in the newborn using glucocorticoids (deksazon, dexamethasone) on one of the schemes:

- At 6 mg / m or / in 6 hours. Only 4 injections.

* Prophylaxis will be effective from the date when the first injection before delivery will take place not less than 48 hours.

* The time within which the effectiveness of prevention of the SDR is not more than 7 days.

If 37 weeks

Assessment of maturity of the cervix and delivery planning.

• cervix may mature autopsy of membranes in the absence of progression of labor within a few hours, you can apply the induction of labor or prostaglandins oksitatsinom

• immature cervix may prepare, using prostaglandins or a Foley catheter, with no effect rozhovozbuzhdenie for several days, as far as the woman and the fetus, or to schedule a cesarean section.

Rehabilitation after childbirth:

- Medical check-up in a family clinic in conjunction with experts in various fields for the timely recovery outside of pregnancy and subsequent pregnancy planning;
- Selection of contraceptive methods with their contra-indications.

4.2. An analytical part

Situational problem №1

To GP 4.03.2011 pregnant woman D has addressed. 26 years with complaints to periodic increase the AP in a current of week, hyperactivity of a fruit, work capacity decrease, fast fatigue. According to the pregnant woman these complaints disturb only during this pregnancy. In a current of week has appeared frequent шевеление a fruit. Increase the AP took place from 130/90 to 150/100 mm.hg. Hypertensive preparations did not accept. To the doctor did not address. Works as the bookkeeper at factory. Bad habits: smokes. From the transferred diseases: since 20 years. 2 foreign pyelonephritis.

The obstetrics anamnesis: In total pregnancy - 2, from them urgent childbirth - 1, last normal mensis - 2.07.2010

Status: D condition satisfactory, the AP 130/80 140/90 мм.рт.ст., pulse of 82 blows in minute

Akushersky survey:. A uterus bottom between a navel and sternum a shoot, out of a tone, II position, a forward kind, head prelying. height of a bottom of a uterus – 28 sm, stomach circle – 82 sm, fruit palpitation are listened on the right below a navel, 146 blows in minute

The additional information to a situational problem

The indicators received in a pre-medical office		
1	Growth	*162м*
2	Weight	*74*
3	IMW	
4	Stomach circle	*82*
5	HBU	*28*
6	Body temperature	*36,5*
7	AP	*130/80; 140/90*
8	Pulse	*82*

Data spent общеклинических inspections

№	Researches	Результат
1.	*The general analysis of blood*	Haemoglobin - 112 г/л; Er-3.8-4h10*12/l; Leukocytes - 4,7h10*9/l - - *basofill - (-);-monotsity - 4 %;* SDE-10 mm/hour
2.	*The general analysis of urine*	antity - *150 ml;*

		Colour - *light yellow;* Relative density of urine - *1015* The Transparency - *transparent;* Reaction - *sour;* Fiber - *traces;* Bilious pigments - *negative;* □□ - *1-2-3 in sight;* *Leukocytes - 1-2 in sight.*

Data of the spent biochemical inspections

№	researches	result
1.	***Blood glucose***	3,90-5,80 mmol/l
2.	*kreatinin*	Жен. 44-80 mk mol/l
3.	*Urea*	1,7-8,3 mk mol/l

Data of the spent tool inspections

1.	ELECTROCARDIOGRAM	sinus a rhythm, HP 82 . In a minute, moderated hypertofic sinister ventricula . (An electrocardiogram a tape)
2.	Eye bottom	Narrowing of arteries and arteriols, a moderate thickening of their walls; pressure veins of arteriols, tortuosity and expansion of veins (the student should define a stage). Changes correspond to the second stage hypertensive angiopati.es
3.	Uterus ultrasonic	On ultrasonica fruit one, head prelying the size of a head-82 of mm, length of a hip-60 of mm, a placenta on back walls, II degree of a maturity, thickness of 52 mm petrificats, individual cists, amniotic waters in enough, normal.
4.	Uterus ultrasonic	At research the right kidney 118x74мм, 114x68, the usual form, 16 mm, both kidneys it is condensed, excursion normal.

The definitive diagnosis

The basic: *Pregnancy II, 31-32 weeks. HPI. FPD.. (A category 1).* **Accompanying:** *IUT not complicated pyelonephritis (a category 1) (the student should prove the exposed definitive diagnosis).*

Not medicamentous treatment:

□ Auto-training (elimination of negative psychoemotional and psychosocial stressful situations);

□ Dietetic therapy (strict conformity of power value of a diet to organism power inputs, at accompanying adiposity - restriction of daily caloric content; an exception of the products raising mean and heart - strong meat and fish broths, strong tea, coffee; the products causing strengthened, intestines swelling - beans, the peas, the aerated drinks; restriction of table salt to 5-6 gr/sut, sharp dishes, seasonings and the products containing animal fats; enrichment of a diet by the products containing magnesium and kalii; inclusion in a diet of fresh fish);

□ Struggle with hypodinamics (to apply regular admissible dynamic physical activities);

□ Rational psychotherapy;

□ Herbal medicine (corn рыльце, a half-floor);

□ The Mode of work and rest 8 hour dream;

□ Training of the patient to skills of measurement the AP; calculation ЧСС and pulse; to self-help rendering at sudden increase the AP.

Informed the pregnant woman on medicamentous methods of treatment HPI:

 Now for treatment HPI during pregnancy do not apply antihyprtensive preparations and diuretics.

The following periodicity of surveys is recommended: *the weekly control*
Full clinical inspection includes:

Survey GP;

- The AP, urine on protein uri 2 times week, a fruit condition weekly!
- If there is protein uri, a conducting as at easy preeclamcia
- Under indications survey by the neuropathologist, the oculist, the urologist;
- Measurement of growth, weights of a body, SC, HBU, BIW;
- Gravidogramma;
- Auscultation of palpitation of a fruit;
- KTG and ultrasonic if necessary and under indications;
- At revealing of a fruit or deterioration of a condition of a fruit - urgent hospitalisation in a hospital for preschedule delivery
- To Consult the pregnant woman and her family concerning dangerous signs preeclamcia and eclampcia
- If the condition of the pregnant woman remains stable carrying out of normal sorts and podelivery is shown in time.

The basic medical-improving actions at prophylactic medical examination of patients with a hypertensia the induced pregnancy are:

 Training to skills of a healthy way of life;
 Restriction in food of table salt and the sated fats;
 Psychotherapy;
 Positive influence of aspirin, calcium and other preparations for treatment HPI is not proved
 Family Training, social support

Situational problem №2

In VDP on reception to GP 4.01.2011 years the pregnant woman of M. of 30 years with complaints to periodic increase the AP in a current of the several years, the raised impellent activity of a fruit, work capacity decrease, fast fatigue has addressed. According to the pregnant woman these complaints disturbed to pregnancy and were aggravated during pregnancy. In a current of week has appeared "rough" шевеление a fruit. Increase the AP took place from 130/90 to 150/100 mm.hg. Hupotensive preparations accepted off and on. During pregnancy did not accept. To I will hand over never addressed. Works as the teacher at school. Bad habits: likes to eat well.

The ostetrics anamnesis: In total beremennostej-3; delivery-1; abortion-1; Last menstruatsija-02.06.2010

Objectively: the general condition of the patient at the moment of survey rather satisfactory, is marked гиперемия persons, heart borders are expanded to the left, the AP 130/80; 140/90 mm.hg., pulse 86 in minute.

Akushersky survey: the uterus Bottom on 2 cross-section fingers above a navel, II position, a forward kind, head prelying, out of a tone, height of a bottom of a uterus – 26 sm, stomach circle – 76 sm, fruit palpitation is listened on the right below a navel, 136 blows in a minute.

The additional information to a situational problem

The indicators received in a pre-medical office		
1	Growth	*154см*
2	Weight	*77кг*
3	BWI	

4	Stomach circle	*76*
5	HBU	*26*
6	Body temperature	*36,5*
7	AP	*130/80; 140/90*
8	Pulse	*86*

Data spent labarotor inspections	
	Indicators of the patient
The general analysis of blood	Hemoglobin - 112 г/л; Er -3.8h10*12/l; Leukocytes - 4,7h10*9/l - eozinofils - 2 %; - basofils - (-); -monotsity - 3 % -limfotsity-12 %; SUE -10 mm/hour.
The general analysis of urine	Quantity - *150 ml;* Colour - *light yellow;* Relative density of urine - *1015* The Transparency - *transparent;* Reaction - *sour;* Fiber - traces*;* Bilious pigments - *negative;* Эпителий-*1 2-3 in sight;* • *Leukocytes - 1-2 in sight.*

Data of the spent tool inspections

4	ELECTROCARDIOGRAM	sinus rhythm, 86 In minute, signs SVG.
5	Eye bottom	Narrowing of arteries and артериол, a moderate thickening of their walls; pressure veins arteriols, tortuosity and expansion of veins (the student should define a stage).
6	ULTRASONIC	On ultrasonics 1 fruit, in head prelying. BPR-74мм, a placenta on a back wall of 3 degrees of a maturity, a thickness of 40 mm, отечная. amniotic waters in moderate quantity.

The definitive diagnosis

The basic: Pregnancy III, 29-30 weeks. ХАГ. ФПН. ОАА. (A category 1). **Accompanying:** Adiposity of 1 degree (a category 1) (the student should prove the exposed definitive diagnosis).

Not medicamentous treatment:

 Auto-training (elimination of negative psychoemotional and psychosocial stressful situations);

 Dietetic therapy (strict conformity of power value of a diet to organism power inputs, at accompanying adiposity - restriction of daily caloric content; an exception of the products raising mean and heart - strong meat and fish broths, strong tea, coffee; the products causing strengthened e, intestines swelling - beans, the peas, the aerated drinks; restriction of table salt to 5-6 gr/sut, sharp dishes, seasonings and the products containing animal fats; enrichment of a diet by the products containing magnesium and калий; inclusion in a diet of fresh fish);

 Struggle with гиподинамией (to apply regular admissible dynamic physical activities);

 Rational psychotherapy;

 Herbal medicine;
 A work and rest Mode;

Training of the patient to skills of measurement the AP; calculation heart and pulse; to reception rules hypotensivex preparations; to self-help rendering at sudden increase the AP.

Informed the pregnant woman on medicamentous methods of treatment ХАГ at pregnancy:

Now to treatment НАГГ during pregnancy apply АК, metildopa, ББ.

It Atenalol on 0,25 2 times constantly, at an inefficiency with the subsequent selection of an individual dose of a preparation or nifedipine of 20 mg (коринфар 10 mg) 4 times in day under the control the AP.

Group диспансерного supervision *(group D III):*

Since the moment of detection raised the APL, and also from an establishment of diagnosis GD of the patient should be under regular supervision. Frequency of surveys is defined by size the APL, a therapy kind, speed of approach of therapeutic effect, character of developing by-effects at medicamentous treatment.

The following periodicity of surveys is recommended:

1. HAG at pregnancy demands survey GP, each 2 weeks when carry out the control of efficiency of treatment,protein uri, the eye bottom looks round.
2. Watch signs fetoplacentar status, status a fruit.
3. Spend labaroror and obstetrics surveys of pregnant women with performance listed above laboratory researches. Treatment should be continuous, even during the periods of improvement of a condition.

Full clinical inspection includes:

- Survey GP;
- Under indications survey by the neuropathologist, the oculist, the urologist;
- Measurement of growth, weights of a body;
- AN ELECTROCARDIOGRAM.
- gravidogramma;
- Auscultation of palpitation of a fruit;
- КТГ and ultrasonic if necessary and under indications;

The basic medical-improving actions at prophylactic medical examination sick of hypertensive illness are:

- Training to skills of a healthy way of life;
- Elimination of risk factors ishcemi and AG;
- Restriction in food of table salt and the sated fats;
- Psychotherapy;
- Continuation medicamentous гипотензивной therapies at AG II and III stages in individually picked up mode;

Improvement in sanatorium-dispensary

Situational problem №3 Independent work with application of data of demonstrative medicine PFT

Speciality, scope: GP therapy, obstetrics-gynecology, anesthesiology

Theme: « **Hypertensive state in pregnancy and childbirth.** »

Problem: the Choice of tactics of conducting, diagnostics and rendering of the urgent help at гипертензивных infringements during pregnancy and sorts in the conditions of VDP and CDP.

Summary of a clinical case

In VDP on reception pregnant woman D has come. 27 years with complaints to a headache, pains in эпигастрии, two-multiple vomiting since yesterday. In a current of week there were hypostases on all body and began to raise the AP to 140/90 mm hg. Treatment did not receive. No bad habits has. The housewife.

The obstetrics anamnesis: Pregnancy of the third, 36-37 weeks. 2 sorts without complications.
Objectively: the general condition of the pregnant woman at the moment of survey heavy, is marked гиперемия persons, генерализованные hypostases. The AP 160/110; 170/110 mm hg, pulse 92 in the minute, strained.
Akushersky survey: the Uterus in normal, a uterus bottom on 2 cross-section fingers more low мечевидного a shoot, I position, a forward kind, head prelying, out of a tone, height of a bottom of a uterus – 33 sm, stomach circle – 86 sm,, fruit palpitation is listened at the left below a navel of 140 blows in a minute, muffled, rhythmical.
Aim to define methods of diagnostics, inspection and tactics of conducting and at гипертензивных infringements during pregnancy and sorts at level of a primary link
Problems:
• To Learn to diagnose and be able to carry out monitoring at гипертензивных infringements;
• To List diagnostics methods, to make and prove the inspection plan at level VDP and CDP.
• To Generate skills of rendering of the urgent help in a primary link at heavy преэклампсии and эклампсии;
• Will learn to criteria of differential diagnostics and interpretation of the basic functional methods of researches at pregnancy with гипертензивным a syndrome;
• To Define degree of necessity of the subsequent supervision (medicamentous and not medicamentous treatment)
• To Develop skills on postnatal rehabilitation of women having гипертензивные infringements, including contraception methods.
Trigger questions
• Make definition HPI, HAG, easy and heavy преэклампсии, эклампсии;
• What to enter to criteria of an arterial hypertensia during pregnancy;
• What changes occur at a fruit at heavy преэклампсии;
• What additional researches are necessary in the given situation in the conditions of VDP, CDP?
• Kinds противосудорожных preparations and антигипертензивных means
Whether • It is necessary rendering of the emergency help and hospitalisation, if yes, in what hospital of a profile?
Communications with other sections of a course
• Anatomy and physiology
• Therapy
• Obstetrics and gynecology
• Urgent conditions
Lecture No. 4: High temperature of the postpartum.

Lecture plan:

1. Complications of reproductive function in women who have had septic postpartum diseases;

2 Criteria for diagnosis and differential diagnosis of septic postpartum diseases;

3 Develop tactics for managing women at risk for septic diseases;

4 Develop criteria for post-treatment treatment of women who have fever after childbirth;

5 Influence on newborn and lactation of drugs used in the treatment of septic postpartum diseases.

In the postpartum department, a young mother is under supervision of midwives. Every day during circumvention, the doctor determines the rate of contraction of the uterus, the nature of postpartum excreta, examines the mammary glands. If there are stitches on the perineum (after ruptures, episiotomy) or on the anterior abdominal wall (after cesarean section operation), the puerpera is invited once a day to the treatment room to process the sutures. And of course, every morning of the postpartum department begins with body temperature measurement.

Body temperature is a very important criterion by which doctors can judge the general condition of a young mother and restore her body after giving birth. With the development of any complication of the postpartum period, the temperature almost always increases. And most often the rise in temperature is the first sign of a beginning complication. By the nature of the rise in temperature, the figures and the time of its appearance, physicians can quickly establish and then eliminate the cause of the disease

Microflora in postpartum diseases is diverse, but the most common are staphylococci, colibacillus bacteria, enterococci.

Predisposing factors of development of purulent-septic diseases of the postpartum period are:

• Presence in the anamnesis of extragenital diseases (cardiovascular system, gastrointestinal tract, urinary tract), viral-respiratory, endocrine diseases.

• Asymptomatic bacteriuria

• Chronic inflammatory diseases of the pelvic organs, trichomoniasis, chlamydial colpitis.

• Invasive methods of fetal examination

• Pathological delivery:

-a long anhydrous gap.

extended labor

-sounds complicated by surgical interventions (perineal incision, manual separation and discharge after discharge, application of obstetric forceps, caesarean section, etc.)

• pathological blood loss

• high frequency of vaginal tests in childbirth.

Rapid primary evaluation at high temperature after delivery (temperature 38 ° C and above, with all the diagnoses listed below)

Ask:

• Does the woman have weakness or drowsiness

• Frequent painful urination.

Check:

• Is the woman unconscious

• Temperature 38 ° C or higher, PS, АД

• Rigidity of neck muscles

• Lungs: shallow breathing

• Abdomen: severe soreness

• Vulva: purulent discharge

• Mammary glands: tenderness

Stabilize the woman's condition:

• Assign Ampicillin 2g IV every 6 hours plus Gentamicin 5 mg / kg of weight in / in

every 24 hours PLUS Metronidazole 500 mg IV every 8 hours

• Urgently transfer the woman to a medical institution of a higher level.

• Begin intravenous fluid injection into two veins if possible using a needle or large diameter catheter.

• Quickly enter Ringer's lactate or saline at a rate of 1 liter for 15-20 minutes. You must enter 2 liters of fluid within the first hour.

In the presence of signs of shock:

• Lay the woman on one side so that the airways remain open. If a woman does not breathe, start recovery measures;

• Make sure the woman is breathing. • Cover the woman with a blanket to keep it warm;

• Before and during transport of a woman, lift her legs, by lifting

the foot end of the bed;

• Continue to monitor vital functions (blood pressure, pulse, BH) and

body temperature every 15 minutes.

• Overestimate the response of a woman to IV fluid after 30 minutes for signs of improvement: a stabilizing pulse (90 beats / min or less), an increased systolic blood pressure (100 mmHg or more), a decrease in confusion or anxiety , increasing urine production (30 ml / hour or more).

• If the woman's condition improves, reduce the IV infusion rate to 1 L for 6 hours.

• Continue to look for the underlying cause of the shock.

• If the woman's condition does not improve, adjust the IV infusion rate to 1 L for 6 hours, continue to give oxygen 6-8 L / min, monitor the vital signs of the body and urine production, if possible, conduct additional laboratory tests.

• Complete the necessary medical history, perform physical examinations and

determine the cause of the shock, if it is still unknown

According to the scale of the developed pathological spasmodic period, it is customary to divide into local (local), that is, limited to one organ or anatomical region,

and generalized - exciting the whole body.

Local complications include postpartum ulcers, metroendometritis, parametritis, salpingoophoritis, pelveoperitonitis, mastitis and thrombophlebitis. Symptomatic of any of the listed diseases combines a rise in temperature with the characteristic signs of inflammation of a certain organ,

A postpartum ulcer is a purulent-inflammatory process in the area of the wound that formed during labor. An ulcer can form when the infection hits the crack, rupture, the area of the suture on the perineum, the wall of the vagina or the cervix. The temperature rises to a low-grade figure (37-38 ° C) approximately two weeks after delivery. In addition to fever, a young mother is concerned about the pain and burning sensation in the area of sexual organs. At the site of damage, purulent deposits are formed, the tissues around look red and swollen. In this case, a doctor should be consulted. Treatment includes antibiotic therapy, bed rest, wound healing therapy

Metritis is an inflammation of the uterus. Occurs 1-5 days after birth.

Pathogenesis: infection of the remains of the fetal egg, which are putrefied with subsequent penetration into the bloodstream of pathogenic bacteria and their toxins, which manifests itself as symptoms of intoxication.

Clinical symptoms: fever 38-40 ° C, chills, pain in the lower abdomen, purulent, foul-smelling discharge.

Criteria for diagnosis: when examined, the general condition of the puerperium is of medium severity or severe. Body temperature 38-40 ° C, pulsed tachycardia. When palpating the abdomen, the sub-involution of the uterus is determined, its tenderness along the ribs. When examined in mirrors: in the vagina, on the cervix of the uterus, stagnation phenomena, echorotic lochia are expressed. Bimanual examination reveals a slowing of the closure of the cervical canal, a painful excursion of the cervix, a slowing of the involution of the uterus, a soreness in the study. In the general analysis of the blood, leukocytosis with neutrophilia is expressed, toxic granulocytic leukocytes, acceleration of the ESR. For early and accurate diagnosis, ultrasound of the uterus is used, which allows you to determine the degree of its involution, the presence of the remains of the fetal egg.

Tactics of GP: hospitalization of the puerpera in the gynecological ward of the hospital. Delayed or inadequate treatment of metritis can lead to pelvic abscess, peritonitis, septic shock,

deep vein thrombosis, pulmonary embolism, chronic pelvic infection with persistent pain in the pelvis and dyspareunia, tubal obstruction and infertility

Metroendometritis is an inflammation of the inner surface of the uterus. Occurs when Hematometra (cluster in the uterus of postpartum bleeding), pyometra (suppuration detained in the uterine cavity clot), with a delay in uterine cavity segments placenta or shell in contact with an infection in the uterus ascending path (vaginal), with exacerbation of the chronic endometritis . The temperature rises to febrile (38-39 ° C) digits on the 3rd-4th day after delivery, and the fever is accompanied by chills. The appetite decreases, sleep is disturbed. The uterus does not contract, it is painful during medical examination. The character, smell and color of postpartum discharges changes: they become fetid, turbid, and the total number of daily discharges may increase. The amount of excreta can also decrease, because their outflow from the uterus is disturbed. This is the case with spasm of cervical musculature. Treatment is carried out in a hospital. The patient is recommended bed rest, antibiotics, vitamin-therapy, drugs that stimulate uterine contraction. If necessary, the lining of the uterus is performed - removal of pathological excretions, clots, introduction of antiseptic fluid.

Parametritis is inflammation of the fat surrounding the uterus. Usually occurs on the one hand, rarely bilateral. Most often, the infection penetrates the parameters through ruptures of the cervix and vagina. The temperature rises on the 10th-12th day after birth until the febrile and high figures (38-4GS), accompanied by a strong chill. The young mother is concerned about the pains in the lower abdomen, sometimes - the violation and painful urination and defecation. On the site of inflammation, an abscess may form. Treatment stationary, similar to conservative therapy in metroendometritis. If necessary, surgical dissection of the abscess is performed.

Pelvoeperitonitis is an inflammation of the peritoneum of the small pelvis. The temperature rises on the 15-25th day after giving birth to febrile, high and even excessive (up to 42 ° C) figures, accompanied by a severe chill. Simultaneously with a fever there are sharp pains in the bottom of a stomach, a nausea, vomiting, significant deterioration of the general or common status. If this complication is suspected, it is urgent to call an "ambulance" for immediate hospitalization. Treatment includes strict bed rest, antibiotics, vitamins, immunostimulating drugs.

Thrombophlebitis - inflammation of the vein wall followed by the formation of a thrombus, which narrows the vein lumen, making it difficult or disturbing the blood flow. Thrombophlebitis of the uterine veins usually occurs against the background of metroendometritis; can spread to the veins of the pelvis and legs. Less often it develops as an exacerbation of chronic thrombophlebitis. The temperature rises in the 2-3 weeks after delivery, often accompanied by chills, reaches high figures and can last 2-3 weeks. In the course of the vessel, soreness and redness are observed, with clotting of the blood vessel with a thrombus there is swelling of the leg. When thrombophlebitis occurs, hospitalization is necessary in the department of vascular surgery, where the young mother will be prescribed anticoagulant (which prevents excessive coagulation of blood) and anti-inflammatory therapy.

Lactostasis, characterized by stagnation of milk in the mammary gland. Occurs in the background of skipping one or more regular feeding, uneven dissolution of the breast, blockage of one or several of the milk ducts, preceding a general supercooling (in draft) or overheating (in a bath, on the beach). The temperature can rise within the febrile condition (up to 39 ° C.) Other complaints are pain and a feeling of overflow in one of the lobules of the breast, the general condition of the young mother usually does not suffer.The temperature decreases immediately after a full emptying of the breast, ie in this case It is important to continue feeding the baby on demand with this breast.If there are no adequate measures, lactostasis can go to mastitis.

Tactics of reference:

1. If a woman is breastfeeding and the baby is not able to suck, persuade a woman to squeeze milk with her hand or breast pump.

2. A woman is breastfeeding and the baby is capable of sucking:

• Encourage a woman to feed more often by putting the baby to both breasts at each feeding.

• Show the woman how to hold the baby and help her put it to her chest. Explain the holding of relaxing activities prior to feeding:

• apply a warm compress to the mammary glands immediately before feeding or take a warm shower

• Massage the woman's back and neck

• express a little milk by hand before feeding and wet the area around the nipples to help the child to stick to the mother's nipple correctly and without difficulty

Relaxing activities after feeding:

• support the chest with a bandage or a bra

• apply a cold compress to the mammary glands between feedings to reduce swelling and pain

Assign paracetamol 500 mg orally if necessary.

If breastfeeding is absent:

• Avoid massage and applying heat to your chest

• avoid nipple stimulation

• Give paracetamol 500 mg orally if necessary.

Mastitis, an inflammation of the mammary gland tissue. Staphylococci, streptococci, E. coli, sometimes Proteus Pseudomonas aeruginosa, anaerobic flora, fungi can be a cause of the disease. Tuberculosis and syphilitic mastitis are also possible.

Classification:

• the nature of the flow distinguish between acute and chronic mastitis

• by the nature of the inflammatory process - serous, acute infiltrative and destructive (abscessing, phlegmonous, gangrenous) mastitis.

. The entrance gates are usually cracks on the nipples, less often the microbes enter the milk ducts with blood or lymph flow from other foci of infection. The disease begins with a sharp temperature jump to 39 ° C and higher with chills. There is pain in the mammary gland, general malaise, headache. The breast is enlarged, reddening of the skin over the inflamed thickened part of the gland can occur. There is a lactostasis - a blockage of the milk ducts with a violation of the outflow of milk. When trying to express from the excretory ducts on the nipple, droplets of pus can be released. If you have these symptoms, you should immediately contact your doctor. When mastitis is carried out conservative (antibiotic therapy) and, if necessary (with purulent mastitis), surgical treatment.

Tactics of GP: refer for consultation to a surgeon. Persuade the woman to continue breastfeeding, support the breast with a bra, apply a cold compress to the chest to reduce pain and swelling for three days, also administer paracetamol 500 mg orally if necessary

Abscess of the mammary gland is a limited inflammatory process.

Clinical picture, diagnosis: increasing chills, body temperature is constantly high or hectic, sharp tenderness and increase in the affected breast, erythema is expressed, the subcutaneous venous network is enlarged. On examination: regional lymphadenitis, fluctuating swelling in the chest, possible outflow of pus.

Tactics of GP: hospitalization in the surgical department of the hospital.

Thrombosis of deep veins - thrombophlebitis of the veins of the uterus, pelvis and femoral veins. It develops more often in the second and third week after childbirth, is associated with a high risk of pulmonary embolism.

Risk factors: age over 40 years, more than five births in the anamnesis, varicose veins, anemia, thromboembolism or trauma (with endothelial integrity disorder) in history, nephrotic syndrome. operative delivery (caesarean section, obstetric forceps), venous congestion (prolonged pastel regimen), severe preeclampsia (decrease in the level of antithrombin 111)

Clinic. The patient complains of pain in the gastrocnemius muscle, an increase in the size of the limb, a change in the color of the affected limb, an increase in temperature, a malaise in the course of the affected vein, a local increase in temperature. There may be a lesion of both limbs. When gynecological examination, it is necessary to assess the condition of stitches on the perineum and in the vagina, the discharge from the cervical canal, the formation of the cervical canal. With thrombophlebitis of the uterine veins in the second week after delivery, the inner pharynx is slightly open, the uterus is enlarged, painful along the ribs, thrombosed veins are palpated in the form of convoluted cords or a sensitive infiltrate with edema.

Tactics of GP: urgent hospitalization in the surgical department of the hospital. Prevention: all women with varicose veins are recommended to wear elastic tights, regular bandaging of the affected limbs.

Acute pyelonephritis is an acute infection of the upper parts of the urinary system, mainly of the renal pelvis, which can also affect the renal parenchyma

Clinical signs: high fever, chills, dysuric disorders, increased frequency and urge to urinate, abdominal pain, lumbar pain, pain over or above the pubis, lack of appetite, nausea, vomiting.

Examination: when examined - a positive symptom of effleurage; in the general analysis of blood - anemia, leukocytosis with a shift to the left, accelerated ESR; in the general analysis of urine-leukocyturia, bacteriuria (more than 105 bacteria in 1 ml of urine), proteinuria (usually less than 1 g / l); in the analysis of urine according to Nechiporenko-leucocyturia over 25-103

; sow urine on the flora with the definition of susceptibility to antibiotics; Ultrasonography of the kidneys is an expansion of the bowl-and-pelvis system.

Tactics of GP: hospitalization in the department of therapy / nephrology / urology. The effectiveness of postpartum disease therapy should be assessed not only on the basis of whether the patient's life has been saved or not, but also to a large extent the patient's condition, absence of disability, complications and chronic diseases in the future

Post-stationary rehabilitation of patients after postpartum infectious diseases is a complex of therapeutic and prophylactic measures aimed at restoring health, the functions of all the systems of the organism that are disturbed due to the disease.

All women who have suffered postnatal purulent-septic diseases need to clarify the importance of hygiene measures, rational nutrition and rest at home.

To reduce adhesions, pain syndrome patients who have undergone metritis, peritonitis use physiotherapy treatment: electrophoresis, ultrasound for a course of 6-12 procedures. With metritis, physiotherapy is started 2 days after the temperature normalization, with peritonitis on the 10th -12th day after relaparotomy, extraction of drains and healing of the sutures.

With prolonged and severe course of the disease, treatment is prescribed at a later date.

Patients who underwent peritonitis after cesarean section require observation up to 1 year.

Spa treatment, including hydrogen sulfide, narzannye, radon baths and mud treatment, can be applied not earlier than in 2 years.

Patients who have suffered thrombophlebitis in the postpartum period need constant monitoring. In the presence of the phenomena of postthrombotic syndrome (persistent pain and swelling of the affected leg), treatment with a surgeon - phlebologist is recommended.

Generalized forms of postpartum complications include peritonitis (inflammation of the peritoneum in the entire abdominal cavity) and sepsis (a condition in which microbes multiply in the blood and spread throughout the body, and their toxins - poisons - cause common poisoning). These diseases are a consequence of non-treated local postpartum complications. The condition of a woman with any of these complications is extremely difficult, the consciousness may be disturbed. The temperature is kept within 39-42 ° C, accompanied by chills and pouring sweat. Treatment stationary, complex (conservative and surgical). These complications are life threatening.

Elevated temperature - not always inflammation

Not always an increase in body temperature indicates the development of the disease. The temperature regime of the body can change with stress, allergic reactions, blood transfusions and blood substitutes, hormonal bursts, and finally, with banal overheating. The postpartum period is not an exception: in the first days of motherhood, there are cases of temperature rise without a pathological process. Here are some of them:

The moment of onset of lactation (the first "arrival of milk") is associated with increased hormonal activity and overfilling of still undeveloped milk ducts. Almost always at this time there is an increase in temperature within 8 ° C. The temperature is normalized after breastfeeding or decanting.

Allergic reactions to the administration of certain drugs, foods, odors in the first days after birth can increase and are often accompanied by a rise in temperature.

In any case, when raising the temperature after childbirth, you should consult a doctor without delay. The doctor will be able to make the right diagnosis on time or, on the contrary, to calm you down by excluding the development of this or that postpartum complication. The correct diagnosis and promptly begun treatment will help you to recover faster and with new forces to start maternal duties. Remember: a young mother should be healthy - it depends on the health of the baby!

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Prevention of postpartum infection of the GP prior to delivery includes recommendations for a rational regimen of the day and nutrition, exercise therapy, a comprehensive examination, identification and sanitation of chronic infection-inflammatory diseases, training pregnant women for the rules of breastfeeding and mammary care. In the maternity hospital - strict adherence to the rules of asepsis and antiseptics during childbirth and in the postpartum period, prevention of cracking of nipples and stagnation of milk from a nursing woman.

Contraception in women who have fever after childbirth depends on whether breastfeeding continues or not, whether there were thromboembolic complications, whether the uterus or other organs were the source of infection. With transferred thromboembolic complications, COCs are absolutely contraindicated (WHO-class 4), even if the woman does not breast-feed, as the risk of developing venous blood clotting disorders increases. After the transferred metritis, the introduction of the IUD should be postponed for 3 months after the complete elimination of the infection (WHO-class 4). If a woman is breastfeeding but does not comply with LAM and there were no thromboembolic complications with fever, COCs can be used no earlier than 6 weeks after childbirth (WHO-class 3), given the recovery and unacceptability of other methods. Barrier methods, spermicides, ENP, CIP can be used immediately after recovery and renewal of sexual activity, but taking into account the general principles of their application in the postpartum period.

Pipe occlusion is possible at 6 weeks after postpartum fever

PERITONITE AND SEPSIS AFTER KESAREV'S SECTION

Peritonitis after cesarean section occurs in 4.6 - 7% of cases. Mortality from peritonitis and sepsis after cesarean section is 26 - 45%. The development of peritonitis causes infection of the abdominal cavity (from complications of the cesarean section - chorionamionitis, endometritis, septic ulceration, acute inflammatory processes in the appendages, infections penetrated by hematogenous or lymphogenous pathway - with parathonsillar abscess, with soft tibia abscess, pyelonephritis

CLASSIFICATION OF PERITONITE.

By the nature of the exudate: fibrinous, purulent, serous.

In prevalence: local limited and diffuse (total) peritonitis.

On the stages: reactive (exudate formation), toxic (suppression of all protective properties of the body, violation of hemodynamics), terminal (multiple organ failure).

According to Serov, three variants of peritonitis flow after cesarean section are distinguished:

Inflammation of the peritoneum occurs during the operation (chorionnionitis, prolonged anhydrous interval, obeminatsiya by amniotic fluid).

Paresis of the intestine (through its wall there is a massive penetration of microorganisms into the abdominal cavity and its infection). Serov: if the paresis grows, the E. coli easily crosses the barriers.

In 90% of cases, peritonitis develops due to insufficiency of the sutures on the uterus. Causes are various pathogens - often associations of pyogenic flora with bacteroids, etc.

PATHOGENESIS. In the first 30-40 hours of the onset of the disease develops an inflammation of the peritoneum: edema, leukocytic infiltration, desquamation of the epithelium, disturbance of peripheral circulation, accumulation of histamine, serotonin, oxidized products which leads to acidosis, an increase in permeability, cardiovascular disorders but not always formed. Exudate is inflammatory, its formation is facilitated by pathological reaction of the peritoneum and blood flow disorders, which lead to increased formation of transudate, accumulation of fluid in the hollow organs. In the tissues dehydration develops, since all the fluid goes into the hollow organs and into the peritoneum. Transudation predominates over absorption. After 48-72 hours. In the process, tissues (atrophy, degeneration) are more deeply involved, the breakdown of proteins, enzymes, metabolites, vitamins, which leads to a sharp decrease in the tone of muscle tissue, which leads to intestinal paresis. Paralytic obstruction of the intestine develops.

The symptom-complex of intoxication intensifies, the microcirculatory bed suffers (corticosteroids ejection increases and reduces inflammation). Increased vascular tone leads to the opening of arteriovenous shunts, which leads to a decrease in oxygenation and perfusion of all organs, hypoxia and tissue necrosis.

Important is an intoxication syndrome, a violation of motility.

Clinical forms:

early peritonitis - the infection penetrates through the wound from the uterus (observed in 30%) due to chorionamnionitis. Manifestations of peritonitis are observed on day 1-2 after the operation. Severe intoxication syndrome, hyperthermia, severe tachycardia, severe condition. There may be encephalopathy due to cerebral edema, which is manifested by adynamia, inhibition, or euphoria. Also there is paresis of the intestine (swelling, absence of peristalsis, but no signs of irritation of the peritoneum or weakly expressed). The general condition worsens, the symptoms of intestinal paresis appear on day 4-5: vomiting, dry tongue, tachycardia, hypovolemia, rapid development of septic shock.

Occurs in 15%. The disease begins on 3-4 days. The leading symptom is paresis of the intestine, passing into paralytic obstruction; subfebrile condition, mild tachycardia, periodic thirst, bloating, poor gas leakage, etc. a woman can walk, but the paresis grows, the weakness is also increasing, shortness of breath, anemia, there may be a loose stool (septic diarrhea). By the 7th-9th day, a jaw paralytic obstruction appears. Plus the symptoms of peritonitis.

Late peritonitis. On the 4th-9th day due to insufficiency of the sutures on the uterus. Up to 4 days after surgery may be all right, but may persist fever, joins tachycardia, uterine tenderness

(especially in the lower segment), Shchetkina-Blumberg symptom in the rumen and lower segment, the tension of the abdominal muscles nevyrazheno. This situation lasts several days and forms a diffuse diffuse peritonitis, which is accompanied by symptoms of intoxication, intestinal paresis.

Methods of diagnosis (except for clinical symptoms).

Ultrasound (check the condition of the walls of the uterus, you can find a cluster of blood clots in the uterus, lochia, spasmodic cervical canal, moderate infiltration in the seam area. You can find a lychiometer, a hematometer).

Dynamic observation of the patient (hourly observation).

ECG (violation of myocardial nutrition, tachycardia, extrasystole)

an expanded clinical blood test. Daily toxic anemia increases with a decrease in hemoglobin and erythrocytes appearance anisyl poikilocytosis reduced color index, high leukocytosis is not typical, and characterized by an increase stab, lymphocytes, neutrophils toxic granularity, high sedimentation rate (55-70 mm / h).

Urine - nephritic syndrome, because intoxication due to renal dysfunction occurs - reducing hourly diuresis (normally 50-60 ml), reduced specific gravity, the appearance of blood cells in the urine: leukocytes - 10-15, erythrocytes, cylinders, mucus , microbes. Since often peritonitis is combined with gestosis, it must be compared to skillfully interpret the results.

Biochemical analysis of blood: hypoproteinemia (up to 40 g / l), reduced albumin inhibition electrolyte balance: hypokalemia, hyponatremia, reducing chlorine ions, calcium, inhibition of liver function: increased AST, ALT, urea, creatinine. The pancreas also suffers ..

Diagnosis is always overdue, however, as well as treatment. The developed tactic of surgical treatment (with the removal of the uterus, since this is the primary source of peritonitis). They operate most often on days 9-15, rarely on day 4-6. It is necessary to assess the severity of the progression of symptoms.

TREATMENT.

Surgical intervention. The earlier surgical treatment is started after the diagnosis of peritonitis, the less organ damage will be observed after the operation. Removal of the organ as a foci of infection (uterus with peritonitis after cesarean section) is etiologically directed. Remove the uterus with the tubes, the ovary is usually left, if there are no inflammatory phenomena in them. Extirpation of the uterus is more often produced than amputation. The lower segment is close to the cervix of the uterus, therefore, it produces supravaginal extirpation of the uterus with removal of the fallopian tubes with revision of the abdominal cavity organs.

Antibiotic therapy: cephalosporins and antibiotics acting on gram-negative microorganisms - gentamycin in maximum doses, better intravenously. Preparations metronidazolovogo series - metragil intravenously (acts on Gram-negative flora, fungal flora). The spectrum of sensitivity of microorganisms to antibiotics must be done necessarily.

Treatment and management of intoxication syndrome. Infusion therapy with drugs that have detoxification properties: rheopolyglucin, lactasol, colloidal solutions. The introduction of solutions improves the patient's condition. Also prescribe drugs that increase the oncotic blood pressure - plasma, aminovirus, protein preparations, amino acid solutions. The amount of liquid is 4-5 liters. Therapy is performed under the control of diuresis.

Restoration of intestinal motility: all infusion therapy with crystalloid solutions, antibiotics improve motility. Also, agents stimulating peristalsis of the intestine (cleansing, hypertensive enemas), antiemetics, proserin subcutaneously, intravenously; oxybarotherapy). The first 3 days should be a constant activation of intestinal motility.

Anti-anemia therapy - fractional blood transfusion (better warm donor blood), anti-anemic drugs.

Stimulation of immunity - the use of immunomodulators - timolin, complex, vitamins, UVO blood, laser irradiation of blood.

Important care and struggle with hypodynamia, parenteral nutrition, then full enteral nutrition - high-calorie, vitaminized - dried apricots, cottage cheese, raisins, dairy products. The struggle with hypodynamia consists in carrying out respiratory gymnastics, early turning in bed, massage.

SEPSIS AFTER GENUS AND AFTER KESAREV'S SECTION.

Sepsis can be of two types: septicopyemia, septicemia (without metastases).

Septicemia: a fibrillation process with chills, alternating with general weakness, heavy sweats, tachycardia, fever, shortness of breath, deterioration in overall well-being. Positive symptoms from the intestine. There are pains in the joints, muscles. The source of sepsis is the uterus. There may be a septic shock-a general (generalized vasospasm), a violation of perfusion in the organs of targets (lung tissue, kidneys (carbuncle, abscess of the kidney, liver abscess, etc.) .All the clinic of all-organ violations joins.

Lecture number 5: "Bleeding from the vagina."

Lecture plan:

1.consistently disclose the criteria for diagnosis and treatment of menstrual irregularities

2. conducts differential diagnostics for vaginal bleeding

3.Divide, evaluate, analyze the clinical situation and the general condition of women with dysfunctional uterine bleeding.

4. Independently make up the algorithm of actions for diagnosis.

5. develop an algorithm for the actions of providing emergency assistance, if necessary

6.know the clinical course of the stages of spontaneous abortion;

7. Expand criteria for methods of diagnosing spontaneous abortions

Placenta previa and premature detachment of normally situated placenta (PONRP) are accompanied by bleeding. PONRP results in 30-50% of perinatal mortality. PONRP - is placental abruption before the birth of the fetus - during pregnancy, in the first or second stage of labor. Meets 1/120 births (1.5% of cases). In 30% of cases PONRP causes massive bleeding and hemorrhagic shock, disseminated intravascular coagulation.

Risk Groups

1), hypertensive disorders in pregnancy;

2) infections, intoxication, vitamin deficiency diseases (especially lack of vitamin C);

3) physical illness (diabetes, kidney disease, heart, hypertension);

4) injury, onset of labor, short umbilical cord, polyhydramnios, multiple pregnancy, rapid delivery, delayed rupture of membranes, flat shape of membranes (predisposing factors).

The mechanism of formation. The placenta is retained on the wall of the uterus due to links with decidua and intrauterine pressure. In normal blood pressure in the intervillous space pressure less than the pressure in the amniotic cavity, which provides normal utero-placental blood flow and protects against premature detachment of the placenta. This is facilitated by the structure of the terminal arteries of the uterus in the attachment of the placenta - their clearance at the confluence of the sinuses is greatly reduced, and the venous drainage is wide enough and they have a valve device which prevents the backflow of blood. Pathological conditions are the deposition of fibrin in the intervillous spaces, infection and vascular placental villi, the development of inflammatory changes and blood clots in arteries - arteries become brittle, lose their elasticity and break even with small mechanical forces, the pressure. Formed basal hematomas, which, reaching larger sizes, destroy basal plate, break in the intervillous space, leading to detachment of the placenta.

Diagnostics. The main manifestations are:

1) vaginal bleeding;
2) pain: the pain of varying intensity, cramping, or constant. On palpation of the uterus determined by local pain, hyper tonicity of the uterus, cannot palpate the body of the fetus. The pain appears suddenly. Pain syndrome appears with an increase in hematoma retroplatsentarnoy to 150 ml and above.

Marked asymmetry of the uterus, abdominal distension;

3) Increased heart rate, drop in blood pressure, weakness, paleness;

4) Distress Syndrome.

PDOP a classification according to severity: mild, moderate, severe. Mild put retrospectively after examining placenta can be found organized bunches with veneers on the surface of the placenta.

Prenatal diagnosis of bleeding

Existents symptoms, other	Sometimes the presence of symptoms	Probable diagnosis

symptoms and signs, typically existents	and signs	
• Bleeding after 22 weeks of pregnancy (the blood can build up in the uterus) Intermittent or constant abdominal pain / in.	• • Shock. • • Voltage / uterine tenderness. • • Reduce / absence of fetal movements. • • Fetal distress or absence of fetal heart tones.	Premature detachment of normally situated placenta.
• Bleeding after 22 weeks of pregnancy.	• Shock. • Bleeding may occur after sexual intercourse. • Relax of the uterus. • • The fruit is not in the pelvis / lower pole of the uterus with the feeling empty. • The normal state of the fetus.	Placenta previa.

Tactics GPs

• Rapid initial assessment, transportation to the nearest maternity hospital.

• Assess blood clotting, using a bedside clotting test. If the test shows the delay clotting clotting than 7 minutes or form a soft, easily degradable clot suppose coagulopathy.

• If you need a blood transfusion.

• If bleeding is severe expedite delivery:

- If the cervix is fully disclosed, spend delivery by vacuum extraction.

-If vaginal delivery is not possible, perform cesarean

• If bleeding from legogo to moderate (the mother is not in immediate danger), further actions will depend on the data auscultation of fetal heart tones:

If the heart rate of the fetus is normal or they lack, break fetal bladder amniotic hook.

-If inadequate contractions, strengthen oksitatsinom generic activities.

-If the cervix is immature, perform cesarean sections.

If the frequency of abnormal fetal heart rate (less than 100 or more than 180 beats per minute):

-Perform emergency vaginal delivery.

-If vaginal delivery is not possible, make an urgent cesarean section**.**

Placenta previa - is placentation in or near the cervix.

7-25% - with placenta previa. Perinatal mortality - death of children in the antenatal period (during pregnancy from 28 to 40 weeks), intrapartum period (during labor), postnatal period (7 days after birth).

Normally, the placenta is located on the back wall of the uterus, a transition to the side walls or the bottom part of the uterus. The distance from the internal os to the edge of the placenta over 7 inches is normal. Such an arrangement due to the fact that the front wall of the uterus, it is much more stretched during pregnancy and during labor, and the back wall of the more powerful and less prone to contractile activity during labor. Nature has a placenta so with the least trauma. Placenta previa, it is located in the lower segment, completely blocking the field of the internal os or in part. Placenta previa occurs in 0.3-0.6% of the total number of births.

Distinguish between full and partial placenta previa.

Complete placenta previa - if the placenta completely covers the region of the internal os. On average, 20-30% of all presentation.

Incomplete - placental tissue overlaps the region of the internal os. The most common: 35-55% of cases. The most rare form - cervical placenta previa and per cervical. All of these options allow abortion in the first trimester (never wears before the deadline).

Transitional variant from full to partial previa is a low location of the placenta, in which the edge of the placenta is above the internal os at a distance of less than 7 cm (transitional version of a normally situated placenta previa).

Risk groups for the development of placenta previa are:

Women with a history of obstetric and gynecological history, that is, women with menstrual irregularities, reduced estrogen manifested in genital hypoplasia, hypomenstrual syndrome, where there is no normal hormonal balance, promotes proper proliferative and secretory changes in the endometrium.

Women with chronic diseases of the uterus with a history of abortion, dilatation and curettage, born with a manual entry into the uterus, with uterine fibroids, multiparous and multiparous).

The factors leading to the placenta previa is increased mobility of a fertilized egg, the high proteolytic activity of chorionic villi, when the fertilized egg does not attach to the bottom area of the body or of the uterus, and quickly moves to the lower segment and is attached there.

Women with placenta previa may be suffering from vaginal bleeding in the first trimester of pregnancy, and then the diagnosis - threatening miscarriage. Subsequently, these bleeding stopped, and in the survey, even in early pregnancy can be established that placental tissue in the first trimester of pregnancy is in the lower segment. Then these bleeding stopped and more diagnosis of placenta previa does not appear, because the placenta has the ability to migrate due to the growth of the uterus. And migrating placenta, which is located on the back wall of the uterus (rises). If the placenta is located on the front wall of the uterus, they will increase their tendency to complete presentation. The main symptom of placenta previa is bleeding. Bleeding due to the fact that the placental tissue lacks the ability to stretch as the wall of the uterus. This discrepancy leads to tissue elasticity that chorionic villi begin to peel away from the uterine wall. Chorionic villus placenta previa penetrate deeper into the muscular wall of the uterus and decidua, the thicker body of the uterus and uterine fundus. Hence placenta previa gives higher percentage of increment than the normally situated placenta.

Bleeding with placenta previa usually begins in the second half of pregnancy. In 1/3 of women - up to 30 weeks, the third - from 32 to 35 weeks, the remaining one-third after 35 weeks. Thus a more even distribution of this symptom.

The earlier one starts bleeding during pregnancy, the more likely that a complete placenta previa.

Diagnostics:

may begin suddenly and can be triggered by defecation, lifting, sudden cough movement, sexual intercourse, vaginal examination.

-Bleeding may be profuse or minor is not always the degree of bleeding indicates full or partial placenta previa.

-Repeated bleeding (full placenta previa). That is, the bleeding may start in 30 weeks, then stop and start at 38 weeks, etc.

-Bleeding is always outside, so how close the cervical canal, separated from the chorionic villi and uterine bleeding branches are naturally in the vagina.

Bleeding always-red blood, because the blood of the mother loses this arterial bleeding.

As a result of bleeding anemic syndrome develops in the mother, although the heavy bleeding, in violation of chorionic villi into the bloodstream may include fetal blood. Necessary to determine whether hemoglobin F or not.

Do not perform vaginal examination until all is ready for an immediate cesarean section. A careful study "with mirrors" can be done to rule out other causes of bleeding, such as cervicitis, trauma, cervical polyps or cancer. However, even with these conditions, we cannot exclude placenta previa.

Tactics of GPs:

• Admit a woman before delivery to the nearest maternity hospital.

• Restore the BCC in / Infusion.

• Estimate the value of blood loss:

- If bleeding is severe and lasts, prepare for delivery by caesarean section, regardless of the degree of maturity of the fruit.

- If the bleeding has stopped and the lung or the fetus alive but premature, take a watchful waiting until delivery or until the symptoms of heavy bleeding:

-correction of anemia fumeratom iron sulfate or 60 mg orally daily for 6 months

- Make sure that you have available blood for transfusion

- If bleeding occurs frequently, choose tactics after weighing the benefits and risks for the woman and fetus during further delaying tactics, compared with actin actions.

Confirmation of the diagnosis

• Ultrasound - locate the placenta. If placenta previa confirmed and full-term fetus, plan delivery.

• If an ultrasound is not possible, or the result is not reliable, and gestational age less than 37 weeks, keep a woman, as a placenta previa before the deadline of 37 weeks.

• If an ultrasound is not possible, or the result is not reliable, and the gestational age of 37 weeks or more, perform vaginal examination in the operating room, prepared for the start of the operation, to exclude placenta previa.

The main treatment

• call for help. Immediately mobilize all free staff.

• Perform a quick assessment of the major indicators of women, including the vital functions (heart rate, blood pressure, respiration, temperature).

• If the shock is supposed, immediately begin treatment. Even if there is no signs of shock, keep shock in mind when assessing the status of women in the future, because her condition can deteriorate rapidly. If the shock begins to develop, it is important to begin treatment immediately.

• Start / in infusion solutions and pour in / and emergency transportation to the nearest hospital.

Post hospital Rehabilitation in patients operated on for, PDOP, previa placenta and often have problems such as disability, asthenia person with loss of interest in active life and work. It is therefore important after surgery for bleeding is a set of measures:

1. psychological rehabilitation.

2. counseling for individual selection of contraceptives.

3. clinical examination: the treatment of anemia, treatment of diseases of the gastrointestinal tract.

4. Early detection and timely treatment of hypertensive disorders in pregnancy, hypertension, chronic infections.

5. evaluation of outpatient treatment.

Lecture number 6: "Vaginal discharge".

Theme Plan:

- Teach students to interpret and classify diagnostic criteria for the presence of background and precancerous diseases of the cervix and endometrium.

-form knowledge on the provision of timely advisory and therapeutic assistance to patients with background and precancerous diseases of the cervix and endometrium.

- Develop skills in clinical examination, identification of women at risk of background and precancerous diseases of the cervix and the body of the uterus.

- To develop knowledge on carrying out rehabilitation measures for post-hospital treatment of background and precancerous diseases of the cervix and the body of the uterus.

Background and precancerous diseases of the cervix.

The incidence of background and precancerous diseases of the cervix on average varies from 10 to 22.6%.

Terminology and classification.

In accordance with the clinical and morphological classification, diseases of the cervix are divided into background diseases, precancerous and cervical cancer.

1. Background processes.

A. Hyperplastic processes associated with hormonal disorders.

- Pseudo-erosion.

- Polyp

-Papilloma

- Leukoplakia.

-Erythroplasty

B. Post-traumatic processes

-Terical erosion

-Electrophion of the cervix

2. Precancerous conditions.

-Dysplasia

-Layoplakia with atypical cells.

3. Cervical cancer

Normally, ectocervix (vaginal part w / m), which is an extension of the vaginal mucosa, is represented by a multilayered flat epithelium lying on the basal membrane. Cervical canal lined with single-layered cylindrical epithelium. In the field of outdoor

throat there is a place of transition of a flat epithelium in cylindrical, in this place most often there is an atypical transformation of cells.

Risk Factors for Pre-Tumor Disease and Cervical Cancer:

I. Exogenous factors:

Injuries

Inflammation caused by:

Viral infection

Chlamydia

Mycoplasma

- Chemical and physical factors used for

contraception and treatment

II. Endogenous factors:

age-related hormonal changes

diseases of endocrine glands

decreased immunological status

III. Social factors:

early onset of sexual activity

early first pregnancy to 18 years

frequent change of sexual partner

- a large number of births at a low social level and early

sex life.

Polyps of the mucous membrane of the cervical canal

Polyps of the mucous membrane of the cervical canal are common diseases: they occupy one of the first places among the benign pathological processes of the cervix.

Polyps develop in the area of the external pharynx, in the middle or upper part of the endocervix. The most frequent polyps are observed in women after 40 years. Clinical manifestations, characteristic of polyps, do not exist.

Diagnosis of polyps of the mucous membrane of the cervical canal presents no difficulties. They are found with a simple examination of the cervix, colposcopy and cervicoscopy ..

Treatment is reduced to the removal of polyps (the subsequent histological examination is mandatory). Polyps are removed by unscrewing, followed by coagulation of the base of the leg. Prevention of cervical polyps is the timely treatment of gynecological diseases and endocrine disorders.

Leukoplakia is a lesion of the skin and mucous membranes of the lower part of the genital organs, characterized by thickening and varying degrees of keratinization of the integument epithelium. Isolate flat and warty (leukokeratosis), in which there is a disorderly arrangement of basal cells with phenomena of atypia of the form of leukoplakia.

When processing iodine solution, the surface of leukoplakia remains white.

The clinical picture of the disease is asymptomatic

The main purpose of the diagnosis is to determine the nature of leukoplakia: simple or with manifestations of basal cell hyperactivity and atypia of cells.

Colposcopy is mandatory and repeated to exclude or timely recognition of signs of atypia.

Treatment of leukoplakia with signs of basal cell hyperactivity and atypia is reduced to their excision, or cryodestruction; in recent years, laser therapy has been successfully used. When the leukoplakia is localized on the cervix, excision or conization is performed taking into account the state of endocervix, with a pronounced atypia performing an amputation of the cervix.

Erythroplasty

Macroscopically erythroplacii are dark red formations of round or irregular shape slightly elevating above the surface of normal mucous membranes. Erythroplasty are often single and have small dimensions.

The red color of erythroplasty is due to the transmission of the vasculature through the thinned (atrophic) layer of the epithelial cover.

Erythroplasty is surgically removed (excision) or other methods causing their complete destruction (diathermocoagulation, cryotherapy, vaporization by the laser beam).

Erosion and pseudo-erosion of the cervix

Erosion (pseudo-erosion) is one of the most common gynecological diseases: it occurs in 10-15% of women who see a doctor with complaints of genital diseases. Often this disease is detected during medical examination in women who consider themselves healthy.

There are the following types of erosion: congenital erosion, true erosion, pseudo-erosion.

Congenital erosion of the cervix is an ectopic cylindrical epithelium of the cervical canal.

Congenital erosions (ectopic cylindrical epithelium) are observed in childhood and adolescence, they are usually subjected to reverse development without treatment. Relatively rarely they persist until puberty. Congenital erosion does not tend to malignant.

True erosion of the cervix is an acquired pathological process characterized by damage and subsequent desquamation of the multilayered flat epithelium of the vaginal part of the cervix. As a result of desquamation, the wound surface (defect of the epithelium) is formed with manifestations of the inflammatory reaction.

True erosion refers to short-term processes: it exists no more than 1-2 weeks and goes to the next stage of the disease - pseudo-erosion, and therefore, the true erosion is observed by the treating physician seldom (the process is usually detected in the pseudo-erosion stage).

Pseudo-erosion is formed during the further development of the pathological process on the basis of true erosion. The defect of the multilayered flat epithelium is covered with a cylindrical epithelium, which creeps on the erosive surface from the mucous membrane of the cervical canal. Symptom, suspicious for the development of malignancy, are contact bleeding.

Diagnosis of erosion and pseudo-erosion. The clinical manifestations of this disease are uncharacteristic ..

Recognition is performed with a detailed examination of the cervix with a colposcope. With prolonged course of the disease, insufficient effectiveness of treatment, relapses, presence of signs of papillary, follicular (and mixed) pseudo-erosions, extensive colposcopy should be widely used, which allows revealing the changes inherent in precancerous processes.

After treatment with a 5% solution of iodine, erosion (pseudo-erosion) appears light pink, the starting zones of transformation are yellow, atypical processes are white.

In the presence of sites that are suspicious and even questionable with respect to atypia (dysplasia), a targeted biopsy is performed in the area of a suspicious area with deep seizure of the mucous membrane and the underlying connective tissue, excision with a portion of the transformation zone is desirable.

Treatment of erosion and pseudo-erosion

Congenital erosion is subject to observation; in the conduct of treatment is not necessary;

Treatment of true erosion and pseudo erosion of the cervix is carried out simultaneously with diseases that contribute to their occurrence (endocervicitis, cervicitis, colpitis, endometritis, salpingoophoritis, ectropion, endocrine disorders, etc.) or prolonged course of pseudo-erosions;

with the inflammatory etiology of pseudo-erosion (erosion), the nature of the pathogen is revealed and a course of treatment (according to the corresponding indications) of trichomoniasis, chlamydia, gonorrhea and other infections is carried out according to the rules adopted for the treatment of these diseases;

true erosion and pseudo-erosion with a pronounced inflammatory response in surrounding tissues is recommended to be treated with gentle methods. To the affected surface of the neck gently apply tampons, richly impregnated with sea-buckthorn or vaseline oil, emulsions containing antibacterial agents. Simultaneously, colpitis, endocervicitis and other diseases are treated, taking into account the pathogen and the stage of the process;

it is recommended to use physiotherapy of true erosions: irradiation of the cervix by short-wave UV rays with the help of a localization tube (OCUF-5 apparatus) or exposure to the cervix by microwaves of the centimeter range (Luch-2 apparatus). Physiotherapy in pseudo-erosions (especially with prolonged course) is not effective enough.

Diathermocoagulation is also used, coagulation not only of the whole pseudo-erosion surface, but also of the mucous membrane of the lower third of the cervical canal. Healing of the coagulated surface occurs after the rejection of necrotic tissues (ends at 3-4 weeks), the epithelization of the resulting defect is completed after 1.5-3 months. (sometimes later).

Clinical effect with diathermocoagulation is achieved in 75-98% of patients, complications (bleeding, exacerbation of inflammatory diseases) are relatively rare.

Cryocoagulation (cryodestruction) in recent years occupies a prominent place in the therapy of pseudo-erosions. The merits of this method include: painless intervention, bloodlessness of its nature, absence of risk of scar scarring of the cervical canal.

Irradiation of the cervix with a laser beam has been successfully used in recent years to treat pseudo-erosion of the cervix. Epithelialization of the surface is observed within 10-21 days.

Diathermocoagulation, cryodestruction and laser radiation are used after advanced colposcopy and biopsy (according to indications) to exclude the processes of severe dysplasia and malignancy.

After applying these methods of treatment, women are under close medical supervision.

Ectropion (eversion) of the mucous membrane of the cervical canal

Recognition of ectropion is quite possible when examining the cervix, which reveals scars (scar) on the site of former injuries, neck deformation (varying degrees), rough or smoothed surface of the turned out mucosa, often folds of the mucous membrane of the cervical canal.

It is recommended to use advanced colposcopy, in which pathological processes (pseudo-erosion, leukoplakia, etc.), which are an indication to a biopsy, are detected.

Treatment It is necessary to correct the structure of the cervix.

With significant scars and severe deformation, cervical uteri undertakes reconstructive-plastic surgery after curing all pathological processes (endocervicitis, pseudo-erosion, etc.).

Cervical dysplasia. "Dysplasia" is a morphological term, which means changes in the epithelium of the cervix and vagina of various genesis and biological potency [Zheleznov BI, 1984]. The basis of dysplasia is the processes of proliferation and structural rearrangement of basal and parabasal cells of flat multilayer epithelium. Dysplasia develops on the background of immature metaplasia of multilayered flat epithelium.

Depending on the degree of intensity of proliferation, the presence of atypia and the localization of the process in different (upper, lower) layers of the epithelium distinguish between mild, moderate and severe dysplasia. In practical work, the concepts and terms "light" (unsharp) and "heavy" (pronounced) forms of dysplasia are used.

In severe dysplasia, there is a risk of intraepithelial carcinoma.

Diagnosis of dysplasia includes examination with the help of a colposcope, cytological examination of epithelial cells, colposcopy with targeted biopsy. The most accurate diagnosis is made as a result of a histological examination of the biopsy specimen.

Treatment of dysplasia is carried out taking into account the nature of concomitant diseases (pseudo-erosion, leukoplakia, etc.) and forms of dysplasia.

In severe dysplasia, more radical interventions are performed: laser therapy, cryodestruction, surgical conization of the cervix, and others.

DISEASES OF THE UTERUS BODY.

Hyperplasia of the endometrium.

Hyperplastic processes in the endometrium have an uneven degree of development and sometimes acquire the character of a precancerous disease.

The histological classification of the WHO identifies 3 main types of hyperplastic processes in the endometrium: endometrial polyps, endometrial hyperplasia, and atypical endometrial hyperplasia.

In the literature of recent years, the following classification is usually used: 1) glandular hyperplasia of the endometrium; 2) glandular-cystic hyperplasia; 3) atypical hyperplasia of the endometrium (synonym - adenomatosis, adenomatous hyperplasia); 4) polyps of the endometrium [Zheleznov BI, 1988; Savelyeva GM, Serov VN, 1994, and others].

To the precancer of the endometrium is attributed atypical hyperplasia (adenomatosis) of the endometrium (diffuse and focal forms). A special oncological alertness is caused by adenomatosis with intense proliferation and atypism of glandular epithelium, as well as atypical hyperplasia in the basal layer of the endometrium.

Precancerous hyperplastic processes pass into endometrial cancer in approximately 10% of patients (according to different authors, from 2 to 50%), they often persist for a long time, sometimes they undergo reverse development. However, taking into account the real threat of the transition of the process to endometrial cancer, the doctor must pay close attention to patients with endometrial adenomatosis and adenomatous polyps.

Etiology, pathogenesis

Hyperplastic processes in the endometrium occur due to functional disorders and diseases that determine the violation of hormonal homeostasis, carbohydrate, lipid and other metabolic species.

The emergence of hyperplastic processes in the endometrium is promoted by hereditary complication (uterine myoma, genital and breast cancer, hypertension, obesity, and other diseases), damaging effects during fetal life, diseases during puberty and associated disorders of menstrual and subsequently reproductive function. In mature women, the appearance of hyperplastic processes is often preceded by gynecological diseases, operative interventions on the genitals.

Clinical picture.

The clinical picture of endometrial hyperplasia is characterized by the so-called dysfunctional (anovulatory) uterine bleeding, which usually occurs after a delay in menstruation. Bleeding is usually prolonged with moderate blood loss or profuse, profuse, sometimes there are intermenstrual bleeding. In some patients, hyperplastic processes occur with little or no

symptom. Hyperplastic processes are usually accompanied by infertility, the main cause of which is anovulation.

Diagnostics.

Diagnostic curettage of the mucous membrane of the uterus body is widely used for diagnosis and subsequent histological examination of the material obtained. Scraping of the endometrium is recommended to be performed on the eve of the expected menstruation or at the very beginning of the appearance of bloody discharge. In this case, it is necessary to remove the entire mucosa, including the area of the uterine fundus and the tubal uterine corners, where foci of adenomatosis and polyps are often located. For this purpose, endometrial scraping is performed under the control of hysteroscopy. The removed mucous membrane is directed to the histological.

To control the treatment, and also in the order of screening examination of women (clinical examination), a cytological method is used to study the contents of the uterus, obtained by aspiration. Aspiration is carried out in the second half of the menstrual cycle in compliance with the rules of asepsis.

The detection of hyperplastic processes, especially during preventive examinations (clinical examination), is facilitated by ultrasound, which allows to determine endometrial hyperplasia by the nature of echoes.

The diagnostic value of hysteroscopy is high. The method allows to detect hyperplasia in the form of a thickened, unevenly folded surface of the endometrium of a pale pink or red color.

For diagnostic purposes, hysterography is also used; on the roentgenogram with glandular hyperplasia, the scalloped contours, especially pronounced in the upper segment and at the bottom of the uterus, are revealed.

The degree of activity of hyperplastic processes can be determined by radioisotopic examination of the uterus. The principle of the method is based on an increase in the degree of absorption by the tissues of the radioactive preparation, respectively, in the growth of the activity of proliferative processes.

Treatment of hyperplastic processes of the endometrium is carried out taking into account numerous factors - the age of the patient, the causes of hyperplasia and the nature of this pathology, clinical manifestations, contraindications to this or that method of treatment, tolerability of medications, concomitant extragenital and gynecological diseases.

In the period of puberty, endometrial hyperplasia is observed in girls suffering from juvenile uterine bleeding. Hormonotherapy in pubertal age is carried out by combined estrogen-progestational drugs from the 5th to the 25th day of the cycle for 3-4 months. After the abolition of these drugs, the release of gonadotropic hormones increases (the phenomenon of "recoil"), which contributes to the process of ovulation.

Hormone therapy for endometrial hyperplasia in women of reproductive age is performed using estrogen-progestational drugs (regividone, regulon, marvelon, novinet, etc.) or gestagens (norkolut, dyufaston, 17-OPK, etc.). The duration of the use of hormonal drugs is determined

depending on the nature of the hyperplastic process. In the case of glandular cystic hyperplasia, estrogen-progestational drugs are used cyclically (from the 5th to the 25th day of the cycle) for 3-4 months, with recurrent hyperplasia 6-8 months. (in the same mode).

With relapsing glandular cystic hyperplasia, 17-OPC is prescribed for 3 months. on the 14th, 17th, 21st days of the menstrual cycle, then for 3 months. on the 17-21th day of the cycle and for another three menstrual cycles - on the 21st day of the cycle.

With atypical hyperplasia of the endometrium (adenomatosis, adenomatous polyps), the use of estrogen-progestogen is not shown. Under the influence of the estrogen component of the drug at the beginning of treatment, hyperplasia of the stroma of the basal layer occurs, which is undesirable in adenomatosis. After the application of estrogen-progestogen drugs, complete isolation of the functional layer of the mucosa does not occur, its full desquamation is observed after therapy with gestagens [Bohman Ya. V. et al., 1978].

When atypical hyperplasia, gestagens are used. 17-OPK is used continuously 3 times a week for 500 mg for 2 months; then - 2 months. on 500 mg 2 times a week and 2 more months. 250 mg twice a week. Norkolut is used from the 5th to the 25th day of the menstrual cycle at 5-10 mg for 6-8 months, then from the 16th to the 25th day of the cycle for 3 months.

The control of the result of treatment is carried out by biopsy of the endometrium (not aspiration) and subsequent histological examination. With diagnostic curettage remove the entire mucosa (including the area of the bottom of the uterus and its tube angles).

With recurrent glandular (glandular-cystic) hyperplasia at 6 months, with atypical hyperplasia after 3 months. from the beginning of treatment, a control histological examination of the endometrium is made.

Surgical methods are preferable for recurrent glandular-cystic hyperplasia, which developed against the diseases of endocrine glands (diabetes, prediabetes, etc.), obesity, hypertension, liver and vein diseases. Surgical treatment is indicated in pre-cancer (adenomatosis, adenomatous polyps) of the endometrium, especially when combined with endometrial pathology with adenomyosis and uterine myoma, pathological processes in the ovaries.

In recent years, for the treatment and prevention of hyperplastic endometrial processes, the ablation of the endometrium, performed with a hysteroresectoscope, has been successfully used.

With atypical hyperplasia (pre-cancer), surgical treatment is preferred; if there are contraindications to surgery, prolonged use of 17-OPC is permissible - 125-250 mg twice a week for 10-12 months.

It is possible to use cryosurgical destruction of hyperplastic endometrium with the subsequent administration of treatment with norocolut (5 mg continuously for 3 months) or 17-OPK (125 mg twice a week for 3 months).

Endometrial polyps are focal endometrial hyperplasia; often they arise from the hyperplastic basal layer of the endometrium. It is customary to distinguish the following forms of endometrial polyps: 1) glandular, originating from the basal layer; consist of stroma and glands,

the lumen of which can be enlarged (glandular-cystic polyp); 2) glandular fibrous polyps, consisting of a connective tissue stroma and a limited number of glands; 3) fibrous polyps - connective tissue formations, which are often collagenized; Glands are very small or absent. In women of reproductive age, polyps usually have a glandular structure.

With intensive proliferation of glands, polyps become adenomatous.

The clinical picture of endometrial polyps depends on the age of the woman, the hormonal and reproductive function of the ovaries, the presence of concomitant pathology (uterine myomas, adenomyosis, inflammatory diseases of the uterine appendages).

The most frequent, almost constant symptom of endometrial polyps are disorders of the menstrual cycle. In polyps against the background of a normal functioning endometrium, women of reproductive age have scanty intermenstrual and premenstrual suppositories with a saved menstrual cycle, as well as an increase in menstrual blood loss.

Diagnostics. If suspicion of endometrial polyps with diagnostic purposes is used ultrasound, hysteroscopy, hysterography, radioisotope study with 32P.

Treatment Removal of the polyp followed by scraping the mucous membrane of the uterus body under the control of hysteroscopy. The management of patients after removal of the polyp determines its structure, the nature of the endometrium and the presence of exchange-endocrine diseases in women.

Thus, the pathology of the cervix and endometrium is a very widespread condition among women of different age groups, with whom a general practitioner and a gynecologist meet daily. Knowledge of the peculiarities of the diagnosis of this pathology is necessary for the timely detection of diseases, therefore, every general practitioner should be able to conduct and interpret the results of cervical examination, vaginal examination, sampling for a cytological examination (Pap - smear).

Sh. Conclusion.

In conclusion, it should be noted that the wide spread of malignant diseases of the cervix and the body of the uterus dictate the need for widespread introduction of screening methods, one of which is the cytological method.

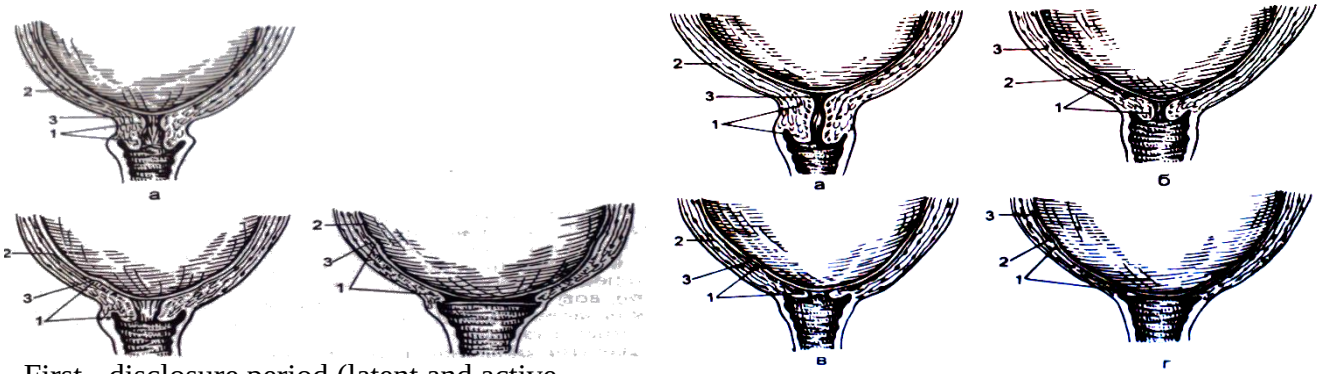
Timely diagnosis of background diseases helps to reduce the incidence of precancerous diseases and cervical and uterine carcinoma, which in turn is aimed at reducing the incidence of female morbidity and mortality.

Contents of practical exercises

Theme number 1: Physiological birth. Tactics of reference. Urgent care for physiological labor of GP. Breast-feeding. Physiological postpartum period. Tactics of reference.

Childbirth - an unconditional reflex act aimed at the expulsion of the ovum from the uterus that reaches the fruit of vitality. It is now believed viability of the fetus for a period not less than 22 weeks gestation, weighing not less than 500 g, not less than 25 cm is considered the timeliness of deliveries in the period from 37 to 42 weeks of pregnancy. Birth after 42 weeks of pregnancy

is called late. Termination of pregnancy before 22 weeks is called abortion.
Onset of labor is preceded by the appearance of hook-called precursors of birth.
Harbingers of sorts - these are signs of the onset of their loved arising from 38 weeks of pregnancy before birth and manifested as a result of lowering the bottom of the uterus pressing pre ¬ lying part of the fetus to the entrance of the pelvis and reduce the amount of amniotic fluid, a discharge of "mucus plug", the lack of weight gain , increased excitability STI muscles of the uterus, etc.
In contrast to the precursors of birth preliminary limited to a few hours of pain-mi, immediately preceding the onset of labor, and should not impede the natural processes of life (sleep, diet, activity). Preliminary clinically pain occur for pregnant almost unnoticeably marked irregular painless contractions of the uterus, which are gradually becoming stronger and more persistent, and finally go into battle.
Preliminary pain correspond to the time of formation of the dominant clan and are accompanied by a biological "ripening" of the cervix. The cervix softens over-occupies a central position on the wire axis of the pelvis and drastically shortened. When pathological pain during the duration of the preliminary prolonged, uterine acquires a painful character, and the ripening of the cervix occurs.
Childbearing is divided into three periods:



- First - disclosure period (latent and active phase)
- Second - the period of the expulsion of the fetus (not evicted early and late phase casts out)
- The third - the sequence period.

At birth a pregnant woman in labor is called.
The first stage of labor - this is the part of labor, which begins with the appearance of contractions and ends with a complete disclosure of the uterine mouth.
Contractions - is the involuntary rhythmic contractions of the muscles of the uterus with at least one in 10 minutes. Contractions are characterized by four features: frequency, duration, strength and tenderness. In early labor contractions occur every 10 minutes, and further breaks are gradually reduced to 1-2 minutes.
Duration of contractions in early labor 10-15, in the middle of giving birth - 30-40. after delivery - 50-60 s. The contractions are weak, medium and strong strength. Soreness labor depends on the strength of the central nervous system and on the quality of the genera pregnant.

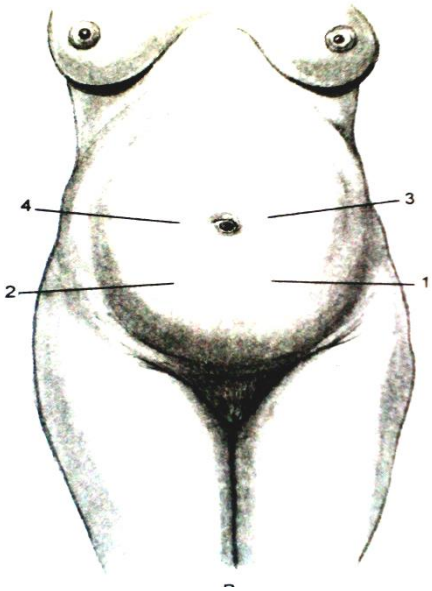
Figure cervical dilatation in nulliparous and multiparous.

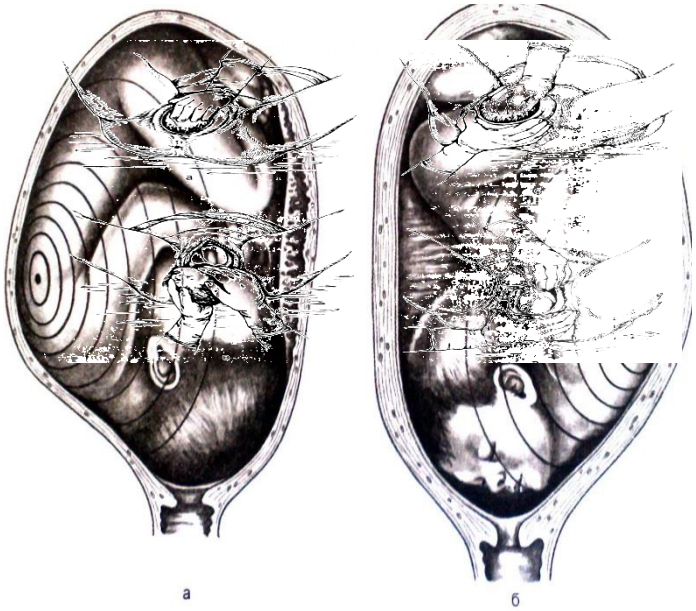
Disclosure of uterine throat is due to a reduction (contraction), and of displaced relative to each other (retraction) of muscle fibers of the uterine body and stretching of the expansion (distraction) neck and the lower segment of the uterus. The lower segment of the uterus - a part pericervica; area of the body of the uterus, forming a clan ¬ howling channel in the first stage of labor as a result of processes of retraction and distraction. As the formation of the birth canal on the border of the upper and lower segments of the uterus is formed furrow, called the contraction ring. At the beginning of first-time mothers giving birth outer and inner mouth shut.

Disclosure necks starts at the top. First revealed the inner mouth of the cervix and cervical canal. In the future, the cervix is still more shortened, and then fully anti-aliased, and only its outer mouth remains closed. Then, on the edges of external os gets thinner, and it begins to open up, as long as it does not happen complete disclosure. In this case, it is defined as a narrow rim in the birth canal, ¬ Call of formation of cavities merged together vagina and uterus. At the end of pregnancy in multiparous entire cervical canal to pass one or two fingers (as a result of its expansion in the previous birth). Therefore, anti-aliasing and the cervix throughout the first stage of labor is but at the same time ¬. Disclosure of uterine mouth is to fully open, which corresponds to 10 cm discharge of amniotic fluid should be at close to full opening of the uterine mouth. Rupture of membranes in the first stage of labor before the disclosure of 4-6 cm, and before regular labor is called premature.
During the first stage of labor identified two phases: latent - from onset of labor to the disclosure of the uterine mouth to 3-4 cm, active - from 4 cm to fully open. In turn, the active phase time of acceleration is isolated, and its maximum speed deceleration (decelerations). Rate of uterine mouth opening is an important indicator of the correct course of labors. The rate of cervical dilatation at the onset of labor (latent phase) is 0.35 cm / h in the active phase - 1.5-2 cm / h in nulliparous and 2-2.5 cm / h - multifarious.
Disclosure of uterine mouth from 8 to 10 cm (deceleration phase) passes more slowly - 1 -1.5 cm / h Meanwhile ¬ Py disclosure of uterine os dependent on contractility of the myometrium, Cervical resistance and combinations thereof. The duration of the first stage of labor in nulliparous an average of 10 to 14 hours, and multifarious - half the size.
In the first stage of labor, the doctor should monitor the overall health of mothers, the dynamics of labor and the heartbeat of the fetus.
The behavior of women in the first stage of labor should be active. It should to use techniques of anesthesia, which taught her classes on psycho preventive -ray preparation for childbirth. Acceptable attendance at childbirth husband and other relatives. Bed rest is recommended for stored the fetal bladder in cases of polyhydramnios, premature birth, breech presentation, we recommend taking food and liquids.

After full disclosure of the uterine mouth begins the **second stage of labor** - the period of Gnagno-which ends with the birth of the fetus. In the second period identified two phases: Early (not evicted) - full disclosure, the presenting part is omitted, but does not reach the bottom of the pelvis, there is no urge to dry heaving. Late (expulsion) - Full raskrytie5, presenting part of the fetus reaches the bottom of the pelvis, the woman begins to push. Characteristic of the period of exile is the appearance of any attempts - synchronous with the uterus reflex contractions of the abdominal muscles, the diaphragm and the pelvic floor. Attempts should start with finding the presenting part at the bottom of the bands small pelvis when the lower pole of the presenting part presses on the abdominal muscles and the pelvic floor. On this false appearance of any attempts to identify the beginning of the period of exile - they appear at the end of this period and help to overcome the presenting part of the narrowest part of small pelvis. Attempts repeat every 2-3 minutes and last for 50-60 seconds.
In the second stage of labor the doctor should carefully monitor the status of women in labor, the nature of labor, the heartbeat of the fetus (it should be auscultated after each attempts), promotion of the presenting part of the fetus, the character of discharge from the genital tract, hold receptions of "protecting the perineum"
The third stage of labor - the sequence - comes after the birth of the fetus and continues through the placenta. Its duration is an average of 10 to 15 minutes, but no more than 30 minutes. To date, the third stage of labor are actively using controlled cord traction with the first battle sequence, highlighting the active participation of women in labor with no consequences.

Figures: Auscultation of fetal heart





A woman called postpartum
women in childbirth. Within 2 hours it should be in the delivery room under the supervision of a midwife, while continuing to maintain its activity. If all is well, women in childbirth transferred to the postpartum unit.

The set of movements made by the fruit as it passes through the pelvis and the soft parts of the birth canal, called the biomechanics of delivery. **The first point** - bending head (flexio capitis). Under the influence of intrauterine pressure, partly transmitted ¬ direct the spine to the head of the fetus, the cervical part of the spine is bent in such a ¬ time that chin close to the chest, back of the head is lowered. As you lower the back of the head small fontanelle is set below a large, approaching the pro ¬ water line of the pelvis

The second point biomechanism childbirth is a combination of translational ¬ relative motion of the head and its internal rotation.

The second point biomechanism childbirth begins after the head is bent over and getting up at the entrance to a small basin. Then head able to moderate flexion one of the sizes goes skew widest part of the pelvic cavity. Since the internal rotation ¬ mouth, in a narrow part of the pelvic cavity. As a result, the size of the head of the skew becomes a straight line. Turning ends when the head reaches the exit plane of idle once established as the head of the arrow-shaped seams in the direct output of the pelvis, begins **the third time** biomechanism birth - extension of the head. Between the symphysis pubis and the suboccipital fossa of the fetal head is formed fixation point around which the extension is the head. As a result, by extension therefore ¬ born crown, forehead, face and chin of the fetus.

Fixation point or fulcrum (punctum fixiim) is a point on the fetal head, which abuts against the lower edge of symphysis (and in some previa and coccyx tip) is then bending or unbending Birth and any part of the fruit.

Head born small oblique size equal to 9.5 cm and a circumference of 32 cm

Figure of **perineum protection**

After the birth of the head is an internal rotation of shoulders and outer rotation ¬ mouth head - the fourth time. Shoulders of the fetus produce internal rotation, as a result they are set out in the forward of the pelvis so that one shoulder (front) is located under the womb, while the other (back) paid to the coccyx. Born fetal head rotates back of his head to the left thigh of the mother (in the first position) or to the right (at the second position).

Between the anterior shoulder (in the deltoid muscle attachment to the humerus) and the lower edge of the symphysis, a new point of fixation. There is a bend of body to fetal thoracic and rear shoulder of birth and pens, and then easily given birth the rest of the body.

Biomechanism delivery at the front as the occipital previa is the most physiological and beneficial to both mother and fetus, as in this variant Biomechanism head passes through the plane of the pelvis and its smallest size is born ¬ authors.

In the delivery room or in the home immediately after the birth of a child is held first toilet newborn, which includes:

• treatment of the eye.

• Two-moment cut off the umbilical cord and umbilical handling balance.

• study anthropometric data-child weighing (minus the weight of the total weight of the diaper), the measurement centimeter ribbon growth child's head circumference (along brow to small fontanelle) and breast (the line passing through the nipple).

1. Partograph (organaizer) - is a graphical way to display the birth process:

- The progression of birth

-Disclosure cervix

- Promotion of the fetal head

- Labor-

the fetus and status of the mother

Partoprograph of WHO, 1988:Features and benefits

- Effective monitoring standard
- Early detection of unsatisfactory progress in labor
- Detection of pelvic disproportion-head before the symptoms of obstruction
- The timely adoption of a reasoned decision on the future tactics of birth
- The definition of the necessary interventions
- Simplicity, low cost, accessibility, visibility.

The basic principles of the partograph:

- Partograph used for doing basically t-he first stage of labor

- However, in the second stage of labor should continue to record indicators of the mother and fetus, as well as uterine contractions

- Partograph begins filled in the presence of
  - One or more contraction of uterus within 10 minutes of 20 seconds or more duration in the latent phase

- Two or more ccontractions of uterus within 10 minutes of 20 seconds or more duration in active phase
- Absence of complications requiring emergency care or deliveries
- Partograph populated at the time of delivery, and not after their completion
- During labor partograph should be in the delivery room
- The completion and interpretation of the partograph should be a trained staff (doctor or midwife)
- Keeping partograph will get terminated if
  there are developed complications requiring emergency delivery

Advancing of the fetal head, determined by visual inspection:

- Head over the entrance to the pelvis
- The head of a large segment of the entrance to the pelvis
- The head is palpated by the width of the 5 fingers on the top edge of the symphysis - 5/5
- The head is palpated by the width of two fingers above the top edge of the symphysis - 2/5

Amniotic fluid:

- Ts – a bag of waters, C – clear amniotic fluid, B – amniotic fluid stained with blood, M – meconium-stained amniotic fluid/

Configuration of fetal head:

- 0 – bones don't contact and connective tissues gets easy to define between the edges of skull
- + bones lightly touch each other
- ++ bones overlap
- +++ Bones significantly overlap

Conclusions:

- Simple, intuitive, easy-to-use and effective tool for monitoring the flow of labor and decision-making
- The use of the partograph significantly improved perinatal outcomes
- Partograph can be used effectively in the institutions of any level of care
- The effectiveness of the partograph is ensured compliance with the rules of use
- Partograph should be used for all kinds, i.e women as low-and high-risk

2. **Discussion** - is used in the discussion stage homework and determine the initial knowledge of the students.

Questions / Answers:

1. Periods of delivery

Childbearing is divided into three periods:

first - the period of disclosure,

second - a period of expulsion,

third - the sequence period.

2. The duration of labor in first-and multiparous

The duration of labor in nulliparous is 11,5-14,5 hours, including - first stage of labor - 9-12 hours, the second - up to 2 hours. The duration of labor in bipara - 8,5-11,5 hours, including the first stage of labor lasts 8-11 hours, second - to 1 hour. The third stage of labor in nulliparous as well as multifarious actively conducted.

3. Biomechanism delivery at the front as the occipital previa (a demonstration on models or phantom)

The first point - bending head (flexio capitis). Under the influence of intrauterine pressure, partly transmitted ¬ direct the spine to the head of the fetus, the cervical part of the spine is bent, chin close to the chest, back of the head is lowered. As you lower the back of the head small fontanelle is set below a large, approaching the pro ¬ water line of the pelvis

The second point biomechanism childbirth is an internal rotation of the head. It begins after the head was bent and inserted into the entrance to the pelvis. Then the head is in a state of moderate flexion in one of the oblique size goes wide part of the pelvic cavity from the internal rotation ¬ mouth. In the narrowest part of the pelvic cavity head ends rotational movement. As a result, the size of the head of the skew becomes a straight line. Turning ends when the head reaches the exit of the pelvis

The third point biomechanism birth - extension of the head. Between the symphysis pubis and the suboccipital fossa of the fetal head is formed fixation point around which the extension is the head. As a result, by extension therefore ¬ born crown, forehead, face and chin of the fetus. The head is born small oblique size equal to 9.5 cm and a circumference of 32cm, it is appropriate. After the birth of the head is an internal rotation of shoulders and outer rotation ¬ mouth head - the fourth time. Shoulders of the fetus produce internal rotation, as a result ¬ Tate they are set out in the forward of the pelvis so that one shoulder (front) is located under the womb, while the other (back) paid to the coccyx. Born fetal head rotates back of his head to the left thigh of the mother (in the first position) or to the right (at the second position). Between the anterior shoulder (in the deltoid muscle attachment to the humerus) and the lower edge of the symphysis, a new point of fixation. Bending that occurs of fetal body in the thoracic and the birth and rear shoulder of the handle, and then easily given birth ¬ rest of the body.

4. What are the ways of the placenta

A) central (by Schultze) - placenta begins from the center to form retro placental hematoma. In this case, no external bleeding, hematoma retro placental born with afterbirth and placenta - its fruit surface.

B) boundary (by Duncan) - separation of the placenta begins to edge retro placental hematoma is formed. From the very beginning of branch starts bleeding from the genital tract, the placenta is born of its parent surface.

5. What happens when blood loss physiological delivery?

Blood loss on the average is 150-200 ml. The upper limit of the permissible scope of physiological blood loss - 0.5% of body weight, or 5 ml per 1 kg.

6. How often should be conducted outside midwifery research in the I stage of labor?
Outside midwifery, research in the period of disclosure should be done repeatedly and systematically. Recording of medical records shall be made not less than every 2 hours.
7. What should I look for when external OB exam?
To: - the shape of the uterus, its consistency in and out of battle, fundal height and condition of the contraction of the ring;

- The strength and duration of contractions (with the hand placed on the fundus of the uterus), the degree of relaxation of uterine contractions is (by palpation);

- Standing height of the contraction of the ring;

- Position, position, look and fetal presentation and the attitude of the presenting part to the entrance of the pelvis (methods of Leopold-Levitsky), and - on the clinical correlation between the size of the head and pelvis (sign Vasta).

8. What is the heart rate of the fetus?
It normally is 100-180 beats per minute. Increased heart rate, as well as its slowing is signs of fetal hypoxia.
9. When there is a discharge of amniotic fluid?
Discharge of amniotic fluid should be at close to full opening of the uterine mouth. Rupture of membranes in the first stage of labor prior to the disclosure of 6-7 cm, and before regular labor is called premature.

The analytical part

Task 1.

In the SVP delivered pregnant 28 years. Pregnancy III -; 39-40 weeks. Reproductive history - not burdened. Complaints against irregular dragging pain in the abdomen and lumbar region over the past 3 hours. Outside research: the uterus corresponds to a full-term gestation, excitable palpation. Longitudinal position of the fetus. Presentation of fetus is head way. Amniotic fluid is not poured out. Fetal heart rate 148 beats per minute, rhythmical. A perturbation of the fetus feels. Vaginal examination: cervix length of 2.5 cm, soft, cross the cervix 1.5 cm all over, the bag of waters is intact, the fetal head on the plane I pelvis.

question:

1. diagnosis
2. tactics GP

answer:

Pregnancy III, 39-40 weeks, the preliminary period.
Hospitalization in obstetric hospital.

Task 2.

To the doctor asked bipara 39 weeks of pregnancy. On examination established that the stomach is increased at the expense of the pregnant uterus, the fetus longitudinal, presenting part - the head. Labors - the fight for 10 minutes - 3 contractions for 40 seconds. Amniotic fluid is not poured out. The general condition of the woman is satisfactory, pulse - 80 beats per minute, blood pressure 110/70 mm. Hg. At vaginal examination established that the cervix is smoothed, the disclosure of the mouth uterine is 4 cm.
question:
1. diagnosis

2. tactics GP
answer:
1. 38 weeks of pregnancy, I stage of labor.
2. Surveillance and emergency hospitalization.

Theme number 2: Conducting pregnancy in healthy women. Antenatal care. Order No. 137 of the Ministry of Health of the Republic of Uzbekistan. Personal hygiene.

Theoretical part

Antenatal care

In recent years, views on antenatal care and care during childbirth have changed significantly. There are eight major Millennium Development Goals (MDGs) formulated by WHO in the World Health Report (2005).

Goal 1: Overcome extreme poverty and hunger

Goal 2: Achieve global primary education

Goal 3: Promote gender equality and empower women

Goal 4: Reduce the child mortality rate

Goal 5: Improve maternal health

Goal 6: Combat the spread of HIV / AIDS, malaria and tuberculosis

Goal 7: Ensure environmental sustainability

Goal 8: Develop a global partnership for global development

Despite the fact that only three goals are directly related to perinatal care, others also have a link to the health care system.

Maternity is a positive experience for most women. This means that most women and their families experience a sense of happiness, pride and exalted emotions during pregnancy, childbirth and the postpartum period. However, in today's world, many mothers die because of problems associated with pregnancy, and even more women suffer from illness and disability.

One of WHO's "Health in the 21st Century" Strategies is to ensure a healthy start to life. The WHO Safe Motherhood Initiative was developed to help achieve this goal, and later in 2004 it grew into the "Making Maternity Safe" program. The basic principles and values of effective perinatal technologies were developed by a WHO expert group from the European Region during meetings in Venice in 1998 and in Verona in 2003. These principles were subsequently widely supported, disseminated and implemented in all countries of the region.

The fundamental principle of effective perinatal care: the woman is given the main role in all decisions related to safe pregnancy and safe childbirth. The best model of health protection is based on three pillars: security, evidence-based medicine and the needs of the patient.

Antenatal care programs are designed to find ways to reduce maternal and perinatal mortality, as well as perinatal morbidity.

The role of health workers involved in antenatal care is to:

To support the psychological adaptation of a woman to pregnancy, childbirth, breast-feeding and parental role.

Monitor the course of pregnancy to ensure the health and well-being of both the mother and the fetus.

Examine all women and identify signs of possible complications.

Provide women with important information about their health: healthy eating, quitting, HIV prevention, family planning, prevention of violence.

First of all, a woman needs to be informed about the anxiety symptoms that arise during pregnancy, including the appearance of complications. Prenatal classes play an important role in providing information to the woman and her family about pregnancy and childbirth.

In the Republic of Uzbekistan », every pregnant woman must have a minimum of 7 planned antenatal visits (up to 12 weeks, 16 weeks, 28 weeks, 30 weeks, 34 weeks, 36 weeks, 38 weeks) or more, if necessary for counseling and examination.

The purpose of folic acid in order to prevent neural tube defects, complete examination and proper counseling for women with diabetes, should be timely, even before the onset of pregnancy. In addition, you can give advice on healthy eating and lifestyle changes (for example, women smokers).

Advisory / clinical skills of ANU

Stages of examination of a pregnant woman at 1 admission (up to 12 weeks of gestation):

1. Prepared for the reception of the patient and accompanying persons: the necessary documents; place of physical examination; tools and gloves.

2. Welcomes the patient, appears to her.

3. Fills in or gets acquainted with the data of an outpatient card: - patient's name and surname; her age; - data on her place of residence and work; - Whether is in marriage.

4. Draws attention to the appearance and behavior of the pregnant (whether there are any symptoms of oppression, fear, anxiety, etc.)

5. Ask the patient about her general medical history and complaints

6. Ask the patient, and make notes on the outpatient card about the transferred

gynecological diseases and the course of previous pregnancies.

7. Interrogates and makes notes on the outpatient card about the nature and date of the last menstruation.

8. Explains all procedures to be carried out.

9. Conducts the necessary studies:

measurement of A / D (if diastolic A / D exceeds 90 mmHg from the baseline to 20 weeks of gestation, assessment and consultation of a specialist is necessary);

urinalysis (examination for asymptomatic bacteriuria, the presence of protein, glucose, ketone bodies);

Weighing (Determine Body Mass Index (BMI) = weight (kg) / height (m2) Acceptable boundaries are from 18 to 35. If a BMI is ≥35 or ≤18, the appropriate dietary advice is given or forwarded for further examination (no attention should be paid to increase the weight of a woman with normal BMI and prescribe restrictive diets);

Ultrasound is recommended in the early stages, provided there are any good reasons for this type of research. Ultrasound examination to determine abnormalities of fetal anatomy is usually not recommended before 18 weeks, and in the study of the heart - about 22 weeks of pregnancy);

Assignment of tests: blood for syphilis - RW, hepatitis B and C, after informed consent of the woman - voluntary testing for HIV / AIDS, general blood test, group and Rh factor, blood for sugar, general urine analysis, analysis of excretions from 3 points , stool analysis for the determination of parasites.

10. Inspects the legs of a pregnant woman for the detection of edema and varicose veins.

11. Conducts a study of the organs of the genitals:

Examination of external genitalia:

Inspection with the help of mirrors;

Bimanual examination.

12. Conducts breast exams.

13. Based on the history and results of objective, laboratory and instrumental studies determines the duration of pregnancy. In the presence of pathological abnormalities - formulates a diagnosis.

14. Counts the expected date of delivery: by the date of the last menstruation (the first day) adds 7 days and subtracts 3 months.

15. The results of all examinations are added to the woman's antenatal card. Records should be accurate, with the signature of the person who conducted the examination of the pregnant woman.

16. Teaches you to fill in a pregnant pregnant card

17. Prophylactically appoints 60 mg of iron and 1 mg of folic acid.

18. Designate the time and date of the next visit.

19. Following the rules of infection prevention processes the observation table, tools and gloves.

Consultative and clinical skills in conducting physiological pregnancy (follow-up visits):

1. Welcomes the patient, asks for more comfortable accommodation

2. Ask about the woman's health, complaints, feelings for the period that has passed since the previous visit.

3. Draws attention to the appearance and behavior of the patient

4. Draws attention to the color of the skin.

5. Explains all the procedures that will be performed.

6. Palpate the region of the tibia to determine the presence of edema.

7. The centimeter tape measures the shin circumference around the ankles.

8. Measures blood pressure on both hands.

9. Interprets urine analysis.

10. Repeats the general analysis of urine and blood in 30-32 weeks

11. In 14-20 weeks, conducts ultrasound examination to exclude fetal development abnormalities (if there is a risk)

12. Conducts midwifery study:

examines the mammary glands;

determines the height of the standing of the bottom of the uterus;

conducts palpation of the abdomen;

he listens to the fetal heartbeat;

- determines the movements or movements of the fetus.

13. Conducts an analysis of vaginal discharge.

14. The results of the studies are added to the outpatient card of the pregnant woman.

15. If there are deviations from the physiological parameters of the studies carried out, he appoints a specialist's consultation to decide the question of further tactics of reference.

16. Makes notes in the card of the pregnant woman.

17. Converses with the patient, answers the questions of her interest.

18. Assigns the date and time of the next visit.

19. Thanks for coming.

20. Observes the rules of infection prevention during and after the patient's admission

Care during pregnancy

1. Greets the couple respectfully and kindly.

2. It appears to them. Tells parents about their future child, from conception to birth. Using visual materials, tells about the physiological changes that occur in the body of a woman during pregnancy and her sensations at the same time: in the endocrine system; metabolism: respiratory system: the gastrointestinal system; in the urinary system; in the reproductive system; in the mammary glands; in the bone system.

3. Hygiene of pregnant women.

Teaches the patient how to ease the so-called "small" complaints during pregnancy:

nausea:

you need to eat less, but more often:

if possible, have breakfast in bed, and then lie down for 15 minutes before getting up;

there are for breakfast products containing proteins (meat, eggs); dairy products (kefir, curdled milk, cheese, kurt), and others:

avoid reception of difficult to digest products, such as fats, boiled cauliflower;

there is more solid food than liquid food;

to drink carbonated water, but within reasonable limits, it facilitates digestion, but increases appetite and contains salts, which can lead to excessive weight gain.

heartburn, constipation:

- do not eat much;

- is often and fractional:

-do not eat high-calorie and acidic foods:

- physical exercises;

- include in the diet foods rich in fiber (vegetables, fruits, bread, cereals, etc.)

- in the morning on an empty stomach and during the day to drink several glasses of liquid.

Shortness of breath:

minimize physical effort to a minimum;

if it becomes very difficult to breathe, you need to see a doctor.

accompanied by a feeling of heaviness, heat, "creepy", pain in the legs, swelling and convulsions;

the condition is aggravated with long standing, fatigue, and also in hot weather and, especially at the end of the day.

4. Describes the proper nutrition of a woman during and after pregnancy.

The dietary intake of pregnant women should be varied

In the first trimester, it is important to ensure the intake of a high-grade protein (low-fat meat, chicken, eggs).

Refractory fats (lamb, pork, beef) should not be consumed. Vegetable oil contains vitamin E. necessary for the development of pregnancy.

It is necessary to limit the amount of refined sugars, confectionery, candies, jam introduced with food. Useful for pregnant carbohydrates are contained in plant fiber (bread from wholemeal flour, a variety of fruits and vegetables).

Specify the daily ration and calorie content of food, the so-called "pyramid" of nutrition.

the necessary amount of microelements in the daily diet.

5. Explain the need for preparation for breastfeeding, nipple preparation.

6. Teach antenatal exercises that improve the function of internal organs. In the system of psychophysical preparation for childbirth there is a complex of special exercises that contribute to a more favorable course of pregnancy, childbirth and the postpartum period. Exercise during pregnancy should be done under the supervision of a doctor.

Breathing exercises:

- Chest breathing. A. Breathing with delay. B. shallow breathing.

B. intermittent breathing.

- Abdominal breathing. A. Full breathing. Muscle Exercises.

7. Highlights issues of sexual life during pregnancy.

8. Convinces parents of the need to lead a healthy lifestyle for a successful outcome of pregnancy: the dangers of smoking; about the harm of alcohol; about the dangers of drugs.

9.Explains the spouse about the need to create a favorable psychological climate in the family for a pregnant woman.

10. Teaches the pregnant woman to keep the mother's home records.

11. Teaches a couple how to recognize early warning signs of the most common complications during pregnancy:

anemia;

- Hypertensive disorders during pregnancy;

bleeding from the genital tract;

- retardation of intrauterine development of the fetus;

- Fetal distress.

12. Carefully listens and responds exhaustively to all questions raised by patients.

13. Requests briefly to repeat the instructions to verify the correctness of the information learned.

14. Assigns the date of the next session.

Basic medical measures

Administration of iodine preparations 200 mg / day during the entire pregnancy

Folic acid 1 mg / day until 12 weeks of pregnancy

If anemia is detected and anemia in the regions is prescribed, 60 mg iron / day

The following groups of women will need additional care:

- Women with heart disease, kidney disease, hypertension, psychiatric, hematological problems, epilepsy, diabetes, malignant tumors, autoimmune diseases, HIV and other extragenital diseases.

- women with a lack of psychological support during pregnancy

- women over the age of 35 and under 20 years of age

- if the body mass index is BMI <18.5 or> 32.3 kg / m2

- women who underwent a cesarean section

- women with preeclampsia, HELLP syndrome or history of eclampsia

- women with two or more spontaneous abortions in anamnesis

- women who have a history of premature birth or spontaneous termination of pregnancy in the second trimester

- women with mental illness or postpartum psychosis in the anamnesis

-women who at least one of the previous pregnancies ended in stillbirth or the death of a child in the neonatal period

- women who gave birth to a child with genetic or congenital anomalies

- women who gave birth to children whose maturity did not match the gestational age

- women with infertility in history and after IVF

- women with this multiple pregnancy

It is important to carry out a survey of women with stillbirth in an anamnesis for the carriage of CMV

Indications for hospitalization

In the case of newly diagnosed EPZ requiring observation and treatment, as well as sub- and decompensated stages of EPH - hospitalization with the decision of whether to prolong pregnancy

4.2 Practical part

List of practical skills:

External obstetric examination of pregnant women

Listening to the fetal heartbeat

Calculation of the estimated weight of the fetus

Determining the period of pregnancy and childbirth

Taking a smear of vaginal discharge.

Analytical part

APPLICATION OF CASE-TECHNOLOGY ON THE TOPIC:

"PREGNANCY IN HEALTHY WOMEN. ANTENAL CARE »

I Pedagogical Annotation

The main goal of antenatal care is to reduce maternal and perinatal morbidity and mortality.

The goal of prenatal care is to help a woman stay healthy and thereby preserve the health of her future child. Prenatal care also includes the care and support provided to a pregnant woman and her partner or family. This means that health workers should not only provide care, but also inform, and also train a pregnant woman and her partner or family members.

Antenatal care is provided in primary health care facilities (PHC), it is conducted by the GP, obstetrician-gynecologist, midwife, health nurse. The main responsible specialist for antenatal care is GP.

The purpose of this case: To teach antenatal care in healthy women (with physiological pregnancy) at the primary level.

Expected training results - students get skills based on the results of work with the case:

To support the psychological adaptation of a woman to pregnancy, childbirth, breast-feeding and parental role.

Monitor the course of pregnancy, determine the plan for examination and assess the condition of the mother and fetus.

To survey all women and to reveal signs of possible complications (determination of deviations from the physiological course of pregnancy) and in case of deviations, provide appropriate assistance and, if necessary, provide translation to the appropriate institution

Provide women with important information about their health: healthy eating, quitting, prevention of HIV / AIDS, adherence to the intergenic interval, use of contraceptive methods, prevention of violence

To conduct training cycles for pregnant women and their families in institutions and mahallas

Ensure accurate documentation at every visit to the pregnant SP / SVP (Individual card of the pregnant woman and the puerperas Form 111 / U, Mother's medical passport - MMM)

In addition, the student will master and be able to independently demonstrate skills:

External obstetric examination of pregnant women using gravidogram

Listening to the fetal heartbeat

Calculation of the estimated weight of the fetus

Determining the period of pregnancy and childbirth

Taking a smear of vaginal discharge.

To successfully solve this case, the student must be able to perform the main tasks of the GP in ANU:

- Detection of pregnant women in early gestation;

- Full initial examination of a pregnant woman with the participation, if necessary, of narrow specialists (obstetrician-gynecologist, endocrinologist, cardiologist, etc.);

- The decision of a question on possibility of prolongation of pregnancy from medical positions;

- Provision of qualified antenatal care throughout the pregnancy, based on advanced technologies and evidence base;

- Conducting sanitary and educational work to promote healthy lifestyles, proper nutrition, micronutrient intake, the dangers of smoking and alcohol use;

- Carrying out work on counseling pregnant women, providing the necessary information in families;

- Informing the pregnant woman and her family about "dangerous signs during pregnancy and childbirth";

- Referral of a pregnant woman to a screening study in terms of 14-20 weeks to exclude fetal development abnormalities, interpretation of results, referral to abortion in case of fetal abnormalities;

- Screening of pregnant women on RW and HIV twice: when registering for pregnancy in 1 trimester and at 30 weeks

- Carrying out preventive measures to prevent complications of pregnancy;

- Early detection of complications of pregnancy or extragenital diseases, if necessary, provision of emergency care and timely hospitalization, taking into account the regionalization of medical care for pregnant women;

- Organization and holding of the "mother's school";

- Training pregnant women in the "MMM" and entering the necessary information;

- Discussion and development of a plan of activities in the event of hazardous situations;

- Development of a plan of measures to prepare for the forthcoming birth, taking into account the principle of regionalization of medical care for pregnant women and women in childbirth, choosing a place for delivery;

- Provision of full-fledged post-natal care, including postpartum contraception, within 40-45 days after delivery;

- Organization and implementation of measures to prevent unwanted pregnancies for compliance with the intergenic interval of at least 3-3.5 years, in women with absolute contraindications to pregnancy, younger than 20 and over 35 years.

- Providing women with legal protection in accordance with the legislation of the Republic of Uzbekistan.

This case reflects the real situation in the context of primary care

Sources of information of the case

Antenatal follow-up card

Directory of the University of California // Obstetrics under the editorship of K.Niswander

Characteristics of the case according to typological features

This case is classified as a desk, story. It is short, structured. This is a case study.

For didactic purposes, the case is a training, stimulating thinking in a real situation in the conditions of SVP and GWP.

The case can be used in the following disciplines: Obstetrics and gynecology, GP therapy.

II SITUATION-CASE

During the first visit - a re-pregnant A., 25 years old she turned to the SVP doctor with complaints about the delay of menstruation for 2 months, nausea in the mornings, weakness. In the mirrors: the walls of the vagina and the cervix are cyanotic. PV: the length of the cervix is 2.5 cm in the region of the isthmus - softened, the body of the uterus in AFV, increased to 5-6 weeks. pregnancy, excitable at palpation, appendages are not determined, discharge is bright.

Anamnesis of life: sexual life since 20 years, Works as an accountant at the plant. There are no bad habits.

Obstetric anamnesis: of all pregnancies - 1, of them - 1 urgent delivery 3 years ago, without complications.

From the transferred diseases - catarrhal diseases;

menstruation from 13 years, sex life from 20 years, marriage first.

Family / social anamnesis: married, has two children, the husband works as a cook, does not smoke, does not drink.

Epidemic history

In contact with infectious patients was not,

I did not receive any blood products

Injection therapy denies

In the last 6 months at a gynecologist's and dentist's reception was not

Physical examination

Skin and mucous membranes are clean, of normal color. Consciousness is clear, the position is active.

Pulse regular - 90 beats per minute, satisfactory filling and tension of blood pressure 110/70, auscultation of the heart - normal, no pathological noise was detected,

There are no respiratory disorders, auscultatory - there are no changes in lungs.

The abdomen is soft, palpation painless, the liver and spleen are not enlarged.

The symptom of effleurage is negative on both sides.

Gynecological anamnesis:

Notes the absence of menstruation for 2 months.

Inspection in the mirrors (the external genitalia are developed correctly, female hair type, vaginal mucosa, cervical uteri are clean, cyanotic, mucous discharge, light)

Bimanual examination (neck of cylindrical shape, dense, deflected posteriorly, external zev - closed, cervical excursion painless, body of uterus in AFV, increased to 5-6 weeks of gestation, excitably during investigation, isthmus softened, area of appendages, arches, parameter - without changes, allocation - light, slimy)

Surveys conducted in the SVP showed:

UAC: HB-112 g / l, Leukocytes -4.2 thousand / ml, ESR -15 mm / h

The general or common analysis of urine in norm or rate

Pregnancy test positive

During a subsequent visit at 30 weeks: No complaints. Condition - satisfactory. VDM - 29 cm, OZh-82 cm, uterus in normotonus, painless, the position of the fetus is longitudinal, the head is above the entrance to the small pelvis, the fetal heart rhythm is rhythmic, 160 beats per minute.

Questions and tasks:

Conduct a pregnant woman

Define a survey and maintenance plan

Determine the duration of pregnancy and the date of expected delivery for the last menstruation

Conduct a follow-up examination of a pregnant woman at 30 weeks gestation and develop a birth plan

The technological map of the training session based on the decision of the case

7. Test questions

What are the criteria for outpatient monitoring of pregnant women?

What methods of pregnancy diagnosis do you know?

Identify complex tactics for managing pregnancy

What is the volume of clinical examination of pregnant women using laboratory and instrumental research methods?

How to evaluate the fetal status of the fetus?

What are the rules for monitoring pregnant women in a family clinic, what is the role of the family?

8. Literature

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Essential Antenatal, Perinatal and Postpartum Care. WHO, Copenhagen, 2002.

Murray W. Enkin et al. A guide to effective care in pregnancy and childbirth. Third edition, Oxford University Press, 2000. Marrey Enkin, M. Kitre, J. Neilson. (Translated from English under the editorship of Mikhailova AV) Guidelines for effective care for pregnancy and childbirth. SPb, 2003.

Villar J, Bergsjo J. WHO Antenatal Care Randomized Trial: Manual for the Implementation of the New Model. Geneva, World Health Organization (WHO)

Theme number 3: Keeping pregnant with a scar on the uterus. Cesarean section in modern obstetrics. Diagnostics. Keeping pregnant.

Theoretical part C-section -obstetric surgery intended for delivery through laparotomy incision and uterine wall, when giving birth vaginally for whatever reason are not possible or are accompanied by complications for the mother and the fetus.
All indications for caesarean section is divided into absolute and relative by both the mother and the fetus.
Absolute indications for caesarean section.
Absolute indications include a group of causes:
-(III)—(IV)the degree of narrowing of the pelvis;
-Tumor and cicatricial changes to birth the fruit;
-Complete placenta previa or incomplete bleeding her fetus;
-Premature detachment normally situated placenta (in the absence of rapid vaginal birth);
-Eclampsia during pregnancy or the first stage of labor; lack of quick delivery pregnant with severe gestosis therapy, very hard, the appearance of renal deficiency baked;
-Threatening uterine rupture;
-Incorrect position of the fetus;
-Disability wall of the uterus (after cesarean section in the past, myomectomy, uterine perforation, etc.);
Incorrect insertion of the presentation and the fetal head (brow, perednetemennoe, asinklitic, high standing seam directly arrow, etc.);
-The presentation and cord prolapsed with live fruit; the severe form of heavy late toxicoses of pregnant with no conditions for immediate delivery through the birth canal, and (most);
-Uterine inertia forces with inefficiency therapy;
-Progressive course and extra genital diseases in decomposition condition (idiopathic hypertension, diseases of the cardio-vascular system, etc.) that require an urgent delivery and there are no facilities for it through most of the major birth canal;

-Deformations and fractures of the pelvis;
-Genitourinary and gastro-sexual fistulas in history;
-Threatening and began tearing the uterus;
Varicose veins-expressed in the external genital organs;
-Numerous combined testimony (large fruit for breech presentation in nulliparous age, etc.).

Relative indications for caesarean section.

To relative grounds include a situation where there is a possibility of delivery by natural means, but the risk of complications for the mother and/or the child exceeds the risk of complications of abdominal delivery.

Common **relative** indications:
-scar at the womb after preceding operations;
-pelvic fetal position;
-extra genital diseases in which the breech vaginal birth is increased risk to women's health (myopia with Dystrophic changes in the fundus, epilepsy, posttraumatic ènce falopatiâ, etc.);
-premature rupture of membranes;
-anomalies birth (uterine inertia forces);
-presence of obstetrical history (infertility, habitual miscarriage);
-age over 30 years 1st labor;
-over term pregnancy;
-diabetes mellitus and large fruit;
-anatomically narrow hips p & I degree, especially in combination with other unfavorable factors (elderly women, pelvic presentation etc.); facial previa; multiple uterine fibroids; diseases of the central nervous system; fetal hypoxia; malformations of the uterus; by combining different evidence.

Early caesarean section is shown by:
-preterm rupture of membranes or premature development of labor activity and presence of intrauterine fetus development delays(II)—(III)degree;
-moderately expressed hypoxia according to CTG combined fetal development delay(II)—(III)degree.
-(II)degree of hemodynamic abnormalities in mother-placenta-fetus with bilateral uterine blood flow in the arteries of the violation and the presence of notches on the spectrogram dichotic.
-Indications for emergency delivery in the presence of fetoplacental insufficiency, as well as support the development of the fetus during pregnancy more than 32 weeks are:
-Detection of signs of pronounced hypoxia according to CTG (antenatal spontaneous emergence late decelerations, deceleration in oxitocin test);
-Critical state fruit-placental blood flow Doppler ultrasound data (lack of diastolic or retrograde blood flow in the umbilical artery);
-The emergence and progression of clinical (rhythm or heart rate with the development of bradycardia, low tones) and/or cardiografic (late decelerations) signs of fetal hypoxia in childbirth (in the absence of the conditions for rapid vaginal birth);
-Drop loop of umbilical cord with cephalic presentation;
-The lateral position of the second fetus from the twins.

Delivery by caesarean section routinely are pregnant in the following clinical situations:
-Delay of the development of the fetus or cause doplerometric symptoms over term blood circulation in its centralization of pregnancy (fetal aorta in a 8.0 and JDO in Middle cerebral artery is less than 2.8);
-Pelvic presentation or lateral position of the fetus;
-Combination(I)-(II)degree of hemodynamic abnormalities in mother-placenta-foetus, early signs of fetal hypoxia with other obstetrical pathology (large fruit, age 30 years older than 1st labor, weighed down by obstetric history, etc.);

-Early signs of fetoplacental insufficiency Progression (worsening of CTG, JDO or signs of increasing centralization of blood circulation in doplerometric research), despite ongoing treatment.

However, the increase in the number of operations cesarean VA section leads to an increase in the number of women having a scar on the uterus, and is accompanied by increased risk of complications in the postoperative period. Therefore, it is important to consider the conditions and contraindicated of the IDB to caesarean section.

Conditions for caesarean section are: a viable fetus, the classification of the qualification of the surgeon, a woman's consent to the operation.

It should be remembered that a scar on the uterus is uterine rupture in perspective (asymptomatic or minor symptoms).

Abdominal pain, lower back pain, across the abdomen, in the region. the scar, on the abdominal wall, the unclear localization during physical exercise, even minor, especially not peel spazmolitikami, analgesics should be interpreted as a threat of uterine rupture of rubcu, not the threat of miscarriage.

In term pregnancy in women with scar at the womb long preliminary period should also be considered as threatening uterine rupture.

At the same time, under the guise of threatening preterm birth in late pregnancy may show clinical failure of the scar on the uterus and thereby threatening uterine rupture. The positive effect of the therapy aimed at preserving the pregnancy (Tocolytic, sedatives), and no local pain in the scar on the uterus, and ultrasound data (evidence about the full lower segment) and cardiotocography (indicating the absence of acute fetal hypoxia) confirm the diagnosis of premature delivery. Persistent local pain in the scar on the uterus, thinning and acoustic heterogeneity ehoplotnost regions (detected at ultrasound of the lower segment of the uterus), and the signs of the deterioration of the fetus (according to CTG) is called the failure of the uterine scar - or rather, to a threatening rupture of the uterus. In these cases, the required emergency abdominal delivery.To develop tactics of pregnancy and delivery method of choice for women with scar at the womb has an important meaning of NOE, the assessment of the condition of the uterus, which is carried out using a transabdominal and transvaginal ultrasonography in pregnancy.

Ehografic criteria for full healing of the lower uterine segment are:

-U-shaped it with a thickness of not less than 4-5 mm;

-Normal èhogennic′ of the lower segment, similar to the one in the other divisions of the uterus;

-Small areas of low sound transfer on the background of normal acoustic density.

The **èhografic** featured **the insolvent** transverse scar we include:

-Cans-or conical form of the lower segment of the uterus;

-The thickness of the lower segment of less than 3 mm;

-Local thinning of the lower segment of less than 3 mm in the background of normal thickness (4-5 mm);

-Enhanced acoustic density throughout the area of the former.

Many complications that arise in gestational period give reason to treat the scar on the uterus like a disease "after the uterus, cervical incompetence".

Complications during gestation: the threat of termination of pregnancy, placental insufficiency, SZRP, PONRP, wrong position of fetal, perinatal complications, the risk of uterine rupture, uterine rupture of rubcu, coma, lethality.

Complications in childbirth: birth anomalies, bleeding (PONRP, hypotension, etc), perinatal complications, the risk of uterine rupture, uterine rupture of rubcu, coma, lethality.

Recommandations to abdominal′nomu delivery are: intrauterine fetal death or being, incompatible with the existence of intrauterine (Glu-bokaya prematurity, very pronounced degree of hypoxia and fetal malnutrition, foetal malformations, incompatible with life), acute infectious-inflammatory diseases

Criteria for the selection of women with scar at the womb to conduct **spontaneous deliveries** are:
-one c-sections in history, made a cut in the lower uterine segment to a non-repeating (transient) condition: fetal hypoxia, birth abnormalities, pelvic presentation and abnormal position of the fetus, placenta previa and Abruptio, heavy forms hypertensive States;
-No new evidence during this pregnancy to the birth of samoproizvol′;
-satisfactory condition of the mother and fetus.
previa-head sole fruit;
-a full lower cervical segment (clinical and ultrasound data);
-a woman's consent to conduct spontaneous deliveries.
-favourable currents of this pregnancy with no sign of the threat her interruption, signs of fetoplacental insufficiency of gipoksičeskom syndrome of fetus and its placenta location, wasting away, the alleged "scar" on the uterus;
-the biological maturity of the cervix 4th degree;
-preservation of the principle of "triple downward gradient between the divisions, including the lower segment of the uterus; with the start of labour;
-establishing the correct position of the fetus and members head location at the entrance of the pelvis, or centered above the pelvis in the preparatory period for childbirth.
Conservative management of women with scar at the womb is possible only in large hospitals equipped with obstetric enough (or perinatal centres), with 24-hour supervision of highly qualified obstetricians and gynaecologists who endorsed full ext of assistance (including hysterectomy).
Diagnostics of the scar in the out-patient stage:
Visit pregnant women in turn.(I)half of 1 times in 2 weeks, in(II)– 1 time per week.
ULTRASOUND in Dynamics: the I-II trimester 1, III – 3 times.
To èhografičeskim scar at the womb insolvency during pregnancy include thinning of the lower segment of the scar (less than 0, 3 cm), a significant number of acoustically dense inclusions, indirectly indicating the presence of scar tissue, reshaping the lower segment in the form of niches.
To determine the usefulness of the uterine muscles in the area of the former incision should take into account the objective data obtained by palpation. To do this, pushing aside a skin scar the uterus, pal′piruût when the incision the previous operation. In response to palpation, the uterus is usually reduced. If a scar, then it is not defined and the uterus is uniformly reduced. With nepolnocennom rumen connective tissue is reduced and not pal′piruûsie fingers feel the deepening (notch) in the uterus.
CTG in Dynamics: from 24 weeks.
Date of hospitalization for women with scar at the womb:
-up to 12 weeks, to assess the condition of the SCAR and to address the issue of pregnancy prolongirovani.
-In 24-26, 30-34 weeks. for the treatment of fetal hypoxia, ÈGZ and attendant complications during gestation.
In a 38-37 weeks for the birth, and when in the rumen nepolnocennom 35-36 weeks.
For delivery, pregnant with scar at the womb State of pitaliziruûtsâ in obstetrical hospitals in 37-38 weeks gestation, where they conducted a full survey of the General and special maternity, childbirth timing TBC, valued the fetoplacental system (using ultrasonic fetometrii, placentografii and dopplerometričeskogo study of blood flow in the umbilical artery and the uterine arteries) and is determined by the estimated weight of the fetus, an assessment of the status of the scar on the uterus (clinically and èhografičeski), be sure to include the data history.
In order to improve the outcomes of repeated Caesarean section for fetal surgery is very significant in the timing, close to childbirth: 39-40 weeks. The transformation of prior years ' arrears, to avoid the risk of uterine rupture is most often coming with the start of labor activity, repeated abdominal delivery were at 38 weeks. The children were born with a birth weight of

full-term, but often with gratitude, Kami morfofunkcional′noj immaturity, that in some cases led to the development of respiratory distress syndrome.

Management of pregnancy in women with scar at the womb:

(I)term:
(a) medical-conservative) mode;
b) General recreational activities;
in the laboratory and instrumental examination);
g) treatment of concomitant ÈGZ;
d) treatment complications during gestation;
e) programming follow-up.
(II)term:
(a) medical-conservative) mode;
b) General recreational activities;
in laborotorno)-instrumental examination;
g) treatment of concomitant ÈGZ;
d) treatment complications during gestation;
e) programming follow-up.
(III)term:
(a) medical-conservative) mode;
b) General recreational activities;
in laborotorno)-instrumental examination;
g) treatment of concomitant ÈGZ;
d) treatment complications during gestation;
e) programming of prenatal hospitalization with the traditional preparation for childbirth and with the assessment test readiness indicators.

Concept and types of inappropriate regulations and presentations.

A situation in which the longitudinal axis of the fruit forms a sharp corner or right angle with the longitudinal axis of the mother in the absence of the presenting part.

Causes of the wrong position and fetus.

Excessive fetal movement: when polyhydramnios, gipotrofičnom or nedonošennom fruit, multiple pregnancy, the muscles of the anterior abdominal wall skin flabbiness multiparous. Limited mobility: Fetal malovodii, big fruit, there, you have uterine fibroids, uterine cavity strain, increased uterine tonus, threat of termination of pregnancy. Obstacle vstavleniû head: placenta previa, narrow hips, the presence of uterine fibroids in the lower segment. Abnormalities of the uterus: the uterus dvurogaâ septum, the septum. Fetal anomalies: hydrocephaly, anencephaly.

Diagnosis and incorrect presentations.

-Belly shape: oval or cross-kosooval′naâ; -low standing of seafloor of the uterus; the absence of the presenting part;
-pelvic palpation, head end in the side sections of the uterus fetal heartbeat heard;-in the navel area;-lack of the presenting part of the vaginal examination, and when izlitii amniotic fluid when you can define study vaginal shoulder, handle the umbilical cord, ribs or spine of the fruit; ULTRASOUND study).
--Prevention of constipation; It is recommended for pregnant women to lie on her side, and at the same position on the side of Kos a major part of the fruit;
-admission to 35 weeks;

Complications of pregnancy and childbirth in the wrong position and fetus fetus.

-premature birth by prenatal observing the amniotic fluid in the absence of the belt is tight, may be accompanied by Syncope: small parts (knobs, feet, hinges of the umbilical cord),
-infection of the fetus,
-running lateral position, which threatens to fetal hypoxia, when continuing cuts the uterus may at first, then pererastâženie, and uterine rupture.

Prevention activities:

-polupostel′nyj mode;
-prophylaxis of constipation;
-It is recommended to pregnant women lying on the side of the position, and when the situation on the side of Kos a major part of the fruit;
-admission to 35 weeks;
-combined fetal rotation on foot;
-the best method of delivery is by caesarean section;

Tactics of fetal pelvic presentation in redležanii..

. Pelvic presentation requires an expectant observation.

From 29-30 weeks are recommended: gymnastic exercises (pregnant lies on the right and left side perevoračivaâs′, every 10 minutes, repeat 3-4 times a day).

INCORRECT POSITION OF THE FETUS.

A situation in which the longitudinal axis of the fruit forms a sharp corner or right angle with the longitudinal axis of the mother in the absence of the presenting part.

1. Excessive fetal movement: when polyhydramnios, gipotrofičnom or nedonošennom, plural pregnancy the foetus (the second fetus), the muscles of the anterior abdominal wall skin flabbiness multiparous.
2. limited mobility of the fetus: malovodii, big fruit, there, you have uterine fibroids, uterine cavity strain, increased uterine tone under the threat of termination of pregnancy.
3. Obstacle vstavleniû head: preležanie placenta, narrow hips, the presence of uterine fibroids in the lower segment.
4. abnormalities of the uterus: the uterus dvurogaâ septum, the septum.
5. fetal Anomalies: hydrocephaly, anencephaly.

DIAGNOSTICS.

-Belly shape: oval or cross-kosooval′naâ;
-low standing of seafloor of the uterus;
-absence of the presenting part;
-pelvic palpation, head end in the side sections of the uterus;
-fetal heartbeat should be heard in the area of the navel;
-absence of the presenting part of the vaginal examination, and when izlitii amniotic fluid when you can define study vaginal shoulder, handle the umbilical cord, ribs or spine of the fruit;
-Ultrasound study.

PREGNANCY AND CHILDBIRTH.

Often when you cross the pregnancy without complications, sometimes with increased mobility is not a stable position of the fetus.

The most common complications of prematurity with prenatal observing the flow of amniotic fluid in the absence of the belt is tight. Premature rupture of water may be accompanied by Syncope: small parts (knobs, feet, hinges of the umbilical cord), infection of the fetus.

Premature rupture of waters from intensively reduction uterus, limiting the mobility of the fetus is called a running situation. Fetal hypoxia, which may face when continuing cuts the uterus may be at first, then pererastâženie, and uterine rupture.

MANAGEMENT OF PREGNANCY AND CHILDBIRTH.

-polupostel′nyj mode;
-prophylaxis of constipation;
-It is recommended to pregnant women lying on the side of the position, and when the situation on the side of Kos a major part of the fruit;
-admission to 35 weeks;
-combined fetal rotation on foot;
-the best method of delivery is by caesarean section;
-If a woman comes in the second stage of labour with a live fetus small mass motility can be saved of the combined rotation of the fetus on the foot;

-If you have an infection on the background of a long period when anhydrous live fruit shown caesarean section, the removal of the uterus, the drainage of the abdominal cavity;
-When running a transverse position of the fetus and the dead foetus is èmbriotomiâ.

BUTTOCK PRESENTATIONS.

Divided into purely buttock (pointing to the entrance of the pelvis, and legs âgodički stretched along the body) and mixed the buttock (together with âgodičkami to the door of the small pelvis turned legs of the fetus).

Maternal factors: abnormalities of the uterus, uterine tumors, narrow hips, lowering or raising the tone of womb in mnogorožavših, scar at the womb after operation.

Fruit: prematurity, multiple pregnancy, intrauterine growth, fetal abnormalities, abnormal fetal členoraspoloženie.

Placental factors: placenta previa, its location in the DNA or the angles of the uterus, malovodie or abounding in water.

DIAGNOSTICS.

Exterior obstetrical examinations (Leopold Levytskyy techniques):

-detects the first reception of a rounded, dense, ballotiruûŝej heads; the bottom of the uterus is higher than with cephalic presentation.

-second trick determines the backrest of the fruit;

-third taking over the entrance or at the entrance of the predležaŝaâ in large part determines the pelvis, soft consistency, unable to stand as candidates;

-the fourth trick is predležaŝaâ the part that most often until the end of pregnancy is not pressed to the door of the small pelvis.

The heartbeat of the fetus is being heard above the navel.

When the vaginal Vault through the forward study has major mâgkovatoj predležaŝaâ consistency of the fetus.

ULTRASOUND Diagnostics.

When fetal electrocardiography želudočkovyj complex turned downwards, not upwards, as with cephalic presentation.

PREGNANCY AND CHILDBIRTH.

Most pregnancies complicated by: threat of interruption of pregnancy with signs of cervical incompetence, incompetence of the first half of pregnancy toxemia, hypertensive disorders, anaemia, obvitiem fetal umbilical cord, malovodiem.

The genera is characterized by a large number of complications. In the first period more often early or premature rupture of water because the pelvis is not fitted firmly to distinguish descent not channel water into the front and back of each scene and tension membranes.

However, observing the flow of water could drop small pieces of fruit or umbilical cord.

There is often weakness generic activities, disclosure of the cervix occurs long pelvic end remains over the entrance of the pelvic cavity. Births become protracted because the largest part of the fruit is a head-final is born. First descent is a channel, the end of the pelvic less voluminous and cannot disclose the birth canal for more careful passing shoulder and head. Therefore, at the time of entry into the pelvis shoulder girdle may occur zaprokidyvanie pens and unbending heads that threaten fetal hypoxia and loss.

When passing through the pelvis to the upper half of the body is the squeeze of umbilical cord and the duration of that period more than 3-5 minutes, there is severe fetal hypoxia.

May vkolačivanie the buttocks of the fetus in the pelvis, which is a sign of the mother's pelvis dimensions inconsistencies of the fruit. Another serious complication – rotate the fetus back posteriorly when the Chin is fixed beneath the lobkovym Ingens, unbent head: danger of hypoxia, fetal and maternal trauma.

Breech presentation during childbirth injuries are often caused by the mother's tears: the cervix, vagina and perineum.

Often there is a transition from purely a breech position in mixed, which expands the indications for caesarean section.

MANAGEMENT OF PREGNANCY AND CHILDBIRTH.

Pelvic presentation requires an expectant observation.

From 29-30 weeks are recommended: gymnastic exercises (pregnant lies on the right and left side perevoračivaâs′, every 10 minutes for repeat 3-4 times, 3 times a day).

You can carry out the external routine rotation of the fruit.

Tactics of delivery should be determined before taking into account: Fetal weight, an extension of the head, the evaluation of the fetal heart, utero-placental and fruit-placental blood circulation, the mother's pelvis, cervical maturity.

Delivery may be:

-spontaneous vaginal delivery and the start of vaginal birth;

-rodovozbuždenie at or before the time of the birth;

-delivery by elective caesarean section as planned.

In the first stage of labour with a view to preventing premature izlitiâ amniotic fluid lying-in woman should observe bed rest, lying on its side which faces the back of the fetus. Immediately after izlitiâ amniotic fluid to vaginal examination to exclude cord prolapse loops.

The genera predležaniii, breech requires continuous monitoring of fetal heart activity and uterine contraction. What would change if options to expand the indications for caesarean section.

When the established regular birth (uterine opening Zev 3-4 cm.) shows the introduction: pain medications and remedies, the case of epidural anesthesia, which contributes to the regulation of labour; rapid disclosure of the cervix; relaxation of pelvic floor muscles in the second stage of labour. Required activities for the prevention of fetal hypoxia 2-4 ml. 1% solution sigetina, 50-100 mg, kocarboksilaza 10-20 ml of 40% glucose, oxygen inhalation moistened.

The presence of meconium for breech presentation is not a sign of hypoxia.

In the second stage of labour recommended ET introduction of uterotonic (oxytocin), and by the end of the second period to prevent acute cervical injected 1, 0ml. 0.1% solution of atropine, or 2 ml 2% solution papaverina etc.

During her powers should rest the soles of the feet, hips and hands pressed to his stomach to amplify the powers and reduce the angle of the pelvis.

Delivery in breech presentation there are 4 phases: 1. the birth of a fetus to the navel; 2. the birth of a fetus from the navel to the lower edge of the blades; 3. birth of the shoulder girdle and handles; 4. birth of the head.

Indications for caesarean section.

During pregnancy: perenašivanie, lack of birth, abnormalities of the genitals anatomically narrow hips, HVGP, fruit weight is 3600 more or less 2000, unbending, heads hem primiparae, age of the adverse outcome, previous birth, infertility in anamnesis.

During childbirth: birth anomaly, fetal hypoxia, loss of loops the cord or small pieces of fruit, unbending head.

EXTENZIO OF FETUS HEAD.

There are three degrees of extension wedges heads:

1. Perednegolovnoe previa is a leading point of big spring, the diameter of a large segment of 12 cm.

2. the place of the presentation is the leading point of the nadbrov′e, a large segment of 13 cm.

3. Facial previa is a leading point of the Chin, a large segment of 9.5 cm.

Abounding in water, abounding in water, the aborted fetus, reducing uterine tone, large fruit, narrow hips, placenta previa, uterine and fetal abnormalities (tumors, neck cord entanglement).

DIAGNOSTICS.

For exterior obstetrical survey of higher standing of seafloor uterus, when measuring the direct head size is 12 cm. and more.

ULTRASOUND Diagnostics.

When vaginal birth study found wired dot – big spring, the sagittal suture in the plane of the entrance of the pelvis is in cross sometimes in Koos.
After the birth of a fetus in the birth of large tumor bulging Fontanelle (tower head).

TACTICS OF.

At term, nekrupnom fruit size pelvis normal childbirth and lead.
With the full opening of the conformity assessment of the fetal head size of the pelvis of the mother.
Surgical delivery is shown at: perenašivanii fruit large, narrow, pervorodâŝej, taze an old weakness generic activities.
In the second period when the weakness of labour, fetal hypoxia in the front of the pelvic cavity is shown by means of the delivery of obstetric forceps.
In posledovom and for the prevention of postpartum haemorrhage injected substances that reduce the uterus.

THE PLACE OF THE PRESENTATION.

For exterior obstetrical survey of high standing of seafloor of the uterus, the angle between the head and the back of the fetus. Heartbeat heard better from the side of the chest.
When vaginal delivery study finds the frontal part of the head, forehead seam ending palpated on the one hand with the other great perenosicej rodničkom.
After birth, fetal birth is on the forehead swelling (piramidnaâ head).
ULTRASOUND Diagnostics.

At term, at normal size pelvis deliveries are impossible, since the head is moving its biggest how generic the size with the development of clinically narrow pelvis.
If you place a previa hospitalization to determine the causes of frontal presentation and delivery tactics.
For preterm amniotic fluid izlitii cesarean section.
If a caesarean is missed, the mother was at the front of the pelvic cavity, you must exclude the risk of uterine rupture, monitor the status of the fetus, avoid prolonged standing heads in one plane, to prevent fetal hypoxia, with long period-anhydrous antibacterial therapy.
Late fetal birth, signs of hypoxia require immediate delivery, application of obstetric forceps or plodorazrušaûŝie operation even with live fruit.

TRANSVERSE FACIAL.

For exterior obstetrical survey definition of deepening between the head and the back of the fetus, the lack of convexity of the back. The heartbeat is most clearly heard from the side of the chest.
When vaginal study identifies part of a fruit facial: Chin, brow bones, nose, mouth with hard lumps of gum. The foetal position is determined by the Chin.

If you require hospitalization previa facial to determine the causes of frontal presentation and delivery tactics.
Creating a protective regime for the prevention and treatment of premature izlitiâ amniotic fluid.
When the personal presentation, at normal size and pelvic nekrupnom fruit deliveries more often end favorably. Follow labour and palpitation of the fruit.
In the first period to ensure continued as rear view front view if you have genera vaginal birth is not possible.

Indications for caesarean section: fetal hypoxia, loss of loops the cord or small parts of the fetus, the development of clinically narrow pelvis, large fruit, perenašivanie, old Primiparous, front view of personal presentation, the weakness of labour.
In the case of a secondary weakness of labour, fetal hypoxia in the front of the pelvic cavity (there is no way to extract the fetus by Cesarean section), to save the life of the pregnant woman is plodorazrušaûŝaâ surgery, even if the fetus is alive.

4.2 practical part

List of practical skills:

1. Exterior obstetrical exam.
2. listening to the heartbeat of the fetus.
3. emergency care at the pre-hospital stage
4. Determination of gestational age and birth date

(see the annex to the manual skills)

4.3 analytical part

Annex No. 1 small-group work

Students are divided into 2 groups by the account of 1.2, ...All students with Figure 1-1 is the Group sit to the right, with the number 2 is a 2-oz, left. Then the teacher asks you to select each group of cards with prepared questions.

To prepare and record is 10 min. With each group meets one student. A rival group along with a teacher are experts. The first group answered and gave the full answer to the question is the winner.

Test questions:

1. Absolute indications for caesarean section.
2. the relative indications for caesarean section.
3. incorrect Diagnosis of fetus
4. complications during pregnancy and delivery in these States.
5. Prevention of incorrect position of the fetus
6. prenatal ISSUES's tactics, with transverse position of the fetus.
7. the ISSUE, maintenance Tactics pregnant women with fetal pelvic delivery
8. What are the contraindications for cesarean section you know.
9. under what circumstances may give birth vaginally in women with scar at the womb.
10. Diagnostics of the scar in the out-patient stage:
11. Periods of hospitalization for women with scar at the womb.
12. management of pregnancy in women with scar at the womb.

Responses (see section teoritičeskuû)

Annex No. 2 "hidden treasure".

On a piece of paper to the teacher in advance to write questions on the content of the lesson. Before the arrival of students enlisted questions to their chairs and students reported that at every stool hidden treasure that they need to find. When all will find leaflets, the student should read the question aloud and answer it.

1. definition and types of inappropriate regulations and presentations. (A situation in which the longitudinal axis of the fruit forms a sharp corner or right angle with the longitudinal axis of the mother in the absence of the presenting part).

2.Causes of incorrect position and fetus. (Excessive fetal movement: when polyhydramnios, gipotrofičnom or nedonošennom fruit, multiple pregnancy, the muscles of the anterior abdominal wall skin flabbiness multiparous.

Limited mobility: Fetal malovodii, big fruit, there, you have uterine fibroids, uterine cavity strain, increased uterine tonus, threat of termination of pregnancy. Obstacle vstavleniû head: placenta previa, narrow hips, the presence of uterine fibroids in the lower segment. Abnormalities of the uterus: the uterus dvurogaâ septum, the septum. Fetal anomalies: hydrocephaly, anencephaly).

3. Diagnostics the wrong position and fetus. (form: abdominal transverse-oval or kosooval′naâ;-low standing of seafloor uterus; lack of the presenting part; -pelvic palpation, head end in the side sections of the uterus fetal heartbeat heard;-in the navel area;-lack of the presenting part of the vaginal examination, and when izlitii amniotic fluid when you can define study vaginal shoulder, handle the umbilical cord, ribs or spine of the fruit; ULTRASOUND study).

4. During pregnancy and in the wrong position and fetus. (prevention of constipation; pregnancy are advised to lie on her side, and at the same position on the side of Kos a major part of the fruit-admission to 35 weeks;

5. complications of pregnancy and childbirth in the wrong position and presentation of the fetus. (preterm delivery with prenatal observing the flow of amniotic fluid in the absence of the belt is tight, may be accompanied by Syncope: small parts (knobs, feet, hinges of the umbilical cord), fetal infection, running lateral position, which threatens to fetal hypoxia, when continuing cuts the uterus may pererastâženie first, and then to uterine rupture).

Annex 3

Objective No. 1.

The family clinic has a woman 35 weeks gestational age. A history of Cesarean section 2 years ago. Determine the condition of the scar on the uterus.

To determine the usefulness of the uterine muscles in the area of the former incision should take into account the objective data obtained by palpation. To do this, pushing aside a skin scar the uterus, pal′piruût when the incision the previous operation. In response to palpation, the uterus is usually reduced. If a scar, then it is not defined and the uterus is uniformly reduced. With nepolnocennom rumen connective tissue is reduced and not pal′piruûŝie fingers feel the deepening (notch) in the uterus.

Send for an ultrasound in Dynamics**:** the I-II trimester 1, III -2 times.

To èhografičeskim scar at the womb insolvency during pregnancy include thinning of the lower segment of the scar (less than 0, 3 cm), a significant number of acoustically dense inclusions, indirectly indicating the presence of scar tissue, reshaping the lower segment in the form of niches

Objective No. 2.

The family clinic, a woman called 9 weeks of pregnancy. A history of Cesarean section 2 years ago. Tactics of women's ISSUES, explore with scar at the womb

-up to 12 weeks, to assess the condition of the SCAR and to address the issue of pregnancy prolongirovani.

-38-37 weeks-to address the issue of delivery method, and when in the rumen nepolnocennom 35-36 weeks.

For delivery, pregnant with scar at the womb State of pitaliziruûtsâ in high risk obstetrical hospitals in 37-38 weeks gestation, where they conducted a full survey of the General and special maternity, childbirth timing TBC, valued the fetoplacental system (using ultrasonic fetometrii, placentografii and dopplerometričeskogo study of blood flow in the umbilical artery and the uterine arteries) and is determined by the estimated weight of the fetus, an assessment of the status of the scar on the uterus (clinically and èhografičeski), be sure to include the data history.

In order to improve the outcomes of repeated Caesarean section for fetal surgery is very significant in the timing, close to childbirth: 39-40 weeks. The transformation of prior years ' arrears, to avoid the risk of uterine rupture is most often coming with the start of labor activity, repeated abdominal delivery were at 38 weeks. The children were born with a birth weight of full-term, but often with gratitude, Kami morfofunkcional′noj immaturity, that in some cases led to the development of respiratory distress syndrome.

Objective No. 3

Pervoberemennaâ asked in family health center 36 weeks of pregnancy. When inspecting the stomach increased by pregnancy, ovoidnoj correct form. WDM at the tip of the metasternum. Predležaŝaâ, testovatoj, neballotiruet, volumetric consistency, is above the pelvis. S/b the fetus should be heard at the level of the navel 144 beats per minute. rhythmic)

Diagnosis: Ber. 36 weeks 1. Pelvic fetal position.

Tactics: monitoring ISSUES in family clinic of complications (prenatal rupture waters)-admission to hospital.

Theme number 4: Premature birth. Diagnostics. Tactics of reference.

Theoretical part Non taken out pregnancy - a spontaneous interruption to pregnancy at period from conceptions before 37 weeks.

The Spontaneous interruption to pregnancy with 22 before 37-week name the premature birth. The Children under premature birth are considered born prematurely.
Non taken out pregnancy presents itself one of the the most important problems practical obstetrics. At present frequency to non taken out pregnancy varies from 10 before 25%; in I - a trimester she can reach 50%, in I I trimester - 20%, in I I I - a trimester - 30%.
On recommendations carry, in that event if pregnancy is broken at period 22 weeks and more, mass of the fetus forms 500 gr. and more, newborn survives for 7 days, birth consider to be premature with extreme low mass of the fetus. The Ruin child, been born after 22 weeks gestation (the mass 500 gr. and more) in 7 days following birth falls into factor perinatal to death-rate.

The Factors of the risk to non taken out pregnancy:

- Social - a biological factors: low social - an economic position (the low incom, low level of the formation, insufficient feeding), work, connected with physical voltage, stresses;
- Given obstetric-gynecologic anamnesis: age spending the first woman in childbirth full-grown less 16 years, premature birth in anamnesis, burdened obstetric anamnesis;
- Presence ekstragenital to pathology: sugar diabetes, arterial hypertension and the other diseases heartily - a vascular system, bronchial asthma, pielonephritis, accustomed intoxication (receiving the alcohol, smoking), drug addiction;
- A Complications to pregnancy: the lot of fetus, lot of water, pelvic prelyinng fetus (the premature birth in 205 events), prelying placentas (the premature birth in 5 once more often), tearing away placentas (the premature birth in 4 once more often), intrauterus infection, pre-natalinfection of fetus, hypertension of the breach.

The Threat of the interruption to pregnancy - increasing reductional to activities of the womb, which potentially can bring about tearing away fetal egg and exile him(it) from cavity of the womb.

Accustomed non taken out pregnancy - a spontaneous interruption to pregnancy two and more once contract before 37 early weeks gestation.

In connection with particularity obstetric tacticians and miscellaneous upshot premature birth for fruit reasonable to select 3 periods such sort with account of the periods gestation:
1 in 22-27 weeks; 2 in 28-33 weeks; 3 in 34-37 weeks.
The Premature birth in 22-27 weeks (the mass of the fetus from 500 before 1000 gr.) forms 5% from the gross amount. Most often they are conditioned isthmico-servical by insufficiency, infection lower pole fetal bubble and his(its) premature breakup. The Upshot sort for fruit in this group exceedingly disadvantage, high perinatal disease and death-rate.
The Premature birth at period gestation28-33 weeks (the mass of the fetus 1000-1800 gr.) are conditioned more varied reason, than early premature birth. That, light fruit else unripe, by means of purposes glucocorticoids or the other medicamentous of the facilities manages to obtain the speedups of their maturation. The Upshot sort more favourable, than in previous group.
The Premature birth at period gestation 34-37 weeks (the mass of the fetus 1900-2500 gr. and more) are conditioned else more varied reason, than in previous group.

The Clinical picture and diagnostics.

Distinguish:

- threatenning premature birth
- begun premature birth

For threatenning premature sort characteristic of presence of the changeable pains in lower part of belly and loin. Excitability and tone of the womb increased. At vaginal study find that neck of the womb is preserved, external pharynx locked.
Under beginning premature sort exist the pains adown belly and loin, smoothness and opening shakes wombs before 3 - 4 cm to Begun premature birth are characterized presence of the regular fights, sometimes exists leaking amniotic of water. Opening shakes wombs more then on 3 - 4 cm to.

Diagnos fixed on the grounds of anamnesis data, clinical picture, as of TIE (the local bulge miomethriy, increasing to motor activity of the fruit, sometimes reduction amount amniotic of water) and KTG (increasing to motor activity of the fetus)

Tactics conduct and treatment premature birth must be individual. The Treatment of all clinical forms premature birth is conducted in stationary condition. On this from general practitioner is required immediate hospitalization pregnant in obstetric permanent establishment.

At arrival pregnant on cause premature birth necessary:

- to realize the reason of the approach premature birth.
- to install the period to pregnancy, supposed weight of the fruit, his(its) position, prelying, heartbeat of the fetus, nature vaginal separations, condition shakes wombs and fetal bubble, presence or absence to infections.
- to define the stage premature birth, since therapy must be strictly differentiated.
- Under threatenning or beginning premature birth can be organized therapy, directed on conservation of pregnancy.

Under begun sort such therapy inefficient. In such events tocolis used for time of the maturation of the light fetus.

The Treatment. For reduction of excitability of the womb and suppressions her(its) reductional to activity (tocolis) is offered following treatment:

- a bed mode

- an tocolitics : salbutamol (the ginipral, partusisten, ritiodrin) 10 mg in 1 l isotonic of the solution sodium chloride as from 10 drops at minute and dose increases for each 30 minutes on 10 drops before stop reductional or pulse full-grown will not exceed 120 ud. in mines;

Indometacin - 100 mg loading dose peroraly or rectaly. Hereinafter on 25 mg each 6 hours for 48 hours.

The Alternative medicinal facilities: нифедипин (коринфар, тербуталин) on 25 mg each 6 hours peroraly.

Spazmolitiki: facility reducing activity of the womb : 25% solution magnesium sulphate on 5 - 10ml. i\m 2 times in day or 10 ml 25% solution in 400ml isothonic of the solution sodium chloride i/v droplet or tablets magnesium B6 on 1 - 2 tablets 3 times in day in current of the month.

If period to pregnancy less 37 weeks, is fixed full-grown corticosteroids for speedup of the maturation of the light fruit and chances on survivals newborn:

- dexamethasone 12mg i/m, 2 doses with interval 12 hours;
- or bethamethasone6 mg i/m 4 doses with interval 6 hours.

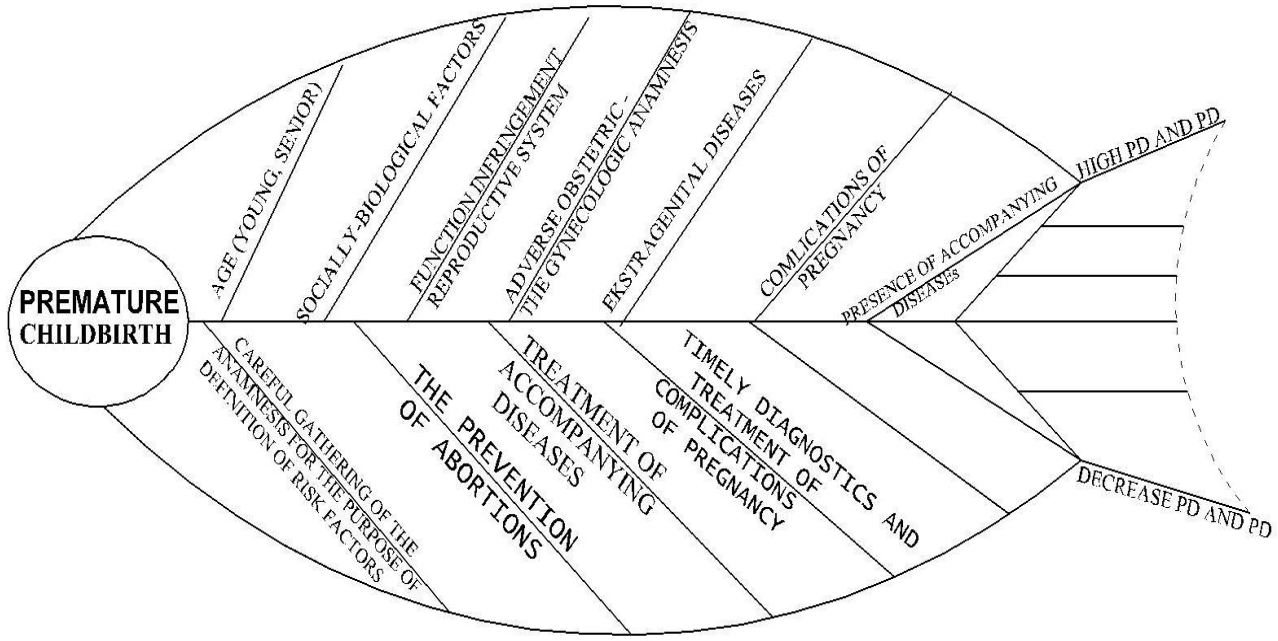
The Postnatal rehabilitation:

- careful collection anamnesis given with account of the general disease, ginecologic of the diseases, analysis reproductive to functions, number abortion, periods of the interruption, clinic and possible complications, methods of the treatment.
- tests of the functional diagnostics in the manner of graph rectal temperature, on which are noted complaints on pain, separations and given objective study and assignable therapy.
- TIE - values the condition of the womb and gonad.
- Consultation specialist - a physician obstetrician gynecologist for undertaking following methods examinations and choice of the method of the treatment:

a) GSG - is produced for 18-20 days of the cycle. This study allows to put(deliver) or exclude the diagnosis of the vice of the development of the womb, intrauteral sinehias, isthmico-servical to insufficiency.

b) by necessary section of the examination is an exception bacterial and viral infection as reasons non taken out pregnancy.

c) determination in slime cervical channel (PCR-diagnostics) VPG, CMV, hlamidia, micoplasms,ureaplasms.
c) at gormonal of the studies, their conduct on 7-8 and 22-23 days of the menstrual cycle. Under non taken out pregnancy of the rough breaches of the cycle can and be not, but beside majority patients comes to light the breach an lyuthein phases with anovulation by cycle. This type of the breach of the cycle typical of patients with hyperandrogenia, for patients with defeat resepthor device endomethriy as a result chronic endomethritis or genital infantilisms.
d) Physician-genetic examination marital pair(vapour)s is conducted in that events, when there is accustomed non taken out early periods to pregnancy, under birth of a dead fetus and birth childs with vice of the development in anamnesis.
e) is Also shown study spermogramms husband, consultation andrologs.
j) All woman of the group of the risk on non taken out pregnancy for time of the examination and treatments is fixed contraceptive of the facility with provision for evidences and contraindications.



Theme number 5: Perenasivanie. Diagnostics. Tactics of reference. Induction of childbirth. Medico-genetic consultations.

Recarrying pregnancy. Recarrying consider pregnancy, which lasts more than 10-14 days following expected period sort - 290-294 days with birth of the fruit with sign dead-rape stage and changes to placenta. The Frequency to recarrying pregnancy as of different authors and forms from 2 - 10%. Perinatal death-rate under recarrying pregnancy varies from 20 before 130 promill. The big amount of the complications exists Under recarrying pregnancy in sort and in after birth period beside full-grown and newborn, high percent birth-desthroying operation and operative interference during sort.
Exists chronologic recarrying pregnancy for 14 days and more, which ends the birth mature child without sign dead-rape stage. Such pregnancy is identified prolonged. She meets in 2 times less recarrying.
The Birth under recarrying pregnancy name tardy. They pertain to count;calculate;list pathological. Under prolonged pregnancy birth are identified well-timed i.e physiological.
Premorbid background serves the different somatic diseases, baby infections, having importance in formation hypothalam - an hypophisal of the processes, participating in system reproductive shaping beside girl and beside girl. Recarrying pregnancy promotes infantilismis, breaches of the menstrual cycle, abortions, inflammatory diseases internal sexual organ,

causing changes to nervously - a muscular device of the womb and bring about endocrine breaches, but endocrine diseases, breach of the fatty exchange, psychic traumas.

The Factor of the risk of the development recarrying is an age of the women(woman) (young and senior age, particularly firtht birth woman), nature of the labour (the employees and houswife), generative and menstrual function, carried and accompanying given pregnancy infectious, catarrhal, extragenital to pathology, complications previous and persisting pregnancy.

Simptoms, current. Recarrying pregnancy is characterized absence to generic activity after outflow of the supposed period sort, absence of the groth of the mass of the body pregnant, reduction to circumferences of the belly on 5-10 cm to and heights of the standing of the bottom of the womb in consequence of suck amniotic of water, absence to readiness of the organism and shakes of the womb to sort, large size of the fruit, thick bone of the skull, change to warmhearted activity of the fruit (the condition chronic gipocsy, as of fetal EKG). The fetus under recarrying is found in threatened condition (often exist pre-natal gipocsia and ruin of the fetus). Sometimes exist the anomalies of the development of the fruit (anensephaly, hydrosephaly and others.). In sort appears the weakness to generic activity, discrepancy of the sizes of the basin and heads of the fruit in birth, generic traumas beside full-grown and fruit, danger intracranial haemorrhages and distress fetus.

The Diagnosis to recarrying pregnancy possible to install on TIE. To typical ultrasonic sign recarrying pregnancy pertains the reduction of the thickness of the placenta, her(its) calsinosis and increase the sizes, not enough water, absence of the groth biparietal size of the head of the fetus, bulge of the bones of the skull, more large sizes of the fetus.

KTG. The Typical sign at study KTG is a change the frequency of the rhythm of the warmhearted reductions - a monotonous rhythm heart.

The admixture meconiy find At amnioscopics in amniotic water.

At study amniotic water, got under amniosentesis, find the reduction to concentrations of the glucose before 0,1 g/l and less (at rate 0,2-0,5 g/l).

The Contents in urine estriole is reduced.

Under cytological study vaginal dab are defined big amount of the intermediate hutches and absence orogovevayushih hutches.

The Diagnosis to recarrying pregnancy is definitively confirmed after birth child and afterbirth at presence typical sign: thick bones of the skull, narrow seams and роднички, absence сыровидной lubrificant, dry flaccid or " polished" skin, maseration skins on palm and foot - "hands and foots washerwomen", yellow or green colour of the skin and umbilical cords, placenta with expressed phenomenas calsinosis and heart attack.

The Tactics of conduct must be individual. In dispensary - an polyclinic section physician general practical persons is obliged after 38 weeks to pregnancy to value the degree to maturity shakes wombs, in the event of absence of readiness to sort and trends to recarrying, notify the woman on all possible complications in birth and in after birth period under recarrying to pregnancy. Explanatory work must be organized In family. The Careful collection anamnesis (the current to previous pregnancy, sort and postnatal period) for revealing factor risk on reccarying (the women(woman) with early and late approach menarche, breach to menstrual function, infantilizm, breach of the fatty exchange). The Observation for pregnant each 2 - 3 days following expiration birth. The Hospitalization in puerperal house for choice of the method and way resolve childbirth at period 41 weeks under satisfactory condition full-grown and fetus. A at presence of the complications (OAA, FPN, change to BRIDLES and KTG) of the womans with risk on recarrying pregnancy hospitalize immediately.

Induction birth can aplying:

- at contraindication to resolve childbirth through natural generic ways;
- when danger to prolongations pregnancy for health full-grown and child exceeds the danger, connected with stimulation birth.

The Evidences to inductions sort:

- Preeklampsion, eklampsion;
- a premature breakup fetal shell;
- Chorionamnionitis;
- Recarrying pregnancy;
- a request full-grown after 41 weeks.

The Contraindications to inductions birth are contraindications to vaginal births:

- transverse and sidelong fetal position;
- a birth by large fruit;
- morphofunctional insolvency of the womb after operative interference;
- prelying placentas;
- a varicose vein of the generic ways;
- active genital gerpes;
- invasive cancer shakes wombs.

That pregnant to whom are shown birth through natural generic ways treatment is concluded in excitement of generic activity medicamentous facility.

The Conditions of the undertaking to inductions sort:

- Estimation of the evidences and contraindications
- Estimation of the period to pregnancy
- Consideration of the potential risk for full-grown and fetus
- Consultancy of the patient:
    - an evidences, preparations and ways to inductions birth
    - a possibility repeated stimulation or resolve birth way of the caesarean section
    - a conversation with pregnant and her(its) family must be documented
- Estimation of the condition shakes wombs
- Sizing and fetal positions
- Estimation of the condition amniotic to liquids

Types to inductions sort:

- Manual open fetal shell
- Amniotomy
- Prostaglandins
- Oksitocin

CHOICE of the WAY to INDUCTIONS SORT depend ON CONDITIONS SHAKES WOMBS

The Simplest way opening amniotic shell by way of the careful introduction finger hands in sterile glove, oiled by antiseptic cream, in servical channel. In the event of realization by experienced physician or midwife this procedure must not cause observable discomfort. After 40 weeks to pregnancy such procedure can reduce need to additional induction double, however at period 38-40 weeks she does not bring about essential increase amount womans, beside which birth occur for the following 7 days.

Before undertaking the formal induction sort to woman follows to offer manual opening amniotic shell. [A] In the event of offer of the undertaking manual opening amniotic shell, during preliminary discussion of this question with woman necessary to explain that this procedure does not entail:

- Increase to probability infection full-grown or fetus;
- Can cause certain discomfort during checkup and with blood separations.

Readiness of the generic ways (maturity shakes wombs) to inductions sort is valued on scale Bishop

Scale Bishop

	0	1	2	3

The Length shakes wombs	4 cm	2-4 cm	1-2 cm	1 cm
Constitution shakes wombs thick average soft	thick	average	soft	
Opening shakes of the womb	1 cm	1-2 cm	2-4 cm	4 cm
Position shakes wombs on attitude to axis of the basin	declined	centred		
Position prelying part of the fetus on attitude to interspinal of the lines	-3	-1	+1	+2

At readiness of the generic ways (maturity shakes wombs) to inductions sort is conducted ripening shakes of the womb:
Glandin 3 mg in back code vagina
Amniotomy (the artificial breakup fetal shell) presents itself it is enough simple procedure, which can be executed without additional help of the other medical personnel for the reason inductions sort at presence of the conditions for her(its) undertaking (accessibility fetal shell). Amniotomy allows to avoid the pharmacological influence.
The Traditional way to inductions sort is an opening fetal shell and streamed amniotic to liquids. Front water can be released with the help of simple hook (Amnihook (EMS Medical Group)), pair(vapour)s grip Kohera or pair(vapour)s special grip for amniotomy. The Selected instrument in sterile condition is entered in servical channel. Under visual checking is produced opening fetal bubble that leads to streaming amniotic to liquids. Herewith follows to value her(its) colour and volume. Immediately hereon follows to produce auscultation FWR fruit to make sure in absence of some dangers for fruit. Using KTG is recommended only in person events.
At effect from amniotomy obligatory using oxytosin.
I/v infusion 10 U oxitosin on 400 ml isotonic of the solution begins with 5-6 drops 1min. with the following increase the drop on 5 drops each 5мин. bring 40 drops in 1 min. and/or 3-4 fights of the womb for 10 mines.
The Tablets mizoprostol with contents of the preparation 25 mkg are enclosed in the main roll medicinal preparation carry.
The Mode of the acceptance mizoprostol in small dose (25 mkg each 6 hours) turned out to be more efficient in contrast with receiving the magnified doses (25 мкг each 3 hours), herewith less existed hyperstimulation wombs.
Thereby, in spite of high efficiency, cheapness and comfort of the using mizoprostol as facility to inductions birth, at the point he can be not recommended for stale use. Besides, in many country he is not registered for using with such purpose.
Significant economic and possible clinical advantage mizoprostol обуславливают need of the undertaking the further studies for the reason clarifications of his(its) safety.
The Possible complication at inductions sort:
- Giperstimulation-breakup of the womb
- Breaches of the condition of the fetus
- Postnatal bleedings conditioned atony of the womb
- Fallout loop umbilical cords
- moving placentas
- Infection
- Increase amount instrumental sort

Rehabilitation after sort:

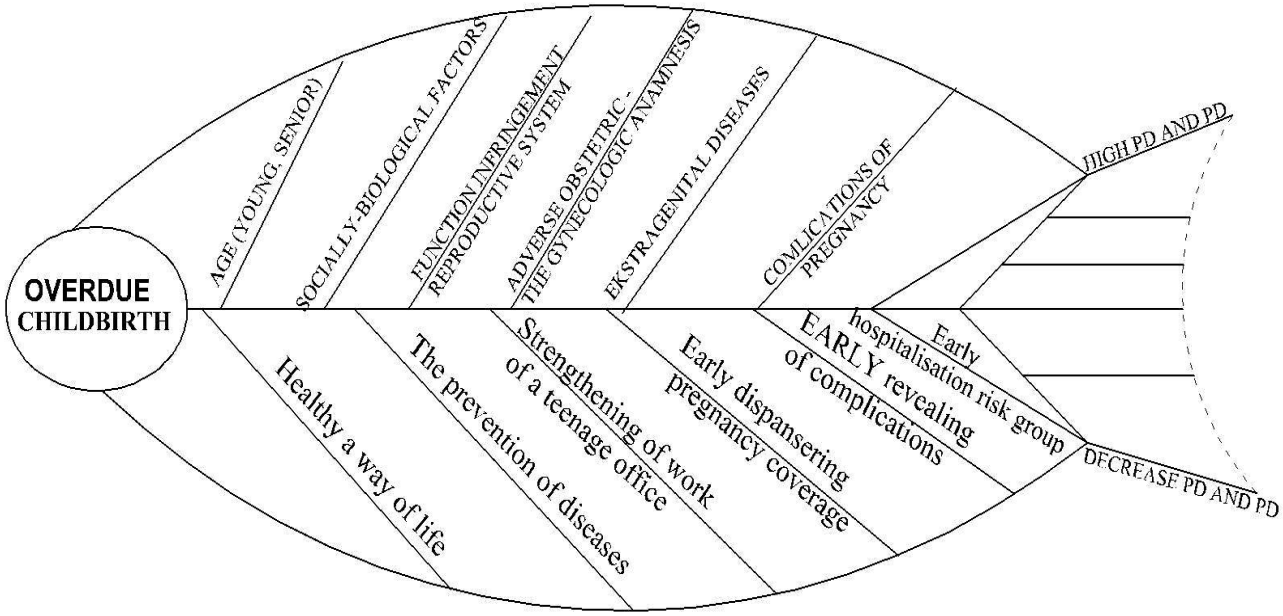
- Dispanser observation in polyclinic with provision for anamnestic date;
- BRIDLES;
- Undertaking test functional diagnostics (the measurement базальной temperature, symptom "pupil of an eye" and others) beside womans with breaches of the menstrual function and endocrine breaches;
- undertaking the examination and treatments with specialist of the different profile (the obstetrician - a gynecologist, endocrinologist, internist, honey - a geneticist) for well-timed recovery outside of pregnancy and planning following;
- selecting the method to contraceptions with provision for evidences and contraindications

4.2. Analytical part

Exhibit 1 Organayzer "skeleton of fish "

Group is divided on 2 subgroups and they are given task:

1. The Reasons premature birth and way of their decision
2. The Reasons to recarrying pregnancy and way of their decision Sharing the group and explanation of the task - 5 mines, Work on task - 10 mines, Presentations on 5 mines. Discussion - 10 mines.



Theme number 6: Conducting pregnancy with overstretched uterus (with multiple birth, polyhydramnios). Diagnostics. Tactics of reference. Observance of the intergenetic interval.

Multiple pregnancy is called two or more fruits. In the presence of pregnancy, two fruits speak of twins, three - about triplets, etc. Each of the fruits in a multiple pregnancy is called a twin. The genera of twins are encountered once for 87 genera, triplets - once for 872 (6400) twins, four times for 873 (51200) troen, and so on. (according to Gallin's formula).

The causes of multiple pregnancies are not well understood. It is proved that two follicles and more can ripen in one ovary. In addition, ovulation can occur simultaneously in both ovaries. In favor of these possibilities are the facts of finding during the operation for tubal pregnancy in the same ovary two blossoming yellow bodies or in each of the ovaries one blooming yellow

body. In addition, in one follicle there may be two or more ovules. The cause of a multiple pregnancy can be the fertilization of sperm of different partners, fertilization against the already existing pregnancy, induced pregnancy. Twins, formed from the fertilization of two eggs, are called bipartite, single-egg twins occur as a result of atypical crushing of the egg. Where the separation of the egg occurs completely, two completely identical twins are formed. Such twins are called monotonous. Odnoyaytsevye twins are much less common than the twins (1:10). If, with complete separation of the egg, the two rudiments are located in the uterus at a sufficient distance from each other, then the embryos developing from them form each separate amnion for themselves and remain biominiotic twins. If both amniotic sacs are enclosed in a common chorion for both twins, and the septum between them consists of two membranes (two amnions), then such twins are called monochorionic. They have a common placenta. If both rudiments lie side by side, this leads to the formation of one common for both amniotic cavities (monoamnotic twins). The identical twins are always the same sex - or both boys, or both girls, they are similar to each other, their blood type is always the same. In case of multiple pregnancy, because of the heavy burden on the body, women notice an early fatigue, dyspnea, urination disorder, constipation. Frequent and early complications of pregnancy are premature birth (50% of cases), toxicosis and gestosis, varicose veins, polyhydramnios, low weight and immature fruit, the death of one of the fruits. In some cases, polyhydramnios in one cavity may be accompanied by low water levels in another. Recognition of multiple pregnancy in the first months is difficult and becomes easier in the second half of pregnancy. Pay attention to the discrepancy between the size of the uterus and the period of pregnancy. At palpation define many small parts, two heads, two backs. When auscultation - two or more points of the determination of the fetal heartbeat and the zone of silence between them. The height of the standing of the uterine fundus is greater than in the case of a single pregnancy at the same time. When measuring the length of the fetus, the tasometer is a large length of the fetus with a small head. The most reliable diagnostic method is ultrasound. In the overwhelming majority of twins (88.0%), both fetuses are in longitudinal position and occupy one right, the other - the left half of the uterus. Most often, both fetuses have a head (45.0%). Other variants of the arrangement of the fetuses in the uterus are possible. One fetus may be in the head presentation, the second - in the pelvic (43.0%). Both fetuses are in pelvic presentation (6.0%). One fetus is longitudinal, the other in transverse position (5.5%), or both fetuses in transverse position (0.5%). Medical supervision of pregnant women with multiple pregnancy is performed taking into account possible complications, allocating them to the risk group for the development of perinatal pathology.

Polyhydramnios (hydroamnion) is a pathological condition characterized by the presence of excess amniotic fluid in the amniotic cavity (over 1.5 liters). It occurs in 0,3-0,6% of all genera. Polyhydramnios can develop in pregnant women suffering from diabetes, kidney disease, cardiovascular disease, after infectious diseases during pregnancy, due to immunological incompatibility of blood of the mother and fetus. Polyhydramnios develops in violation of the secretory and resorption function of the amnion. Polyhydramnios can be acute and chronic. In acute polyhydramnios pregnancy usually prematurely aborted, the fetus dies (placentofetal failure, abruptio placenta) or born with malformations, possible threat or uterine rupture. With chronic polyhydramnios, the amount of amniotic fluid increases gradually, the prognosis of pregnancy depends on the degree of its severity and the rate of build-up. Perhaps polyhydramnios and with odnoyaytsovoy double. The diagnosis is based on the increase in the

uterus, the inconsistency of its size (the abdominal circumference, the height of its bottom above the bosom) the term of pregnancy. The uterus becomes tauto-elastic consistency, tense. Fetus - mobile, note its unstable position, difficult palpation of parts of the fetus, muffled heartbeat. Crucial in the diagnosis of polyhydramnios is ultrasound (the presence of large echo-negative spaces in the uterine cavity, the measurement of free from the fetal parts of amniotic fluid in two mutually perpendicular sections). When polyhydramnios are more likely to observe various complications of pregnancy. Vomiting occurs in 36%, premature termination of pregnancy - in 28.4% of pregnant women. Incorrect position and presentation of the fetus diagnosed in 6.5%, bleeding - at 38.4% (acute polyhydramnios - 41.3% in chronic - 6.2%), late gestosis - 5-20% of pregnant women with hydramnios. Furthermore, hydramnion can progress and promote placental insufficiency and hence, chronic hypoxia and death ploda.Beremennye suspected hydramnion need to be hospitalized for diagnosis, treatment and, when indicated, delivery. Genera with polyhydramnios are quite dangerous for the mother and the fetus, since it is often accompanied by complications (preterm labor, prenatal rupture of membranes, abnormal labor, premature detachment of the placenta, loss of small parts and the umbilical cord, malposition, its hypoxia). In connection with the increase in obstetrical pathology in women with polyhydramnios, the number of obstetric aids and surgical interventions during pregnancy and childbirth increases to 21.5-57.7%. In the case of the presence of malformations of the fetus, pregnancy is interrupted according to medical indications. At not expressed symptoms of polyhydramnios (light and average degree) pregnancy prolong to physiological completion against the background of appropriate treatment. Antibiotic therapy is mandatory (intra-amniotic, when determining the sensitivity), diuretics, vitamin, therapeutic amniocentesis (under ultrasound - 500 ml per 1 hour and 1 day intervals). A prostaglandin synthetase inhibitor, indomethacin, is used (starting 24-25 weeks and ending at 35-38 weeks at 2.2-3 ml / kg body weight) for 2-11 weeks. With the increase in clinical symptoms of hydramnios, despite treatment, the appearance of signs of intrauterine fetal suffering is used early delivery. Often a high-risk group is identified as possible for the development of polyhydramnios. It includes pregnant women suffering from diabetes, chronic infections, Rh-negative blood, deformities of the fetus in history, with twins.

Conduct a comprehensive examination-bacteriological, immunological, genetic, endocrinological, biochemical. Multiple pregnancy poses to women and Delivery Service special problems that are associated with an increased risk of premature birth and perinatal mortality, with poor fetal growth, and posleduyuschem- with the development of cerebral palsy. In addition, women with multiple pregnancy are more likely to experience general unpleasant pregnancy symptoms, such as heartburn, hemorrhoids, and fatigue, in comparison to a normal single-pregnancy pregnancy. At present, there is no reliable evidence in favor of the widespread practice of routine hospitalization with the appointment of bed rest for all women with twin pregnancies. Indications for delivery by cesarean section during multiple pregnancies have not yet been established.

Young primiparas are women up to 19 children

2. Elderly primiparous women are considered to be 26-29 years old and old - 30 years and older.

3. Intergravidar period is the interval between births and must be at least 2 years;

4. Study of the placenta in young primiparas revealed a certain "immaturity" of placental structures at the end of a long term of pregnancy. These structural changes in the placenta play a role in such complications of pregnancy and childbirth as chronic intrauterine hypoxia, fetal hypotrophy, newborn asphyxia and the birth of malignant children, which may be due to the thickening of the placental barrier between the blood of the mother and the fetus .. This thickening is associated with pain ¬ a major area of chorionic epithelium, an insufficient number of subepithelial located vessels, a large number of malodifferentiated cells with a mass of amorphous interstitial substance in the stroma, which is inappropriate ie increases the exchange needs of the fetus in kon¬tse full-term pregnancy.

5. Significantly expressed processes of physiological "aging" in the placenta found at the end of a full term pregnancy can undoubtedly affect its functional state, primarily on the transport possibilities of the feto-placental barrier before and during childbirth. Evidence of the pronounced processes of physiological aging in the placenta of elderly primiparas are such changes as hemodynamic disturbances in terminal villi, sclerosis of the villi stroma, fibrinoid necrosis of the villi, functional exhaustion of the syncytia species and a number of other features. Structural changes in placenta can also be one of the causes of miscarriage, inadequate biological readiness of the organism for childbirth, and the weakness of labor.

6. The approaching pregnancy at a young age takes place against the background of an unprepared organism, which undoubtedly reflects on its course.

Complications during pregnancy are revealed in every second young primipara. Toxicosis I and II half of pregnancy meets every fourth woman. So, dropsy of pregnant women is observed in 16.8%, hypertension induced by pregnancy - in 2.9%. Hypertension induced by pregnancy at a young age is more likely to develop before childbirth, and after the onset of an improvement. Iron deficiency anemia is detected in 27.75% of the primigest young age, which may be due to the inferiority of the hematopoietic system and the low adaptive capacity at this age.

The incidence of miscarriage in young primiparas varies from 2.3 to I9%, and is observed, mainly in the second half of pregnancy. A definite relationship was established between the age of the primipara and in 14.8% of the primiparous before the age of 19.

A frequent complication of the gestational period is hypoxia and delay in the growth of the fetus due to the lack of feto-placentar complex.

A uniformly dense pelvis occurs in 8.9% of young primipara, which indicates incompleteness of the formation of the bone pelvis at this age, of which a clinically narrow pelvis develops in 1.7%.

In the preparatory period, more than half of the young first-born have a slow formation of the body's biological readiness for childbirth, characterized by "immature" or insufficiently "mature" cervix of the uterus.

7. Taking into account the decrease in the adaptive capacity of the organism in the elderly age and the high parity of women, the increase in the concomitant EGZ. When monitoring the pregnant women of this group, it is especially necessary to conduct, examine and treat together with a physician of this profile.

1. Complications of pregnancy in young primipara

The course of labor is complicated in 57.4% of this contingent of women. Premature rupture of the fetal membrane is observed in 21.7%, weakness of labor activity - in 12.8%, most often with the development of paternal activity in parturients of young age with "immature" cervix of the uterus.

Complications of pregnancy and childbirth increase the number of surgical interventions at this age to 45.2%. Pereneotomy in connection with a rigid crotch is used in 23.4% of women. Caesarean section in the direction of the clinically narrow pelvis (1.9%) and premature detachment of the normally located placenta (0.99%) is performed in 2.9% of the young pervious.

For young age, the birth of small children (36.5%) is characteristic, which can be associated with functional and structural disorders in the feto-placental complex. These same reasons, obviously, bring to birth in asphyxia every fourth newborn. At one third of newborns by the 7th day of life, the mass of the body but recover to the original figures. Perinatal mortality of newborns in young primiparas is 2.9%. The main cause of death of children in the neonatal period is asphyxia, intracranial birth trauma.

2. Complications of pregnancy in age-bearing primipara

Complications during pregnancy are revealed in 66.4% of elderly primiparas. Each 3-4th woman develops toxicosis I and II half of pregnancy, and late toxicosis of pregnant women often occurs in the form of hypertension induced by pregnancy. Iron deficiency anemia is detected in 18.4% of the primiparous elderly, which is 2 times more likely compared with the younger age. Every fourth woman has a threat of miscarriage, but often in the first and second half of pregnancy. Premature birth is observed in 12.6% of elderly primiparas. Overpopulation up to 42-43 weeks of pregnancy is observed in 17.6% of women of this age. Hypoxia of the intrauterine fetus is detected more often than at a young age, which in all likelihood is associated with fetoplacental insufficiency and an increase in the frequency of exstogenital pathology with age.

3. Complications of pregnancy in often and many-rooted

Complications of the gestational period are associated with a relatively elderly growth, EGZ, a decrease in the adaptive mechanisms of the body, with dystrophic changes in myometrium, the inability of the body to restore its condition in a short interval between births, a decreased tone of the muscles of the abdominal and pelvic floor.

4. Prophylaxis in the out-patient and out-patient department of young and age first-borns.

a. The doctor of the woman's consultation is obliged to inform the woman about all possible complications of the gestational period as in the young primipara as in the age group.

at. Careful collection of anamnesis (general and midwifery parity, the character of menstrual function, pay attention to the development of scintilla, the size of the pelvis).

from. Careful examination of a woman to resolve the issue of interruption or prolongation of pregnancy.

5. Doing in a polyclinic:

Visit to a pregnant wife. in I half 1 time in 2 pedules, in II - I once a week. Terms of hospitalization:

6. Terms of hospitalization:

1-state drink. - up to 12 sing. for the decision of a question on prolongation or abortion of pregnancy.

2-state hospital. - at 22-24. 28-30 under. in the presence of concomitant EGZ and complications of the course of gestation and their treatment.

3-gospit.- At 38 weeks to address the issue of the timing and method of delivery.

Ultrasound in dynamics. KTG in dynamics: from 24 weeks.

In connection with the increase in the number of births of children with developmental defects in age-related parents, it is necessary to examine the spouses in a medical-genetical laboratory, especially the first-borns over the age of 30.

7. Contraindications to pregnancy: the state of physiological not maturity of the body - under the age of 16 years and the state of extinction of the functions of the reproductive system of a woman is 40 years or more.

8. Rehabilitation after childbirth:

-Dispensary observation in a polyclinic together with experts of a various profile for timely improvement outside of pregnancy and planning the subsequent; selection of contraception, taking into account their contraindications: in the postpartum period, oral contraceptives should be used with only progestogens, or low doses of estrogen-progestin drugs. Given the increase in the change in lipid metabolism, the content of insulin and the coagulation system can be recommended for young primipara minipillas, and for age-related three-phase contraceptives (triqui-lar), depilatory versus depopavera and surgical sterilization.

4.2. Analytical part

Annex 1 Situational task number 1

4. A pregnant 22-year-old woman received complaints about nausea, vomiting up to 6-8 times a day. Estimated gestational age is 9 weeks, however, with a vaginal examination it was found that the uterus is increased correspondingly to a 12 week pregnancy

Question

Diagnosis

Tactics of the GP.

Answer:

1.Pregnancy 9 weeks, multiple pregnancy. USD. Vomiting of moderate to moderate pregnant women. 2. Hospitalization in a hospital, examination

Situational task number 2

Pregnant 25 years have arrived with an indication of an increase in body weight, increased coolant, increased uterine tone (pulling pains in the lower abdomen and lower back), rapid fatigue. These symptoms continue to increase over the last week of pregnancy. In the first trimester she underwent ARD with a temperature of 38.8, was treated with home remedies. The gestation period of 28 weeks, according to the external examination corresponds to 32-34 weeks of pregnancy

Question

Diagnosis

Tactics of the GP.

Answer:

1.Pregnancy 28 weeks, hydramnios. Threatening premature birth. 2. Hospitalization in hospital, ultrasound.

Situational task number 3

Primordial, 32 years old was reported with an indication of the outflow of amniotic fluid an hour ago at a gestation period of 42 weeks. No labor activity. At external research it was revealed: the pelvic size is normal, the estimated weight of the fetus is 3100.0. Fetal position longitudinal, back to the left, the head of the fetus is pressed to the entrance to the small pelvis. C / b fetus clear, rhythmic, 140 beats. in min.

Question:

1. Diagnosis

2. Tactics of the GP.

Answer:

1. IGregnost, 42 weeks, old, primitive, pregnant pregnancy. Prenatal outflow of amniotic fluid.

2. Hospitalization for hospitalization for delivery.

Practical part Annex 3

List of practical skills

1. Determination of the estimated weight of the fetus

2. Determination of the period of pregnancy and childbirth

3. Determination of pelvis size by tasometer

4. External obstetric examination

Control questions:

What are the features of pregnancy management in age-related primipara?

What are the characteristics of pregnancy management in young primiparas?

What are the features of managing pregnancy with overgrown uterus?

Diagnosis of multiple pregnancies.

Complications during pregnancy and childbirth with multiple pregnancies.

Features of management of pregnancy and sorts at a multiple pregnancy.

Tactics of management of pregnancy at mnove.

Terms of hospitalization for multiple pregnancies.

Timing of hospitalization with polyhydramnios.

Complications of pregnancy in young primiparas.

Complications of the course of pregnancy in primiparous age.

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5. Interpret the main laboratory and functional methods of research used in these pregnant women.

Theme number 7: Assessment of the fetus during pregnancy and childbirth. Threatening conditions of the fetus. FAR. FPN.

We can identify some specific details about the condition of the fetus

With a correct understanding of the physiology of the fetus, doctors can ask specific questions about his condition. Is he well? Does it tolerate the environment in which it is well, and does it develop well? Is it safe for him to be in the uterus? Is it safe for him to give birth?

Recent advances in obstetric technology have been able to provide some answers to these questions.

Objectives of antenatal care:

Help a woman stay healthy

Identify and treat existing pathological conditions

Ensure fetal health

Key information

Small fetus for gestational age (MGVP) is a fetus that does not have the weight or size for the given pregnancy period

Intrauterine growth retardation (Fetus) is a pathological condition that is a subgroup of MGHP (30-50%), which has not reached its growth potential. Characterized by high morbidity and mortality

The definitions of "feto-placental insufficiency", "hypoxia", which are the main indication for antenatal hospitalization and unnecessary interventions, are pathophysiological and metabolic processes and have no clinical significance

"Fetal threatening state" is the only correct term that determines violations in the fetus, characterized by impaired cardiac activity of the fetus and changes in other biophysical tests that can lead to the onset of neonatal asphyxia

To assess the condition of the fetus, biometric and biophysical diagnostic tests are used, but none of them has sufficient prognostic significance for low-risk pregnant women

Most perinatal interventions aimed at improving fetal growth and preventing the development of fetal acidosis do not give good results for perinatal outcomes

The only treatment for ZVUR and the "threatening condition of the fetus" is timely delivery at the most optimal time and in the most acceptable way

The concept of a "small child" in medical literature emerged in 1919, when it was suggested that all newborns weighing less than 2,500 g (5 lb. 8 ounces) should be classified as "premature babies." However, it was only in 1961 that the World Health Organization (WHO) recognized that many children who were classified as prematurely simply had low birth weight, and were not born before the due date. In accordance with current WHO criteria,

low birth weight is less than 2.500 g or below the 10th percentile for gestational age.

Assessment of the fetus during pregnancy and childbirth.

For the diagnosis of impairments in the fetus, the frequency, rhythm, and variability of the heartbeat during functional tests are determined. Estimation of heart rate (HR) should be performed taking into account the period of pregnancy (bradycardia in I, tachycardia in II and normocardia in III trimesters). The decrease in heart rate to 80 beats / min or less indicates a severe hypoxia of the fetus, and the persistence of this symptom is a poor prognostic sign.

Assessment of the biophysical profile of the fetus (determined from 28 weeks gestation)

1. CTG - in the norm of heart rate of 120-160 beats / min.

when hypoxia:

tachycardia: aetiology:

- moderate 140-180 beats per minute. - moderate 118-100

-express more than 180-expressed less than 100

The most informative is the change in heart rate in response to the fight. Tachycardia (above 180 beats / min) and bradycardia (below 100 beats / min) should be regarded as a symptom of severe fetal distress.

2. Biophysical profile of the fetus:

- Reduction of respiratory movements of the fetus less than 30 respiratory movements / min.

- Reduction of fetal motor activity less than 6 movements in 60 min.

-the fetus of hypotension

-nestressive test tachycardia on the wiggling (normal) The increase in heart rate of the fetus by 15-35 strokes in response to perturbation (positive "myocardial reflex" or reactive NCT test) characterizes its normal state.

Modern methods for assessing the fetal condition include ultrasound diagnosis, which allows to determine the size of the biparietal size of the fetal head, the thickness and the placenta area and the amount of amniotic fluid.

In antenatal care, a simple and inexpensive method is used that involves measuring the height of the standing of the uterine fundus and recording changes in the schedule of antenatal development. This method allows to diagnose a small or large fetal size for the corresponding gestational age, and can be used as a screening test for further research.

Antenatal development schedule

Often the concepts "small for gestational age fetus" and "fetus with low birth weight" are identified. The concept of "fetus with low birth weight" combines two pathological and one normal state. A normal state is when a child is healthy, but small by constitution. Pathological

conditions include premature birth and intrauterine growth retardation (FNC). In the medical literature there is also a synonym for the intrauterine growth retardation of the fetus.

Newborns with HLRF are much more likely to die or have respiratory distress syndrome, or to get complications such as intraventricular hemorrhage and necrotizing enterocolitis.

There are several factors predisposing to EHEP, but the main ones are divided into 4 groups: maternal, placental, external and hereditary.

The mother factors include the following: a small size of the mother's body; previous births with low weight; multiple pregnancies; multiple pregnancy; malnutrition; irregular shape or size of the uterus of the mother; bleeding during pregnancy; mother's health; a premature pregnancy; infection during pregnancy in the mother (syphilis, herpes, rubella, toxoplasmosis, hepatitis); cardiovascular complications (high blood pressure, certain heart diseases, preeclampsia or eclampsia); diabetes; APS; any chronic or prolonged illness in the mother (for example: sickle cell anemia, systemic diseases, lung diseases with the development of respiratory failure, kidney disease, etc.).

Placental factors include defects associated with the placenta and umbilical cord, which limit the blood supply to the fetus. For example, the blood supply can be reduced, because there is only one, and not two arteries in the umbilical cord. The blood supply may be limited by the entanglement of the umbilical cord around the fetal body part; also, the blood supply can be reduced because of the true node of the umbilical cord, the membrane attachment of the umbilical cord. Structural abnormalities and malformations of the placenta lead to a disorder of the placental circulation. Insufficient mass and surface of the placenta (less than 8% of the body weight of the newborn) are an important risk factor for the occurrence of an HPW, as well as an anomaly of placenta attachment (low placental location, presentation).

External factors include: some medications (such as Coumadin (warfarin) and Dilantin Hydantoin (phenytoin)), other substances that the mother uses can have a direct effect on the fetus: smoking, alcohol, cocaine, living in a high-altitude area (above 3000 m above sea level).

Hereditary factors include gene and chromosomal abnormalities, as well as congenital malformations of the fetus: trisomy on chromosome 13 (Patau syndrome), 18 (Edwards syndrome) or 21 (Down's syndrome), 22 autosomal pairs, Shereshevsky-Turner syndrome (45 XO), triploid (triple chromosome set), additional X or Y chromosome

It is more often diagnosed after 32 weeks. If appears after 28 weeks, it is more often symmetrical, if after 32 weeks - asymmetric.

Symmetrical - when there is a proportional decrease in the size of the fetus. All organs are underdeveloped, do not correspond to the term of gestation. It often happens with intrauterine infection, chromosomal abnormalities, malnutrition, smoking, etc. It develops from early pregnancy.

Asymmetric - a characteristic lag in the dimensions of the trunk at a normal biparental head size. There is an uneven lag: to a lesser extent the brain, the skeleton, and in the larger parenchymal organs (the liver). It develops in the third trimester, against the background of obstetric pathology or extragenital pathology.

Degrees of severity (according to ultrasound):

1 degree - developmental lag for 2 weeks

2 degree - for 2-4 weeks

3 degree - more than 4 weeks

Tests used in prenatal care to assess fetal status

Evaluation of fetal motor activity

Routine formal counting of fetal movements is not recommended. Preferably not a formal count, but a qualitative assessment of the mother's fetal activity

Auscultation of fetal heart rate Can confirm that the fetus is alive

Routine listening is not recommended. Should be held at the request of the mother, to assure her that the fetus is alive

Ultrasound examination (ultrasound)

Routine ultrasound at an early stage of pregnancy (up to 24 weeks) is effective for:

Estimates of gestational age

Early definition of multiple fertility

Early detection of an unanticipated developmental fetal disorder at a time when abortion is still possible

Routine ultrasound for women in the late stage of pregnancy, belonging to the low-risk group, or for women whose risk group is not defined:

It does not benefit the mother or the fetus

General surveys used in antenatal care for the detection of IHVP

Palpation of the abdomen

Measurement of standing height of the uterine fundus

Ultrasound Biometrics

Biophysical tests and dopplerometry of the umbilical artery for the diagnosis of MGHP / ZVUR

Fetal monitoring with growth retardation during pregnancy

Screening

Gravidogram is a suitable way of screening for EHEC among healthy women

Diagnosis

If there is an opportunity to confirm the diagnosis, use ultrasound biometry

Monitoring

Doppler is the best method of monitoring the fetus with suspected HBVD

If the dopplerometric indicators are normal, then the probability is high that the fetus small for gestational age does not have a delay in the intrauterine development

Measures for the management of the AECD

The only effective treatment for HBVA

RHODORASRESHENIE at the most optimal time

Placental insufficiency.

This is a violation of the placenta due to morpho-functional changes in the placenta and violations of compensatory-adaptive mechanisms that ensure the functional usefulness of the organ. It manifests itself as a violation of the transport, trophic, endocrine and metabolic functions of the placenta.

Classification.

1.Hemodynamic placental insufficiency-violation of utero-placental and fetoplacental blood circulation.

2.Platsentarno-membrane - a decrease in the ability of the placental membrane to transport metabolites.

3. Cellular parenchymatous - a violation of the cellular activity of trophoblast and placenta.

Allocate: Primary placental insufficiency (PPN) - is formed during implantation, early embryogenesis (up to 16 weeks) and placentation under the influence of genetic, endocrine and infectious factors. These factors act on gametes, zygotes, blastocysts, placenta and female genitalia. As a result, the structure, location and attachment of the placenta change. Primary placental insufficiency contributes to the development of fetus deformities, congenital malformations, undeveloped pregnancies.

Secondary placental insufficiency (VLN) - is formed after 16 weeks. pregnancy under the influence of the maternal organism and exogenous factors.

PPN and VPN are divided into acute and chronic:

Acute - occurs when PONRP, detachment of the placenta.

Chronic - as a result of EHF or genital diseases, develops early, it flows for a long time; Compensatory-adaptive processes are violated with the development of circulatory disorders and vospitelno-degenerative changes.

Diagnostics. The development of modern methods for studying the state of the fetoplacental complex in the dynamics of pregnancy and childbirth has enabled timely diagnosis and

treatment of the main clinical forms of fetal suffering: retardation of intrauterine development (hypotrophy) and / or chronic hypoxia.

It is recommended to send all newborns, especially small or very small children, along with their mothers to a specialized department. If it is necessary to transfer a woman to a higher level of care, it is advisable to translate it before delivery (while the baby is in the womb). In conditions of regionalized perinatal care, women who give birth much earlier than the term should be referred to a maternity ward with a higher level of care, where a premature or "very small child" can receive proper care.

There are two categories of "small" children / children born with low weight:

Preterm baby with birth weight from 1500g to 2500g.

Finished children, too small for their uterine age, who were born with a weight less than 2500 g. These children are more mature than premature babies.

The main reasons for the birth of a "small" child

Smoking, drinking alcohol or drugs during pregnancy

Maternal malnutrition

Anemia in the mother

Infections:

-Bacterial: streptococcus B, E. coli, Listeria

-Virus: influenza, measles, cytomegalovirus

- Parasitic: malaria, toxoplasmosis

Hypertension during pregnancy

Multiple pregnancy - twins, triplets

Abnormalities of the uterus or placenta

Prenatal rupture of membranes

Some congenital malformations and genetically conditioned conditions of the newborn.

The problems of caring for a "small" child

"Small child:

-It has more chances of getting sick than a child born with a weight of more than 2500 grams

- Has a higher risk of mortality than a child weighing more than 2500 grams

- Needs more careful care and control of the condition than a child born with a weight of more than 2500 g

-Stays in the maternity ward longer than a child born with a weight of more than 2500 grams

-There often needs to be directed to a higher level of assistance.

Some features of the "little" child

"Little" children have some features:

-Biological immaturity (especially among preterm neonates)

-Small sizes: large body surface relative to weight, small volume of stomach

-Defined reserves of fat, glycogen, iron, calcium and vitamins.

Special preparation for the birth of a "small" child

The temperature in the delivery room must be at least 25oC, ideally 28oC; heaters must be switched on; prepare warm towels and clothes for the child

"Small" children are more likely to need intensive care than children born with normal weight:

- a team of neonatologists with equipment for resuscitation (including a laryngoscope and medicines) should be in the delivery room

Particular attention should be paid to the prevention of hypothermia and infections

The best way to prevent hypothermia of a "small" child is to provide immediate skin-to-skin contact with the mother if the child does not need resuscitation.

Thermal protection of newborns.

This is a series of activities that take place at birth and in the first days of life and provide a regime in which the newborn is not overcooled and does not overheat, but maintains a normal temperature of 36.5-37.5 ° C. The smaller the weight of the newborn, the greater the risk of hypothermia. Temperature stability increases with increasing weight of the child. The temperature in the mother's womb is 38 ° C, the greatest cooling of the newborn occurs in the first minutes after birth and if the loss of heat is not prevented, the child develops hypothermia.

In hypothermia, a child, especially with a low weight or a sick person, is at great risk of problems in his or her health state or the risk of death.

Thermal protection of newborns consists of the following principles. It does not depend on the fact that the child is born at home or in a medical institution:

Warm maternity ward> 25 C;

Immediate wiping;

Skin-to-skin contact (at least 2 hours);

Breastfeeding;

Postpone weighing and bathing;

Joint stay of mother and child;

Corresponding swaddling and wrapping;

Transportation in warm conditions;

Animation in warm conditions;

Increase the level of training and knowledge of employees.

Treatment of hypothermia. A newborn child with signs of hypothermia should be warmed as soon as possible. Light hypothermia (body temperature 36.0-36.4 ° C) the child can be warmed by contact with skin-to-skin, in a warm room (at least 25 ° C).

Hypothermia of moderate severity:

Under the lamp-heater;

In an incubator, at 35-36 ° C

With the help of a water mattress-warmer;

In a warm room: the temperature in the room should be 32-34 ° C (and above) if the child is sick or weak;

In a warm baby cot, it can be warmed with a hot hot-water bottle or hot stone, which must be removed before putting it into the crib of the child;

If these methods are not available or if the child's condition is stable, skin-to-skin contact with the mother can be used in a warm room (at least 25 ° C)

The process of warming must be continued until the child's temperature reaches a normal level. The temperature should be measured every hour, as well as the temperature of the device that is used, and at room temperature. The child needs to continue to feed.

Abnormal body temperature in a newborn.

Low body temperature (hypothermia-the child's temperature is less than 36.5oC) and elevated body temperature (hyperthermia-the child's temperature is more than 37.5oC) signs of anomaly of body temperature.

In severe hypothermia (the child's body temperature is less than 32oC) the following measures are taken:

Immediately warm the child by warming. With proper warming, the child's body temperature increases by at least 0.5 ° C per hour during the last three hours.

Remove cold or wet clothing from the baby and wear warm clothes.

To restore hypoglycemia.

The child has a respiratory rate more than 60 times per minute, or he has a sternum retraction or a noisy exhalation (granting), and respiratory disorders must be treated.

If the child shows signs of being ready to suckle, breastfeeding should be done, if not, give it expressed breast milk through the stomach probe as soon as the child's temperature reaches 35oC.

When the body temperature of the child is normalized, it is necessary to measure it every three hours for 12 hours.

At a hypothermia of average gravity (body temperature 32o-36oC) it is carried out, as well as at heavy.

Hyperthermia (the child's body temperature is more than 37.5oC) is caused by overheating when using a source of radiant heat or an incubator, the following principles should be followed:

Reduce the parameters of the heating device and open the door.

Partially or completely undress the baby for 10 min. then again dress and cover

Every hour, measure the temperature in the incubator or under the source of radiant heat, and, accordingly, select the necessary parameters.

THE ASYMPHY OF THE NEWBORN

This pathological condition associated with the violation of the mechanisms of adaptation in the transition from intrauterine existence to extrauterine, manifested by the lack or ineffectiveness of breathing, a violation of blood circulation and depression of the neuro-reflex activity of the central nervous system.

ETIOLOGY.

Factors leading to asphyxia are the same as for hypoxia.

The acquired, secondary neonatal asphyxia develops with aspiration with amniotic fluid, pneumopathy, trauma of the brain and spinal cord, congenital heart defects, diaphragmatic hernias, metabolic disorders (hypoglycemia) and inappropriate tactics of treating primary fetal and newborn hypoxia.

CLINIC.

Apgar (1950), after 1 and 5 minutes, palpitations, respiration, tone, reflexes, and skin color are evaluated.

Vomiting, diarrhea, bleeding or pallor, ancestral swelling, skin and mucous membrane problems, birth trauma, birth defects, convulsions.

If a child has severe vomiting that does not depend on the method of feeding, and with an admixture of bile or blood, the following measures should be taken:

To study the data of the anamnesis,

Inspect the child for tenderness of the abdomen and atresia of the anus.

Start intravenous infusion

During the care of a child with diarrhea, the requirements for the prevention of infections should be observed.

Do not prohibit breastfeeding.

The child should be given a solution for oral rehydration.

When the liquid and frequent stools continue, infusion therapy should be continued.

A child who has a bleeding or is marked with pallor at birth or at any time after birth, with signs or without signs of internal or external bleeding, the following principles apply:

Provide emergency measures to stop bleeding.

In the presence of signs of shock or signs of shock manifested during the examination of the child to begin infusion therapy with Ringer's solution, if necessary, pour the blood.

Most of the birth cancers that occur during labor are small and pass spontaneously; however, bleeding under the supracranial aponeurosis can be life-threatening, so it should be immediately recognized and treated.

It is necessary to assess the state of the child:

-palp location and size of the birth tumor;

-Check for fluctuations and pain.

- Determine the level of hemoglobin, hematocrit, check heart rate and breathing.

Start to breastfeed.

Begin intravenous fluids.

Skin and mucous membrane problems.

Skin infections in newborn infants are highly contagious. They are in the form of: red or swollen, pustules or blisters, white spots in the tongue or in the mouth. In this case, it is necessary to wash the affected area of the skin using an antiseptic solution and clean gauze wipes. In severe conditions with the help of the laboratory, it is necessary to determine the sensitivity of the pathogen, and start antibacterial therapy. If there is fluctuation in the area of swelling, it is desirable to open and drain the abscess.

Birth trauma is the unusual position of one of the bones (arm, leg, or shoulder) of a child without visible bleeding. There is an asymmetry in the movements of the hands. From an anamnesis it is necessary to pay special attention to difficult sorts, for statement of the probable diagnosis. If necessary, you need to use an X-ray study.

Children born with congenital defects such as dermal processes or additional fingers or toes, congenital cleft lip or palate, clubfoot, atresia of the anus are sent to a specialized center

for surgical treatment. Duties of honey. The staff provide emotional support to the mother and comfort her.

Seizures can cause asphyxia, birth trauma, or hypoglycemia; they can also be a sign of meningitis or neurological disorders. In the interval between cramps, a child may appear healthy, or be unconscious, lethargic or irritable.

Tactics of reference:

- intravenous infusion;

-to eliminate hypoglycemia

- administer phenobarbital 20 mg / kg body weight intravenously or intramuscularly.

-If necessary, enter phenytoin intravenously in 15 ml of phys. solution.

The respiratory distress syndrome (SDR) is manifested by respiratory failure with retraction of the sternum and "grunting" during exhalation, which in turn is often accompanied by apnea. Usually SDR is manifested in small children (less than 2.5 kg at birth or born before 37 weeks of pregnancy) from the first hours of life.

Such children need special care.

Record the infant's respiration rate, observe possible sternum or granting during exhalation and the presence of apnea episodes every three hours while the baby receives oxygen, and then for the next 24 hours.

If central cyanosis persists even with the appointment of 100% oxygen, if possible, it is necessary to transfer the child to a hospital in which it is possible to carry out artificial ventilation.

Neonatal sepsis

Characteristics characteristic of neonatal sepsis

Lethargy or lethargy of muscle tone

Drowsiness or decreased activity

Vomiting (probability of sepsis)

Bloating

Sluggish feeding or total refusal of food after a period of normal feeding (the probability of sepsis)

Symptoms of the disease, manifested at birth or on the first day of life

Prolonged delivery

Childbirth in Adverse Conditions

Complicated or difficult pregnancy and childbirth and fetal distress

Tactics: hospitalization specialized hospital.

Treatment

Provide intravenous access and in the first 12 hours pour in intravenous fluid depending on the child's age

Blood on the tank. sowing and sensitivity, the Hb level

If there is no meningitis, assign IV ampicillin and gentamicin

With the improvement of the condition with a 3-day course of antibiotics and with negative seeding, we continue treatment for 5 days

With a positive culture, according to sensitivity, we continue treatment for 7-10 days

After 12 hours of antibiotic treatment and improving the condition of the baby, start applying to the chest. If you can not suck, give expressed breast milk.

After stopping antibiotics, we observe for 24 hours

Sudden Infant Mortality Syndrome (SIDS) is an unexpected, non-violent death of an infant, in which there are no clinical and pathological signs of the disease that are adequate to explain the causes of death.

Risk factors:

The social

Bad habits of parents (smoking, alcoholism, drug addiction)

Unfavorable living conditions

Soft (down) pillow, baby's mattress, tight swaddling.

Biological

Weighed obstetric-gynecological anamnesis (abortions, miscarriages, young and elderly pervasive)

Weighed down pregnancy (EGZ, rapid delivery, pre-eclampsia, arterial hypotension)

Neonatal pathology (the birth of a child with a very large body weight, or with a low weight, ESRD, fetal hypoxia, later applying to the chest, spinal trauma, probing food in the early days of life)

Frequent infections

There are two versions of SHS:

primary cardiac arrest associated with ventricular fibrillation leading to secondary brain death

primary respiratory arrest followed by slow cardiac arrest

Prevention:

Identify a risk group and teach mothers the right care for newborns.

To spend on age massage and gymnastics, hardening.

Measures to prevent SIDS

Step 1 - Sleep on the back: the position of the child during sleep - on the back

Step 2 - Refuse from smoking during pregnancy and after childbirth

Step 3 - Avoid overheating of the child

Step 4 - Put the child to sleep on a hard surface

Step5- Remove soft objects and loose bedding from a baby cot

Step 6 - Sleep in a separate bed, but in the immediate vicinity of the child

Step 7 - Adhere to breastfeeding

Step 8 - Follow the company «Back to Sleep» («Sleep on the back»)

5. Analytical part

Appendix No. 1

The game "Hot Potato" is used at the stage of discussing homework and determining the initial knowledge of students. Students pass each other "hot potatoes", the teacher turns away and, when he says stop, the student, who has potatoes, should answer the questions:

1) The concept of fetoplacental insufficiency (This is a violation of the placenta due to morpho-functional changes in the placenta and violations of compensatory-adaptive mechanisms that ensure the functional usefulness of the organ.);

2) Define the hypoxia of the fetus (a complex of changes in the fetus that arise from the inadequate supply of oxygen to tissues and organs or the inadequate utilization of oxygen by oxygen);

3) Causes leading to fetal hypoxia (preplacental, placental, postplacental).

4) Forms of the FCHR of the fetus (symmetrical, asymmetrical);

5) Tactics of GP in the diagnosis of fetal heart failure (hospitalization)

6) Degrees of severity of ZVUR (grade 1 - delay in development for 2 weeks, 2 degree - for 2-4 weeks, 3 degree - more than 4 weeks)

7) What form of FPN is an indication for emergency delivery (Chronic decompensated FPN not amenable to drug therapy for a viable fetus)

8) List the drugs for FPN treatment (Tocolytics, antispasmodics, actovegin, anitiagreganty, vitamins)

9). Etiopathogenesis of threatening fetal and neonatal conditions

10). Definition and classification of threatening conditions of the fetus and newborns

11) laboratory-instrumental diagnosis of distress of fetal syndrome

12) principles of management and treatment

13) concept, clinic and treatment of newborn asphyxia

Appendix No. 2

The game "Problem Solving Method" is used at the stage of discussion and strengthening of theoretical knowledge received by students and given practical work.

The teacher offers students to be divided into three groups. Students are relieved at the first, second; all first numbers - the first group, all the second - the second.

Each group draws a lot by lot: FPN, ZVUR

It is necessary to prepare answers to the following questions:

the causes of FPN, AECD

the causes of FPN, AECD

diagnostic criteria

algorithm of actions

principles of treatment

indications for abortion

In the group, students at the end of the assignment choose a representative to announce the answer. The competing group is an expert with the teacher.

Briefing - 3 minutes; division into groups - 2 min .; preparation time-10 minutes; presentation of the representative of the group - for 8 minutes. = 24 minutes; discussion of answers - 6 min.

Appendix №3

Situational task number 1.

The first-born 24 years turned to the SVP. From the anamnesis sexual life from 23 years, delay of menstruation for 2 months. He works as a vet in a poultry farm. Objectively: there are no pathologies on the part of the internal organs. When vaginal examination revealed 8 weeks of pregnancy.

Questions:

What survey methods are required?

Do I need iron containing medications?

Is the examination for toxoplasmosis mandatory or not?

Risks of complications of pregnancy?

Answers:

Blood group, Rh factor, OAB, OAM, kaogulogram, biochemical blood test, HBSAg, RW, analysis of excretions

Yes.

Be sure to check for toxoplasmosis

Risk of spontaneous miscarriage, undeveloped pregnancy.

Situational task number 2

Patient A., 30 years old, the fourth pregnancy. Previous pregnancies were uncomplicated and ended with normal birth of full-term children. Now she is 39 weeks pregnant, entered the hospital 3 hours ago in childbirth. According to the partograph, the progress of labor was normal 30 minutes before. Since then, the heart rate of the fetus was 90-100 beats per minute between contractions (before this was 120-130 beats per minute). Patient A. has no temperature and she was not given any medication during labor. There is no vaginal bleeding or unusual pain. The mother has no signs of infection.

There are no umbilical cord in the vagina.

Fetal heart rate is 94 beats per minute.

Question:

What is the diagnosis of the patient A., and why?

What is your plan to help patient A., and why?

Answer:

Symptoms and signs of a patient A. (eg, a sharp slowing of the fetal heart rate in the absence of labor or a slowdown after contractions) indicate fetal distress; however, the reasons are not revealed

Follow-up of the patient A. should be continued using the partograph. Continuous follow-up should include the following: maternal and contractions every half hour, fetal heart rate every 5 minutes, blood pressure and temperature every 4 hours, urine test for protein and acetone every 2-4 hours, vaginal examination as often as needed cervical dilatation, the degree of lowering of the fetal part, amniotic fluid, the configuration of the head), with a preliminary palpation of the abdomen (lowering of the fetal part).

The polyclinic on 28/11/09 was addressed by a pregnant woman complaining of a lack of fetal movement. Pregnancy II. Last menstruation from 10 / 2.09 to 13 / 2.09. Palpitation of the fetus is not heard. Allocations are bright.

Questions:

Preliminary diagnosis

Additional research methods

Tactics of GPs

Answers:

Pregnancy II 42 weeks. Antenatal fetal death

Ultrasound

Referral to hospital

List of practical skills:

Listening to the fetal heartbeat

External obstetric examination of pregnant women

Calculation of the estimated weight of the fetus

Definition of the period of pregnancy and childbirth (see the appendix to the training manual practical skills)

9. Test questions

concept of a small fetus for gestational age

etiopathogenesis of threatening fetal conditions

criteria for diagnosis of fetal conditions

definition and classification of FPN, ESRD, distress of fetal syndrome

laboratory-instrumental diagnostics of FPN, ZVUR, distress of fetal syndrome

principles of management and treatment of FPN, ESRD, distress of fetal syndrome

10. Recommended literature

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http: surgeryclinic.medserv.com/o

Theme number 8: Hypertensive disorders during pregnancy and childbirth.

Diagnostics. Tactics of management (Chronic hypertension. Hypertension induced by pregnancy).

Hypertensive state in pregnancy and childbirth.

Classification:

I. Chronic arterial hypertension (CAH) (hypertension before 20 weeks).
II. Hypertension induced by pregnancy (GiB).
• GiB without proteinuria is a landmark in diastolic blood pressure
• Ease of pre-eclampsia
• Severe pre-eclampsia
• Eclampsia
III. Chronic hypertension with preeclampsia or eclampsia layer these areas using
In the hypertensive disorders diastolic BP (DBP) is an indicator for policy-making management of pregnancy and childbirth.
• DBP shows peripheral resistance and does not vary depending on the emotional state of women
• If diastolic blood pressure of 90 mm Hg or increased in two consecutive measurements at intervals of 4 hours, then it's Hypertension!
• If hypertension develops after 20 weeks, during childbirth or within 48 hours after birth is a pregnancy-induced hypertension.

• If diastolic blood pressure 90 - 100 mm Hg 20 weeks + proteinuria and 2 (1 g / L) - Chronic hypertension with mild preeclampsia merger.

II. Speaking of the **CAG** have in mind that the diagnosis is usually carried out pregnancies, and is conducted in an outpatient setting. If necessary treatment and complications EGZ gestation in a hospital.

• The most common chronic arterial hypertension is:

- Primary (90-95%) or essential
- In other cases it represented a secondary or symptomatic hypertension.

• If there is insufficient data to differentiate between CAH and flexible, then the following criteria for CAH:

- Hypertension occurs before 20 weeks of pregnancy
- Hypertension persists for more than 6 weeks after birth in the absence of treatment
- Recurrent hypertension in every pregnancy should be considered as chronic hypertension.

Error diagnostics. About 40% of pregnant women suffering from hypertension.There is a significant reduction in blood pressure in early pregnancy to increase it in the third trimester, so it is likely setting misdiagnosis of hypertension of pregnancy, and in the presence of proteinuria and minimalnoyf diagnosis of preeclampsia.

Pregnant women with CAH is VOPom on an outpatient basis:

• Encourage extra rest

• Lower blood pressure reduces renal and placental perfusion. BP should be reduced nenizhe level available to the women before pregnancy.

• If a woman taking antihypertensive medications before pregnancy, continue!

• If diastolic blood pressure 110 mm Hg and more and SBP 160 and assign more antihypertensive medications

• If proteinuria is detected, it is joined preeclampsia, and lead, depending on the degree of pre-eclampsia.

• Monitor growth and fetal

• If no complications - in time rodorazreshite

• If \ b fetus <100 or> 180 bpm. per minute - disstres fruit!

• If severe IUGR fetus showed an early delivery

• Determination of gestational age in late pregnancy by ultrasound is notfull-time!

II. **Hypertension induced by pregnancy**. (GiB) is considered high blood pressure after 20 weeks (except for hydatidiform mole).Increased blood pressure during pregnancy is considered to be an adaptive response of the body that occurs in response to inadequate perfusion of different parts of the vascular bed of pregnant and vital organs.

SPM is a weekly observation on an outpatient basis, measurements of blood pressure and proteinuria in the urine study.

The criterion of hypertension during pregnancy:

- Increase in diastolic blood pressure above 90 mm Hg
- Increase in systolic blood pressure above 140 mm Hg
- The true increase in blood pressure can be seen at the base of at least 2-fold pressure for 4 hours.

Factors "at risk" for development GiB

1. Pregnancy
2. Signs point to the lack of an increase in intravascular volume (hypovolemia possible)
3. The absence of a physiological reduction in diastolic blood pressure in the second trimester of pregnancy
4. Increased systolic blood pressure by 30 mmHg from baseline, but did not reach 140 mm Hg (conventional)
5. Increase in diastolic blood pressure by 15 mmHg from baseline, but does not reach 90 mm Hg

6.Intrauterine growth restriction.

II.A. Hypertension without proteinuria, hypertension pregnancy (gestational hypertension)

Pathophysiology

High blood pressure, first noted in the second half of pregnancy, is a response to increased peripheral resistance of blood vessels.Such a reaction is usually an adaptive response aimed at maintaining adequate blood perfusion of vital organs and parts (brain, liver, kidneys, etc.), as a pregnant woman and fetus.

It is obvious that lowering blood pressure with antihypertensive drugs may lead to violation of these divisions and perfusion, including the further deterioration of the fetus.

Of pregnant women with GiB an outpatient basis.

During the initial identification of hypertensive disorders of GPs collects history, during the hearing of complaints reveals any signs of eating disorders of cerebral circulation, examines urine to determine proteinuria.

GP confirming the diagnosis GiB conducts a conversation with the pregnant woman and her relatives about possible complications. Recommends measuring blood pressure 2 times a day and write a weekly examination of urine for proteinuria.GP explains the prognosis of patients with GiB subject of work and rest, good nutrition, and compliance while reducing physical and mental stress is good.But with the progression of hypertensive disorders in the home and occurrences of headaches, nausea, vomiting, blurred vision, pain in the epigastrium - call an ambulance or go to the hospital Blajan.

Prevention:

1.Restricting food intake kallarozha, fluid and salt does not prevent the progression of hypertensive disorders and may be harmful to the fetus.

2. Not shown a positive effect of aspirin, calcium and other medications to prevent hypertensive disorders

3.Identifying women at risk and provide them with timely assistance is an important factor in the treatment and prevention of seizures GiB. Women included in this group are under control and must clearly explain when and under what circumstances should seek medical attention.Education relatives is an important factor in identifying the progression of GiB and timely admission to hospital.

Events organized at the antenatal clinic:

1. measurement of blood pressure, urine (proteinuria) and fetal once a week;
2. in cases of elevated BP as being in the mild pre-eclampsia;
3. If signs of lagging behind the growth of the fetus or impairment of urgent hospitalization to assist or premature delivery;
4. mandatory counseling for women and families about danger signs severe pre-eclampsia and eclampsia;
5. if all the indicators the study showed no pathological changes in delivery vaginally.

III.B. Arterial hypertension with proteinuria, preeclampsia

Pathophysiology

Kompesatorno-adaptive reaction of the body to improve perfusion of the pregnant vital organs and the fetus. This is an adaptation that accompanies the hypertensive:

• Generalized vasospasm, leading to increased peripheral vascular resistance and consequent reduction in perfusion of vital organs (brain, liver, kidney, placenta), which in turn leads to a decrease in:

- Placental perfusion and may lead to growth retardation and fetal is a major cause of perinatal morbidity and mortality. Reduced uteroplacental blood flow by 50-60% occurs 3-4 weeks before the hypertension becomes apparent.

- Decreased renal blood flow and glomerular filtration rate is the reason:
1. Glomeruli and hypoxia, as a consequence - proteinuria, water retention and edema development
2. Increase in plasma Occupational uric acid, creatinine and urea (in severe cases).
3. Gemokontsetratsiya as a result of increased vascular permeability with a decrease in intravascular fluid (hypovolemia) and signs of extravascular growth.

• Damage to the vascular endothelium (due to peroxidation products as a result of reaction to a fruit tissue) is:
- Stimulation of the coagulation mechanisms, reflected in increased platelet aggregation.
- Violation of production and decay of prostacyclin / thromboxane - prostaglandins having opposite effects on vascular tone and platelet aggregation.

Pre-eclampsia - a hypertension + proteinuria in the second half of pregnancy.On the recommendation of WHO pre-eclampsia is divided into two forms:

By gravity:
• Light
• severe

For gestational age:
• full-term (> or = 36 weeks gestation)
• prematurity (<36 weeks gestation)

III. **Light pre-eclampsia** - a double-marked rise in diastolic blood pressure above 90 mm Hg to 110 mm Hg within 4 hours after 20 weeks of gestation with proteinuria over 0.3 g/l to 1 g/l

Management of mild preeklapsii

If <37 weeks - if the symptoms are not modified or normal state, the woman is observed twice a week on an outpatient basis:

• Pregnant measure blood pressure twice a day and takes her record;
• GP watches twice a week, or by treatment (blood pressure checks, urine for proteinuria, reflexes and fetal);
• Mandatory counseling for women and families about danger signs severe pre-eclampsia and eclampsia;
• Encourage extra rest a pregnant woman;
• encourage compliance with a balanced diet;
• reducing physical and mental stress;
• If the outpatient surveillance woman can not, send her to the hospital;
• When gestation 34 weeks and fetal weight less than 2000 g to prevent the SDR in the newborn. For the prevention of the SDR in the newborn using glucocorticoids (deksazon, dexamethasone) on one of the schemes:
- At 6 mg / m or / in 6 hours. Only 4 injections.
* Prophylaxis will be effective from the date when the first injection before delivery will take place not less than 48 hours.
* The time within which the effectiveness of prevention of the SDR is not more than 7 days.

If 37 weeks

Assessment of maturity of the cervix and delivery planning.

• cervix may mature autopsy of membranes in the absence of progression of labor within a few hours, you can apply the induction of labor or prostaglandins oksitatsinom
• immature cervix may prepare, using prostaglandins or a Foley catheter, with no effect rozhovozbuzhdenie for several days, as far as the woman and the fetus, or to schedule a cesarean section.

Rehabilitation after childbirth:

- Medical check-up in a family clinic in conjunction with experts in various fields for the timely recovery outside of pregnancy and subsequent pregnancy planning;

- Selection of contraceptive methods with their contra-indications.

4.2. An analytical part

Situational problem №1

To GP 4.03.2011 pregnant woman D has addressed. 26 years with complaints to periodic increase the AP in a current of week, hyperactivity of a fruit, work capacity decrease, fast fatigue. According to the pregnant woman these complaints disturb only during this pregnancy. In a current of week has appeared frequent шевеление a fruit. Increase the AP took place from 130/90 to 150/100 mm.hg. Hypertensive preparations did not accept. To the doctor did not address. Works as the bookkeeper at factory. Bad habits: smokes. From the transferred diseases: since 20 years. 2 foreign pyelonephritis.

The obstetrics anamnesis: In total pregnancy - 2, from them urgent childbirth - 1, last normal mensis - 2.07.2010

Status: D condition satisfactory, the AP 130/80 140/90 мм.рт.ст., pulse of 82 blows in minute

Akushersky survey:. A uterus bottom between a navel and sternum a shoot, out of a tone, II position, a forward kind, head prelying. height of a bottom of a uterus – 28 sm, stomach circle – 82 sm, fruit palpitation are listened on the right below a navel, 146 blows in minute

The additional information to a situational problem

The indicators received in a pre-medical office		
1	Growth	*162м*
2	Weight	*74*
3	IMW	
4	Stomach circle	*82*
5	HBU	*28*
6	Body temperature	*36,5*
7	AP	*130/80; 140/90*
8	Pulse	*82*

Data spent общеклинических inspections

№	Researches	Результат
1.	*The general analysis of blood*	Haemoglobin - 112 г/л; Er-3.8-4h10*12/l; Leukocytes - 4,7h10*9/l - - *basofill - (-);-monotsity - 4 %;* SDE-10 mm/hour
2.	*The general analysis of urine*	ıantity - *150 ml;* Colour - *light yellow;* Relative density of urine - *1015* The Transparency - *transparent;* Reaction - *sour;* Fiber - *traces;* Bilious pigments - *negative;* □□ - *1-2-3 in sight;* *Leukocytes - 1-2 in sight.*

Data of the spent biochemical inspections

№	researches	result
1.	***Blood glucose***	3,90-5,80 mmol/l
2.	*kreatinin*	Жен. 44-80 mk mol/l
3.	*Urea*	1,7-8,3 mk mol/l

Data of the spent tool inspections

1.	ELECTROCARDIOGRAM	sinus a rhythm, HP 82 . In a minute, moderated hypertofic sinister ventricula . (An electrocardiogram a tape)

2.	Eye bottom	Narrowing of arteries and arteriols, a moderate thickening of their walls; pressure veins of arteriols, tortuosity and expansion of veins (the student should define a stage). Changes correspond to the second stage hypertensive angiopati.es
3.	Uterus ultrasonic	On ultrasonica fruit one, head prelying the size of a head-82 of mm, length of a hip-60 of mm, a placenta on back walls, II degree of a maturity, thickness of 52 mm petrificats, individual cists, amniotic waters in enough, normal.
4.	Uterus ultrasonic	At research the right kidney 118x74мм, 114x68, the usual form, 16 mm, both kidneys it is condensed, excursion normal.

The definitive diagnosis

The basic: *Pregnancy II, 31-32 weeks. HPI. FPD.. (A category 1).* **Accompanying:** *IUT not complicated pyelonephritis (a category 1) (the student should prove the exposed definitive diagnosis).*

Not medicamentous treatment:

 Auto-training (elimination of negative psychoemotional and psychosocial stressful situations);

 Dietetic therapy (strict conformity of power value of a diet to organism power inputs, at accompanying adiposity - restriction of daily caloric content; an exception of the products raising mean and heart - strong meat and fish broths, strong tea, coffee; the products causing strengthened, intestines swelling - beans, the peas, the aerated drinks; restriction of table salt to 5-6 gr/sut, sharp dishes, seasonings and the products containing animal fats; enrichment of a diet by the products containing magnesium and kalii; inclusion in a diet of fresh fish);

 Struggle with hypodinamics (to apply regular admissible dynamic physical activities);

 Rational psychotherapy;

 Herbal medicine (corn рыльце, a half-floor);

 The Mode of work and rest 8 hour dream;

 Training of the patient to skills of measurement the AP; calculation ЧСС and pulse; to self-help rendering at sudden increase the AP.

Informed the pregnant woman on medicamentous methods of treatment HPI:

 Now for treatment HPI during pregnancy do not apply antihyprtensive preparations and diuretics.

Group диспансерного supervision *(group D III):*

The following periodicity of surveys is recommended: *the weekly control*

Full clinical inspection includes:

Survey GP;

- The AP, urine on protein uri 2 times week, a fruit condition weekly!
- If there is protein uri, a conducting as at easy preeclamcia
- Under indications survey by the neuropathologist, the oculist, the urologist;
- Measurement of growth, weights of a body, SC, HBU, BIW;
- Gravidogramma;
- Auscultation of palpitation of a fruit;
- КТG and ultrasonic if necessary and under indications;
- At revealing of a fruit or deterioration of a condition of a fruit - urgent hospitalisation in a hospital for preschedule delivery
- To Consult the pregnant woman and her family concerning dangerous signs preeclamcia and eclampcia

• If the condition of the pregnant woman remains stable carrying out of normal sorts and podelivery is shown in time.

The basic medical-improving actions at prophylactic medical examination of patients with a hypertensia the induced pregnancy are:

- Training to skills of a healthy way of life;
- Restriction in food of table salt and the sated fats;
- Psychotherapy;
- Positive influence of aspirin, calcium and other preparations for treatment HPI is not proved
- Family Training, social support

Situational problem №2

In VDP on reception to GP 4.01.2011 years the pregnant woman of M. of 30 years with complaints to periodic increase the AP in a current of the several years, the raised impellent activity of a fruit, work capacity decrease, fast fatigue has addressed. According to the pregnant woman these complaints disturbed to pregnancy and were aggravated during pregnancy. In a current of week has appeared "rough" шевеление a fruit. Increase the AP took place from 130/90 to 150/100 mm.hg. Hupotensive preparations accepted off and on. During pregnancy did not accept. To I will hand over never addressed. Works as the teacher at school. Bad habits: likes to eat well.

The ostetrics anamnesis: In total beremennostej-3; delivery-1; abortion-1; Last menstruatsija-02.06.2010

Objectively: the general condition of the patient at the moment of survey rather satisfactory, is marked гиперемия persons, heart borders are expanded to the left, the AP 130/80; 140/90 mm.hg., pulse 86 in minute.

Akushersky survey: the uterus Bottom on 2 cross-section fingers above a navel, II position, a forward kind, head prelying, out of a tone, height of a bottom of a uterus – 26 sm, stomach circle – 76 sm, fruit palpitation is listened on the right below a navel, 136 blows in a minute.

The additional information to a situational problem

The indicators received in a pre-medical office		
1	Growth	*154см*
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7	AP	*130/80; 140/90*
8	Pulse	*86*

Data spent labarotor inspections	
	Indicators of the patient
The general analysis of blood	Hemoglobin - 112 г/л; - Er -3.8h10*12/l; - Leukocytes - 4,7h10*9/l - eozinofils - 2 %; - basofils - (-); -monotsity - 3 % -limfotsity-12 %; SUE -10 mm/hour.

The general analysis of urine	Quantity - *150 ml;* Colour - *light yellow;* Relative density of urine - *1015* The Transparency - *transparent;* Reaction - *sour;* Fiber - traces*;* Bilious pigments - *negative;* Эпителий-*1 2-3 in sight;* • *Leukocytes - 1-2 in sight.*

Data of the spent tool inspections

4	ELECTROCARDIOGRAM	sinus rhythm, 86 In minute, signs SVG.
5	Eye bottom	Narrowing of arteries and артериол, a moderate thickening of their walls; pressure veins arteriols, tortuosity and expansion of veins (the student should define a stage).
6	ULTRASONIC	On ultrasonics 1 fruit, in head prelying. BPR-74мм, a placenta on a back wall of 3 degrees of a maturity, a thickness of 40 mm, отечная. amniotic waters in moderate quantity.

The definitive diagnosis

The basic: Pregnancy III, 29-30 weeks. ХАГ. ФПН. ОАА. (А category 1). **Accompanying:** Adiposity of 1 degree (a category 1) (the student should prove the exposed definitive diagnosis).

Not medicamentous treatment:

 Auto-training (elimination of negative psychoemotional and psychosocial stressful situations);

 Dietetic therapy (strict conformity of power value of a diet to organism power inputs, at accompanying adiposity - restriction of daily caloric content; an exception of the products raising mean and heart - strong meat and fish broths, strong tea, coffee; the products causing strengthened e, intestines swelling - beans, the peas, the aerated drinks; restriction of table salt to 5-6 gr/sut, sharp dishes, seasonings and the products containing animal fats; enrichment of a diet by the products containing magnesium and калий; inclusion in a diet of fresh fish);

 Struggle with гиподинамией (to apply regular admissible dynamic physical activities);

 Rational psychotherapy;

 Herbal medicine;

 A work and rest Mode;

Training of the patient to skills of measurement the AP; calculation heart and pulse; to reception rules hypotensivex preparations; to self-help rendering at sudden increase the AP.

Informed the pregnant woman on medicamentous methods of treatment ХАГ at pregnancy:

Now to treatment НАГГ during pregnancy apply АК, metildopa, ББ.

It Atenalol on 0,25 2 times constantly, at an inefficiency with the subsequent selection of an individual dose of a preparation or nifedipine of 20 mg (коринфар 10 mg) 4 times in day under the control the AP.

Group диспансерного supervision *(group D III):*

Since the moment of detection raised the APL, and also from an establishment of diagnosis GD of the patient should be under regular supervision. Frequency of surveys is

defined by size the APL, a therapy kind, speed of approach of therapeutic effect, character of developing by-effects at medicamentous treatment.

The following periodicity of surveys is recommended:

1. HAG at pregnancy demands survey GP, each 2 weeks when carry out the control of efficiency of treatment,protein uri, the eye bottom looks round.
2. Watch signs fetoplacentar status, status a fruit.
3. Spend labaroror and obstetrics surveys of pregnant women with performance listed above laboratory researches. Treatment should be continuous, even during the periods of improvement of a condition.

Full clinical inspection includes:

- Survey GP;
- Under indications survey by the neuropathologist, the oculist, the urologist;
- Measurement of growth, weights of a body;
- AN ELECTROCARDIOGRAM.
- gravidogramma;
- Auscultation of palpitation of a fruit;
- КТГ and ultrasonic if necessary and under indications;

The basic medical-improving actions at prophylactic medical examination sick of hypertensive illness are:

- Training to skills of a healthy way of life;
- Elimination of risk factors ishcemi and AG;
- Restriction in food of table salt and the sated fats;
- Psychotherapy;
- Continuation medicamentous гипотензивной therapies at AG II and III stages in individually picked up mode;

Improvement in sanatorium-dispensary

Situational problem №3 Independent work with application of data of demonstrative medicine PFT

Speciality, scope: GP therapy, obstetrics-gynecology, anesthesiology

Theme: « **Hypertensive state in pregnancy and childbirth.** »

Problem: the Choice of tactics of conducting, diagnostics and rendering of the urgent help at гипертензивных infringements during pregnancy and sorts in the conditions of VDP and CDP.

Summary of a clinical case

In VDP on reception pregnant woman D has come. 27 years with complaints to a headache, pains in эпигастрии, two-multiple vomiting since yesterday. In a current of week there were hypostases on all body and began to raise the AP to 140/90 mm hg. Treatment did not receive. No bad habits has. The housewife.

The obstetrics anamnesis: Pregnancy of the third, 36-37 weeks. 2 sorts without complications.

Objectively: the general condition of the pregnant woman at the moment of survey heavy, is marked гиперемия persons, генерализованные hypostases. The AP 160/110; 170/110 mm hg, pulse 92 in the minute, strained.

Akushersky survey: the Uterus in normal, a uterus bottom on 2 cross-section fingers more low мечевидного a shoot, I position, a forward kind, head prelying, out of a tone, height of a bottom of a uterus – 33 sm, stomach circle – 86 sm,, fruit palpitation is listened at the left below a navel of 140 blows in a minute, muffled, rhythmical.

Aim to define methods of diagnostics, inspection and tactics of conducting and at гипертензивных infringements during pregnancy and sorts at level of a primary link

Problems:

- To Learn to diagnose and be able to carry out monitoring at гипертензивных infringements;
- To List diagnostics methods, to make and prove the inspection plan at level VDP and CDP.

• To Generate skills of rendering of the urgent help in a primary link at heavy преэклампсии and эклампсии;
• Will learn to criteria of differential diagnostics and interpretation of the basic functional methods of researches at pregnancy with гипертензивным a syndrome;
• To Define degree of necessity of the subsequent supervision (medicamentous and not medicamentous treatment)
• To Develop skills on postnatal rehabilitation of women having гипертензивные infringements, including contraception methods.

Trigger questions

• Make definition HPI, HAG, easy and heavy преэклампсии, эклампсии;
• What to enter to criteria of an arterial hypertensia during pregnancy;
• What changes occur at a fruit at heavy преэклампсии;
• What additional researches are necessary in the given situation in the conditions of VDP, CDP?
• Kinds противосудорожных preparations and антигипертензивных means

Whether • It is necessary rendering of the emergency help and hospitalisation, if yes, in what hospital of a profile?

Communications with other sections of a course

• Anatomy and physiology
• Therapy
• Obstetrics and gynecology
• Urgent conditions

Theme No. 9: Hypertensive disorders during pregnancy and childbirth (preeclampsia, eclampsia). Diagnostics. Tactics of reference.

Hypertensive state in pregnancy and childbirth.

Classification:

I. Chronic arterial hypertension (CAH) (hypertension before 20 weeks).
II. Hypertension induced by pregnancy (GiB).
• GiB without proteinuria is a landmark in diastolic blood pressure
• Ease of pre-eclampsia
• Severe pre-eclampsia
• Eclampsia
III. Chronic hypertension with preeclampsia or eclampsia layer these areas using
In the hypertensive disorders diastolic BP (DBP) is an indicator for policy-making management of pregnancy and childbirth.
• DBP shows peripheral resistance and does not vary depending on the emotional state of women
• If diastolic blood pressure of 90 mm Hg or increased in two consecutive measurements at intervals of 4 hours, then it's Hypertension!
• If hypertension develops after 20 weeks, during childbirth or within 48 hours after birth is a pregnancy-induced hypertension.
• If diastolic blood pressure 90 - 100 mm Hg 20 weeks + proteinuria and 2 (1 g / L) - Chronic hypertension with mild preeclampsia merger.

III. Speaking of the **CAG** have in mind that the diagnosis is usually carried out pregnancies, and is conducted in an outpatient setting. If necessary treatment and complications EGZ gestation in a hospital.
• The most common chronic arterial hypertension is:
- Primary (90-95%) or essential
- In other cases it represented a secondary or symptomatic hypertension.

• If there is insufficient data to differentiate between CAH and flexible, then the following criteria for CAH:
- Hypertension occurs before 20 weeks of pregnancy
- Hypertension persists for more than 6 weeks after birth in the absence of treatment
- Recurrent hypertension in every pregnancy should be considered as chronic hypertension.
Error diagnostics. About 40% of pregnant women suffering from hypertension.There is a significant reduction in blood pressure in early pregnancy to increase it in the third trimester, so it is likely setting misdiagnosis of hypertension of pregnancy, and in the presence of proteinuria and minimalnoyf diagnosis of preeclampsia.
Pregnant women with CAH is VOPom on an outpatient basis:
• Encourage extra rest
• Lower blood pressure reduces renal and placental perfusion. BP should be reduced nenizhe level available to the women before pregnancy.
• If a woman taking antihypertensive medications before pregnancy, continue!
• If diastolic blood pressure 110 mm Hg and more and SBP 160 and assign more antihypertensive medications
• If proteinuria is detected, it is joined preeclampsia, and lead, depending on the degree of pre-eclampsia.
• Monitor growth and fetal
• If no complications - in time rodorazreshite
• If \ b fetus <100 or> 180 bpm. per minute - disstres fruit!
• If severe IUGR fetus showed an early delivery
• Determination of gestational age in late pregnancy by ultrasound is notfull-time!
II. **Hypertension induced by pregnancy**. (GiB) is considered high blood pressure after 20 weeks (except for hydatidiform mole).Increased blood pressure during pregnancy is considered to be an adaptive response of the body that occurs in response to inadequate perfusion of different parts of the vascular bed of pregnant and vital organs.
SPM is a weekly observation on an outpatient basis, measurements of blood pressure and proteinuria in the urine study.
The criterion of hypertension during pregnancy:
- Increase in diastolic blood pressure above 90 mm Hg
- Increase in systolic blood pressure above 140 mm Hg
- The true increase in blood pressure can be seen at the base of at least 2-fold pressure for 4 hours.
Factors "at risk" for development GiB
1. Pregnancy
2. Signs point to the lack of an increase in intravascular volume (hypovolemia possible)
3.The absence of a physiological reduction in diastolic blood pressure in the second trimester of pregnancy
4. Increased systolic blood pressure by 30 mmHg from baseline, but did not reach 140 mm Hg (conventional)
5. Increase in diastolic blood pressure by 15 mmHg from baseline, but does not reach 90 mm Hg
6.Intrauterine growth restriction.
II.A. Hypertension without proteinuria, hypertension pregnancy (gestational hypertension)
Pathophysiology
High blood pressure, first noted in the second half of pregnancy, is a response to increased peripheral resistance of blood vessels.Such a reaction is usually an adaptive response aimed at maintaining adequate blood perfusion of vital organs and parts (brain, liver, kidneys, etc.), as a pregnant woman and fetus.

It is obvious that lowering blood pressure with antihypertensive drugs may lead to violation of these divisions and perfusion, including the further deterioration of the fetus.

Of pregnant women with GiB an outpatient basis.

During the initial identification of hypertensive disorders of GPs collects history, during the hearing of complaints reveals any signs of eating disorders of cerebral circulation, examines urine to determine proteinuria.

GP confirming the diagnosis GiB conducts a conversation with the pregnant woman and her relatives about possible complications. Recommends measuring blood pressure 2 times a day and write a weekly examination of urine for proteinuria.GP explains the prognosis of patients with GiB subject of work and rest, good nutrition, and compliance while reducing physical and mental stress is good.But with the progression of hypertensive disorders in the home and occurrences of headaches, nausea, vomiting, blurred vision, pain in the epigastrium - call an ambulance or go to the hospital Blajan.

Prevention:

1.Restricting food intake kallarozha, fluid and salt does not prevent the progression of hypertensive disorders and may be harmful to the fetus.

2. Not shown a positive effect of aspirin, calcium and other medications to prevent hypertensive disorders

3.Identifying women at risk and provide them with timely assistance is an important factor in the treatment and prevention of seizures GiB. Women included in this group are under control and must clearly explain when and under what circumstances should seek medical attention.Education relatives is an important factor in identifying the progression of GiB and timely admission to hospital.

Events organized at the antenatal clinic:

1. measurement of blood pressure, urine (proteinuria) and fetal once a week;
2. in cases of elevated BP as being in the mild pre-eclampsia;
3. If signs of lagging behind the growth of the fetus or impairment of urgent hospitalization to assist or premature delivery;
4. mandatory counseling for women and families about danger signs severe pre-eclampsia and eclampsia;
5. if all the indicators the study showed no pathological changes in delivery vaginally.

III.B. Arterial hypertension with proteinuria, preeclampsia

Pathophysiology

Kompesatorno-adaptive reaction of the body to improve perfusion of the pregnant vital organs and the fetus. This is an adaptation that accompanies the hypertensive:

• Generalized vasospasm, leading to increased peripheral vascular resistance and consequent reduction in perfusion of vital organs (brain, liver, kidney, placenta), which in turn leads to a decrease in:

- Placental perfusion and may lead to growth retardation and fetal is a major cause of perinatal morbidity and mortality. Reduced uteroplacental blood flow by 50-60% occurs 3-4 weeks before the hypertension becomes apparent.
- Decreased renal blood flow and glomerular filtration rate is the reason:

1. Glomeruli and hypoxia, as a consequence - proteinuria, water retention and edema development
2. Increase in plasma Occupational uric acid, creatinine and urea (in severe cases).
3. Gemokontsetratsiya as a result of increased vascular permeability with a decrease in intravascular fluid (hypovolemia) and signs of extravascular growth.

• Damage to the vascular endothelium (due to peroxidation products as a result of reaction to a fruit tissue) is:

- Stimulation of the coagulation mechanisms, reflected in increased platelet aggregation.
- Violation of production and decay of prostacyclin / thromboxane - prostaglandins having opposite effects on vascular tone and platelet aggregation.

Pre-eclampsia - a hypertension + proteinuria in the second half of pregnancy.On the recommendation of WHO pre-eclampsia is divided into two forms:

By gravity:

• Light
• severe

For gestational age:

• full-term (> or = 36 weeks gestation)
• prematurity (<36 weeks gestation)

III. **Light pre-eclampsia** - a double-marked rise in diastolic blood pressure above 90 mm Hg to 110 mm Hg within 4 hours after 20 weeks of gestation with proteinuria over 0.3 g/l to 1 g/l

Management of mild preeklapsii

If <37 weeks - if the symptoms are not modified or normal state, the woman is observed twice a week on an outpatient basis:

• Pregnant measure blood pressure twice a day and takes her record;
• GP watches twice a week, or by treatment (blood pressure checks, urine for proteinuria, reflexes and fetal);
• Mandatory counseling for women and families about danger signs severe pre-eclampsia and eclampsia;
• Encourage extra rest a pregnant woman;
• encourage compliance with a balanced diet;
• reducing physical and mental stress;
• If the outpatient surveillance woman can not, send her to the hospital;
• When gestation 34 weeks and fetal weight less than 2000 g to prevent the SDR in the newborn. For the prevention of the SDR in the newborn using glucocorticoids (deksazon, dexamethasone) on one of the schemes:

- At 6 mg / m or / in 6 hours. Only 4 injections.

* Prophylaxis will be effective from the date when the first injection before delivery will take place not less than 48 hours.

* The time within which the effectiveness of prevention of the SDR is not more than 7 days.

If 37 weeks

Assessment of maturity of the cervix and delivery planning.

• cervix may mature autopsy of membranes in the absence of progression of labor within a few hours, you can apply the induction of labor or prostaglandins oksitatsinom
• immature cervix may prepare, using prostaglandins or a Foley catheter, with no effect rozhovozbuzhdenie for several days, as far as the woman and the fetus, or to schedule a cesarean section.

Rehabilitation after childbirth:

- Medical check-up in a family clinic in conjunction with experts in various fields for the timely recovery outside of pregnancy and subsequent pregnancy planning;
- Selection of contraceptive methods with their contra-indications.

4.2. An analytical part

Situational problem №1

To GP 4.03.2011 pregnant woman D has addressed. 26 years with complaints to periodic increase the AP in a current of week, hyperactivity of a fruit, work capacity decrease, fast fatigue. According to the pregnant woman these complaints disturb only during this pregnancy. In a current of week has appeared frequent шевеление a fruit. Increase the AP took

place from 130/90 to 150/100 mm.hg. Hypertensive preparations did not accept. To the doctor did not address. Works as the bookkeeper at factory. Bad habits: smokes. From the transferred diseases: since 20 years. 2 foreign pyelonephritis.
The obstetrics anamnesis: In total pregnancy - 2, from them urgent childbirth - 1, last normal mensis - 2.07.2010
Status: D condition satisfactory, the AP 130/80 140/90 мм.рт.ст., pulse of 82 blows in minute
Akushersky survey:. A uterus bottom between a navel and sternum a shoot, out of a tone, II position, a forward kind, head prelying. height of a bottom of a uterus – 28 sm, stomach circle – 82 sm, fruit palpitation are listened on the right below a navel, 146 blows in minute

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Data of the spent biochemical inspections

№	researches	result
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2.	*kreatinin*	Жен. 44-80 mk mol/l
3.	*Urea*	1,7-8,3 mk mol/l

Data of the spent tool inspections

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The basic: *Pregnancy II, 31-32 weeks. HPI. FPD.. (A category 1).* **Accompanying:** *IUT not complicated pyelonephritis (a category 1) (the student should prove the exposed definitive diagnosis).*

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	Indicators of the patient
The general analysis of blood	Hemoglobin - 112 г/л; - Er -3.8h10*12/l; - Leukocytes - 4,7h10*9/l - eozinofils - 2 %; - basofils - (-); -monotsity - 3 % -limfotsity-12 %; SUE -10 mm/hour.
The general analysis of urine	Quantity - *150 ml;* Colour - *light yellow;* Relative density of urine - *1015* The Transparency - *transparent;* Reaction - *sour;* Fiber - traces*;* Bilious pigments - *negative;*

		Эпителий-*1 2-3 in sight;* • *Leukocytes - 1-2 in sight.*
Data of the spent tool inspections		
4	ELECTROCARDIOGRAM	sinus rhythm, 86 In minute, signs SVG.
5	Eye bottom	Narrowing of arteries and артериол, a moderate thickening of their walls; pressure veins arteriols, tortuosity and expansion of veins (the student should define a stage).
6	ULTRASONIC	On ultrasonics 1 fruit, in head prelying. BPR-74мм, a placenta on a back wall of 3 degrees of a maturity, a thickness of 40 mm, отечная. amniotic waters in moderate quantity.

The definitive diagnosis

The basic: Pregnancy III, 29-30 weeks. ХАГ. ФПН. ОАА. (A category 1). **Accompanying:** Adiposity of 1 degree (a category 1) (the student should prove the exposed definitive diagnosis).

Not medicamentous treatment:

 Auto-training (elimination of negative psychoemotional and psychosocial stressful situations);

 Dietetic therapy (strict conformity of power value of a diet to organism power inputs, at accompanying adiposity - restriction of daily caloric content; an exception of the products raising mean and heart - strong meat and fish broths, strong tea, coffee; the products causing strengthened e, intestines swelling - beans, the peas, the aerated drinks; restriction of table salt to 5-6 gr/sut, sharp dishes, seasonings and the products containing animal fats; enrichment of a diet by the products containing magnesium and калий; inclusion in a diet of fresh fish);

 Struggle with гиподинамией (to apply regular admissible dynamic physical activities);

 Rational psychotherapy;

 Herbal medicine;

 A work and rest Mode;

Training of the patient to skills of measurement the AP; calculation heart and pulse; to reception rules hypotensivex preparations; to self-help rendering at sudden increase the AP.

Informed the pregnant woman on medicamentous methods of treatment ХАГ at pregnancy:

Now to treatment НАГГ during pregnancy apply АК, metildopa, ББ.

It Atenalol on 0,25 2 times constantly, at an inefficiency with the subsequent selection of an individual dose of a preparation or nifedipine of 20 mg (коринфар 10 mg) 4 times in day under the control the AP.

Group диспансерного supervision *(group D III):*

Since the moment of detection raised the APL, and also from an establishment of diagnosis GD of the patient should be under regular supervision. Frequency of surveys is defined by size the APL, a therapy kind, speed of approach of therapeutic effect, character of developing by-effects at medicamentous treatment.

The following periodicity of surveys is recommended:

1. HAG at pregnancy demands survey GP, each 2 weeks when carry out the control of efficiency of treatment,protein uri, the eye bottom looks round.
2. Watch signs fetoplacentar status, status a fruit.

3. Spend labaroror and obstetrics surveys of pregnant women with performance listed above laboratory researches. Treatment should be continuous, even during the periods of improvement of a condition.

Full clinical inspection includes:

- Survey GP;
- Under indications survey by the neuropathologist, the oculist, the urologist;
- Measurement of growth, weights of a body;
- AN ELECTROCARDIOGRAM.
- gravidogramma;
- Auscultation of palpitation of a fruit;
- КТГ and ultrasonic if necessary and under indications;

The basic medical-improving actions at prophylactic medical examination sick of hypertensive illness are:

- Training to skills of a healthy way of life;
- Elimination of risk factors ishcemi and AG;
- Restriction in food of table salt and the sated fats;
- Psychotherapy;
- Continuation medicamentous гипотензивной therapies at AG II and III stages in individually picked up mode;

Improvement in sanatorium-dispensary

Situational problem №3 Independent work with application of data of demonstrative medicine PFT

Speciality, scope: GP therapy, obstetrics-gynecology, anesthesiology

Theme: « **Hypertensive state in pregnancy and childbirth.** »

Problem: the Choice of tactics of conducting, diagnostics and rendering of the urgent help at гипертензивных infringements during pregnancy and sorts in the conditions of VDP and CDP.

Summary of a clinical case

In VDP on reception pregnant woman D has come. 27 years with complaints to a headache, pains in эпигастрии, two-multiple vomiting since yesterday. In a current of week there were hypostases on all body and began to raise the AP to 140/90 mm hg. Treatment did not receive. No bad habits has. The housewife.

The obstetrics anamnesis: Pregnancy of the third, 36-37 weeks. 2 sorts without complications.

Objectively: the general condition of the pregnant woman at the moment of survey heavy, is marked гиперемия persons, генерализованные hypostases. The AP 160/110; 170/110 mm hg, pulse 92 in the minute, strained.

Akushersky survey: the Uterus in normal, a uterus bottom on 2 cross-section fingers more low мечевидного a shoot, I position, a forward kind, head prelying, out of a tone, height of a bottom of a uterus – 33 sm, stomach circle – 86 sm,, fruit palpitation is listened at the left below a navel of 140 blows in a minute, muffled, rhythmical.

Aim to define methods of diagnostics, inspection and tactics of conducting and at гипертензивных infringements during pregnancy and sorts at level of a primary link

Problems:

- To Learn to diagnose and be able to carry out monitoring at гипертензивных infringements;
- To List diagnostics methods, to make and prove the inspection plan at level VDP and CDP.
- To Generate skills of rendering of the urgent help in a primary link at heavy преэклампсии and эклампсии;
- Will learn to criteria of differential diagnostics and interpretation of the basic functional methods of researches at pregnancy with гипертензивным a syndrome;
- To Define degree of necessity of the subsequent supervision (medicamentous and not medicamentous treatment)

• To Develop skills on postnatal rehabilitation of women having гипертензивные infringements, including contraception methods.

Trigger questions

• Make definition HPI, HAG, easy and heavy преэклампсии, эклампсии;
• What to enter to criteria of an arterial hypertensia during pregnancy;
• What changes occur at a fruit at heavy преэклампсии;
• What additional researches are necessary in the given situation in the conditions of VDP, CDP?
• Kinds противосудорожных preparations and антигипертензивных means

Whether • It is necessary rendering of the emergency help and hospitalisation, if yes, in what hospital of a profile?

Communications with other sections of a course

• Anatomy and physiology
• Therapy
• Obstetrics and gynecology
• Urgent conditions

Themes №10: Vaginal bleeding in late pregnancy and childbirth. PONRP, placenta previa. Diagnostics. Tactics of reference

Placenta previa and premature detachment of normally situated placenta (PONRP) are accompanied by bleeding. PONRP results in 30-50% of perinatal mortality. PONRP - is placental abruption before the birth of the fetus - during pregnancy, in the first or second stage of labor. Meets 1/120 births (1.5% of cases). In 30% of cases PONRP causes massive bleeding and hemorrhagic shock, disseminated intravascular coagulation.

Risk Groups

1), hypertensive disorders in pregnancy;

2) infections, intoxication, vitamin deficiency diseases (especially lack of vitamin C);

3) physical illness (diabetes, kidney disease, heart, hypertension);

4) injury, onset of labor, short umbilical cord, polyhydramnios, multiple pregnancy, rapid delivery, delayed rupture of membranes, flat shape of membranes (predisposing factors).

The mechanism of formation. The placenta is retained on the wall of the uterus due to links with decidua and intrauterine pressure. In normal blood pressure in the intervillous space pressure less than the pressure in the amniotic cavity, which provides normal utero-placental blood flow and protects against premature detachment of the placenta. This is facilitated by the structure of the terminal arteries of the uterus in the attachment of the placenta - their clearance at the confluence of the sinuses is greatly reduced, and the venous drainage is wide enough and they have a valve device which prevents the backflow of blood. Pathological conditions are the deposition of fibrin in the intervillous spaces, infection and vascular placental villi, the development of inflammatory changes and blood clots in arteries - arteries become brittle, lose their elasticity and break even with small mechanical forces, the pressure. Formed basal hematomas, which, reaching larger sizes, destroy basal plate, break in the intervillous space, leading to detachment of the placenta.

Diagnostics. The main manifestations are:

1) vaginal bleeding;
2) pain: the pain of varying intensity, cramping, or constant. On palpation of the uterus determined by local pain, hyper tonicity of the uterus, cannot palpate the body of the fetus. The pain appears suddenly. Pain syndrome appears with an increase in hematoma retroplatsentarnoy to 150 ml and above.

Marked asymmetry of the uterus, abdominal distension;

3) Increased heart rate, drop in blood pressure, weakness, paleness;

4) Distress Syndrome.

PDOP a classification according to severity: mild, moderate, severe. Mild put retrospectively after examining placenta can be found organized bunches with veneers on the surface of the placenta.

Prenatal diagnosis of bleeding

Existents symptoms, other symptoms and signs, typically existents	Sometimes the presence of symptoms and signs	Probable diagnosis
• Bleeding after 22 weeks of pregnancy (the blood can build up in the uterus) Intermittent or constant abdominal pain / in.	• • Shock. • • Voltage / uterine tenderness. • • Reduce / absence of fetal movements. • • Fetal distress or absence of fetal heart tones.	Premature detachment of normally situated placenta.
• Bleeding after 22 weeks of pregnancy.	• Shock. • Bleeding may occur after sexual intercourse. • Relax of the uterus. • • The fruit is not in the pelvis / lower pole of the uterus with the feeling empty. • The normal state of the fetus.	Placenta previa.

Tactics GPs

• Rapid initial assessment, transportation to the nearest maternity hospital.

• Assess blood clotting, using a bedside clotting test. If the test shows the delay clotting clotting than 7 minutes or form a soft, easily degradable clot suppose coagulopathy.

• If you need a blood transfusion.

• If bleeding is severe expedite delivery:

- If the cervix is fully disclosed, spend delivery by vacuum extraction.

-If vaginal delivery is not possible, perform cesarean

• If bleeding from legogo to moderate (the mother is not in immediate danger), further actions will depend on the data auscultation of fetal heart tones:

If the heart rate of the fetus is normal or they lack, break fetal bladder amniotic hook.

-If inadequate contractions, strengthen oksitatsinom generic activities.

-If the cervix is immature, perform cesarean sections.

If the frequency of abnormal fetal heart rate (less than 100 or more than 180 beats per minute):

-Perform emergency vaginal delivery.

-If vaginal delivery is not possible, make an urgent cesarean section**.**

Placenta previa - is placentation in or near the cervix.

7-25% - with placenta previa. Perinatal mortality - death of children in the antenatal period (during pregnancy from 28 to 40 weeks), intrapartum period (during labor), postnatal period (7 days after birth).

Normally, the placenta is located on the back wall of the uterus, a transition to the side walls or the bottom part of the uterus. The distance from the internal os to the edge of the placenta over 7 inches is normal. Such an arrangement due to the fact that the front wall of the uterus, it is much more stretched during pregnancy and during labor, and the back wall of the more powerful and less prone to contractile activity during labor. Nature has a placenta so with the least trauma. Placenta previa, it is located in the lower segment, completely blocking the field of the internal os or in part. Placenta previa occurs in 0.3-0.6% of the total number of births.

Distinguish between full and partial placenta previa.

Complete placenta previa - if the placenta completely covers the region of the internal os. On average, 20-30% of all presentation.

Incomplete - placental tissue overlaps the region of the internal os. The most common: 35-55% of cases. The most rare form - cervical placenta previa and per cervical. All of these options allow abortion in the first trimester (never wears before the deadline).

Transitional variant from full to partial previa is a low location of the placenta, in which the edge of the placenta is above the internal os at a distance of less than 7 cm (transitional version of a normally situated placenta previa).

Risk groups for the development of placenta previa are:

Women with a history of obstetric and gynecological history, that is, women with menstrual irregularities, reduced estrogen manifested in genital hypoplasia, hypomenstrual syndrome, where there is no normal hormonal balance, promotes proper proliferative and secretory changes in the endometrium.

Women with chronic diseases of the uterus with a history of abortion, dilatation and curettage, born with a manual entry into the uterus, with uterine fibroids, multiparous and multiparous).

The factors leading to the placenta previa is increased mobility of a fertilized egg, the high proteolytic activity of chorionic villi, when the fertilized egg does not attach to the bottom area of the body or of the uterus, and quickly moves to the lower segment and is attached there.

Women with placenta previa may be suffering from vaginal bleeding in the first trimester of pregnancy, and then the diagnosis - threatening miscarriage. Subsequently, these bleeding stopped, and in the survey, even in early pregnancy can be established that placental tissue in the first trimester of pregnancy is in the lower segment. Then these bleeding stopped and more diagnosis of placenta previa does not appear, because the placenta has the ability to migrate due to the growth of the uterus. And migrating placenta, which is located on the back wall of the uterus (rises). If the placenta is located on the front wall of the uterus, they will increase their tendency to complete presentation. The main symptom of placenta previa is bleeding. Bleeding due to the fact that the placental tissue lacks the ability to stretch as the wall of the uterus. This discrepancy leads to tissue elasticity that chorionic villi begin to peel away from the uterine wall. Chorionic villus placenta previa penetrate deeper into the muscular wall of the uterus and decidua, the thicker body of the uterus and uterine fundus. Hence placenta previa gives higher percentage of increment than the normally situated placenta.

Bleeding with placenta previa usually begins in the second half of pregnancy. In 1/3 of women - up to 30 weeks, the third - from 32 to 35 weeks, the remaining one-third after 35 weeks. Thus a more even distribution of this symptom.

The earlier one starts bleeding during pregnancy, the more likely that a complete placenta previa.

Diagnostics:

may begin suddenly and can be triggered by defecation, lifting, sudden cough movement, sexual intercourse, vaginal examination.

-Bleeding may be profuse or minor is not always the degree of bleeding indicates full or partial placenta previa.

-Repeated bleeding (full placenta previa). That is, the bleeding may start in 30 weeks, then stop and start at 38 weeks, etc.

-Bleeding is always outside, so how close the cervical canal, separated from the chorionic villi and uterine bleeding branches are naturally in the vagina.

Bleeding always-red blood, because the blood of the mother loses this arterial bleeding.

As a result of bleeding anemic syndrome develops in the mother, although the heavy bleeding, in violation of chorionic villi into the bloodstream may include fetal blood. Necessary to determine whether hemoglobin F or not.

Do not perform vaginal examination until all is ready for an immediate cesarean section. A careful study "with mirrors" can be done to rule out other causes of bleeding, such as cervicitis, trauma, cervical polyps or cancer. However, even with these conditions, we cannot exclude placenta previa.

Tactics of GPs:

• Admit a woman before delivery to the nearest maternity hospital.

• Restore the BCC in / Infusion.

• Estimate the value of blood loss:

- If bleeding is severe and lasts, prepare for delivery by caesarean section, regardless of the degree of maturity of the fruit.

- If the bleeding has stopped and the lung or the fetus alive but premature, take a watchful waiting until delivery or until the symptoms of heavy bleeding:

-correction of anemia fumeratom iron sulfate or 60 mg orally daily for 6 months

- Make sure that you have available blood for transfusion

- If bleeding occurs frequently, choose tactics after weighing the benefits and risks for the woman and fetus during further delaying tactics, compared with actin actions.

Confirmation of the diagnosis

• Ultrasound - locate the placenta. If placenta previa confirmed and full-term fetus, plan delivery.

• If an ultrasound is not possible, or the result is not reliable, and gestational age less than 37 weeks, keep a woman, as a placenta previa before the deadline of 37 weeks.

• If an ultrasound is not possible, or the result is not reliable, and the gestational age of 37 weeks or more, perform vaginal examination in the operating room, prepared for the start of the operation, to exclude placenta previa.

The main treatment

• call for help. Immediately mobilize all free staff.

• Perform a quick assessment of the major indicators of women, including the vital functions (heart rate, blood pressure, respiration, temperature).

• If the shock is supposed, immediately begin treatment. Even if there is no signs of shock, keep shock in mind when assessing the status of women in the future, because her condition can deteriorate rapidly. If the shock begins to develop, it is important to begin treatment immediately.

• Start / in infusion solutions and pour in / and emergency transportation to the nearest hospital.

Post hospital Rehabilitation in patients operated on for, PDOP, previa placenta and often have problems such as disability, asthenia person with loss of interest in active life and work. It is therefore important after surgery for bleeding is a set of measures:

1. psychological rehabilitation.

2. counseling for individual selection of contraceptives.

3. clinical examination: the treatment of anemia, treatment of diseases of the gastrointestinal tract.

4. Early detection and timely treatment of hypertensive disorders in pregnancy, hypertension, chronic infections.

5. evaluation of outpatient treatment.

Appendix № 1

"Working in groups"

To carry out this game you need to prepare two cards:

1 - "PDOP" 2 - "placenta previa." The group is divided into 2 teams. One student from each group chooses a card. Teacher at FC is the main symptoms. After training with each group of students presenting the answer.

Briefing 2 minutes. The grouping 1min. Preparation 17 minutes. A 7 min. 5 min discussion. Only 30 minutes.

Clinical symptoms	**PDOP**	**Placenta previa**
Pain	Light to moderate	Not
Bleeding	Exterior, interior, mixed	Only the external
Hematic	Light, Dark, sanioserous	Scarlet
blood clot	Old blood clots	Sometimes after separation of the placenta can be clots
Fetal membranes	Haemorrhage after rupture of membranes	Haemorrhage after rupture of membranes
BP	In hypertension is more common	Reduced bleeding
H /B fetal	When suffering from minor bleeding	When significant bleeding suffers
shape of the uterus	In tone, asymmetry, does not relax	The shape does not change, is always palpable
uterine contractions	With retro placentary hematoma	Bleeding causes uterine
Per vaginum	The placenta is not defined	The placenta is determined
Shock	Does not depend on the	Depends on the amount of

	number of blood loss	blood loss

Themes № 11: Rhesus conflict and ABO conflict. Early toxicosis of pregnant women. The tactics of the doctor.

Toxicoses of the first half of pregnancy are the diseases of women arising in connection with the development of the entire fetal egg or its individual elements, characterized by a multiplicity of symptoms, of which the most constant and expressed are: disorders of the central nervous system, vascular disorders and metabolic disorders. When the fetal egg or its elements is removed, the disease usually stops.

The following pregnancy complications are related to early toxicosis of pregnancy:

• vomiting of pregnant women

• drooling

• rare forms of toxicosis: chorea of pregnant women, osteomalacia, bronchial asthma of pregnant women, dermatosis, acute fatty liver, etc.

5. Management of pregnancy and the ways of complex treatment in case of Rh-conflict, AVO-conflict and early toxicosis.

Vomiting of pregnant women is the most common form of early toxicosis of pregnant women. The clinic of vomiting of pregnant women, as the name of the disease itself says, is manifested by a leading symptom - vomiting. Depending on the severity of this symptom of the disease, the course of it is divided into a light form, medium and heavy. The severe form of vomiting of pregnant women is also called indomitable vomiting of pregnant women.

Diagnostics. Vomiting of pregnant mild degrees is repeated several times a day (up to 3-5 times), usually after meals and in the mornings. The general condition is not significantly affected, the appetite decreases, the mood of the pregnant woman changes. There is a tendency to hypotension, the pulse is slightly increased to 90 beats per minute, the woman's body weight does not decrease, body temperature and diuresis are normal. Analyzes of blood and urine without pathological changes.

Vomiting of moderate pregnant women is characterized by increased vomiting up to 10-12 times a day, regardless of food intake. The patient can not keep the food eaten. The general condition of the patient deteriorates noticeably. Salivation occurs, dehydration of the body occurs, the body weight decreases to 2-3 kg per month. Pulse increases to 100-120 beats per minute, subfebrile temperature is noted, hypotension develops, skin dryness, diuresis decreases. When the disease progresses, there are changes in carbohydrate, fat, water-salt and electrolyte metabolism. Patients complain of weakness, adynamy, apathy. In 5-7% of patients, jaundice is observed, in 20-30% hyperbilirubinemia (up to 40 μmol / ml) and in 20-50% acetonuria Indomitable vomiting of pregnant women is repeated up to 20-25 times a day and proceeds with the phenomena of severe intoxication of the body. The general condition of the patient is

severe. Body temperature rises to 38 degrees Celsius and above, tachycardia develops to 120 beats per minute or more, heart sounds are muffled, blood pressure drops to 30 mm. gt; Art.

Patients significantly lose body weight (up to 2-5 kg per week), apathy progresses, adynamia.

When examining women, there is a pronounced dryness of the skin, a symptom of a "dusty trace" (a strip of exfoliated epidermis scales when you slide your finger along the skin), a reduced turgor. Appear jaundice of the skin and sclera, the smell of acetone from the mouth, glossitis, gingivitis. Diuresis is reduced to 400-300 ml per day, in the blood there is a pathological increase in residual nitrogen, urea, billirubin (up to 40 -80 μmol / l), there is a decrease in albumins, cholesterol, potassium, chlorides. Proteinuria, cylindiuria appear. The reaction to acetone is sharply positive.

Salivation often accompanies the vomiting of pregnant women. Salivation starts with a symptom of excess in the oral cavity of a pregnant woman and a significant loss of fluid

- up to 1 liter per day. The woman swallows it, which leads to overfilling of the stomach with saliva. This, in turn, causes vomiting and makes the patient's condition worse. In some cases, ptimalism can manifest itself as an independent disease and with moderate salivation it is easy to tolerate. With a severe form of ptimalism, the daily saliva can reach several liters. This leads to the loss of proteins, carbohydrates. vitamins, salts and dehydration of the body. The general condition of the patient becomes severe.

Diagnostics. Diagnosis of these pathological conditions is not difficult. A well-collected medical history and patient's observations allow the doctor to establish the diagnosis fairly accurately and assess the severity of the pathological process. In the diagnosis of these pathological conditions, blood and urine tests are important. When a blood test is performed, a high hematocrit (indicating a thickening of the blood) is observed. Increased content of residual nitrogen, bilirubin, decrease in the number of chlorides and the appearance of acidosis. In the study of urine, acetone is detected, which should not be in normal analysis. In patients with severe form of toxicosis, the amount of acetone often reaches 100-150 mg% or more. In addition to acetone, protein and cylinders appear in the analyzes.

Acetonuria and proteinuria. the appearance of icteric skin color and sclera are prognostic unfavorable signs that indicate the ineffectiveness of the therapy.

Treatment: Treatment of vomiting of pregnant women should begin when the first symptoms appear, especially in pregnant high-risk groups, which include:

- women with NDCs;

- Chronic tonsillitis;

- with diseases of the digestive tract (gastritis, cholecystitis, biliary dyskinesia

pathways, pancreatitis, peptic ulcer disease);

- women with a menstrual disorder, such as algodismenorea, late menarche, infantilism, obesity;

- Allergic diseases, inflammatory diseases of the pelvic organs, intolerance to oral contraceptives, smoking women.

The purpose of complex therapy in the vomiting of pregnant women:

1) Normalization of disturbed relationships between the processes of excitation and inhibition in the central nervous system, the means that affect the central nervous system.

2) The use of drugs that eliminate dehydration.

3) The use of desensitizing therapy.

4) Carrying out detoxification of the body

5) Elimination of the consequences of prolonged fasting

With ptistalism, the same therapy is used as in the vomiting of pregnant women. In addition, to reduce salivation, intramuscular injection of atropine - 0.1% solution in the amount of 1 ml 2 times a day. Subjective relief is achieved by frequent rinsing of the mouth with a 1% menthol solution, sage infusion, chamomile and other astringents. Physiotherapy methods of influencing the nervous system - galvanization and diathermy on the cervical sympathetic nodes - are also used.

With moderate vomiting of pregnant women, the patient should be hospitalized. In order to influence the central nervous system of the patient, as with mild vomiting of pregnant women, it is advisable to use tranquilizers according to the above scheme. The most effective in clinical terms are the following combinations.

• atropine 0.5 ml 0.1% w / m + tavegil 1 ml IM

• Cerucal, Raglan 2.0 w / m + Atropine 0.5 ml 0.1% w / m

With hypotension, which arose as a consequence of the use of these drugs and the disease itself, it is advisable to administer 0.1 mesotone solution.

To combat dehydration and hypoproteinemia, a solution of HES or a 10% albumin solution - 100 ml is injected intravenously every other day. For the day pregnant should receive 2-3 liters of fluid. To eliminate intoxication, it is expedient to use solutions of crystalloids. For parenteral nutrition intravenously drip solutions of amino acids (infezol) are used. Against the background of infusion therapy, medications that normalize metabolism are prescribed. For this purpose, cofactors of bioenergetic metabolism are used: riboflavin-mononucleotide in 1 ml of a 1% solution w / m, taking into account the existing disturbances of redox processes, it is recommended intramuscular injection of drugs of group B-B1 and B6 1 ml alternately every other day. Complex therapy is continued until a persistent cessation of vomiting, normalization of the general condition, a gradual increase in body weight.

In severe (uncontrollable) vomiting of pregnant women to suppress excitation of the vomiting center, a 2.5% solution of aminazine is used, 1 ml of v / m 2 times a day. In the absence of the effect, aminazine can be administered by dropwise IV method, in which case 1-2 ml of a 2.5% solution of aminazine is diluted in 500 ml of 5% glucose solution. In recent years, for the

treatment of indomitable vomiting of pregnant women use neuroleptic droperidol. Droperidol acts on the cerebral cortex and the reticular formation has an antiemetic effect and suppresses vasomotor reflexes, improves peripheral blood flow due to vasodilation. Droperidol is recommended to be administered according to the following scheme. The first injection of droperidol is done in a dose of 0.5-0.75 ml, then in 2-3 days the dose of the drug is reduced to 0.5 ml. With repeated administration, droperidol can give side reactions, manifested in the form of fear, anxiety, tremor of hands, rigidity of muscles. These phenomena are removed by injecting 0.5 ml of 0.1 atropine solution or ingestion of a cyclodol tablet (up to 0.002 g).

For the purpose of desensitization and regulation of metabolism, splenin is administered in the form of subcutaneous or intramuscular injections of 2 ml. 2 times a day for 10-12 days and hormones of the adrenal cortex -DOXA (deoxycorticosterone acetate) in the form of intramuscular injection of 0.005 g per day every other day for 10-12 days or ACTH at 40 units per day every other day.

Treatment Scheme:

Non-medicamentous. Restriction of foods rich in fats, spices. Mode of food - frequent, fractional up to 6 - 8 times a day.

For the regulation of the central nervous system can continue: tincture of valerian or motherwort 3 times a day for 10 days. A good effect is provided by physiotherapy: electrophoresis calcium on the solar plexus or in the form of a "collar", refloendonasal galvanization.

Immunological conflict in the Rh factor and ABO system.

Immunological conflict is caused by the incompatibility of blood of the mother and fetus in the Rh factor and the ABO system, resulting in hemolytic disease of the fetus and the newborn.

Rhesus factor, getting into the blood of the Rh-negative person, causes its immunization, which is manifested by the production of antiresus antibodies. So the transfusion of Rh-positive blood to the Rh-negative patient stimulates the formation of antibodies in 50% of cases.

Rhesus-negative women can be immunized with intravenous rhesus-positive blood, previous spontaneous or artificial abortions, ectopic pregnancy, but most often pregnancy and childbirth with a Rh-positive fetus, especially in surgical interventions: manual placenta or cesarean section. Rh-immunization contributes to the violation of the integrity of the chorionic villi, observed in gestosis, the threat of termination of pregnancy, infectious and extrogenital diseases, as a result of which a sufficient number of fetal erythrocytes enter the mother's bloodstream.

Rhesus and group antibodies passing through the placenta cause hemolysis of the fetal erythrocytes with the development of typical manifestations of hemolytic disease. Hemolysis of erythrocytes is accompanied by the formation of a large amount of indirect bilirubin. which is a strong tissue poison, resulting, due to blockade of enzyme systems, to reduce tissue respiration.

In the case of an isosensitization of a woman with a Rhesus factor and an ABO system, not only the fetus with signs of hemolytic disease is observed, but also the antenatal death of the

fetus and the repeated spontaneous termination of pregnancy. At high activity of antibodies spontaneous abortions can come in the early terms of pregnancy.

A great diagnostic value is the study of Rh-antibodies in the blood of a pregnant woman. The study draws attention to the amount of antibody titer and its fluctuations during pregnancy.

At a titer of Rhesus antibodies 1:16 the risk of intrauterine fetal death reaches 10%.

Titer 1:32 in most laboratories is considered critical, that is, if this value is exceeded, the possibility of stillbirth becomes significant.

Hemolytic disease of the fetus and newborn is a condition that arises from the incompatibility of the blood of the mother and fetus over certain antigens. Most often, hemolytic disease of the newborn develops due to rhesus-conflict. In this case, the pregnant woman has Rh-negative blood, and the fetus Rh-positive.

During pregnancy, the Rh factor with erythrocytes of the Rh-positive fetus enters the blood of the Rh-negative mother and causes in its blood the formation of antibodies to the Rh factor (harmless for it, but damaging the red blood cells of the fetus). Disintegration of erythrocytes leads to damage to the liver, kidneys, fetal brain, development of hemolytic disease of the fetus and newborn. In most cases, the disease develops rapidly after birth, which is facilitated by the flow of large amounts of antibodies into the blood of the child when the integrity of the placental vessels is compromised.

Rh-conflict between mother and fetus.

Women who have a risk of conflict should be under the careful supervision of an obstetrician / gynecologist during pregnancy. Throughout pregnancy, it is necessary to determine the level of Rh antibodies in the blood (1 time per month until 32 weeks of pregnancy, 2 times a month from 32 to 35 weeks, and then weekly). The height of the antibody titer helps to determine the condition of the fetus, predict the severity of the problems of the newborn and, if necessary, take measures to prevent the development of complications.

To prevent the development of conflict during repeated pregnancies, it is possible by introducing anti-Rh-immunoglobulin in women with negative rhesus immediately after: first birth, interruption of pregnancy, transfusion of incompatible blood.

This situation is not so rare. The reason for this is the incompatibility of the blood of the mother and fetus by the so-called Rh factor.

Rhesus factor (in another way - Rh-antigen or Rh-antigen) is a substance located on the surface of red blood cells (erythrocytes). The meaning of Rh-antigen is that it serves as an identification mark for the immune system, a kind of "identity card".

The threat of rhesus conflict during pregnancy exists only if the woman is Rh-negative, and her husband (the father of the unborn child) is Rh-positive. In this case, the fetus must necessarily inherit Rh-antigen from the father. Although this situation does not always lead to a rhesus-conflict. Nevertheless, the remaining combinations of Rh and soreness of the spouses are absolutely safe in this respect.

It should be noted that the first pregnancy of Rh-negative women Rh (-) - the fruit usually ends normally. In subsequent similar pregnancies, the risk of conflict increases. Why this happens will become clear after explaining the mechanism of Rh-conflict.

The essence of Rh-conflict is as follows: during pregnancy, the red blood cells of the fetus enter the mother's blood through the placenta. Rhesus antigen, located on the red blood cells of the fetus, plays the role of an "incorrect identity card" for the mother's immune system. Fetal cells are recognized as foreign and are destroyed with the help of special proteins - antibodies. Since the fetal red blood cells continue to flow into the mother's bloodstream, the development of harmful antibodies continues. Antibodies "look" for the source of the "foreign" cells, that is, fetus. On their way the placenta rises. And if antibodies manage to break through its barrier, then they begin to destroy the red blood cells of the fetus already in its own vessels. In this case, a large amount of a substance called bilirubin appears. Bilirubin can damage the brain of the fetus, color its skin in yellow ("jaundice"). Since the fetal erythrocytes are continuously being destroyed, his liver and spleen try to speed up the production of new red blood cells, while increasing in size. In the end, they do not cope. There is a strong oxygen starvation and a new round of serious disorders in the fetus is launched.

The most important thing in solving the problem of Rh-conflict is its prevention. In the women's consultation at the first appearance, women are determined to determine her Rh-affiliation. If a woman is Rh (-), then she is taken to a special account.

It is also necessary to determine the Rh-belonging of her partner. If there is a risk of Rhesus conflict, during pregnancy, a repeated study of the level of antipruritic antibodies in a woman's blood is carried out.

Rhesus immunization is a humoral immune response to erythrocyte AH of the fetus of the Rhesus group. The resulting antibodies, penetrating the placenta, cause extravascular hemolysis and Anemia, leading to the development of erythroblastosis of the fetus. All Rhesus - AG are located on the erythrocyte membrane, stimulating in the body the pregnant synthesis of AT class JgG.

Identification of isoimmunization

Determination of the titer of Rh Rh in the blood of a pregnant woman is carried out once a month until 32 weeks of pregnancy, twice a month 32-35 weeks of pregnancy, and then weekly. If Rh is negative to a mother of a Rhesus positive partner, anti-Rh -AT is found, it is necessary to determine their class. JgM AT - is not involved in the development of hemolytic disease of the fetus and newborn. JgG-AT may be the cause of erythroblastosis of the fetus, the level of AT is determined by titration. If both the mother and father of Rh are negative, there is no need for further testing for anti-Rh.

Tactics of pregnancy management in Rh (-) women in the event of isoimmunization.

1. Blood test for antibodies titer at least once a month.

2. To conduct antenatal diagnosis of hemolytic disease of the fetus (CTG, fetus and placenta ultrasound, dopplerometry, amniocentesis in 24 to 32 weeks to determine the optical density of bilirubin in amniotic fluid, amnioscopy after 37 weeks).

3. HBO, UFO, plasmapheresis

4. Desensitizing therapy: dimedrol, suprastin, tavegil, fenkarol.

5. After 16-20 weeks, prednisolone 5 mg daily before delivery.

6. Intravenous infusion of dextrans.

7. Prevention and treatment of fetal hypoxia and placental insufficiency.

8. In the case of a burdened anamnesis, allotransplantation of the father's skin flap is shown, followed by irradiation of its helium with a neon laser.

9. At a titer of antibodies 1:32 and above, revealing of hemolytic disease of a fetus is shown abortion of pregnancy on medical indications.

10. The optimal time for delivery is 36-38 weeks.

To prevent the development of conflict during repeated pregnancies, it is possible by introducing anti-Rh-immunoglobulin in women with negative rhesus immediately after: first birth, interruption of pregnancy, transfusion of incompatible blood.

Possibilities for the cause of sensitization.

1) Ectopic pregnancy.

2) Abortion - spontaneous and artifical.

3) Transfusion of Rhesus - positive blood in the past.

4) Intrauterine sensitization (when the Rh-negative pregnant is sensitized at birth by the Rh-positive mother's blood cells).

5) Birth of the Rh positive child Rh-negative mother with ABO-incompatibility.

6) Birth in the past of children with hemolytic disease.

Diagnostics

The titre of AT in the mother and the obstetric anamnesis help to predict the severity of the erythroblastosis of the fetus. Absolute values of the title are considered high at a titer of 1: 8 and higher. Using ultrasound, you can monitor the fetal condition, identify signs of initial and progressive fetal dropsy.

Symptoms of an initial dropsy: polyhydramnios, hepatosplenomegaly

Signs of pronounced dropsy:

1. increased intestinal echogenicity

2. cardiomegaly and pericardial effusion

3. ascites and hydrothorax

4. edema of the subcutaneous tissue of the head and limbs

5. hypertrophy and thickening of the placenta

APPENDIX № 2. Game: Method of problem solving.

All participants in the class are divided into 3 groups A, B, B, and so on for 3 people. * In the group, they are assigned the numbers 1,2,3- and then regroup by numbers.

All the first numbers form the group one, the second group two, the third group 3. A task is given on the topic of the lesson "Immunoconflict pregnancy".

In the form of the following problem: Repeated pregnancy, 32 years 1st birth without complications, 2nd birth complicated by hypotonic hemorrhage, received without taking into account the rhesus accessory blood transfusion, which was accompanied by a reaction. From the 10th week of this pregnancy in the blood, there were detected contradictory antibodies in a titer of 1: 4, received 3 courses of desensitizing therapy. At 36 weeks. the antibody titer rose to 1: 32.

Group 1 is invited to discuss the problem: Tactics of further management of pregnancy.

Solution: Creation of VGCK background, intensive desensitizing, detoxification, restorative therapy. Early delivery at 38 weeks.

Group 2: Possible complications in the fetus and the newborn.

Solution: Antenatal fetal death, the birth of a child with a severe form of Hemolytic disease of the newborn.

Group 3: Methods of examination and treatment of the newborn.

Solution: After the birth of the baby, determine the group and Rh component of the cord blood, the content of bilirubin, hemoglobin and erythrocytes - in the peripheral blood. If there is a Rh positive blood, the child should undergo a blood transfusion.

Time for work 10 min. Then the numbers return to their original groups A, B, and B. students exchange their own answers.

APPENDIX №3.

Situational task no. 1.

25 years old, appealed to the polyclinic on March 30 about pregnancy.

From anamnesis: Last menstruation on December 24 - 28. 2 births, children died antenally from hemolytic disease of the fetus. This pregnancy is the third, the husband (father) blood group A (II) Rh (-). From the transferred or carried diseases: in the childhood a trauma of the bottom extremities, a hemotransfusion without taking into account the Rh factor.

Laboratory methods of research.

The general analysis of a blood: Ayr 3,2x1012 / l. Hv 105 g / l, Ht 30%, Tc 225x109 / l, ESR 20 mm / h.

Blood group A (II) Rh (-), antibody titer 1: 4.

Questions:

1. Diagnosis

2. Methods of examination and plan for the introduction of pregnancy

3. Treatment

Answers:

1. Diagnosis of the main: Pregnancy 14 - 15 weeks.

Complications: Isoserological incompatibility of blood of the mother and fetus by the Rh factor. Anemia of mild severity.

Accompanying: Weighed down obstetrical anamnesis.

2. Plan of introduction of pregnancy

A blood test for the antibody titer is at least once a month.

Conduct antenatal diagnosis of hemolytic disease of the fetus (CTG, fetus and placenta ultrasound, doppler, amniocentesis in 24 to 32 weeks to determine the optical density of bilirubin in amniotic fluid, amnioscuo after 37 weeks).

3. Treatment:

HBO, UFO, plasmapheresis

Desensitizing therapy

Intravenous infusion of dextrans

Anti-anemic therapy

Taking into account the heavily burdened history, the intergestational period is less than 2 years, blood transfusion is incompatible by the Rh factor, the allotransplantation of the father's skin flap is shown, followed by irradiation of its helium with a neon laser;

Situational task number 2.

Appealed to the GP reception with complaints of general weakness, aversion to food, vomiting. The first appeal to the consultation was 2 weeks ago with a pregnancy of 6 weeks.

With the onset of pregnancy in the patient in the morning on an empty stomach appeared vomiting became frequent up to 10 - 12 times a day, began to arise even one thought about food. During the last two days he does not eat, as vomiting appears even after taking water.

A biochemical blood test revealed an increased content of bilirubin and residual nitrogen. The urine contains acetone and traces of protein.

Questions:

Diagnosis

Methods of examination of GPs

What is the treatment and prognosis?

Answer:

1. Diagnosis: Pregnancy for 8 weeks, early toxicosis of pregnant women - excessive or indomitable vomiting.

2. Methods of examination: a general analysis of blood and urine, ultrasound.

3. Treatment:

Pregnant should be immediately hospitalized. Treatment should be comprehensive, with the provision of a curative and protective regimen, the diet - individual, with the use of nutritional enemas. To combat dehydration, 5% glucose solution, isotonic sodium chloride solution, vitamins, rheopolyglucin, polyglucin, sedatives are administered. It is also recommended to introduce alkaline solutions (sodium bicarbonate). A positive effect is provided by psychotherapy, sleep treatment, physiotherapy methods. In the absence of a curative effect, abortion is recommended.

4.2 Practical part

APPENDIX №4.

List of practical skills.

1. Determination of the period of pregnancy and childbirth

2. External obstetric examination

5. Criteria for assessing the current control (TC)

(see the table at the beginning of the work program)

Control questions

Representation of blood groups and Rh-factor.

Ways and mechanisms of the emergence of the immune-conflict situation.

Diagnosis of the immunoconflict.

Tactics management of pregnancy in the presence of immunoconflict.

Rehabilitation of women after a complicated immuno- and ABO-conflict pregnancy.

The concept of toxicosis of the first half of pregnancy.

Classification of toxicosis of the first half of pregnancy.

Diagnosis of vomiting of pregnant women

Diagnosis of drooling

Treatment of early toxicosis of pregnancy.

Literature

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Primary prenatal, perinatal and postnatal care. WHO manual. 2005

Obstetrics. Directory of the University of California, ed. K. Niswander, A. Evans. M., 1999

Assist in complicated pregnancy and childbirth. WHO 2002.

Themes №12: High temperature after delivery. Postpartum septic diseases. Peritonitis after caesarean section. Diagnostics. Doing.

In the postpartum department young mother is under the supervision of midwives. Every day during rounds doctor determines the rate of contraction of the uterus, the nature of postpartum discharge, examining the breast. If there are seams at the crotch (after the explosions, episiotomia), or on the anterior abdominal wall (after cesarean section), women in childbirth every day are invited to the treatment room for the seams, And of course, every morning starts with postpartum staff measuring body temperature.

Fever - an important criterion by which doctors can judge the overall condition of a young mother and her organism’s recovery after childbirth. In the development of any complications post-partum period is almost always increases the temperature. More often when the temperature rise is the first sign of incipient complications. By the nature of the temperature rise, the numbers and the time of its occurrence physicians can quickly install and then remove the cause of the disease

Micro flora at postnatal diseases varied, but the most common negative staphylococci, bacteria amount of enterococci.

Predisposing factors for the development of septic diseases postpartum period are:

• Have a history of extra-disease (cardiovascular system, gastrointestinal tract, urinary tract

infection), viral respiratory, endocrine diseases.

• Asymptomatic bacteriuria

• Chronic inflammatory diseases of the pelvic organs, Trichomonas, Chlamydia coleitis.

• Invasive methods of examination of the fetus

• Pathological during labor:

-Long dry period.

-Prolonged labor

Labors complicated by surgical interventions (incision of the perineum, manual removal of the placenta, excretion, forceps delivery, caesarean section, and etc.)

• abnormal blood loss

• High frequency of vaginal examination during labor.

Rapid initial assessment at a high temperature after delivery (temperature 38 ° C and above, all of the following diagnoses)

Ask:

• There is a woman if she has weakness or drowsiness

• Frequent painful urination.

Check out:

• Is the woman unconscious

• The temperature of 38 ° C or higher, PS, BP

• Stiffness of the neck muscles

• Light: shallow breathing

• Abdomen: severe pain

• Vulva: purulent

• Breast: pain

Stabilize state of a woman:

• Assign Ampicillin 2 g / every 6 hours plus gentamicin 5mg/kg weight / in

Every 24 hours plus 500 mg of metronidazole in / q8h

• Urgently put the woman in a medical institution of higher level.

• Start / in the introduction of the liquid as possible in the two veins using a needle or catheter

of large diameter.

• quickly enter Ringer's lactate or normal saline at a rate of 1 liter for 15-20 minutes. L 2 should enter the liquid in the first hour.

If there are signs of shock:

• Put a woman on one side, so that the airways remain open. If a woman is not breathing, begin measures to revive;

• Make sure that the woman is breathing. • Cover the woman with a blanket so she kept warm;

• Before and during transportation of women lift her legs by lifting the foot end of the bed;

• Continue to monitor vital signs (blood pressure, pulse, breathing rate) and

body temperature every 15 minutes.

• overestimate the response of women on / in the administration of fluid by 30 minutes for signs of improvement: stabilizing pulse (90 beats / min or less), increased systolic blood pressure (100 mm. Hg or more), reducing confusion or anxiety, increases the production of urine (30 ml / hr or more).

• If the woman is improving - to reduce the speed of I / O infusion of up to 1 liter in the next 6 hours.

• Continue to look for the main cause of shock.

• If the woman is not improving - to adjust the speed of I / O to 1 liter infusion for 6 hours, to continue to provide oxygen 6-8 l / min, to monitor the vital signs of the body and the output of urine, if possible, to conduct additional laboratory tests.

• Fill in, if it necessary medical history, perform a physical exam and tests for determine the cause of the shock, if any, is still unknown

In scale only abnormal postnatal period can be divided into **local (local)**, then there is a limited body or anatomical region and **generalized** - exciting the entire body.

Go to a local complications include postpartum sore metroendometritis, salpingoophoritis, pelveoperitonitis, mastitis, and thrombophlebitis. Symptoms of any of these diseases combines temperature rise with the characteristics of a particular organ inflammation.

Postpartum ulcer - purulent inflammation in the area of the wound, which was formed during the birth. The ulcer may occur by ingestion of infection on the crack, gap, seam at the crotch area, vaginal wall or cervix. The temperature rises to subfebrile (37-38 ° C) for about two

weeks after giving birth. In addition to fever, a young mother worried about the pain and burning sensation in the genital area. At the site of injury is formed purulent plaque tissue around look reddened and swollen. With this type of accident, contact a doctor immediately. Treatment includes antibiotics, bed rest, healing therapy.

Metritis - an inflammation of the uterus. Develops at 1-5 days after birth.

Pathogenesis: Infection remains of the ovum, which undergo putrefaction, followed by penetration into the bloodstream of pathogenic bacteria and their toxins, which manifested symptoms of intoxication.

Clinical symptoms: increased body temperature 38-40 ° C, chills, abdominal pain, purulent, foul-smelling discharge.

The criteria for diagnosis: when viewed overall puerperal moderate or heavy. The body temperature of 38-40 °C, the pulse-expressed tachycardia. On palpation of the abdomen is determined subinvolution of uterine. tenderness in the ribs. When viewed in a mirror in the vagina, on the cervix expressed stagnation, lochia. Bimanual examination reveals the slow closure of the cervical canal, painful tour of the cervix, slow involution of the uterus, pain in her study. In general blood pronounced leukocytosis with neutrophilia, toxic granularity of leukocytes, ESR acceleration. For early and accurate diagnosis is used ultrasound of the uterus, which allows to set the degree of involution, the presence of residues of the ovum.

Tactics of GP: hospitalization puerperal to a gynecological ward of a hospital. Untimely or inadequate treatment of metritis can lead to pelvic abscess, peritonitis, septic shock, deep vein thrombosis, pulmonary embolism, chronic pelvic infection with persistent pain in the pelvis and dyspareunia, obstruction of the fallopian tubes and infertility.

Metroendometritis - inflammation of the lining of the uterus. Occurs when hemometra (congestion in the uterus of post-partum bleeding), pyometra (festering held up the clot in the uterus), with a delay in the uterus or placenta membrane segments, penetration of infection into the uterus by ascending (from the vagina), an exacerbation of the chronic metroendometritis. The temperature rises to febrile (38-39 ° C) digits on a 3-day 4 after birth, rise in temperature accompanied by a fever. Decreased appetite, disturbed sleep. The uterus is not shrinking, painful on physical examination. The changing nature of the smell and color of postpartum discharge: they become fetid, muddy, and the total number of daily discharge may increase. The amount of bleeding may also decrease because the outflow from the uterus broken. This is what happens when muscle spasm of the cervix. Treatment is carried out in a hospital. Patients are advised bed rest, antibiotics, vitamins ¬ monotherapy, drugs that stimulate uterine contractions. If necessary, make lavage of the uterus - removing abnormal discharge clots, the introduction of antiseptic liquid.

Parametritis - the inflammation of the fatty tissue surrounding the uterus. Usually occurs on

the one hand, is less two-sided. Most often, the infection enters through breaks in the parameters of the cervix and vagina. The temperature is increased by 10 to 12 days after giving birth to febrile and high numbers (38-4GS), accompanied by a strong fever. Young mother concerned about pain in the abdomen, sometimes - violation and tenderness of urination and defecation. At the site of inflammation may form an abscess. In patient treatment is similar to conservative therapy in metroendometritis. If it necessary, make surgical opening of the abscess.

Pelveoperitonitis – an inflammation of the pelvic peritoneum. The temperature rises to 15-25th day after delivery to febrile, high and even excessive (up to 42 ° C) numbers, accompanied by shivering. Along with the fever appear sharp abdominal pain, nausea, vomiting, a significant deterioration in the general condition. If you suspect that this complication is necessary to urgently call the "first aid" for immediate hospitalization. Treatment includes strict bed rest, antibiotics, vitamins, immune-boosting drugs.

Thrombophlebitis - inflammation of the vein wall with subsequent formation of a blood clot, which narrows the lumen of the vein, making it difficult or impairing blood flow. Vein thrombophlebitis cancer usually arises against metroendometritis, may apply to the veins of the pelvis and legs. Less likely to develop an aggravation of chronic thrombophlebitis. The temperature rises to 2-3rd week after birth, often accompanied by chills, reaches high numbers and can keep for 2-3 weeks. In the course of the vessel there is soreness and redness in the thrombus occlusion of the vessel there is swelling of feet. In the event of thrombosis requiring hospitalization in the department of vascular surgery, where a young mother appoint anticoagulant (preventing excessive blood clotting), and anti-inflammatory therapy.

Lactostasis - a condition characterized by stagnation of milk in the mammary gland. Arises because of the passing of one or more regular feedings, uneven decanting of breast can, blockage of one or more ducts prior to the general hypothermia (in draft) or overheating (in the bath, on the beach). The temperature can rise within the febrile (up to 39 "C). Other complaints are pain and a feeling of fullness in one of the lobules of the breast, the general condition of a young mother usually does not suffer. Temperature decreases immediately after a full breast discharge, ie in this case it is important to continue to feed the baby on demand of the breast. the absence of adequate measures lactostasis can go to mastitis.

Clinical management:

1. If a woman is breastfeeding and the child is not capable of sucking, convince a woman to express milk by hand or breast pump.

2. A woman breastfeeding a child is capable of sucking:

• Reassure the woman to feed more often, putting the baby to both mammary glands at each feeding.

• Show the woman how to hold the baby and help her put it to his chest. Explain holding relaxing activities before feeding:

• apply a warm compress to the breast immediately before feeding, or take a warm shower

• massage the woman's back and neck

• pump a little milk before feeding your hands and the area around them wet nipples to help the child to cling to the mother's nipples correctly and easily

Relaxing activities after feeding:

• Support the chest bandage or bra

• apply a cold compress to the breast between feedings to reduce swelling and pain

Assign paracetamol 500 mg orally if needed.

If breastfeeding is missing:

• Avoid massaging and applying heat to the breast

• Avoid nipple stimulation

• Assign paracetamol 500 mg orally as needed.

Mastitis is inflammation of the breast tissue. The causative agent of the disease may be staphylococcus, streptococcus, E. coli, Proteus, Pseudomonas aeruginosa sometimes, anaerobic flora, mushrooms. It is also possible tubercular and syphilitic mastitis.

Classification:

• the nature of the flow are acute and chronic mastitis

• the nature of the inflammatory process - serous, acute infiltrative and destructive (abscessed, abscess, gangrenous) mastitis.

Entrance gates are usually the nipple cracks, sometimes germs get into the milk ducts through the blood or lymph from other foci of infection. The disease begins with a sharp rise in temperature to 39 ° C or higher with chills. There is pain in the breast, malaise, and headache. Breast increases may experience redness of the skin over the inflamed gland sealing regions. It is noted lactostasis - blockage ducts violation of the outflow of milk. When you try pumping of ducts to the nipple may be released droplets of pus. If you experience these symptoms should seek immediate medical attention. At mastitis is holding conservative (antibiotics) therapy and, if it necessary (in purulent mastitis) - surgical treatment.

Tactics GP: referral to a surgeon. To convince the woman to continue breastfeeding support

the breast bra, apply a cold compress to the chest to reduce pain and swelling for three days, just assign paracetamol 500 mg by mouth as needed.

Abscess of breast cancer - is limited inflammation.

The clinical picture, diagnosis: growing chills, body temperature constantly high or hectic, sharp pain and an increase in the affected breast, pronounced erythema, subcutaneous venous network expanded. On examination: regional lymphadenitis, fluctuating tumor in the breast may leak pus.

Tactics GP: admission to the surgical department of a hospital.

Deep vein thrombosis - venous thrombosis of the uterus, pelvic and femoral veins. Develops most often on the second - the third week after birth is associated with a high risk of pulmonary embolism.

Risk factors: age over 40 years, more than five parity, varicose veins, anemia, thromboembolism, or injury (in violation of the integrity of the endothelium), a history of nephrotic syndrome. surgical delivery (cesarean section, forceps), venous stasis (long pastel mode), severe preeclampsia (decreased antithrombin 111).

Clinic. Patient complained of pain in the calf muscle, increase in the volume of the limb, skin discoloration of the affected extremity, fever, tenderness during the affected vein, a local increase in temperature. It may be the defeat of both limbs. At gynecological examination to assess the condition of joints on the perineum and vagina, discharge from the cervical canal, the formation of the cervical canal. Vein thrombophlebitis of the uterus in the second week after birth inner mouth slightly open, the uterus is enlarged, painful ribs, thrombosed vein palpable as convoluted filaments or sensitive infiltration edema.

Tactics of GP: emergency hospitalization in a surgical department of a hospital. Prevention: all women with varicose veins recommended wearing elastic stockings, regular bandaging the affected limbs.

Acute pyelonephritis is an acute infection of the upper urinary tract, mainly the renal pelvis, which may also affect the renal parenchyma

Clinical signs: fever, chills, disuric disorders, increased frequency and urgency of urination, abdominal pain, back pain, pain behind or above the pubis, lack of appetite, nausea, and vomiting.

Examination: when viewed - positive symptom tapping, in general blood - anemia, leukocytosis shift left accelerated ESR, in urinalysis- leuococyturia, bacteriuria (more than 105 bacteria in 1 ml of urine), proteinuria (usually less than 1 g / l) in the analysis of urine Nechiporenko - leuococyturia over 25-103. Urine culture of the flora with the definition of sensitivity to

antibiotics, renal ultrasound is an extension of the renal pelvis.

Tactics of GP: hospitalization in the internal medicine ward / nephrology / urology. The effectiveness of treatment of postpartum disorders must be assessed not only on the basis of whether or not life is saved by the patient, but also to a large extent of the patient, the absence of disability, complications and chronic diseases in the future

Post-hospital rehabilitation of patients undergoing postpartum infectious diseases is a complex of therapeutic measures aimed at restoring health and function of all body systems damaged as a result of the disease.

All women who have had postpartum purulent-septic diseases need to clarify the meaning of hygiene measures, nutrition and rest at home.

To reduce the adhesive processes, pain patients who have had metritis, peritonitis apply physiotherapy treatment: electrophoresis, ultrasound procedures on the course 6-12. When metritis physiotherapy treatment begins 2 days after normalization of temperature, in case of peritonitis on 10-12th day after relaparotomia, remove sutures and wound drains.

With prolonged and severe disease treatment is prescribed at a later date.

Patients who have had peritonitis after cesarean section delivery, supervision is required for a 1 year.

Spa treatments, including hydrogen sulfide, narzan, radon baths and mud baths, can be applied not earlier than 2 years after treatment.

Patients with a history of thrombosis in the postpartum period are in need of constant supervision. In the presence of phenomena post-thrombotic syndrome (persistent pain and swelling of sore feet) recommended treatment with a surgeon - phlebologist.

By the generalized forms of postnatal complications include peritonitis (inflammation of the peritoneum in the whole of the abdominal cavity), and sepsis (a condition in which bacteria multiply in the blood and are carried throughout the body, and their toxins - toxins - cause general poisoning). These diseases are the result of neleche ¬ governmental local obstetric complications. The woman under any of these complications is extremely difficult, may be impaired consciousness. The temperature is kept within 39-42 ° C, accompanied by chills and heavy sweats. Inpatient treatment, complex (conservative and surgical). These complications are life-threatening.

Increased temperature - not always the inflammation

Not always fever shows the development of the disease. The temperature regime of the body can change with stress, allergic reactions, blood transfusion and blood products, hormonal surges, finally, for the banal overheated. Postpartum is no exception: in the early days of motherhood may be cases rise in temperature without the presence of a pathological process. Here are some of them:

The onset of lactation (the first "coming of milk") is associated with increased hormonal activity and over-yet undeveloped ducts. Almost always, at this time the temperature rises within z8 ° C. Temperature returned to normal after breastfeeding or decanting.

Allergic reaction to the introduction of certain drugs, foods, smells in the first days after birth may increase and is often accompanied by a rise in temperature.

In any case, when the temperature after birth should, without delay, consult your doctor. The doctor will be able to make the correct diagnosis in time or, alternatively, to reassure you, eliminating the development of a post-natal complications. The correct diagnosis and timely initiation of treatment to help you recover faster and with new forces begin to maternal duties. Remember: a young mother should be healthy - because it affects the health of your baby!

Post-hospital rehabilitation of patients undergoing postpartum infectious diseases is a complex of therapeutic measures aimed at restoring health and function of all body systems damaged as a result of the disease.

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Prevention of postpartum infection GP before delivery includes recommendations for the rational mode of the day and the food, exercise therapy, a comprehensive survey, detection and remediation of chronically occurring infectious and inflammatory diseases, learning the rules of pregnant women breast feeding and care of the breasts. In the maternity ward - strict adherence to the rules of aseptic and antiseptic during childbirth and the postpartum period, preventing the formation of cracked nipples and stagnation of milk in lactating women.

Contraception for women undergoing postpartum fever depends continues breastfeeding or not,

whether thromboembolic complications, whether the source of infection of the uterus and other organs. When transferred thromboembolic complications OC is contraindicated (WHO Class 4), even if a woman does not breastfeed, as it increases the risk of venous blood clotting disorders. After suffering metritis, IUD insertion should be delayed for 3 months from the date of the complete elimination of infection (WHO Class 4). If a woman is breastfeeding, but does not comply with MLA and fever had thromboembolic complications, COCs can be used not earlier than 6 weeks after birth (WHO Class 3), given the unacceptability of recovery and other methods. Barrier methods, spermicides, the ENP, IPC can be used immediately after recovery and the resumption of sexual activity, but with the general principles of their use in the postpartum period.

Tubal occlusion is possible in 6 weeks after undergoing postpartum fever

PERITONITIS AND SEPTICEMIA AFTER CESAREAN SECTION.

Peritonitis after cesarean section occurs in 4.6 - 7% of cases. Mortality from peritonitis and sepsis after caesarean section is 26 - 45%. The development of peritonitis causes infection of the abdominal cavity (from complications of cesarean section - horionamnionitis, endometritis, festering seam, acute inflammation of the appendages, infections infiltrated by hematogenous or lymphatic - with paratonsillar abscess, abscess of soft tissues, pyelonephritis.

CLASSIFICATION:

By the nature of exudate: fibrinous, purulent, serous.

As the prevalence of: limited local and diffuse (total) peritonitis.

In stages: reactive (formation fluid), toxic (suppression of the protective properties of the organism, hemodynamic instability), the terminal (multiple organ failure).

According to Serov are three types of the course of peritonitis after cesarean section:

infected peritoneum occurs during operation (horionmnionitis, long dry period, insemination of amniotic fluid).

Enteroplegia (through its wall is a massive infiltration of microorganisms into the peritoneal cavity and its infection). Serov: if paresis increases, the E. coli easily passes barriers.

In 90% of cases of peritonitis develops due to the insolvency of stitches in the uterus. The reasons - different agents - often association with pyogenic flora bacteroids, etc.

PATHOGENESIS. In the first 30-40 hours of the onset of the disease is inflammation of the peritoneum: edema, leukocyte infiltration, desquamation of the epithelium, the peripheral blood circulation, accumulation of histamine, serotonin, oxidized products which leads to acidosis, increased permeability, vascular abnormalities but not always formed. Exudate is inflammatory

in nature, it promotes the formation of pathological reaction of the peritoneum and impaired blood flow, leading to increased formation of transudate, accumulation of fluid in the hollow organs. In the tissues of developing dehydration, so all the liquid goes into the hollow organs and peritoneum. Extravasation dominates absorption. After 48-72 hours. In the process more deeply involves tissue (atrophy, degeneration), the breakdown of proteins, enzymes, metabolites, vitamins, leading to a sharp decrease in muscle tone, which leads to paresis of the intestine. Paralitic developing bowel obstruction.

Enhanced symptom of intoxication, suffering microcirculation (corticosteroid output increases and decreases inflammation). Increased vascular tone leads to arteriovenous shunts disclosed that reduces perfusion and oxygenation of all organs, tissue hypoxia and necrosis.

Important intoxication syndrome, impaired motor skills.

Clinical forms:

Early peritonitis - an infection of the wound penetrates through the uterus (seen in 30%) due to horionamnionitis. The manifestations of peritonitis are observed for 1-2 days after surgery. Severe intoxication syndrome, hyperthermia, severe tachycardia, severe condition. Encephalopathy may be due to swelling of the brain, which manifests adynamia, or euphoria. Also, there is enteroplegia (bloating, lack of peristalsis, but no signs of peritoneal irritation or poorly marked.) General condition worsens, symptoms of intestinal paresis on day 4-5: vomiting, dry tongue, tachycardia, hypovolemia, the rapid development of septic shock.

It occurs in 15%. The disease begins 3-4 days. The leading symptom - enteroplegia passing in paralytic ileus, low-grade fever, mild tachycardia, recurrent thirst, bloating, bad carminative, etc. a woman cannot walk, but paresis is growing, as the rising charm weakness, shortness of breath, anemia, may be loose stools (diarrhea septic). It appears 7-9 day jay paralitic obstruction. Plus symptoms of peritonitis.

Late peritonitis. At 4-9 day because of the insolvency of stitches in the uterus. Up to 4 days after surgery may be all right, but it may persist fever, joins tachycardia, uterine tenderness (especially in the lower segment), symptom of Shcetkin - Blumberg in the rumen and the lower segment, the tension of the abdominal muscles are not expressed. This situation lasts for several days and formed a diffuse peritonitis, which is accompanied by symptoms of intoxication, intestinal paresis.

Methods of diagnosis (except clinical symptoms).

Ultrasound (check the condition of the walls of the uterus, can be found accumulation of blood clots in the uterus, lochia, spastic cervix, moderate infiltration in the weld area. Lohiometra can find, hemometra).

Dynamic monitoring of the patient (hourly observation).

ECG (malnutrition infarction, tachycardia, extrasystoles)

detailed clinical analysis of blood. Daily toxic anemia increases with a decrease in hemoglobin, red blood cells and the appearance of anisotropic Poikilocytosis, reduced color index, high

leukocytosis is not typical, and is characterized by an increase of band, lymphocytes, neutrophils toxic granularity, high erythrocyte sedimentation rate (55-70 mm / h).

Urine - nephritic syndrome, as due to intoxication is impaired renal function - reducing the hourly urine output (normal 50-60 ml), lower specific weight, appearance of blood cells in the urine: leukocytes - 10-15, red blood cells, cylinders, mucus , microbes. Since peritonitis often combined with preeclampsia it is necessary to compare the skill to interpret the results.

Biochemical analysis of blood: hypoproteinemia (40 g / l), decreased albumin, inhibition of electrolyte balance: hypokalemia, hyponatremia, a decrease of chloride ions, calcium, inhibition of hepatic function: increased AST, ALT, urea, creatinine. Also suffers from the pancreas.

Diagnosis is always belated, but as treatment. Developed tactics of surgical treatment (with the removal of the uterus, as it is the primary source of peritonitis). Operate most often in the 9-15 day, for 4-6 days rarely operate. It is necessary to assess the degree of severity on the progression of symptoms.

Treatment.

Surgical. The earlier the surgery after diagnosis of peritonitis, the smaller organ failure will occur after surgery. Removal of an organ as the site of infection (peritonitis uterus after cesarean section) is etiologically oriented. Remove the tube from the uterus, ovary usually leave unless they inflammation. Hysterectomy, more than amputation is performed. The lower segment is close to the cervix, so make supravaginal hysterectomy with removal of the fallopian tubes to the audit of the abdominal cavity.

Antibiotic therapy: cephalosporins and antibiotics active against Gram-negative bacteria - in the highest dose gentamicin, better intravenously. Drugs ofmetronidazole series - metragil intravenously (in effect on gram-negative flora, fungal flora). The range of sensitivity of microorganisms to antibiotics must be done carefully.

Treatment and relief of intoxication syndrome. Infusion therapy drugs, possessing detoxication properties reopoliglyukin, laktasol, colloidal solutions. Administration of solutions improves the condition of the patient. Also prescribe medications increase the oncotic pressure of the blood - plasma, aminokrovin, protein drugs, solutions of amino acids. 4-5 liters of liquid. Therapy is conducted under the control of diuresis.

Restoration of intestinal motility: the whole infusion therapy crystalloid solutions, antibiotics, improve motor skills. Also use the funds stimulate peristalsis (cleaning, hypertensive Cleese), antimimetics, proserin subcutaneous, intravenous, oksibaroterapy). The first 3 days should be held constant activation of intestinal motility.

Antianemic therapy a fraction of blood transfusion (preferably warm blood donations), antanemic.

Stimulation of the immune system - the use of immunomodulators - timolin complex, vitamins, UV blood, laser irradiation of blood.

Critical care and the fight against physical inactivity, parenteral nutrition, enteral nutrition, then a full - high-energy, fortified - dried apricots, cheese, raisins and milk products. The fight against physical inactivity is to conduct breathing exercises, early turning in bed, massage.

SEPSIS AFTER CHILDBIRTH AND AFTER CESAREAN SECTION.

Sepsis can be of two kinds: pyosepticemia, septicemia (without metastases).

Septicemia: febrile process with chills alternating with general weakness, heavy sweats, tachycardia, fever, shortness of breath, worsening of general health. Positive signs in the bowel. There are pains in the joints and muscles. The source of sepsis is the uterus. Maybe septic shock - a common (generalized vasospasm), impaired perfusion in the target organs (soft tissues, kidney (bacteremia, renal abscess, abscess of the liver, etc.). Joins the entire clinic general organs violations.

4.2 Analytical part.

Task № 1

Deliveries on time, labor - hypotonic bleeding. Produced manual examination of the uterine cavity. Blood loss was 500 ml, blood transfusion was performed. On the 5th day postpartum home temperature rose to 38 ° C. Pulse of 106 beats. per min., rhythmic. Tongue clean, damp. The breasts are soft, painless. The abdomen was soft, painful in the lower divisions. Fundus 4 sm below the navel. Lochia bloody, cloudy, with a smell. Symptoms of peritoneal irritation are negative. Urination is not broken. Blood test: Hb 96 g / L, L - 11,5-109, a formula with a shift to the left. Urine test - no pathology.

Questions:

1. Diagnosis.

2. Survey methods.

3. Treatment and tactics GPs.

Answers:

1. Puerperal metritis.

2. Pelvic ultrasound.

3. Emergency hospitalization in the gynecology department.

Task №2.

Delivery 3 weeks ago without complications. Appealed to the RA, with complaints of pain in the breast, fever up to 38 ° C. On examination, the pulse was 120 beats per minute, blood pressure 120/80 mm Hg. Art., respiratory rate 20 breaths per minute, tenderness, tension, wedge-shaped redness of one segment in the left breast.

Questions:

1. Diagnosis.

2. Survey methods.

3. Treatment and tactics GPs.

Answers:

1. Mastitis.

2. Complete blood count, urinalysis.

3. Surgical consultation.

Themes №13: Vaginal bleeding in early pregnancy. Abortions and their complications. Diagnostics. Tactics of reference.

Abortion, or miscarriage, is called the termination of pregnancy before the onset of viability (22 weeks gestation). Abortions are divided into self-arbitrary and artificial.

In spontaneous abortions are spontaneous, ie, occurring without the Special exposure to interrupt the pregnancy. Are called artificial abortions made in health care and abortion, which are a consequence of outpatient interventions are considered criminal.

Septic abortion is defined as an abortion, complicated by infection. Sepsis can be the result of infection of the lower genital tract as after spontaneous, and because of criminal abortion.

Spontaneous abortion

The causes of miscarriage are very diverse, often to pre-pregnancy interrupts leads not one, but several causative factors. Despite the conventionality of these factors can be grouped as follows: 1) pathology mat-ki, 2) abnormalities of chromosomal apparatus, and 3) immunological disorders, and 4) endocrine pathology, and 5) infectious agents, 6) physical illness and intoxication, 7) psi Hogen-factors, 8) complications during pregnancy.

By pathology of the uterus, promoting spontaneous abortion, include anomalies of Mullerian duct (septum, saddle, bicornuate uterus), adhesions in the uterus, Cervical incompetence, hypoplastic uterus and fibroids.

Anomalies of chromosome apparatus, leading often to abortion in the early stages of pregnancy, associated with structural abnormalities or quantitative-governmental chromosome aberrations.

Immunological causes of miscarriage caused by several reasons: violation of cellular and humoral immunity, the role of histocompatibility antigens; izoserologicheskaya incompatibility group and Rh blood of mother and fetus, an autoimmune reaction to phospholipids.

Endocrine pathology with profound changes of functions often leads to infertility than to miscarriage. Miscarriage usually occurs in women with deleted forms of hormonal disorders. This primarily refers to hypovarianism usually expressed luteal insufficiency and androgenemiey adrenal and ovarian origin.

Common cause of miscarriage is an infection of the parent body. This group of etiologic factors include both common acute and chronic infectious diseases, maternal and reproductive system

of local lesions caused by bacterial flora, Mycoplasma, Chlamydia, Toxoplasma, Listeria, viruses, fungi.
We can not exclude the role of psychogenic factors, which are often
trigger on the background of other predisposing factors.
Pathogenesis.In spontaneous abortions, any of the above reasons, ultimately leading to increased uterine activity, the separation of the ovum from the uterine wall and its expulsion. In the beginning I and II trimester (up to complete formation of the placenta), the fertilized egg is removed and separated from the uterus without opening the membranes. At a later date when the placenta formed abortion is the type of childbirth: the cervix opens, pour the amniotic fluid, the fetus is born, and then the last.
In the clinical course of spontaneous abortion are following stages or forms, threatening miscarriage, starting a miscarriage, abortion in progress, complete and non-complete abortion.

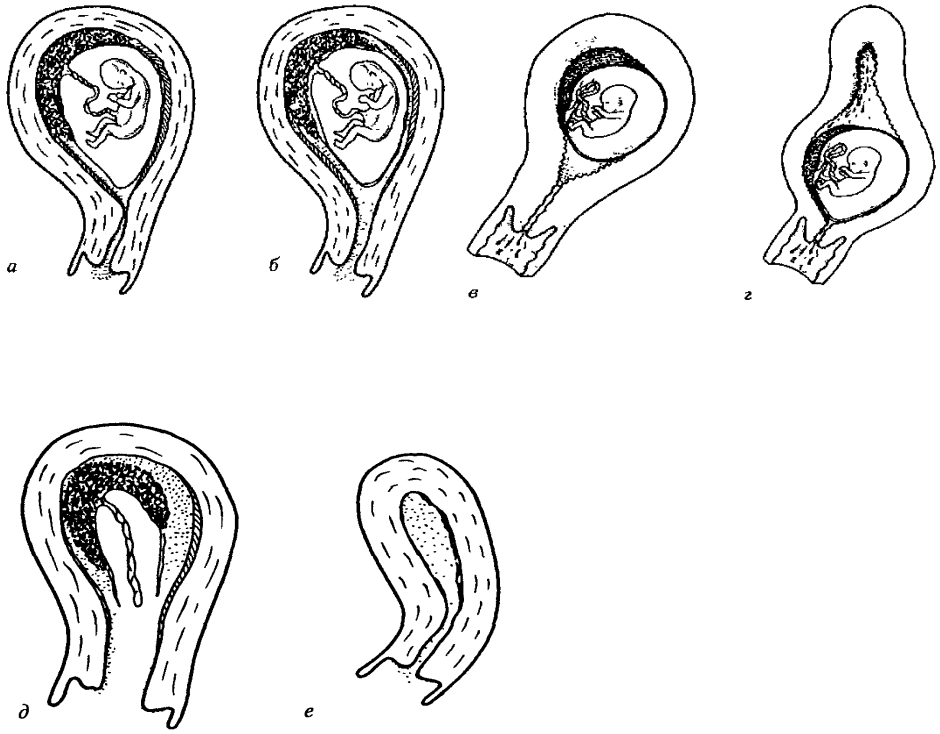


Fig. Stage samoprizvolnogo abortion and - threatened miscarriage, b - began miscarriage, c, d - abortion in progress, e - incomplete abortion, g - complete abortion

Threatened spontaneous miscarriage

The clinical picture. For threatened miscarriage is typical gain-state decreased muscle activity in the uterus, but the fertilized egg is fully retains its connection with the uterus. Clinically threatening miscarriage appears weak aching in the lower abdomen and (or) in the sacrum. No bleeding.

Diagnosis. The diagnosis of spontaneous abortion based on complaints predyav-lyaemyh patient; public data and gynecological examination, ultrasound results kovogo survey method.
Presenting complaints of patients with different degrees of severity are described above.
The general condition of the patient is satisfactory.
These pelvic exam: the uterus corresponds to the period of pregnancy. Structural changes in the cervix not.

Ultrasound.Echographic signs of miscarriage in the early stages are: the emergence of fuzzy contours of the ovum, strains, constrictions of the ovum, the local voltage myometrium.

Treatment. With the threat of miscarriage treatment should be performed taking into account the duration of pregnancy, stages of clinical course and causes of the disease.

According to WHO, therapeutic activities include:

• The medication is usually not necessary.

Advise the woman to refrain from effortless activity and sexual snoshu-making.

Started spontaneous miscarriage

The clinical picture.

When started miscarriage increased contractile activity of the myometrium leads to a partial detachment of the ovum and the appearance of small bleeding from the cervical canal.

Started miscarriage accompanied by increased pain, which sometimes acquires-melting nature of weak labor and meager appearance of bleeding.

Diagnosis.

Presenting complaints of patients with different degrees of severity are described above.

The general condition of the patient depends on the extent and duration of the bleeding.

These pelvic exam: When started miscarriage uterus corresponds to the period of pregnancy. The neck may be somewhat shortened slightly gaping maw outside.

Treatment

• Bed rest

• If the bleeding has stopped, continue monitoring in the outpatient setting. If the bleeding was repeated, re-evaluate the woman's condition.

• If bleeding continues, assess the viability of the fetus (beremen-nost/UZI test) or the possibility of ectopic pregnancy. Ongoing bleeding, especially if the uterus is increased more than expected, may indicate twins or molar.

• Assign the treatment depending on the etiology

• If the reason - hormonal disorders

- Assign chorionic gonadotropin 1000 IU / m in a day number three

HCG is assigned to 3 weeks to 10-11 weeks. period

- 4 tablets duphaston. once, then 1 tablet 3 times a day, every day, duration

sequence receiving individual. Duphaston is assigned to 3 weeks. up to 20 weeks. period

 Dicynone 2.0 f / m, not more than 3 days

 No-spa 2.0 x 2 times a day / m

 rectal suppositories with papaverine 1 suppository x 2 times a day

Vit E 10% -1.0 V / m in a day, from 7 weeks pregnant

Abortion in progress

The clinical picture.

Abortion in progress accompanied by severe cramping pain in the lower abdomen, significant and massive bleeding. Ovum loses touch with plodovmestilischa and down into the lower uterine or cervical canal.

Diagnosis.

Presenting complaints of patients with different degrees of severity are described above.

The general condition of the patient depends on the extent and duration of the bleeding.

These pelvic exam: spastic uterus, be the corresponding term of pregnancy, the lower pole of the ovum is easily achieved through the cervical canal, evidence of abortion in progress.

Treatment

• Treatment of abortions carried out in the course of hospital

• If the pregnancy is less than 16 weeks, plan to delete the contents of the cavity cancer by the FDA. If such removal can not be made immediately, and no bleeding:

- Assign mitilergometrin 0.2 mg / m (if necessary, repeat after 15 minutes) or misoprostol (Cytotec) 400 mg orally (Repeat again in 4 hours);

- Prepare for uterine evacuation as soon as possible.

• If the pregnancy is more than 16 weeks:

- Wait for the spontaneous expulsion of the ovum, and then make aspirate the contents of the uterus to remove the remaining fragments;

- If necessary, pour oxytocin 40 IU in 1 liter of solution / in (in saline or Ringer's lactate) at 40 drops per minute to help ekepul-sion of the ovum.

Provide follow-up for women after therapy.

Incomplete abortion

The clinical picture.

If part of the ovum has moved beyond the uterus, the uterus contains only its remnants, such abortion is called incomplete.

For incomplete abortion typically decrease in pain due to the ongoing blood flow of varying severity.

Diagnosis.

Presenting complaints of patients with different degrees of severity are described above.

The general condition of the patient depends on the extent and duration of the bleeding.

These pelvic exam: Incomplete abortion uterine size less than a minute SRO pregnancy, the cervical canal is open.

Treatment

• Treatment of incomplete abortion is carried out in a hospital

• If bleeding is mild to moderate, and the pregnancy is less than 16 weeks, Use fenestrated forceps to remove fragments of the ovum, descended from the uterus to the cervix.

• If bleeding is severe, and the pregnancy is less than 16 weeks, evacuate the contents of the uterus: manual vacuum aspiration is the preferred this method of evacuation. Evacuation sharp curette should be used only if the FDA is not possible;

- If an immediate evacuation of the uterus is not possible, assign methyl lergometrin 0.2 mg / m (if necessary, repeat after 15 minutes) or misoprostol (Cytotec) 400 mg orally (if necessary, repeat one more time after 4hours.

• If the pregnancy is more than 16 weeks:

- Overfill oxytocin 40 IU in 1 liter of solution / in (in saline or Ringer's lactate) at 40 drops per minute to mo ¬ mentekepulsii conceptions;

- If necessary, assign misoprostol (Cytotec) 200 mcg vaginally 4 hours prior to the expulsion of the ovum, but the total dose of 800 mg;

- Remove all the remaining fragments of the uterus (MVA)

- Provide follow-up of a woman.

Complete abortion

The clinical picture.

At full abortion ovum rejected entirely, the uterus may be only part of the decidua. Such a form of abortion occurs rarely. At full abortion pain subsides, the bleeding stops.

Diagnosis. The diagnosis of spontaneous abortion based on complaints predyav-lyaemyh patient; public data and gynecological examination, ultrasound results kovogo survey method.

Presenting complaints of patients with different degrees of severity are described above.

The general condition of the patient depends on the extent and duration of the bleeding.

These pelvic exam: The complete abortion uterine size less than the time of pregnancy, the cervical canal is closed.

Treatment

• The evacuation of the uterus is usually not necessary.

• Look for a woman not to miss the heavy bleeding.

• Ensure follow-up of a woman.

Follow-up for women who have had an abortion.

Before discharge tell women undergoing spontaneous abortion, that miscarriages are very common and they completed about 15% (one in seven) is clinically recognized pregnancies. Also convince women that the chances of a successful subsequent pregnancy are high. Necessary to establish the cause of the incident of abortion, which may have a negative impact on those-chenii subsequent pregnancies, if any.

A woman should be persuaded to postpone the next pregnancy until full recovery.

It is important to advise women about contraceptive that can be started immediately (within 7 days) provided:

• No major complications requiring further treatment:

• the development of women appropriate advice and help in choosing a suitably th method of family planning.

In addition, some women may need to:

 Treatment of diseases, sexually transmitted

 Screening for cervical disease diagnosis

Induced abortion

For the purpose of abortion used different methods, The choice is determined by the (first) of pregnancy. To interrupt the pregnancy used in the I trimester curettage of the uterus, and vacuum aspiration abortion, to induce prostaglandin and antiprogesteronom mifepristone. In II trimester abortion used intraamnialnoe, ekstraamnialnoe introduction of a hypertonic solution, a small abdominal cesarean section, vaginal Cesarean section, expand the cervical canal and opening of membranes, the most common - and extra-intraamnialnoe prostaglandin.

With up to 12 weeks. abortion is performed on the desirability of Women in the absence of contraindications for this operation.

Contraindication for abortion are:

 acute and subacute inflammatory diseases of female genital spe-ray and non-specific etiology,

 acute infectious diseases and inflammation of any location.

Induced abortion can be performed only after the pathological processes that represent a high risk to the health of women due to complications that arise when performing surgery.

Termination of pregnancy:

Abortion in pregnancy before 12 weeks.

1. Instrumental abortion

The most common and the most reliable method. Cervical canal extends special tools, then curette scraping the uterine wall.

2. Vacuum aspiration (mini-abortion)

Vacuum aspirator - is a big syringe with a long nozzle introduced into the uterine cavity.

3. Medical abortion.

For the implementation of medical abortion using the drug Mifepristone (Mifegin, RU-486). It is a drug - progesterone antagonist (pregnancy hormone). Cessation of action of progesterone leads to the death of the embryo and its rejection with the endometrium. Luchschy to uterine contractions and cervical dilatation additionally used drugs prostaglandins.

Complications. The most serious complication of abortion is perforations uterus, which can be made with any tool, use-yuschimsya for scraping of the uterus: probe, expanders, curette and less - aborttsangom.

When perforation of the uterus, regardless of its size, location and condition of patients, shows laparotomy. Conservative management of patients is high and unnecessary risk.

Incomplete removal of the ovum is one of the most frequent complications of induced abortion. Postoperatively, there is a long-stye blood from the genital tract, cramping pain in the abdomen, in the future, combined with infectious complications. The diagnosis is confirmed by bimanual and al-trazvukovom studies.

Placental polyp - a complication of abortion, which occurs when the delay in the uterus remains fuzzy shell elements that grow connective tissue and thereby firmly attached to the uterine wall. Clinical manifestations of placental polyp characterized by long-vyanistymi blood discharge from the genital tract. The diagnosis is confirmed by bimanual and ultrasound.

Treatment of placental polyp is to remove the remnants of the ovum by uterine curettage. In cases where there are signs of infection connection, additional anti-inflammatory therapy is conducted.

These complications do not complete the list of adverse effects of artificial abortion.

Remote consequences of induced abortion:

- the menstrual cycle,
- Infertility
- endometriosis
- chronic inflammatory diseases of genitals

Appendix № 1

Play "Daisy"

Teacher, pre-prepared chamomile of colored paper. Each student pulls on the lobe, where the back of the proposed question on the subject to which it must respond.

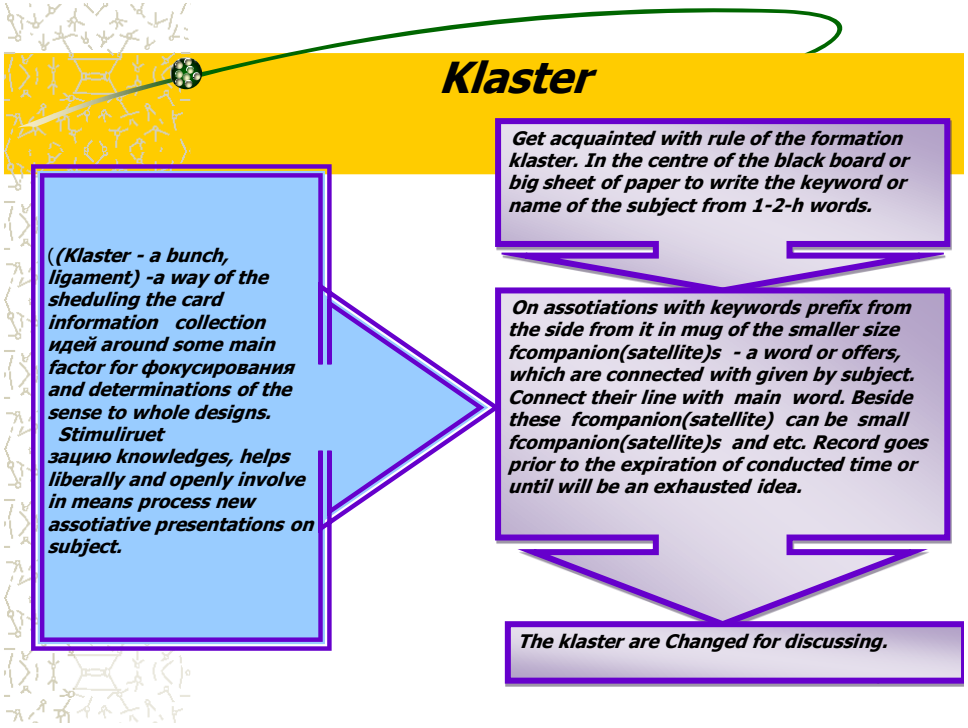
A definition of abortion

Spontaneous abortion is defined as the early termination of pregnancy before
the onset of viability (22 weeks gestation).

The causes of miscarriage?

Common infectious and non-infectious diseases, disorders of the internal glands secretion her, metabolic and autonomic nervous system, eating disorders and hyper-povitaminozy blood

diseases, blood incompatibility izoantigennaya spouses; anomaly of genital organs, pathology fertilized
egg.
Types of abortion?
Abortion is divided into artificial and samopoizvolshnye
Stage of miscarriage
Stage of miscarriage include: threatened abortion (pregnancy may continue); abortion in progress (pregnancy can not continue and moves in a static diyu incomplete / complete abortion), incomplete abortion (embryo fragments spun partially) complete abortion (fragments of the fetus
fully selected).
Possible complications after the abortion?
cervical laceration, uterine perforation, endometritis, parametritis, inflammation of the uterinepelvioperitonit, peritonitis, sepsis.
Application number 2:
Analysis of clinical cases
The teacher explains to students, as will be analysis of the cases in order to develop skills-problem solving and interpersonal communication. Explained using the general structure and May parsing (assessment, diagnosis, tactics). Students are divided into 2 groups, each group is invited to the clinical situation, and given the opportunity to discuss each case. The representative of the group shall, within 5 minutes to tell everyone about the solution case.
Clinical situation
Ms. A. 28. She was 12 weeks pregnant, when applied to a sting med.centre-bout of slight vaginal bleeding. This pregnancy - first. This is of planned pregnancy and still it felt good:
That you include in the initial assessment and why? Hello, listen, production lead a rapid assessment of whether it is in a state of shock - a fast, weak pulse, systolic less 90mm.rt.st., pallor, sweating or chills, clammy skin, rapid breathing; sudoro-gi.
What aspects of the physical exam will help you in making a diagnosis? Inspection of the region of the abdomen, vaginal examination (the size and consistency of the uterus, the sensitivity of the w / m and determine whether it is closed, the presence of any tissue in the m / m and the volume of bleeding-tion).
What reasons should be excluded?
Abortion (threatening, started, full, part-time), ectopic pregnancy, hydatidiform mole, non-developing pregnancy. After evaluation information was obtained:
Temperature - 36.8 C, pulse - 82ud/min, BP 110/70mm.rt.et. The skin is not pale and moist. She has a slight pain in the abdomen and slight vaginal bleeding. Uterus corresponds to the period of pregnancy, w / m painless and closed.
What is the diagnosis? Incipient abortion.
What is your policy and why?
At the moment required hospitalization for treatment for the preservation and prolongation of pregnancy.



4.2. The analytical part of

Situational problem number one

Patient I. appealed to the clinic complaining of severe abdominal pain pulling character.

Of history: There were five pregnancies ended 2-urgent delivery, 3 - artifi-cial abortion in the early stages, with no complications. Last abortion made 1.5 of the month before. Felt good. The body temperature was normal. In term of the expected menstrual bleeding were absent, but there were aching abdominal pain, which intensified during the night. The patient turned to the clinic in the morning.

Vaginal study: Cervix cylindrical rejected posteriorly to close the mouth. The uterus is correct, soft, movable, painless, enlarged to 10-11 weeks. Appendages on both sides are not defined.

Questions:

1. Diagnose:
2. Additional studies:
3. Future Tactics:

Answers:

1. Hemometra. Synechia cervical
2. Ultrasound.
3. Hospitalized in a hospital

Situational problem number two

Patient S., 41, turned to the clinic with complaints of bleeding in lovyh ways in moderation.

Of history: had nine pregnancies: 3 of them ended urgent normal ro-DAMI uneventful six - artificial abortion in the early stages, with no complications. Last normal menstrual period was 2.5 months ago.

In the mirror: The cervix is clean. Marked cyanosis of the cervix.

Vaginal examination. The cervix is a cylindrical outer jaws closed. The body of the uterus increased to 7 weeks of pregnancy. On the front of the unit is determined by the myoma. 1.0 x 2.0 cm on both sides of the appendages are not defined. Allocation dark, bloody.

Questions:

1. Diagnosis:
2. Additional studies:
3. Further tactics.
Replies
1. 7 weeks of pregnancy. Started spontaneous miscarriage
2. Ultrasound.
3. Hospitalization

Themes № 14: Violation of the menstrual cycle. Dysfunctional uterine bleeding. Clinic. Diagnostics. Treatment. Preventive examination of children and adolescents

Juvenile bleeding

Uterine bleeding associated with dysfunction of the ovaries in girls at puberty is called juvenile(UK). UK frequency reaches up to 10%.
Etiology and pathogenesis. UK due to the emergence of a variety of harmful effects on the developing organism. This poor living conditions, malnutrition, acute and chronic infections and intoxication, physical and nervous tension, fatigue, fear, fright, anxiety, a one-time mental shock, permanent psychological trauma, abnormal condition of the heart, lungs and other internal organs. Various diseases and reduce the harmful effects of adaptive capabilities and contribute to the emergence of disorders of the reproductive glands, which lead to changes in hormonal balance and the endometrium.For a typical UK type of anovulation at which the follicle atresia under the age of ovulatory maturity. The follicles are developing, but without reaching the level of maturity, are regressive changes.Aterogenic follicles falls and they maintained a long follicular fluid (cystic atresia). Gradually formed in the ovaries of many aterogenic follicles. Formed in the follicles hormones continuously stimulate the proliferation of endometrial hyperplasia and therefore are, secretory transformation of the endometrium is not happening.
Clinic. The clinical picture of juvenile bleeding characterized by long, heavy, sick anemiziruyuschimi acyclic bleeding. Bleeding usually occurs after a missed period by 1.5 - 4 months.Typical complaints of weakness, loss of appetite, fatigue, headache, pallor, tachycardia.
Diagnostics. Diagnosis is based on presenting complaints patient, these general examination, rectal examination, ultrasound, laboratory data analysis.
Uterine bleeding in adolescence should be differentiated from blood diseases, polycystic ovary syndrome, uterine fibroids, cancer of genitals.
Treatment. Treatment of UK can be divided into two stages: the first stage - the second phase of hemostasis and - prevention of bleeding.
When choosing a method of hemostasis should consider the overall condition of the patient and the amount of blood loss. Patients who have not expressed anemia (hemoglobin of 100 g / L, hematocrit 30%), being symptomatic hemostatic therapy. Assign uterotonics (oxytocin), hemostatic agents (Dicynone, menadione, aminocaproic acid, askorutin). When failure symptomatic of hemostatic therapy performed hormonal homeostasis.
Estrogens for hemostasis: mikrofollin (ethinylestradiol) to 0.5 mg every 2-4 hours, or proginova 2 mg, to stop bleeding. But not more than 6 tablets per day. Usually hemostasis occurs within 24 hours after bleeding daily dose reduced to 1 tablet a day, and keep the dosage within 8-10 days. And then immediately move on to progestins in the same week. Norkolut appoint 10 mg per day orally for 10 days, Duphaston 20 mg. And so the cyclic therapy is 3-4

months.The hemostatic effect of estrogen is associated with a blocking action on the GGS, and endometrial proliferative processes are activated and comes fast regeneration. In order to be used hemostatic monophasic estrogen - progestin preparations (rigevidon, mikroginon, regulon and other monophasic COCs). For this medication prescribed 1 tablet every 2 hours after a meal to stop the bleeding, but no more than 6 tablets per day. In the days to reduce the dose of 1 tablet per day, leading to 1 tablet, then treatment should be continued for 21 days. Simultaneously hold Antianaemia therapy (iron supplements orally or intravenously, vitamin B12, WB, C, P), as well as used uterotonic, drugs calcium.
The second stage of treatment is the prevention of juvenile bleeding recurrence. In order to prevent rebleeding after hemostasis against symptomatic and hemostatic treatment can be carried out cyclic vitamin therapy. From the 5th to the 15th day of the cycle prescribed folic acid, 1 tablet 3 times a day, glutamic acid, 1 tablet 3 times a day, vitamin B6, 5% solution of 1 ml intramuscular vitamin E, 300 mg every other day. From the 16th to the 26th day of ascorbic acid administered to 0.05 g 2-3 times a day, vitamin B1 5% solution of 1 mL intramuscularly. Treatment is carried out within 3 months. Prevention of bleeding after hormonal homeostasis is to receive nizkodoziroavnyh synthetic progestins (Novinet, Lindinet, logest etc. COC) 1 tablet with a 5-to 25-day cycle for 2 - 3 months, followed by vitamin therapy. To regulate the menstrual function is used as the physical factors: Endonasal electrophoresis of vitamin B1 or novocaine, electric Good results are obtained with acupuncture, electroacupuncture, laser puncture.

DUB in the reproductive age.

DUB in the reproductive age, as in puberty, called acyclic uterine bleeding after a period of missed period and a half to two months.
Cause violations of the cyclic function of the hypothalamic-pituitary-ovarian system, the end result, which is anovulation, may constitute a violation of hormonal homeostasis (abortion), Cushing's disease, postpartum obesity, emotional and mental stress, infections, intoxication, medication (particularly neuroleptics). With the DUB in the reproductive age in the ovaries is often persistence of follicles with excessive production of estrogen. Because ovulation does not occur and the corpus luteum is formed, created progesteron-deficiency state. Thus there is an absolute hyperestrogenia. Develop hyperplastic changes (glandular hyperplasia). When recurrent anovulation giperestrogeniey combined with an increased risk of adenomatosis and atypical hyperplastic changes in the endometrium.
Clinic. Clinic DUB determined by the duration of bleeding up to 10 days and the degree of blood loss and lead to fatigue, headaches, fatigue, decreased blood pressure, tachycardia. The main complaint of patients with cardiac arrhythmias DUB is menstruation: bleeding often occurs after a missed period, or marked menorrhagias.
Diagnostics. DUB diagnosis of reproductive age placed only after the exclusion of diseases and pathological conditions in which may also have uterine bleeding: impaired uterine pregnancy, uterine, placental polyp, delay parts of the ovum in the uterus, endometrial polyps, internal endometriosis, tubal pregnancy is terminated for type of abortion.
Women with DUB To measure the complex survey:
- Laboratory tests (complete blood count, coagulation)
- Survey of functional diagnostic tests (measuring the basal body temperature, simtom "pupil", simtom tension mucus)
- X-ray of the skull, EEG, CT

- Determination of hormones in the blood plasma
- SPL
- According to the testimony of a physician examination, ophthalmologist, endocrinologist, neurologist, hematologist.

Treatment. Treatment of patients with DUB reproductive period depends on the clinical manifestations. When handling a patient with bleeding from medical diagnostic purposes necessary to conduct separate curettage of the uterus. This operation stops the bleeding, and subsequent histological examination determines the type of scraping therapy to normalize the menstrual cycle.

The next stage of treatment is hormone therapy given the state of the endometrium, the type of violation of the ovaries. Objectives hormone:

- Normalization of menstrual function;
- Rehabilitation of the reproductive function of restoring fertility for infertility;
- Prevention of re-bleeding.

Estrogen - progestin preparations (regulon, rigevedon, Novinet) appoint one tablet with a 5-to 25-day cycle after scraping, then the 5 th to the 25 th day of the menstrual cycle for 3-4 months.

In the reproductive age women with DUB, there are usually anovulation, at least - failure of the corpus luteum.

When giperestrogeniey (persistence follicle) were treated with progestins: Duphaston 10 mg, 5 mg norkolut per day from 16 to 25 per day for three menstrual cycles. Use synthetic progestins with high progestin (rigevedon, mikroginon) from 5 to 25 day cycle.

In order to rehabilitate the reproductive function method is used to stimulate ovulation clomiphene oral dose of 50 mg 1 time a day (at night), from 5 to 9 days of the menstrual cycle. If no effect is repeated use of the drug, spending 3 - 5 courses. Clomiphene reducing levels of circulating estrogens (reducing in high concentrations secretion of gonadotropic hormones), it increases the secretion of luteinizing hormones and follicle-stimulating.

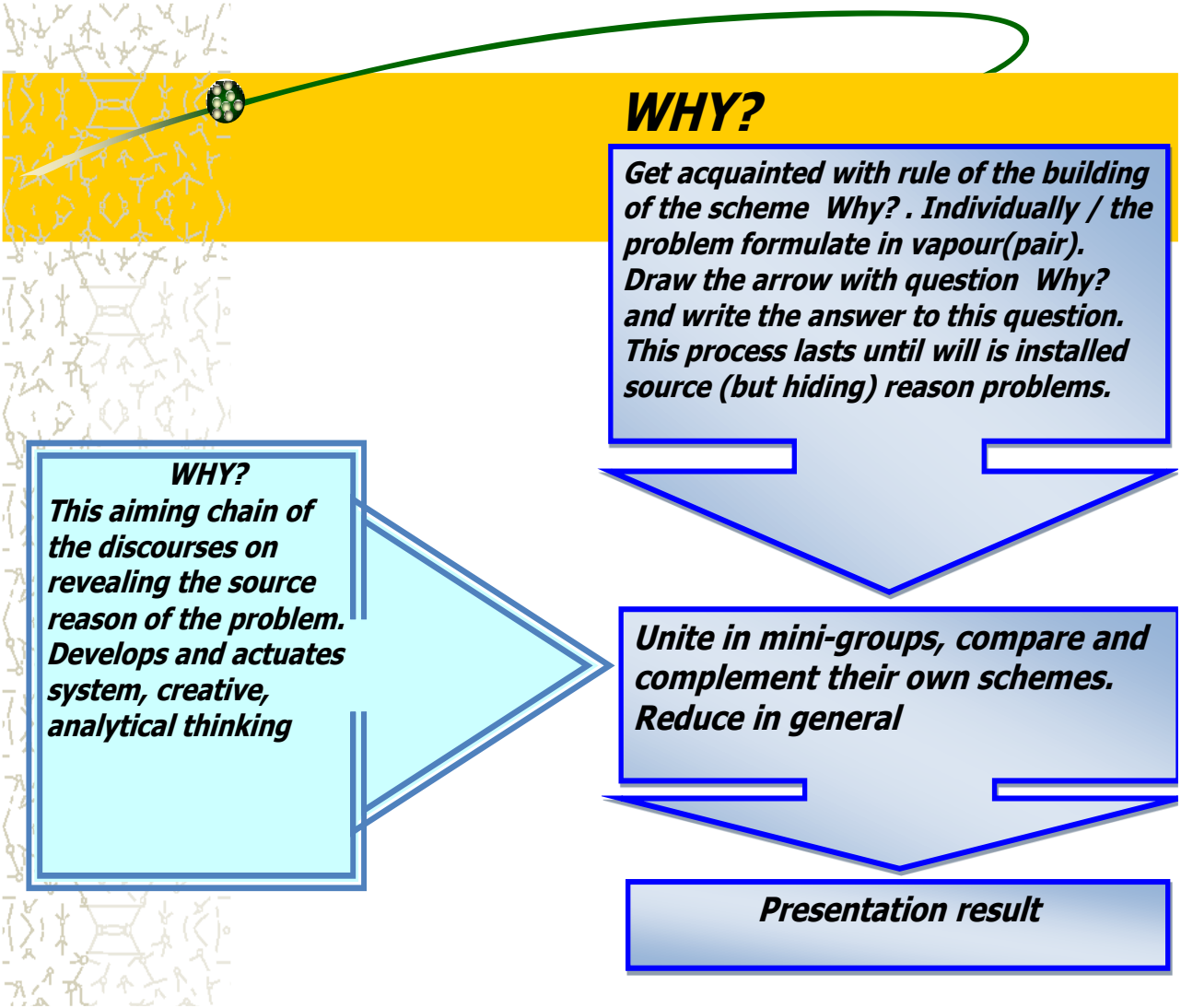
When gipoestrogenii (follicular atresia) shows cyclic estrogen-progestin therapy with high estrogen (rigevidon, regulon) from 5 to 25 days for 3-4 cycles.

Women with inadequate luteal phase with substitution to (lack of corpus luteum hormone) prescribe progestogens: Duphaston 10 mg, 5 mg norkolut per day from 16 to 25 day cycle or 17-MIC of 1 ml at 14, 17 and 21 cycle for three menstrual cycles.

Climacteric bleeding

Women aged 45-55 years uterine bleeding is the most common gynecological diseases and are the most common cause of hospitalization. Uterine bleeding in premenopaused age according to established tradition called menopause. This term emphasizes their relationship with aging of the reproductive system. Menopausal bleeding are due to age-related changes in the functional state of the hypothalamic structures that regulate ovarian function. The aging of these structures is expressed in violation of the cyclic release of gonadotropins. The above changes lead to a breach of the forward and reverse links between centers and peripheral organs. As a result of impaired ovarian function: extended period of growth and maturation of follicles, ovulation does not occur, is formed by the persistence or atresia of the follicle or corpus luteum is formed. Due to prolonged exposure to estrogen is excessive endometrial proliferation. Lining of the uterus grows, thickens, elongated gland and they formed extension (glandular cystic endometrial hyperplasia). Secretory transformation of the mucous membrane does not occur, the compact and spongy layer is formed, blood vessels expand, blood clots are formed in them.

Overgrown mucus fills the uterine cavity, the contact surfaces undergo mutual compression. As a result, vascular disorders and compression is malnutrition, and exclusion of endometrial necrosis, accompanied by bleeding.
Mucosa disappears slowly, gradually, the individual sections, so long bleeding, excessive. Endometrial hyperplasia and its variants - glandular-cystic hyperplasia, glandular polyps, adenomatous and atypical hyperplasia in premenopausal - occur much more frequently than in the reproductive. This is not only age-related changes in the ovaries, but also age immunnodepressiey - decompensation of the cellular immune response, increasing the risk of malignancies.
DUB must be differentiated from organic amendments: endometrial adenocarcinoma, uterine fibroids, internal endometriosis, ovarian gormonprodutsiruyuschie.
Treatment.
Treatment of menopausal bleeding starts with bleeding by surgical curettage of the uterine cavity. Diagnostic curettage of the uterine cavity is carried out as a diagnostic and therapeutic purposes. Reveals submucosal fibroids, and histology scraping - adenocarcinoma, atypical hyperplasia, recurrent glandular-cystic hyperplasia of the endometrium. You should also use ultrasound to detect myoma nodes, the endometrium, foci of adenomyosis. To prevent a recurrence of bleeding after curettage widely used progestin, which has consistently influenced the inhibition of proliferative processes, secretory transformation, the development of the decidual reaction and finally atrophic processes. Progestin effects on the central units, inhibit the release of gonadotropins. Women up to 48 years in case of detection scraping glandular cystic endometrial hyperplasia oksiprgesterona kapronat prescribe injections of 1 ml of the solution to 12.5% / m at 14, 17, 21 days after scraping, then in these days of "menstrual cycle" during the course of 4 - 6 months. You can use norkolut 5 mg orally with 16 to 25-day cycle after scraping, then in these days of "menstrual cycle" for 4 - 6 months. Women over 48 years old therapy is aimed at suppressing the menstrual function. To do this, assign the 17 defense in continuous mode with 2 ml 12.5% solution / m 2 once a week for 6 months. Women aged 50 years and over suppression of menstruation spend gestogennyi monophasic estrogen therapy (klimonorm, Femoston 1/10) in a continuous mode, 1 tablet a day for 3-4 months.



Appendix № 1

Play"Daisy"

Teacher, pre-prepared chamomile of colored paper. Each student pulls on the lobe, where the back of the proposed question on the subject to which it must respond.

- What is called menorrhagia?

This bleeding associated with the menstrual cycle.

- What is called metrorrhagia?

Metrorrhagia, bleeding not related to the menstrual cycle

- What is called the DUB?

Uterine bleeding arising from functional disorders of the hormonal activity of the ovaries and the hypothalamic-giopfizarnoy systems (SHS) in the absence of anatomical changes in the reproductive system are called dysfunctional.

- What may contribute to the DUB?

During the perinatal period, the emotional and mental stress, traumatic brain injury, hypovitaminosis and nutritional factors, abortion, hormonal g.omeostaza; migrated inflammatory genital diseases, diseases of the endocrine glands, and neuroendocrine disorders, various intoxication occupational hazard, adverse etiological factors.

- What age periods meets DUB?

Juvenile uterine bleeding, DUB reproductive age, DUB premenopausal period.

Appendix № 2

Analysis of clinical cases

The teacher explains to students, as will be analysis of the cases in order to develop problem solving skills and interpersonal communication. Explains the general structure used in the analysis (assessment, diagnosis, tactics). Students are divided into 2 groups, each group is invited to the clinical situation, and given the opportunity to discuss each case. The representative of the group shall, within 5 minutes to tell everyone about the solution case.

Clinical situation

Girl 14 years old, asked for help with complaints of prolonged heavy bleeding, weakness, fatigue, and headaches.

From history: frequent angina, chronic tonsillitis. Menarche at age 13, and irregular. Bleeding occurred after a delay menstruation 2mes. and lasts 10 days and plentiful.

Rating:

That you include in the initial assessment and why? Hello, listen, make a quick assessment of whether it is in a state of shock - a fast, weak pulse, systolic less 90mm.rt.st., pallor, sweating or chills, clammy skin;

What aspects of the physical exam will help you in making a diagnosis? Examination, ultrasound is necessary to study, research and rheological properties of blood coagulation.

What reasons should be excluded? Uterine bleeding in adolescence should be differentiated from blood diseases, polycystic ovary syndrome, uterine fibroids, cancer of genitals

What is the diagnosis? DUB juvenile age.

What is your policy and why?

The first stage - hemostasis;

The second stage ~ prevention of bleeding.

The choice of method to stop bleeding depends on the patient, the extent and duration of bleeding. When expressed mild anemizatsii, recommended estrogensoderzhaschie preparations before proceeding to the reception of progestogens.

Estrogens administered for hemostasis in large doses: 0.1% solution of estradiol dipropionate and 1 ml / m every 2-3 hours, or mikrofollin to 0.05 mg folliculin to 10 thousand units every 2 - 3 hours hemostasis usually occurs within 24-48 hours after the bleeding and reduce the dose of the drug was continued for 14 days and then transferred to a progestin for 12 to 25 day cycle (1% solution of progesterone and 1 ml / m daily or 1 ml 12.5% solution 17 OPK on day 21 of

the cycle). And so the cyclic therapy is 3-4 months. In order to be used hemostatic estrogen - progestin preparations (rigevidon, mikroginon, regulon). For this medication prescribed 1 tablet every 2 hours after a meal to stop the bleeding, but no more than 6 tablets per day. Then removed and 1 tablet per day to 1 tablet and 1 tablet taken 21 days. When failure of hormonal homeostasis, or general condition the patient should be made scraping the uterine histology scraping. Simultaneously hold Antianaemia, uterotonic, drugs calcium. In the second phase of prevention of rebleeding. Appointed for this estrogen-progestin preparations with a 5-to 25-day cycle for 3-4 months, or pure progestogens: norkolut from 16 th to the 25-day cycle, or 12.5% solution of 17 mL of 1 defense a 15-day cycle for 3-4 months. We recommend the use of physical factors: Endonasal electrophoresis of vitamin B1 or electrophoresis of novocaine.

4.2. The analytical part of

Situational problem № 1

Patient I. 46, turned to the clinic complaining of vaginal bleeding.

Of history: There were 4 pregnancies: two - ended in normal delivery, 2 - artificial abortion. The last 2 years the menstrual cycle has been disturbed: the interval between periods of 2-3 months. Fifteen days ago, after 2 months. absence of menstrual bleeding started, which continues to the present.

Vaginal examination: Cervix cylindric form outer jaws closed. The body of the uterus is not enlarged, painless on palpation. Appendages on both sides are not defined, their range is painless.

Questions:

1. Diagnosis:
2. Differential diagnosis:
3. Tactics doctor GPs:

Replies

1. Dysfunctional uterine bleeding menopause
2. Differential diagnosis is with endometrial cancer, uterine mime, violation of uterine pregnancy, endometrial polyps
3. Send to the hospital for diagnostic uterine curettage

Situational problem № 2

Patient G., 29 years turned to the clinic with complaints of bleeding from the genital tract. 10 days ago in a patient after 1 month of absence of menstruation began spotting that continues to this day.

Anamnesis: had 3 pregnancies, one ended in artificial abortion, with repeated curettage of the uterine cavity at the remains of the ovum, the other two - spontaneous abortions.

Uterus normal size, mobile, painless, in the right position. Appendages on both sides are not defined.

Questions:

1. Diagnosis:
2. Differential diagnosis:
3. Tactics doctor GPs:

Replies

1. Dysfunctional uterine bleeding.
2. The differential diagnosis is carried out with interrupted uterine pregnancy, impaired ectopic

pregnancy.
3. Hospitalization

Topics №15: Cysts and cysts of the ovaries (benign and malignant). Diagnostics. Tactics of reference.

Ovarian cysts.

Allocate risk group.

1. Women with chronic pelvic inflammatory disease. So women need in the complex treatment of these diseases to recommend the use of hormonal contraceptives.

2. Women with hormonal disturbances - irregular menstruation, hormonal infertility.

3. Women, on the operations of appendages - cystectomy, ectopic pregnancy, etc.

4. Family history - ovarian, endometrial relatives.

5. Women with breast cancer.

For ovarian cysts include follicular, luteal, paraovarial, chocolate cysts.

Follicular cyst - develops from persistent or atrezition follicle. As a result of the inflammatory process in the ovary occurs albuginea thickening it, but because - because of the persistence of the follicle or disorders of the pituitary gland develops gonadotropical atrezition follicle. Fluid accumulates in the follicle by extravasation of blood vessels.

Usually it is the formation of a thin-walled with a smooth surface ovoid form with a size less than 10 cm in size if it is more, it does not exclude malignancy of this education. Consistency-tight elastic. Follicular cysts contain estrogen, and it is hormonally active tumor. As a result, may be clinically amenorrhea giperpolimenorrhea etc. Most often, a follicular cyst is asymptomatic and detected during routine inspection.

Treatment: In the presence of a tumor diameter of more than 8 cm are displayed directly surgical removal (direction of the hospital.) If less than 8 cm tumor was first discovered by a young age, during one menstrual cycle can be made inflammatory and resolution therapy (intended obstetrician gynecologist). If the effect of conservative therapy is not, then the next month to have surgery, because are at high risk for malignancy.

Luteum cyst - distinguished: 1. Luteum cyst is pregnancy - from developing atrezition follicles. 2. Luteum cyst during pregnancy, molar and chorionepithelioma.

Luteum cyst is pregnancy - usually no more than a one-sided 8 cm in diameter, with a smooth surface, with the contents of red and yellow, the inner layer of the capsule folded. Flows as well as the follicular cyst symptoms. But in some cases, during the months was greater in the tumor II - phase and less in the I - phase.

Diagnosis:

1. Bimanual / recto-abdominal examination.

2. Pelvic ultrasound in the dynamics, conducted in the first (7-8 days from the start of menstruation) phase of the cycle.

3. Total blood.

4. Microbiological examination of the contents of sowing vagina flora and sensitivity to antibiotics.

Treatment: luteum cyst during pregnancy resolves itself in the II half of pregnancy. Treatment of functional ovarian cysts and corpus luteum held gynecologist-endocrinologist. Anti-inflammatory therapy: broad-spectrum antibiotics, or take into account the sensitivity of detection of microorganisms (after the results of microbiological testing.) Treatment is carried out under the control of dynamic ultrasound of the pelvic organs. Duration of follow-up of functional ovarian structures must not exceed 3 months. The indication for surgery is the lack of positive dynamics (reduction or disappearance of education on ultrasound equipment of the 7-8 days each menstrual cycle for 3 months).

Parovarian cyst - develops from a tubular appendage ovary - paraovariya. Located between the sheets of the broad ligament, intraligamentary, has no legs. Single-sided, smooth, usually small, but sometimes is enormous. Content serous cyst-like transudate. It grows slowly, so it does not manifest itself clinically, also showed more often during routine inspection.

Treatment: surgical.

Endometrioid (chocolate) cyst.

Develops as a result of implantation in the endometrium ovary, listed on the fallopian tubes of the uterus or endometrium from embryonic rudiments. Chocolate cyst is seen as ovarian endometriosis.

Clinically, this cyst is often accompanied by pain, by micro and getting blood in the abdominal cavity. The pain is usually associated with the menstrual cycle, growing before the menstrual period. Also characteristic of tuberculosis. With symptoms of aseptic inflammatory micro formed adhesions with the surrounding peritoneum, uterus, tubes, intestines, etc.

Treatment.Surgery and hormone after examination at the hospital.

Ovarian tumors.

Classification of ovarian tumors (according to WHO international histological classification of 1977):

1. Epithelial tumors:

• serous (cystadenoma and papillary cystadenoma, surface papilloma adenofibroma and cystadenofibroma);

• mucinous (cystadenoma, and adenofibromacystadenofibroma);

• Brenner tumor (benign);

• clear cell or mezonefroidtion (adenofibroma);

• Mixed epithelial tumors (benign).

• stromal sex cord tumors: tech, fibroma.

• Germ cell tumors: dermoid cyst, ovarian goiter.

Screening on ovarian cancer:

1. Gynecological history.

2. Bimanual examination. Defined mass in the uterus, mobility, density, texture, tenderness and size of uterus, parametrial tissue and vaginal vault.

3. Inspection in the mirror.

4. Ultrasound: abdominal or vaginal probe. Allows you to define the nature of space-occupying lesions, up to 97%.

5. CT, MRI - more accurate, layered study. Clarification of lymph node metastases.

6. Study for bowel cancer (sigmoidoscopy, irrigoskopiya), a study of breast (mammography, ultrasound), the study of the endometrium. Since there might be metastatic ovarian cancer (from the stomach - Krukenberg metastases, colon, pancreas), so we must examine the gastrointestinal tract.

Serous cystadenoma - one-way, one-and smooth-. Tumor size of 0.4 cm in diameter, up to 32 cm, an average of 5-16cm. Form smaller tumors are round, is located behind and to the side of the uterus. Its prominent feature is the shift of education on palpation. Treatment: surgical.

Papillary cystadenoma - often has a round, rarely oval. Its size from 1.8 to 12 cm in diameter. The most characteristic feature of serous papillary cystadenoma is the presence on the inner surface of wall dense growths. Treatment: surgical.

Mucinous cystadenoma - large, single-sided, multi-formation with a smooth inner surface. Mucinous cystadenoma small (up to 6 cm in diameter) located posterior to the side of the uterus, and the formation of large (more than 7cm) - above its bottom. The characteristic feature is the presence in its cavity medium or high echogenicity unmixed fine suspension. Treatment: surgical.

Brenner tumor - formed by the surface epithelial metaplasia volfovyh ducts. In most cases the tumor is benign, but there are borderline and malignant tumors. Some tumors estrogenprodutsiruyuschie Brenner, in connection with what is often observed abnormal uterine bleeding. Treatment: surgical.

Fibroid cyst - a benign tumor that develops from its stroma. Swelling round or oval, one-sided, thick, sometimes encrusted with calcium salts, with nodular or smooth surface. Tumor size ranged from microscopic to determine the formation of the head adult. The tumor has a leg,

which creates the conditions for its twisting. Ovarian fibroma usually occurs in women aged 40 - 50 years. Most characteristic of this group of tumors appearance of ascites.Sometimes when ovarian fibroids simultaneously observed hydrothorax with ascites, anemia (triad Meigs). Fibroid cysts in some patients combined with uterine myoma. Treatment: surgical.

Stromal sex cord tumors. This group includes tumors consisting of cells that arise from the sex cord mesenchymal or embryonic gonads. They contain granulosa cells tekakletki, Sertoli cells and Leydig cells. For tumors of sex cord stromal a characteristic clinical picture compared to other ovarian tumors.

Granuleznokletochnaya tumor (follikuloma) arises from the granulosa cells of the follicle or differentiating residual sex cords. A tumor is hormonally active and produce estrogen. Tumor size ranged from microscopic inclusions in the ovary to 40 cm in diameter. Usually marked by abdominal pain, increasing its volume. The girls in these tumors often occurs early puberty, there are uterine bleeding, appear early secondary sexual characteristics: body hair and pubic hair in the armpits, breast enlargement. External genitalia correspond to their development are older. In young women accompanied by the development of tumors temporary amenorrhea.Which is replaced by acyclic bleeding. When angranuleznokletochnoy tumors occur in postmenopausal uterine bleeding. At gynecological examination noteworthy absence of atrophic changes of the external genitalia, the uterus is slightly enlarged, in the appendages defined unilateral, tugoelasticheskoe mobile education.

Diagnostics. Based on the history, the clinical picture of the disease and the detection of ovarian tumors. Main additional method of diagnosis is laparoscopy, in which a biopsy is performed. The final diagnosis after the post mortem examination of removed tumor.

Tactics GPs - the direction to the hospital for surgery.

Tecoma arises from the theca of ovarian tissue and treats estrogenprodutsiruyuschim neoplasms. Tecom up 3.8% of all ovarian tumors. The disease is not much different from the manifestation of granulosa cell tumors. Tecom occur in old age (6D and over). Most tumors are unilateral. Their sizes range from small to the head of the newborn. Shape of the tumor is round or oval, thick consistency. A characteristic feature of this tumor is ascites, which can occur both in benign and malignant disease course. Malignant course Tecom more common at younger ages.

Diagnostics. Urgent morphological study during surgery can correctly identify the nature of the tumor in most patients and decide on the amount of the transaction.

Tactics GPs - the direction to the hospital for surgery.

Androblastoma (adenoblastoma) arises from the rudiments of the gonads with potentially masculine line of development has masculinization property. Masculinization tumors account for 0.4% of all ovarian tumors. Masculinization tumors occur at any age, but most often - in 20 - 30 years and 50 - 70 years. In the clinical course of masculinization of tumors can be identified during the subsequent development defeminizatsii phenomena virilization. In women of reproductive age at onset of menstruation become rare, scarce and pass in amenorrhea. Simultaneously, atrophy of the mammary glands, uterus, infertility, masculine physique is, the

rise of hair on the face, chest, legs. Appear on the face of acne, changes tone of voice, he gets rough. Appear clitorishypertrophy, male-pattern baldness, reduced or disappears sexual feeling. All of these symptoms develop within a few years, sometimes more quickly, within a few months. At gynecological examination determined unilateral dense round or oval formation in size from microscopic to 30 cm in diameter.

Tactics DGPs - the direction to the hospital for surgery.

Dermoid ovarian cyst refers to a mature teratoma and of ovarian tumors occur in 8% of patients. The most common tumor found in the age 20 - 40 years. The general condition of the patient is rarely disturbed. Sometimes there is pain or a feeling of heaviness in the lower abdomen that occur when large amounts of tumor. Dermoid cyst - a unilateral, rarely bilateral education with a smooth surface has a high mobility due to the long legs, which creates favorable conditions for the day of its torsion. Slow growth of the cyst, it usually does not reach large sizes. On palpation defined sections of elastic consistency, which alternate with more dense. A cyst is often in the front arch.

Diagnostics. Mobile detection of ovarian cyst that is located anterior to the uterus, usually suggests a possible dermoid cyst. The diagnosis is confirmed during surgery.

Tactics DGPs - the direction to the hospital for surgery.

Teratoblastoma ovary occurs in childhood and adolescence, accounting for 2 - 2.5% of all malignant ovarian tumors. Teratoblastomy rich in blood vessels, and therefore are often marked hemorrhages under the capsule and into the interior of the tumor. Teratoblastomy more common in women with asthenic physique. Complaints of patients did not show. The main symptom of the disease is to detect tumor formation moving in the pelvis. Often subjected to twisting the leg tumor, might be broken capsule. Teratoblastoma uneven texture is dense, knobby surface. Ascites appears in the advanced stage of the disease. Teratoblastomy metastasis occurs quickly and is mainly hematogenous route.

Tactics DGPs - the direction to the hospital for surgery.

Dysgerminoma - a malignant tumor arising from the undifferentiated gonad elements remaining in the gate ovary during fetal development. Ovarian dysgerminoma is sometimes part of the immature teratoma combined with chorionepithelioma and other malignant elements teratoblastomy. Hormonal activity is not. Dysgerminoma, about 1% of all ovarian tumors. The tumor occurs in young women aged under 30 years, mostly infantile physique. In most patients the poor, infrequent menstruation. When vaginal study determined sided movable tumor dense texture, with nodular surface. Dysgerminoma rapidly growing and metastasizing lymphatic system, organs of the chest cavity, mediastinum, etc.

Diagnostics. Dysgerminoma recognition is very difficult. Along with the clinical signs of the disease (an indication of infantilism) at diagnosis should consider the presence of sex chromatin in the cells of the mucous membranes of the mouth. If these cells are less than 20%, the ovarian tumor Suspiciousdisgerminomu. Usually the diagnosis is made after a morphological study remote preparation. A microscopic examination of the resected tumor are

large round or polygonal shape, with large, moderately hyperchromatic nuclei and pale cytoplasm slightly frothy.

Tactics DGPs - the direction to the hospital for surgery.

Complication of ovarian tumors.

• malignancy.

• ovarian torsion legs.

• Infection and suppuration of ovarian tumors.

• The gap ovarian tumor capsule.

In the case of diagnosis of complications - emergency hospitalization.

Differential diagnosis.

Symptoms	**Diseases**
Pain.	Ectopic pregnancy Spontaneous miscarriage. PID. Appendicitis. Meckel's diverticulum. Devertikulit.
The increase in abdominal circumference	The pregnant uterus. Uterine fibroids. A full bladder. Malignant neoplasms of the ovary. Kollorektalnaya carcinoma.
Symptoms of compression of adjacent organs	urinary tract infection. Constipation.
The influence of hormones produced	dysfunctional uterine bleeding. Precocious puberty. Bleeding in postmenopausal women.

REHABILITATION OF WOMEN AFTER operating period.

With benign ovarian tumors surgery with removal of the tumor is essential for medical tactics. In women of reproductive age such operations are done with maximum preservation of ovarian tissue.

Endocrine and immune disorders in women of reproductive age after surgery for benign ovarian tumors can serve as a backdrop for relapse and the occurrence of other diseases of the reproductive system.

Interrelated violations of these systems contribute to uncontrolled tumor growth. Patients undergoing surgery for benign ovarian tumors should be under medical supervision throughout life.

I stage. Up of women of reproductive age - the first 6 months after surgery.

Active surveillance of patients after surgery using functional diagnostic tests show that the stabilization of the ovaries begins with 4-5 of the menstrual cycle after surgery. Period of adjustment, most operated is limited to 3 months after the removal of the tumor. During this period begins to show one of the response - the body, to compensate for the missing features. In some patients, this is manifested in the form of a slight increase in the resected or intact ovary.

In other patients, there is an increase the size of the ovary up to the emergence of new large cystic formations. Typically, this is the corpus luteum cyst, regress after 1-2 menstrual cycles. If the cystic formation is increased or maintained for 3 menstualnyh cycles, patients should be operated on.

With favorable postoperative period of 4-5 menstrual cycle should check with the survey. In the list of tests required for the survey include, basal temperature, kolpotsitologiya length of cervical mucus, determination of progesterone and prolactin in the II phase of the menstrual cycle. (21-23 days in a 28 day cycle) and conduct ultrasound at 12-13 days (the days of ovulation by basal body temperature) to determine the size of the mature follicle.

It is mandatory examination of mammary (palpation glands, nipples, if necessary - mammography) glands.

If she installed a complete menstrual cycle in the absence of galactorrhea, the patient is subject to monitoring.

In case of violation of the cycle (anovulation, IDLF) and galactorrhea or correction should be started immediately. For correction can be applied to norkolut 1tab. 1 every 16 to 25 days of the cycle for 3-6 months. Combined with pancreatin at 0.5-1.0 x3p 2 a day from 5 to 16 day cycle or estrogen-progestin monophasic preparations (non-ovlon, regulon, Novinet, ovulation, etc.). Contraceptive po1tab mode.a day from the 5th to the 25th day in combination with pancreatin at 0.5-1.0 x 3 times a day from 5 to 16 day cycle.

II stage. When resistant anovulation is recommended to continue treatment ovulation inducers, with galactorrhea - Parlodelum up to 2 years after surgery.Also, a survey by the tests of functional diagnostics, determination of serum elastase, breast examination. In the following stages after surgery every 4-6 months with examination every 6 months.

III stage. 2 years after the operation for the next 2 years, is of particular importance for the greatest number of tumor recurrence, and other diseases of the reproductive system after the operation identified during this period.

IV stage. 4 years after surgery examination every 6 months, 1 time a year a survey by the tests.

The proposed scheme allows to monitorkorregirovat disadvantaged backgrounds, the study contributes to the prevention of various diseases of the reproductive system. Contingent of women undergoing total and subtotal removal of the ovaries, in which clinical signs postcastration syndrome requires corrective therapy with vitamins, sedatives, antipsychotics, and systemic hormone. therapy (HRT).

A significant number of women currently undergoing bilateral oophorectomy, especially in perimenopause. Surgical off ovarian function leads to complex reactions in the endocrine system. Lack of adaptation of the female body to shut down the ovaries leads to postovariektomicheskomu syndrome observed in 50-80% of cases. Simultaneous off ovarian function causes a more rapid development of the symptoms of menopause and more severe for them. Direct correlation postovariektomicheskogo syndrome severity on the frequency of extragenital pathology.

Dominant syndrome are manifestations of somatic vegetative disorders (hot flashes, intense suspense, a sense of inner experience), irritability, anxiety, emotional instability, hypochondriacal experiences.

Morphological studies show atrophic changes in the epithelium of the cervix and vagina.

Changes the status of bone metabolism, dominated by the processes of resorptionresynthesis, leading to reduced bone density. Currently, the main method of treatment and prevention of the syndrome is a therapy postovariektomii female sex steroids. Hormone treatment is carried out in the absence of contraindications to their use, which include severe damage to the kidneys, liver, embolic lesions, estrogen-dependent tumors of the breast, uterus, kidney, malignant melanoma, indications of breast cancer or uterine sister or mother, bleeding of unknown origin, untreated genital tumors, meningioma.

Hormone replacement therapy (HRT) is a pathogenetically justified to treat patients undergoing oophorectomy at reproductive age. HRT right after surgery contributes to the smooth adaptation to the conditions of female sex hormones ostrovoznikayuschego deficit and prevent the syndrome postovariektomii.

In the world of practice is most common for this purpose the use of natural hormones and their analogues. Some researchers used antidepressants (Zoloft, tianeptine) with severity of depression.

Prevention: Prevention of benign ovarian tumors should begin in childhood, and is performed by healthy girls with correction functions of all vital organs. In the period of reproduction and puberty - timely diagnosis and treatment of menstrual disorders.

Primary prevention may be to correct anovulation and hyper-ovulation (for example, using hormonal contraception in women older than 40 years). In any case, recent epidemiological data, summarizing the experience of long-term observations of several major international centers for long-term use of combined hormonal contraception, clearly showed a significant reduction in the incidence of ovarian cancer and endometrial cancer among women using this form of contraception.

Secondary prevention is reduced to the timely identification of benign and borderline ovarian tumors and their surgical treatment.

Recovery rate menstrual disorders including hormonal status: If insufficient luteal phase of the cycle Duphaston (1 tablet 2 times a day) with a 14-16 day cycle, for 10-12 days at least 6 months. When giperestrogeneemiimikrodoznyh COC use (Novinet, Lindinet-20 Logest) in the 21-day mode with a 7-day intervals for at least 6 months.

Appendix № 1

Working in small groups, "Who is better, who is faster."

The teacher divides the group into two subgroups calculation 1,2,1,2,1,2 etc.

first numbers are the first group of the second - the second. Given a task: to list the main clinical, laboratory, tool, diagnostic criteria for ovarian cystic formations.Drawn by lot by the task of "cysts", "cystoma." We give everyone time to prepare. In the group of students at the end of the job of publicity elect a representative answers.

The rival group is an expert with the teacher .. Discussion of responses (instruction 5 min., Divide into groups 10 min., Presentation by - 10 minutes discussion, 10 min.) Correctly answer the group encouraged the winner. Discussion of criteria for medical and hospital management of cysts, and complications of ovarian cysts.

5. The analytical part of

Situational problem number one

Patient 67 years complains of shortness of breath, weakness, aversion to meat food, vomiting after eating, weight loss the past few months, increasing abdominal patient exhausted.

OBJECTIVE: belly frog form, above the vagina and the sloping ground with percussion marked blunting sound, abdominal circumference 103 cm

PV: The uterus is small in the rectovaginal space defined spikes, parametrial tissue infiltration. Infiltrated the appendages, is sensitive in the study, with both sides determined education without clear contours value 10h10h12 see Discharge light. The neck is in the mirrors clean.

Questions:

1. Diagnosis

2. Survey methods GPs

3. Tactics GPs

Reply to:

1. Ovarian tumor.

2. Ultrasound genitals, computerized tomography, gastrofibroduodenoskopiya.

3. Referral to a hospital for surgery.

Situational problem number 2.

Patient 59 years complains of bleeding from the genital tract in the form of menstruation, which occurred after 5 years of menopause, the vaginal examination mucosa pink, not atrophic. The uterus is normal size. The right to education is palpable adnexal ovoid shape 10x12 cm, dense consistency, mobile, painless. On the left appendages are not defined. Allocation sukrovichnye, dark.

Questions:

1. Diagnosis

2. Plan inspaction

3. Tactics DGPs

Answers:

1. Hormone producing ovarian tumor.

2. UZD, TFD, general.an blood biochemical analyzes.

3. Referral to a hospital for surgery.

Topics № 16: Acute abdomen in gynecology: ectopic pregnancy, ovarian apoplexy, torsion of the leg of the ovarian cyst. Injuries to the genitals. Diagnosis and tactics of reference.

Acute abdomen is a syndrome manifested by pain in the abdomen, muscle tension of the anterior abdominal wall and also nausea, vomiting, abdominal distention, violation of the character of the stool, change in blood pressure, pulse, color of the skin. When the process is neglected, practically with all forms of OC, individual features of the disease are erased, the predominant manifestations are peritonitis and intoxication.

OW in the clinic is found both in gynecological and in surgical practice, which necessitates the knowledge of a clear clinical picture of a number of diseases in which the coolant arises.

So, in gynecological practice, an acute abdomen can occur with the following diseases:

Ectopic pregnancy (impaired)

Ovarian apoplexy

Acute inflammation of the uterus

Torsion of leg of ovarian cyst

Necrosis or torsion of the legs of the myomatous node

Atresia of the vagina, hymen, hematosalpinx.

The clinic and diagnosis of progressive tubal pregnancy is similar to that of a progressive uterine pregnancy, so it is difficult to establish a diagnosis. The woman appears dubious and likely signs of pregnancy. When collecting anamnesis, it is possible to identify risk factors for the onset of ectopic pregnancy. Gynecological examination can detect a small cyanosis of the vaginal mucosa and cervix. With a two-handed vaginal examination, softening of the uterine isthmus and enlargement of the uterus body can be detected. In the area of appendages on one side or posteriorly, the tumor-like formation of a soft ovoid consistency, slightly painful upon palpation, can be determined.

In those cases when the final diagnosis can not be established on the basis of clinical and ultrasound studies, chorionic gonadotropin (HG) in the urine and blood of the patient is determined.

Fig. Possible variants of ectopic pregnancy.

HC is excreted in the urine already on the 8th day after fertilization. With ectopic pregnancy, the production of HG is reduced in comparison with that of uterine pregnancy. The diagnosis of ectopic pregnancy is refined with laparoscopy.

Termination of pregnancy can occur by the type of rupture of the uterine tube or tubal abortion.

Symptoms and signs of interrupted and progressing ectopic pregnancy

Differential diagnosis of ectopic pregnancy:

Progressive tubal pregnancy from uterine pregnancy

Pipe abortion with interruption of uterine pregnancy

Inflammation of the uterus or DMC in the reproductive period

Ovarian apoplexy

Torsion of the legs of the cyst or ovarian tumor

Rupture of the tube with apoplexy of the ovary, peritonitis, trauma of the liver and spleen

Treatment for ectopic pregnancy complex, phased:

Operation - stop bleeding;

Restoring blood loss and fighting shock;

Rehabilitation of reproductive function.

Apoplexy of the ovary (rupture of the ovary) - a sudden onset of hemorrhage accompanied by a violation of the integrity of the ovarian tissue and bleeding into the abdominal region. Among the causes of intra-abdominal hemorrhage, 0.5-2.5% is due to ovarian apoplexy. Pregnancy, menstruation, sexual arousal cause hyperemia of the pelvic organs. The most typical days for apoplexy of the ovary are from the 12th to the 18th day of the menstrual cycle. Bleeding from the ovary is preceded by the formation of a hematoma, which causes severe pain due to the

increase in intraocular pressure. Then there is a break in the tissue of the ovary, which can lead to profuse bleeding. Apoplexy of the ovary is accompanied by acute pain in the lower abdomen, a frequent pulse, the phenomenon of shock with syncope, sometimes the discharge of serous fluid from the mammary glands, dirty-chocolate discharge from the vagina, which may appear after delay in menstruation. The pain can be constant, cramping, stitching. Complaints about general weakness, dizziness, headache, nausea, vomiting, frequent urination, urges to act of defecation.

Examination: the tension of the anterior abdominal wall, Unclear symptoms of irritation of the peritoneum, a positive symptom of Schetkin-Blumberg. The pain radiates into the anus, the groin, the external genitalia, the sacrum, and the legs.

When the vaginal examination the uterus is not enlarged, the ovary is enlarged sharply painful upon palpation. The analysis of a blood more often within the limits of norm.

On ultrasound: the uterus of usual sizes, transformation of the endometrium - 2 phase, effusion in the posterior fornix. In the diagnosis helps to study the history and results of objective research. Urine analysis for CH is negative. In unclear cases, laparoscopy is indicated.

With significant bleeding, surgery is shown - resection or ovary repair, as conservative as possible.

Torsion of leg of ovarian cyst

The clinical picture of torsion of the leg of the ovarian cyst depends on how quickly it has occurred and how many degrees it has occurred.

Torsion to 180 degrees can pass without a trace. When torsion by 270 g. compressed easily veins, the flow of blood is preserved. Gradual blood pressure in the tumor leads to impregnation with blood. The hemorrhagic fluid accumulates in the abdominal cavity. At full 360 gr. twisting the legs of the cyst, blood flow stops, which quickly leads to its necrosis, and then to the development of peritonitis.

The disease begins with a sharp pain in the lower abdomen of the pulling character, irradiating into the groin, the sacrum, into the anus, nausea, vomiting, and fever. Sometimes the pain is accompanied by a picture of shock and faintness.

The skin is pale, a cold sweat appears. The tongue is dry, coated with white coating. The abdomen is tense, painful especially on the side of the tumor process. Symptom Shchetkin-Blumberg positive on the side of the tumor. The pulse is rapid, weak filling, blood pressure is within normal limits. There is a leukocytosis, which is growing in dynamics. Ultrasound is determined by formation, often with signs of perifocal inflammation, an effusion in the posterior arch is possible.

From the anamnesis - frequent inflammatory diseases of appendages, ovarian cyst.

With vaginal examination, a tumor-like formation is determined from the sides, painful, tense, limited in mobility, flattening and soreness of the arches at the site of tumor localization.

Acute inflammation of the uterus

The disease develops gradually, against the background of a previous gynecological disease. The patient notes pain, nedomaganie, general weakness, fever. The pain of a pulling, aching character, radiating into the groin and the sacrum, then the temperature rises. Often, the aggravation of the process provokes menstruation.

Skin and visible mucous membranes are pink, sometimes with a grayish hue, the tongue is dry, coated with a white coating. Nausea, vomiting, frequent urination, tenesmus. Blood pressure within normal limits, pulse rate, moderate leukocytosis, increased ESR.

On examination, the abdomen is painful and tense in the lower parts, the symptom of Shchetkin-Blumberg is positive over the womb.

With gynecological examination, cyanosis of the vagina and cervix of the uterus is determined, the secretions are pusiform, but may also be mucous. Attachments are painful. The soreness of the posterior fornix is determined. When the pelvioperitonitis is attached, the temperature is sharply increased, a periodic chill, a frequent intense pulse. The stomach is swollen, does not take an active part in the act of breathing. The symptom of Schetkina-Blumberg is sharply positive throughout the abdomen, especially in the hypogastrium. The condition becomes heavy, there is a delay of gases, stools, urination is impaired. Also high leukocytosis, a shift of the formula to the left, the phenomena of toxic anemia are noted.

Necrosis or torsion of the legs of the myomatous node

As a rule, it occurs in women who have uterine fibroids. Suddenly, the general condition worsens, there is a headache, nausea, vomiting, poor appetite. Often there is a chill, the temperature rises to a high figure of 39 grams. There is a strong pain in the lower abdomen of a pulling or cramping character. The tongue is dry, coated with white coating. The abdomen is tense, painful in hypogastrium. Symptom Shchetkin-Blumberg positive in the lower abdomen. When the vaginal examination, the uterus is enlarged in size, tuberous, painful over the whole surface, a knot on the stalk is determined separately, painful, often restricted in mobility. In peripheral blood leukocytosis, shift the formula to the left, increase ESR. Leukocytosis in the dynamics of increasing.

Differential diagnosis of the "acute abdomen" in surgery

When developing signs of an "acute abdomen" it is necessary to carry out a differential diagnosis with diseases:

Appendicitis

Diseases of the thoracic cavity: right-sided pneumonia, pleurisy and exudative pericarditis, acute right ventricular failure, myocardial infarction;

Kidney diseases: acute hydronephrosis, thrombosis of renal veins, renal colic.

Diseases of the gastrointestinal tract: acute gastroenteritis, pancreatitis, cholecystitis, hepatic colic, perforation of the stomach ulcer and duodenum, gall bladder, intestinal obstruction, Crohn's disease, acute diabetic stomach, intestinal colic.

Thrombosis and embolism of mesenteric arteries, rupture of an aneurysm of the abdominal aorta.

New pedagogical methods used in this lesson:

Annex 1

Discussion - used at the stage of discussing homework and determining the initial knowledge of students.

Questions / answers.

Appendix 2

Game: Lottery

Students choose lottery numbers and take a pre-prepared card with questions on the corresponding number.

What is meant by the term "acute stomach"?

Acute abdomen is a complex complex of symptoms, in which the leading symptom is sudden pain in any part of the abdomen, accompanied by peritoneal symptoms and marked changes in the patient's condition.

What diseases lead to an acute abdomen in gynecology?

In gynecological practice, an acute abdomen can occur in the following diseases.

Ectopic pregnancy (impaired).

Apoplexy of the ovary.

Acute inflammation of the uterine appendages.

Torsion of the legs of the ovarian cyst.

Necrosis or torsion of the leg of the mammal node.

Atresia of the vagina, hymen, hematosalpinx,

Clinic of an acute abdomen?

The acute abdomen is a symptomatic complex manifested by abdominal pain, muscle strain of the anterior abdominal wall and also sometimes nausea, vomiting, bloating, a violation of the character of the stool, changes in the blood pressure, pulse, color of the skin. When the process is neglected, practically with all forms of OC, individual features of the disease are erased, the predominant manifestations are peritonitis and intoxication.

Types of an acute abdomen?

There are true and false coolants. So, true OZH is a symptom complex that occurs in acute diseases of the abdominal cavity organs (in surgery, gynecology). False OZH occurs with diseases of the chest (myocardial infarction, pneumonia, pleurisy).

In medical practice, it is necessary to clearly distinguish between these two concepts. So, in cases of true OC, emergency surgical care is required, in cases of false OJ, surgical intervention is highly contraindicated.

Causes of pain syndrome?

In acute abdominal pathology, the tension of the abdominal muscles occurs as a result of stimulation of the autonomic nerves with the subsequent transfer of these stimuli to the intercostal nerves, as well as due to irritation of the parietal peritoneum and innervating intercostal nerves.

Symptoms of an ectopic pregnancy?

OZH Clinic. as a rule, develops with interrupted tubal (rarely ovarian) pregnancy. The patient complains of sharp (acute) pain in the abdomen, radiating into the anus, lower back, genitals, general weakness, dizziness, often loss of consciousness.

Tactics GP in an acute abdomen?

(i) Emergency hospitalization

8. What are the features of gynecological examination of patients with the clinic of an acute abdomen?

After finding out the complaints and collecting the anamnesis, proceed to a thorough general examination of the patient with a subsequent gynecological examination:

examination of the cervix in the mirrors (discharge from the cervical canal, cyanosis or hyperemia of the vaginal mucosa and cervix);

bimanual examination (the consistency of the cervix, the soreness of traction for it, the condition of the external throat, the size of the uterus and appendages, their mobility, soreness, the presence of pathological formations in the appendages, the state of the vaginal vaults).

Soreness in the displacement of the cervix and the shortening and soreness of the vaginal arches are characteristic for intra-abdominal bleeding, acute inflammation with pelvicperitoneal phenomena.

The enlarged tuberous uterus is revealed with myomas, and some of its nodes during palpation can be sharply painful, which indicates a violation of blood circulation and necrosis.

In the presence of a sharply painful formation away from the uterus (in the appendages), it is possible to suspect a torsion of the leg of the ovarian tumor or the subserous myomatous node.

With a disrupted ectopic pregnancy, the appendages are thickened, pasty and painful on the part of the disease, the uterus is somewhat enlarged, soft, mobile (a symptom of the "floating" uterus).

With apoplexy of the ovary, the appendages on the part of the disease often can not be palpated clearly, their area is sharply painful.

4.3. Analytical part

PROBLEMLY ORIENTED TRAINING

on topic: Acute abdominal pain

(handouts for teachers and students)

I. Pedagogical Annotation

Subject: "Obstetrics and Gynecology"

Subject: "Acute abdominal pain"

Objective To develop the ability to assess and analyze the situation when women of reproductive age enter with a pain in the abdomen. Elaboration of skills in choosing tactics, diagnosis, provision of emergency care and rational transportation of patients with abdominal pain at the level of primary care using evidence-based medicine.

Planned learning outcomes - by results of work students acquire skills:

Correct search and selection of information on sites of evidence-based medicine

Compiling questions using the abbreviation PICO

Assessment and analysis of the problematic situation when women of reproductive age are treated with abdominal pain

Development of an algorithm for resolving a problem situation for the diagnosis.

The right choice and decision-making on the tactics of conducting in the conditions of SVP and GWP

Be able to conduct a qualified post-hospital rehabilitation.

For successful decision, the student should know

The range of common and dangerous diseases, accompanied by abdominal pain in women of reproductive age.

Carry out differential diagnosis and determine the most likely causes of abdominal pain.

List the methods of diagnosis, draw up and justify a survey plan at the level of SVP and CRH.

Make correct information search based on evidence-based medicine

Justify the need for consultations of narrow specialists, hospitalizations and the profile of the medical institution.

Determine the degree of need for follow-up (drug and non-drug treatment)

This problem reflects the real situation in the primary care setting

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Medical library of the server Medlinks.ru http://www.medlinks.ru/topics.php

Themes №17: Injuries and anomaly of the genitals. Diagnosis. The tactics of vednnia.

Classification of traumatic injuries of female genital organs.

1. Foreign bodies.

2. Fresh wounds and damage to the genitals:

- fresh injuries, depending on the sexual intercourse;

- fresh injuries, not dependent on sexual intercourse,

- injuries caused by cutting and stabbing objects and firearms;

- burns;

3. Old lesions of genital organs and their cicatricial changes:

- damage to the perineum and vagina;

- damage to the uterus;

4. Genitourinary and intestinal fistula.

Foreign bodies can enter the vagina when:

- rendering sick medical aid (uterine rings (pessaries), gauze and cotton swabs);

- use of contraceptives - male and female condoms;

- with the introduction of various items into the vagina for the purpose of abortion, masturbation, etc.

Damage to the hymen occurs, as a rule, at the first sexual intercourse - defloration. The ruptures of the edges of the hymen in this case are shallow and are accompanied by a slight bleeding. Sometimes at the first sexual intercourse

The hymen comes to its base and is accompanied by heavy bleeding. The causes of this pathological rupture are the excessive strength (stiffness) of the hymen, its fleshiness, the underdevelopment of the genital organs, and excessive physical influence in cases of coarseness and violence.

Damage to the vagina occurs due to underdevelopment of a decrease in elasticity or excessive softening of the walls.

Symptoms of ruptures of the genital organs due to sexual intercourse are pain and bleeding, sometimes very profuse. The causes of bleeding are ruptured veins, cavernous lacunae, arterial branches.

Assisting a woman who has been raped. During the examination of the injured, in addition to the doctor, the presence of witnesses (women) is necessary. It is necessary to document the

victim's story in detail. Time of rape. Number and characteristics of the attackers. Attempts to insert something into the vagina, rectum or mouth. Did the victim observe ejaculation. Did the victim produce any manipulations that could destroy or change evidence of rape: taking a bath or shower, rubbing, using tampons, holding oral hygiene, defecating, changing clothes. It is necessary to document in the documents the presence of any damage, including those that affect the oral cavity and the vagina. Postcoital contraception can be performed using tablets containing ethinylestradiol. If more than 72 hours have elapsed after rape, but less than 3 days, IUDs can be used as a contraceptive. You should always take the material for investigation for Chlamydia, Gonorrhea and Trichomonas infection. For the proof in court, a positive result of bacteriological isolation of chlamydia (and not only an ELISA or PCR) is necessary. It is necessary to appoint a test for HIV infection and hepatitis B. If a patient has a wound, you can prescribe tetanus toxoid (you should not forget about injuries to the rectum and vagina!). If there is a suspicion that the offender could be a carrier of sexually transmitted diseases, or at the request of the victim, antibiotics should be prescribed for the prevention. After 4 weeks, a repeated examination of the victim is necessary. If a preventive course of antibiotics is not prescribed, it is necessary to take the material for examination for the possibility of an infectious process. Serological analysis of blood for syphilis should be prescribed 4-8 weeks after the rape. Serological analysis of blood for HIV infection 3-6 months after the rape should be repeated. Victims should be consulted by a psychiatrist.

Genitourinary fistula. A fistula is an artificial stroke formed between two adjacent hollow or hollow organs and external skin integuments. There are the following fistulas:

- Cystic fistulas: vesical-vaginal, vesicle-uterine, vesical-pridatkovye;

- ureteric fistulas: ureteric, ureteric-vaginal, ureteric-uterus;

- urethrovaginal, urethro-vaginal fistula;

- combined fistulas: urogenital, urolithic

- complex urogenital fistulas.

The causes of fistula are varied. These include:

- birth injury;

- trauma to the genitourinary organs and intestines during operations and manipulations;

- developmental anomalies,

- malignant neoplasms in the stage of tumor disintegration;

- radiation damage,

- Breakthrough of pus or other pathological product from the uterine appendages into the urinary organs, vagina or intestine;

- tuberculosis in the lower intestine;

- accidental injuries with damage to the walls of each of the adjacent organs. Genitourinary fistulas occur much more frequently kishechnopolovyh because the urethra and the isthmus bladder located behind the pubic arch easily pressed thereto to insert in a small basin head sigmoid same and rectum are more favorable, because they are protected from the fetal head pressure .

The main symptoms of fistula include the following:

- incontinence of urine and feces;

- inflammation of the vulva, vagina, bladder, in the overlying parts of the urinary system - in the ureter, the renal pelvis, in renal parenchyma;

- with fistulous holes between the cavity of the abscess (pyosalpinx, abscess of the rectum-uterine cavity, etc.) and the vagina; from the latter follows pus. Even during the collection of anamnesis, it is possible to establish the presence of the fistula and its character, localization, and dimensions. A fistula with a large diameter is also detected with a simple examination using mirrors or a two-hand vaginal examination. You can use the sounding of the fistulous passage through the vagina, a test with the filling of the bladder. For this administered about 200 ml of sterile, coloring, disinfecting substances (rivanol1: 1000, methylene blue 1: 2000, potassium permanganate 1: 1000). When examining the vagina with the help of mirrors, fluid leakage from the fistula opening is detected, thus its location and dimensions are determined. Still can be defined by means of a cystoscopy and chromocystoscopy, fistulography.

Treatment is only prompt. The operation is performed no earlier than 4-6 months after the formation of the fistula. In the postoperative period, appoint a permanent catheter, wash the bladder with solutions of antiseptics, antibiotics.

Dull injury of external genitalia. Blunt trauma occurs due to blunt objects (bruising) or indirectly (with bone pelvis damage, gunshot wound, etc.). As a result of such injuries, the hematoma most often develops, which depending on the site of the injury can be formed in the area of the external genitalia, perineum, into the vagina. In the place of injury there is pain, sometimes unbearable; urination becomes frequent and painful. When the hematoma spreads to the cecal and okolovagalischnuyu cellulose appear tenesmus, difficulties with urination and defecation. The swelling at the site of the injury acquires a bluish-black or bluish-red color. When the hematoma spreads through the cellulose, the phenomena of acute anemia, in spite of the absence of external bleeding, come first. Hematoma is recognized by examining the external genitalia, finger examination of the vagina.

Treatment in the first place should be aimed at stopping bleeding, preserving the integrity of the cover of the hematoma, to avoid its infection, to reduce pain. To this end, prescribe rest, anesthetics, an ice pack. If the hematoma builds up together with the phenomena of anemia, then it is opened with a wide medial incision, the clots are removed, the bleeding vessels are stitched. The cavity of the hematoma is drained. Preventive prescribe antibiotics. With significant blood loss, the volume of BCC is replenished.

Recognition of foreign bodies in the vagina is based on a gynecological examination with the help of mirrors and finger, and presents no difficulties.

Treatment consists in removal of a foreign body, the appointment of poorly disinfecting syringings with a solution of potassium permanganate-potassium 1: 4000-1: 6000 or other antiseptics. Vaginal walls are usually torn in the upper third in the region of the posterior or one of the lateral arches. With a deep rupture of the lateral wall of the vagina, the pelvic tissue is exposed.

The prognosis with proper and timely treatment is favorable. This group includes damage caused during various medical manipulations: with a deep expansion of the cervical canal by metal dilators, accidental injuries of the bladder, ureter, uterus during surgery.

The wounds of the clitoris due to the saturation of this organ with blood vessels are extremely dangerous, as they are accompanied by severe bleeding, and therefore require urgent surgical treatment.

Burns of the vulva, vagina and cervix appear as a result of vaginal douches with hot water or an overdose of disinfectants.

Cicatricial deformity of the cervix arises when the ruptures were not sewn and when they were healed by secondary tension.

Symptoms of old cervical ruptures are leucorrhea, infertility, miscarriage. Violations of the menstrual cycle, pain in the lower abdomen and lumbar region. Features of injuries in girls are injuries of the vulva and vagina due to falling on sharp, cutting and stabbing objects, as well as burn injuries due to carelessness of parents (boiling water, open fire).

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Topics № 18: Protection of reproductive health. Reproductive health and family planning, counseling. Advice on marriage.

Reproductive health: IUD- small bending device, carried in cavity of the womb. The Modern varieties are made from plastic arts and contains the medicinal preparation (slowly liberate the small quantities coopers or progestine). The Development intrauterus to contraceptions is connected with offer R. Richter (1909) carry in cavity of the womb ring, made from gut silk hearts.

The Categorization modern IUD:

- Inert:Lippes Loop
- (copper): Copper T 380A, Nova T and Multiload 375
- Selecting progestine: Progestaserd and Levo Nova (LNG), MIRENA

Mechanism kontraseptional actions IUD definitively not studied, exists several theories:

- theory semen-toksic of the action ion cooper;
- theory of the abortion action;
- theory of the speed peristalsis of the uterine pipes;
- theory of the aseptic inflammation;
- theory of the enzymatic breaches;
- theory of the suppression to functional activity endometrial cover.

The Evidences to using VMS:

1. Woman any reproductional age and with any amount of pregnancy in anamnesis, wanting high effection of the long-term method to contraceptions, not requiring daily action.
2. Woman successfully used IUD in past
3. Feeding mother, needing for contraceptions
4. Woman after sort, not feeding bosom
5. Patients after abortion, not having sign to pelvic infection
6. Woman, who can not remember the tablets about daily receiving.

7. Womans having one constant partner (since is absent the risk of the arising the diseases, sent sexual by way).
8. Woman, preferring not to use hormonal of the facility, or one, must not their use (for instance, active smokers senior 35 years)

Advantage

1. High efficiency (0,5-1,0 pregnancy on 100 womans for first year of the use for Copper T 380A)
2. Efficient immediately
3. Long-term method (IUD Copper T 380A efficient up to 10 years)
4. is Not connected with sexual by act
5. does Not influence upon nursing by bosom
6. Immediate return фертильности after removing
7. Little side effects
8. Except послеустановочного of the visit, patients follows be shown physician only in the event of arising the problems
9. Patientse no need nothing buy or keep in stock
10. Can be entered by special nurse or midwife
11. Inexpensive method (Copper T 380A)

Nekontraceptivnye advantage

1. Reduction of the menstrual pains (only progestiv)
2. Reduction of the menstrual bleeding (only progestiv)
3. Reduction of the risk ectopic to pregnancy (with the exclusion of Progestaserd)

Defect:

1. Before entering is required pelvic checkup and is recommended examination on IPP
2. Required presence prepared medical worker for entering and removing
3. Need of the check tendril to spirals after menstruation, being accompanied pain, fight or smearing blooding by separations
4. Woman can not itself stop use (depends on medical worker)
5. Reinforcement of the menstrual bleedings and pains in first several months (only for copper IUD)
6. Possible spontaneous ekspultion
7. Seldom <1/100 events) happens perforation of the womb during introduction
8. Does Not prevent all extrauteral to pregnancy
9. Can enlarge risk of the inflammatory diseases organ basin (IDOP) with following sterility beside womans, falling into group of the risk of the contamination IST and other DST (for instance, VGV, VICH/AIDS DISEASE)

When begin

1. Anytime, when there is confidence that patient not pregnant
2. With 1-go on 7-y day of the menstrual cycle
3. After sort (right after; at the first 48 hours or after 4-6 weeks; after 6 months if uses MOTHER)
4. After abortion (immediately or for 7 days) if no sign to pelvic infection
5. After cessation of the use of other method

Explanation way of the using

Act as follows

1.After inserting IUD plan together with woman her(its) repeated visit through 3-6 weeks - for instance, after menstruation - for checking and ginecological of the checkup. To be certified, on place IUD and no infections. The Visit possible to appoint to any suitable time for women(woman), but not at period of the menstruations. Hereon the repeated visit other visits are not required.

2.Make sure that woman knows:

- What type VMS she uses and as this type IUD looks.

- When she follows to delete or change IUD. Date card with writing the month and year of the installation IUD
- When visit the medical institutions woman must report medical workman on that that beside it is installed IUD

Instructions

The Woman must know that after installing IUD:

1. Beside it can be:
   - Painful spasms during 1-2 days following installing. Possible take NAIP (the ibuprofen, nimesil)
   - Vaginal separations during several weeks after installing. This orderly.
   - More Ample menstruations. The Possible bleedings between menstruation, particularly during the first several months after installing IUD.
2. Checking the position IUD.
   - Once at week for the first month after installing
   - after menstruation Now and then.

For checking the position IUD woman must:

1. To wash up hands.
2. Sit down on skatting.
3. As possible deeper ca66rry in vagina 1 or 2 fingers while she will not find the threads IUD. If woman seems that IUD was displaced, necessary once again to apply to medical institution.

It is impossible pull for thread - can bring about output IUD from cavity of the womb

4. Once again wash up hands

When installing IUD after sort of the threads not always are beyond the scope of shakes of the womb so their possible not to find.

The Conditions requiring precautionary measure (the contraindications)

Absolute:

- Pregnancy (known or suspected) HOofPHS class 4
- Unexplained vaginal bleeding (before clarification of the reasons) HOofPHS class 4
- IDBB (at present or the last 3 months) HOofPHS class 4
- Strong festering (the purulent) of the separation HOofPHS class 4
- Deformed cavity of the womb (the fibroid or anatomical anomalies such as double womb) HOofPHS class 4
- Tuberculosis (the known pelvic tuberculosis) HOofPHS class 4
- Cancer of genitalis (the shakes of the womb, endomeyrial or gonad) HOofPHS class 4
- Woman, having more one partner or whose partner has more one sexual of the partner HOofPHS class 3

Relative:

- Cervikal stenosis.
- Diseases shelters, anemia
- Painful menstruations
- Erosion shakes wombs
- Ekstragenital diseases
- Residiv inflammatory processes of the womb and her(its) apurtenance
- allergy on copper

Side effects

1. Amenoreya - exclude pregnancy and генитальную pathology More
- typical of progestin IUD
2. Irregular bleedings - conduct ginecological checkup to exclude:
- pregnancy uterine or extrauterine
- a disease shakes wombs

- IDBB
If required conduct treatment revealled to pathology
- becalm woman, these change the nature of the menstrual bleedings Normal phenomena and since time they, probably, decrease
- If there is anemia to conduct course of the treatment
3. Bleeding
Conduct ginecological checkup to exclude:
- pregnancy uterine or extrauterine
- a disease shakes wombs
- IDBB
If required conduct the treatment revealled pathology to ask the woman. Wants leave IUD
- If yes, give NAIP, ferriferous preparations and repeated consultancy in 3 months
- If no, delete VMS and help to choose other method to contraceptions
4. Pains
- A TIE position IUD in cavities of the womb
- a checkup organ small basin to exclude pregnancy, IDBB.
- fix NAIP
5. Partner complains of sensation tendril during sexual of the act - a threads possible to cut shorter

Problem a Complication

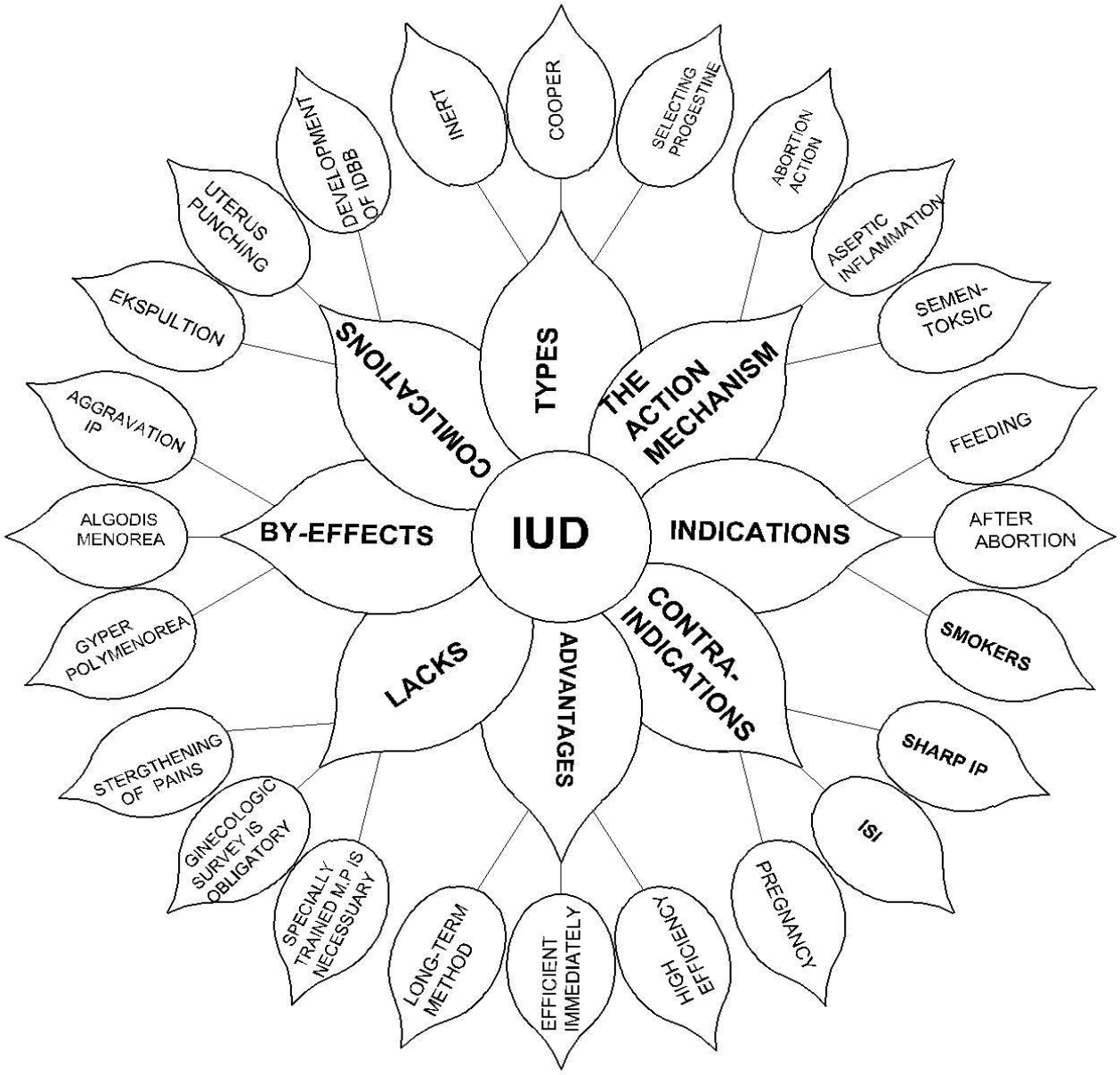
1. Absence tendril - conduct checkup, TIE for revealing the position and presence IUD in cavities of the womb
2. Pelvic infection - conduct treatment
3. Vaginal separations - conduct treatment
4. Suspicion on perforation checking, at presence sign internal bleeding emergency operative interference sew perforative of the hole.

The appendix 1: Organayzer "Lotus"

The Teacher is done group on 2 subgroups by calculation 1,2,1,2, and etc. All are 1 number form the first group and change in left half of the auditoriums, all 2 numbers - a second group - in shift to the right.
It Is Given task: Who quicker will fill the flower лотос using trace given about IUD:

1. Types VMS
2. Advantage VMS
3. The Defect VMS and etc.

Then time is given for training 10 min. for writing the answer of the group in worker of the tetrad. In group students on completion of the task choose the representative for оглашения answer. The Rival group together are an expert.
Discussing the answer.
(The Briefing -5 mines. Division by groups - 5 mines. Time for training -10 mines, appearance - 10 minutes.)
It is Correct answered group is encouraged and declared by winner.



The appendix 2

The role plays on consultancy IUD

The Group is divided on 3 subgroups for practical persons of the undertaking the consultancy patients on 3-h stages:

- on use IUD
- directly before procedure of the introduction IUD
- on the following acceptance.

The Participant is given 20 mines on discussion stage and practical person of the consultancy patients on different stages. On poster are written main moments, which it is necessary to concern, conducting consultancy on each stage. Then, each subgroup presents the consultancy on given by her stage (the role play) before rest group in current 30 mines (10 mines each). The Teacher renders aid subgroup if they have a problems, or makes clear that moments, which were ill-defined are worded.

Refer to. The Scholastic manual to consultancy and technology of the introduction/removing IUD

The appendix 3: Analysis side effect IUD. Group is divided on 3 subgroups on 3-4 persons and each group is offered analyse the events, concerning side effect, complications when use IUD, rendering help and evidences to his(its) removing.
Situation 1 - a Pains after entering
Situation 2 – Giperpolimenoreya
Situation 3 - Pregnancy and IUD
After 15-minute discussion representative from each subgroup presents the results before the whole group. The opinion of the rest group is Heard with offered a variant of the decision. The Teacher answers the appeared questions and explains to vaguenesses.

8.2 Analytical part

Situational problem 1

Pacientka 20 years, beside it 6-month girl. She with husband does not want to have a child in the following 3-h years. Her(its) girlfriend has said her that her(its) mother and grandmother not pregnancy for 2 years after sort. She heard by radio that IUD is an efficient method to contraceptions. She shoulds like to little more learn of this method, as well as about that that has said the girlfriend and wants his(its) use. The Husband agree that they do not follow to have an children during 2-3 years

Question:

1. Tactics squall
2. Methods of the study
3. Interpretation analysis
4. The most Further tactics squall

Answer:

1. Consultancy on all method of the contraceptions and on method IUD, tell about that that can pregnancy in the near future
2. Checkup in mirror bimanual checkup, general blood test, analysis of the separations from 3-h point
3. Normal factors Hb (as well as at anomies 1 cl.), at degree of the purity vagina 1st and 2 cl.) are an evidence of the introduction IUD
4. Introduction IUD

Situational problem 2

Womans 35 years, applied to household polyclinic with complaint on pains and ample and long menstruations in current 3-h months. Objective: skin and visible mucuose pale. From anamnesis: mensis on 7-8 days regular, in 28 days. Pregnancy-5, rody-3, abortov-2. in mirror: the lower pole and tendrils IUD.
Rv: body of the womb of the normal value, painlessly, area apurtenance - w/f. The Separations bleeding moderate.
The Question:

1. Diagnosis
2. Methods of the study
3. The Tactics squall

Answer:

1. Ekspultion IUD. Anemia
2. General blood test
3. Removing IUD, antianemik treatment, protection by other methods to contraceptions after undertaking the consultancy

Themes № 19: Types of contraceptives

Analysis on step, with teacher, manual to technology of the introduction and removing IUD.

Consultancy on VMS

Steps / problems	
Consultancy before introduction	
1. Greets woman valid and well-disposed	
2. Asks patients about her(its) reproductive purpose	
3. If consultation on IUD was not organized, organizes the consultation before performing the procedure.	
4. Elaborates that chosen patients method to contraceptions - IUD.	
5. Examines the checking list of the estimation patients to define, is she suiting candidacy for use IUD.	
6. Defines the knowledges an patients about side effect when using IUD.	
7. Closely s on necessities and sufferingses patients, connected with using IUD.	
8. Explains the procedure of the introduction IUD and that follows to expect during procedure and after it.	
9. Answer questions an patients if they appeared	
Selection an patients for entering IUD	
1. Asks the patients, has she urinary bladder. Ask woman to urinary bladder and put woman on ginecologic easy chair leg, bent in coxofemoral and knee joint	
3. Explains the patients that will is made, and encourages her(its) assign the questions.	
3. Washes the hands by water with soap and wipe pure, dry towel.	
4. Conducts palpation belly and makes sure in that that no morbidity in the field of basin and pathology of the womb.	
5. Puts on new examination, deeply disinfected or sterile gloves on both hands.	
6. Distributes the instruments and sterile material.	
7. Spends examination by means of gynecologic of the mirror: Take mirror Kusko in shift to the right hand, position of the mirror in hand lock in right or mirror Simpsona handle in right	
8. Big and index fingers of the left hand to divorce the medicine to be taken externally a sexual lips patients and folding mirror to carry in vagina in close type, to indecent slot askew. When using the mirror Simpsona for entering lift delay crotch by mirror and parallel to enter lift	
9. The Advanced mirror before half, careful motion turn the screw part downwards, simultaneously promote the mirror deep into and by means of lock to reveal the casements so that neck turned out to be between casement.	
10. Examine mucous walls vagina, shakes of the womb and nature of the separations of them.	
11. Do the analysis allocation from three points; bak. sowing from vagina and neck (the uretral) of the separations and study on IDBB if there is evidences (HDofPHS).	
12. Delete the mirror Kusko, not closing completely casements if mirrors Simpsona, delete in inverse sequence, decontamination mirrors and gloves.	
13. Conducts the bimanual examination:	
Big and index fingers of the left hand to divorce the medicine to be taken externally a sexual lips patients and carefully enter the middle finger of the right-hand man in vagina, delaying back wall down and then enter the index finger of the same hand.	

14. Produce the examination an vaginal part shakes wombs - is defined length, value, consistency and position for basin.	
15. The Left hand palm by surface, place on front abdominal wall on bosom and palpation the body of the womb - are defined position, sizes, consistency, mobility, morbidity.	
16. Alternately translate the hands on the right and left of womb, examining apurtenance with both sides - define morbidity and presence of the formation.	
17. In the last queue examine parametriy, codes vagina and bone ring of the basin.	
18. Conducts the rectovaginal examination if there is evidences.	
19. Removes the disposable gloves and throws them agreeably to instructions; in the event of reusable of the gloves sinks them in solution of chlorine for disinfection.	
20. Conducts the microscopic study of the dab from three points at presence of the equipment (the colouration on Gram).	
21. Washes the hands by water with soap and wipe pure, dry towel.	
22. After exception IDBB, the infection and formation	
Preparation IUD to introduction to sterile package.	
1.Took IUD in sterile package and has produced checkup on wholeness, validity	
2. Has Revealled package on 1/3 part on the part of opposite to IUD	
3.Took peg and carried in conductor before contiguity with tip IUD	
4. Has Placed package to harden, flat surface and big and index fingers of the left hand have seized clothes hanger IUD on packing	
5. Big and index fingers of the right-hand man have seized for end of the conductor several raise upwards	
6. Bends around clothes hanger IUD having produced propulsion by conductor	
7.After contiguity of the tip clothes hanger on applicatore has moved applicatore several back	
8. Raise other end applicatore has fuelled clothes hanger in conductor	
Introduction VMS	
1. Puts on new examination, deeply disinfected or sterile gloves on both hands.	
2. Enters the vaginale mirror for visualization shakes wombs.	
3. Processes the shake and vagina by antiseptic solution.	
4. Carefully seizes the shake of the womb bullet gable.	
5. Enters the uterine probe, using "noncontact" method, and defines the depth and position of the womb.	
6. Enters IUD, using method "retractions".	
7. Cuts the tendrils and carefully deletes the bullet curling irons and mirror.	
8.Places used instruments in solution of chlorine for disinfection.	
9. Deletes the waste according to instruction.	
10. If they were used reusable of the glove, removes them and sinks in solution of chlorine.	
11. Carefully washes the hands by water with soap.	
13. Does record in medical card patients.	
Consultancy after entering	
1. Explains the patients, either as when check the tendrils.	

2. Discusses that to do in the event of origin side effect or problems.	
3. Convinces the patients that she can delete IUD anytime.	
4. Stakes out condition an patients to say the least 15 minutes, previously than release her(it) home.	
REMOVING IUD	
The Consultancy before removing.	
1. Greets the woman valid and well-disposed.	
2. Asks the patients about reason of the removing and answers the questions.	
3. Discusses with patients her(its) reproductive to purposes at present.	
4. Describes the procedure of the removing and explains that possible to expect.	
Removing VMS	
1. Washes the hands by water with soap and wipe чистым, dry towel.	
2. Puts on new examination, deeply disinfected or sterile gloves on both hands.	
3. Conducts the bimanual examination.	
4. Enters the vaginal mirror for visualization shakes wombs.	
5. Processes the shake and vagina by antiseptic solution.	
6. Seizes the tendrils beside shakes of the womb and pulls carefully, but for removing IUD powerfully.	
7. Places the used instruments and solution of chlorine for disinfection.	
8. Deletes the waste as requested.	
9. If they were used reusable of the glove, removes them and sinks in solution of chlorine.	
10. Carefully washes the hands by water with soap.	
11. Does record about removing IUD in medical card patients.	
Consultation after removing	
1. Discusses that follows to do when arising beside patients what or problems.	
2. Advises on cause of the new method if patient will want this.	
3. Renders aid patient in choice of the new method to contraceptions or advises temporary (barrier) method, before that as chosen method can be begin.	

Exhibit 1: "Numeric play"

For 1 day on each participant is stored up slip with typed вразброс numeral from 1 before 60. Each student distributed on 3 slips.

The Teacher in the beginning asks all student to listen to attentively his(its) instructions. As he only will mark time - 30 seconds, each student must take 1й slip and hand to connect the lines of the numerals on order. As soon as time ends, student dribbles in thin rim last found numeral. Then teacher on board draws the graph and brings the factors all student on 1st column on axis of the abscissas. It Is Chosen arithmetic-mean factor of the group and is noted as "Average mark" on graph. The Play has a repetition 2 times. Thereby, 3 columns are drawn with middle mark. When all results are presented, from graphics is seen that results of the group increased with each at once.

The Conclusion: Play promotes the development of attention, act of concentration at the beginning initially scholastic day, besides, from graphics is seen that drill perfects the result. "Repetition - a mother of the teaching". The Same conclusion possible to do to any newly gained skill.

4.2 Analytical part

Exhibit 2

Problem 1

Patient 20 years, beside it 6-month girl. She with husband does not want to have a child in the following 3-h years. Her(its) girlfriend has said her that her(its) mother and grandmother not become pregnant for 2 years after sort. She heard by radio that IUD is an efficient method to contraceptions. She shoulds like to little more learn of this method, as well as about that that has said the girlfriend and wants his(its) use. The Husband agree that they do not follow to have an childrens during 2-3 years.

- Tactics DGE

Consultancy on all method of the contraceptions and on method IUD, tell about that that can become pregnant in the near future.

- Methods of the study

Checkup in mirror bimanual checkup, the general blood test, analysis of the separations from 3-h point

- **Interpretation analysis** to Normal factors Hb (as well as at anemias 1 cl.), at degree of the purity vagina 1st and 2 cl.) are an evidence of the introduction IUD o the most

- Further tactics DGE

Introduction IUD

Problem 2

Womans 35 years, applied to household polyclinic with complaint on pains and ample and long menstruations in current 3-h months. Objective: skin and visible mucous pale. From anamnesis: mensis on 7-8 days regular, in 28 days. Pregnancy-5, childbirth-3, abortion-2. in mirror: visualized the lower pole and tendrils IUD.

Rv: body of the womb of the normal value, painlessly, area apurtenance - w/f. The Separations with blood moderate.

- Diagnosis

Ekspultion IUD. Anemia

- Methods of the study

General blood test

- Tactics DGE

Removing IUD, antyanemic treatment, protection by other methods to contraceptions after undertaking the consultancy

Independent work: 7.1. Themes of independent work

Themes №1: Clinical examination of pregnant women and methods of research.

MINISTRY OF HEALTH OF THE REPUBLIC OF UZBEKISTAN

ORDER

2012 "May 18" № 137

city of Tashkent

On the organization and provision of antenatal

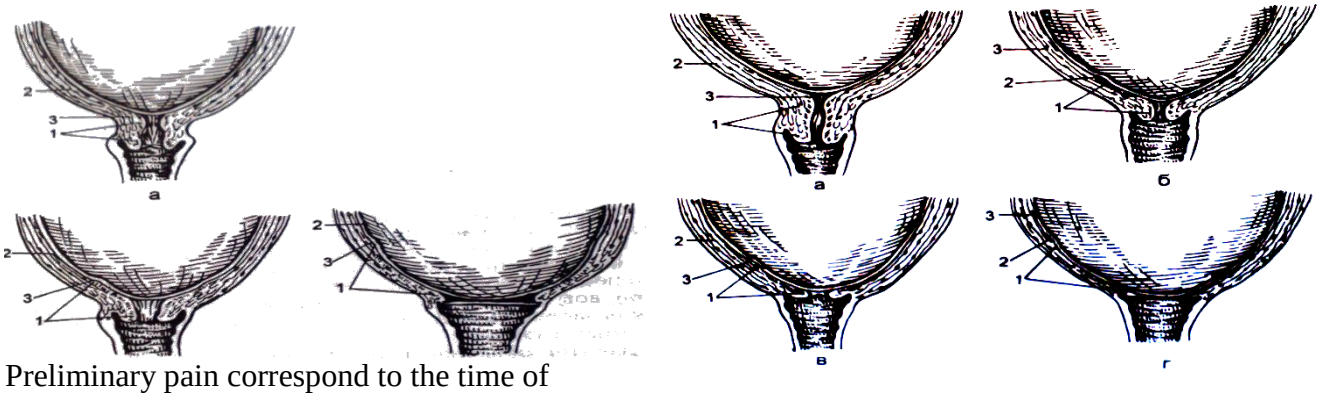
care and medical care

pregnant women in primary health care institutions.

health care

Themes №2: Periods of childbirth

Childbirth - an unconditional reflex act aimed at the expulsion of the ovum from the uterus that reaches the fruit of vitality. It is now believed viability of the fetus for a period not less than 22 weeks gestation, weighing not less than 500 g, not less than 25 cm is considered the timeliness of deliveries in the period from 37 to 42 weeks of pregnancy. Birth after 42 weeks of pregnancy is called late. Termination of pregnancy before 22 weeks is called abortion.
Onset of labor is preceded by the appearance of hook-called precursors of birth.
Harbingers of sorts - these are signs of the onset of their loved arising from 38 weeks of pregnancy before birth and manifested as a result of lowering the bottom of the uterus pressing pre ¬ lying part of the fetus to the entrance of the pelvis and reduce the amount of amniotic fluid, a discharge of "mucus plug", the lack of weight gain , increased excitability STI muscles of the uterus, etc.
In contrast to the precursors of birth preliminary limited to a few hours of pain-mi, immediately preceding the onset of labor, and should not impede the natural processes of life (sleep, diet, activity). Preliminary clinically pain occur for pregnant almost unnoticeably marked irregular painless contractions of the uterus, which are gradually becoming stronger and more persistent, and finally go into battle.



Preliminary pain correspond to the time of
formation of the dominant clan and are accompanied by a biological "ripening" of the cervix. The cervix softens over-occupies a central position on the wire axis of the pelvis and drastically shortened. When pathological pain during the duration of the preliminary prolonged, uterine acquires a painful character, and the ripening of the cervix occurs.
Childbearing is divided into three periods:
- First - disclosure period (latent and active phase)
- Second - the period of the expulsion of the fetus (not evicted early and late phase casts out)
- The third - the sequence period.
At birth a pregnant woman in labor is called.
The first stage of labor - this is the part of labor, which begins with the appearance of contractions and ends with a complete disclosure of the uterine mouth.
Contractions - is the involuntary rhythmic contractions of the muscles of the uterus with at least one in 10 minutes. Contractions are characterized by four features: frequency, duration, strength and tenderness. In early labor contractions occur every 10 minutes, and further Duration of contractions in early labor 10-15, in the middle of giving birth - 30-40. after delivery - 50-60 s. The contractions are weak, medium and strong strength. Soreness labor depends on the strength of the central nervous system and on the quality of the genera pregnant.

Figure cervical dilatation in nulliparous and multiparous.

Disclosure of uterine throat is due to a reduction (contraction), and of displaced relative to each other (retraction) of muscle fibers of the uterine body and stretching of the expansion (distraction) neck and the lower segment of the uterus. The lower segment of the uterus - a part

pericervica; area of the body of the uterus, forming a clan ¬ howling channel in the first stage of labor as a result of processes of retraction and distraction. As the formation of the birth canal on the border of the upper and lower segments of the uterus is formed furrow, called the contraction ring. At the beginning of first-time mothers giving birth outer and inner mouth shut. Disclosure necks starts at the top. First revealed the inner mouth of the cervix and cervical canal. In the future, the cervix is still more shortened, and then fully anti-aliased, and only its outer mouth remains closed. Then, on the edges of external os gets thinner, and it begins to open up, as long as it does not happen complete disclosure. In this case, it is defined as a narrow rim in the birth canal, ¬ Call of formation of cavities merged together vagina and uterus. At the end of pregnancy in multiparous entire cervical canal to pass one or two fingers (as a result of its expansion in the previous birth). Therefore, anti-aliasing and the cervix throughout the first stage of labor is but at the same time ¬. Disclosure of uterine mouth is to fully open, which corresponds to 10 cm discharge of amniotic fluid should be at close to full opening of the uterine mouth. Rupture of membranes in the first stage of labor before the disclosure of 4-6 cm, and before regular labor is called premature.

During the first stage of labor identified two phases: latent - from onset of labor to the disclosure of the uterine mouth to 3-4 cm, active - from 4 cm to fully open. In turn, the active phase time of acceleration is isolated, and its maximum speed deceleration (decelerations). Rate of uterine mouth opening is an important indicator of the correct course of labors. The rate of cervical dilatation at the onset of labor (latent phase) is 0.35 cm / h in the active phase - 1.5-2 cm / h in nulliparous and 2-2.5 cm / h - multifarious.

Disclosure of uterine mouth from 8 to 10 cm (deceleration phase) passes more slowly - 1 -1.5 cm / h Meanwhile ¬ Py disclosure of uterine os dependent on contractility of the myometrium, Cervical resistance and combinations thereof. The duration of the first stage of labor in nulliparous an average of 10 to 14 hours, and multifarious - half the size.

In the first stage of labor, the doctor should monitor the overall health of mothers, the dynamics of labor and the heartbeat of the fetus.

The behavior of women in the first stage of labor should be active. It should to use techniques of anesthesia, which taught her classes on psycho preventive -ray preparation for childbirth. Acceptable attendance at childbirth husband and other relatives. Bed rest is recommended for stored the fetal bladder in cases of polyhydramnios, premature birth, breech presentation, we recommend taking food and liquids.

After full disclosure of the uterine mouth begins the **second stage of labor** - the period of Gnagno-which ends with the birth of the fetus. In the second period identified two phases: Early (not evicted) - full disclosure, the presenting part is omitted, but does not reach the bottom of the pelvis, there is no urge to dry heaving. Late (expulsion) - Full raskrytie5, presenting part of the fetus reaches the bottom of the pelvis, the woman begins to push. Characteristic of the period of exile is the appearance of any attempts - synchronous with the uterus reflex contractions of the abdominal muscles, the diaphragm and the pelvic floor. Attempts should start with finding the presenting part at the bottom of the bands small pelvis when the lower pole of the presenting part presses on the abdominal muscles and the pelvic floor. On this false appearance of any attempts to identify the beginning of the period of exile - they appear at the end of this period and help to overcome the presenting part of the narrowest part of small pelvis. Attempts repeat every 2-3 minutes and last for 50-60 seconds.

In the second stage of labor the doctor should carefully monitor the status of women in labor, the nature of labor, the heartbeat of the fetus (it should be auscultated after each attempts), promotion of the presenting part of the fetus, the character of discharge from the genital tract, hold receptions of "protecting the perineum"

The third stage of labor - the sequence - comes after the birth of the fetus and continues through the placenta. Its duration is an average of 10 to 15 minutes, but no more than 30

minutes. To date, the third stage of labor are actively using controlled cord traction with the first battle sequence, highlighting the active participation of women in labor with no consequences.
A woman called postpartum women in childbirth. Within 2 hours it should be in the delivery room under the supervision of a midwife, while continuing to maintain its activity. If all is well, women in childbirth transferred to the postpartum unit.

The set of movements made by the fruit as it passes through the pelvis and the soft parts of the birth canal, called the biomechanics of delivery. **The first point** - bending head (flexio capitis). Under the influence of intrauterine pressure, partly transmitted ¬ direct the spine to the head of the fetus, the cervical part of the spine is bent in such a ¬ time that chin close to the chest, back of the head is lowered. As you lower the back of the head small fontanelle is set below a large, approaching the pro ¬ water line of the pelvis
The second point biomechanism childbirth is a combination of translational ¬ relative motion of the head and its internal rotation.
The second point biomechanism childbirth begins after the head is bent over and getting up at the entrance to a small basin. Then head able to moderate flexion one of the sizes goes skew widest part of the pelvic cavity. Since the internal rotation ¬ mouth, in a narrow part of the pelvic cavity. As a result, the size of the head of the skew becomes a straight line. Turning ends when the head reaches the exit plane of idle once established as the head of the arrow-shaped seams in the direct output of the pelvis, begins **the third time** biomechanism birth - extension of the head. Between the symphysis pubis and the suboccipital fossa of the fetal head is formed fixation point around which the extension is the head. As a result, by extension therefore ¬ born crown, forehead, face and chin of the fetus.
Fixation point or fulcrum (punctum fixiim) is a point on the fetal head, which abuts against the lower edge of symphysis (and in some previa and coccyx tip) is then bending or unbending Birth and any part of the fruit.
Head born small oblique size equal to 9.5 cm and a circumference of 32 cm

After the birth of the head is an internal rotation of shoulders and outer rotation ¬ mouth head - the fourth time. Shoulders of the fetus produce internal rotation, as a result they are set out in the forward of the pelvis so that one shoulder (front) is located under the womb, while the other (back) paid to the coccyx. Born fetal head rotates back of his head to the left thigh of the mother (in the first position) or to the right (at the second position).
Between the anterior shoulder (in the deltoid muscle attachment to the humerus) and the lower edge of the symphysis, a new point of fixation. There is a bend of body to fetal thoracic and rear shoulder of birth and pens, and then easily given birth the rest of the body.
Biomechanism delivery at the front as the occipital previa is the most physiological and beneficial to both mother and fetus, as in this variant Biomechanism head passes through the plane of the pelvis and its smallest size is born ¬ authors.
In the delivery room or in the home immediately after the birth of a child is held first toilet newborn, which includes:
• treatment of the eye.
• Two-moment cut off the umbilical cord and umbilical handling balance.
• study anthropometric data-child weighing (minus the weight of the total weight of the diaper), the measurement centimeter ribbon growth child's head circumference (along brow to small fontanelle) and breast (the line passing through the nipple).

Themes №3: Types of Cesarean sections

C-section -obstetric surgery intended for delivery through laparotomy incision and uterine wall, when giving birth vaginally for whatever reason are not possible or are accompanied by complications for the mother and the fetus.

All indications for caesarean section is divided into absolute and relative by both the mother and the fetus.

Absolute indications for caesarean section.

Absolute indications include a group of causes:

-(III)—(IV)the degree of narrowing of the pelvis;

-Tumor and cicatricial changes to birth the fruit;

-Complete placenta previa or incomplete bleeding her fetus;

-Premature detachment normally situated placenta (in the absence of rapid vaginal birth);

-Eclampsia during pregnancy or the first stage of labor; lack of quick delivery pregnant with severe gestosis therapy, very hard, the appearance of renal deficiency baked;

-Threatening uterine rupture;

-Incorrect position of the fetus;

-Disability wall of the uterus (after cesarean section in the past, myomectomy, uterine perforation, etc.);

Incorrect insertion of the presentation and the fetal head (brow, perednetemennoe, asinklitic, high standing seam directly arrow, etc.);

-The presentation and cord prolapsed with live fruit; the severe form of heavy late toxicoses of pregnant with no conditions for immediate delivery through the birth canal, and (most);

-Uterine inertia forces with inefficiency therapy;

-Progressive course and extra genital diseases in decomposition condition (idiopathic hypertension, diseases of the cardio-vascular system, etc.) that require an urgent delivery and there are no facilities for it through most of the major birth canal;

-Deformations and fractures of the pelvis;

-Genitourinary and gastro-sexual fistulas in history;

-Threatening and began tearing the uterus;

Varicose veins-expressed in the external genital organs;

-Numerous combined testimony (large fruit for breech presentation in nulliparous age, etc.).

Relative indications for caesarean section.

To relative grounds include a situation where there is a possibility of delivery by natural means, but the risk of complications for the mother and/or the child exceeds the risk of complications of abdominal delivery.

Common **relative** indications:

-scar at the womb after preceding operations;

-pelvic fetal position;

-extra genital diseases in which the breech vaginal birth is increased risk to women's health (myopia with Dystrophic changes in the fundus, epilepsy, posttraumatic ènce falopatiâ, etc.);

-premature rupture of membranes;

-anomalies birth (uterine inertia forces);

-presence of obstetrical history (infertility, habitual miscarriage);

-age over 30 years 1st labor;

-over term pregnancy;

-diabetes mellitus and large fruit;

-anatomically narrow hips p & I degree, especially in combination with other unfavorable factors (elderly women, pelvic presentation etc.); facial previa; multiple uterine fibroids; diseases of the central nervous system; fetal hypoxia; malformations of the uterus; by combining different evidence.

Early caesarean section is shown by:

-preterm rupture of membranes or premature development of labor activity and presence of intrauterine fetus development delays(II)—(III)degree;
-moderately expressed hypoxia according to CTG combined fetal development delay(II)—(III)degree.
-(II)degree of hemodynamic abnormalities in mother-placenta-fetus with bilateral uterine blood flow in the arteries of the violation and the presence of notches on the spectrogram dichotic.
-Indications for emergency delivery in the presence of fetoplacental insufficiency, as well as support the development of the fetus during pregnancy more than 32 weeks are:
-Detection of signs of pronounced hypoxia according to CTG (antenatal spontaneous emergence late decelerations, deceleration in oxitocin test);
-Critical state fruit-placental blood flow Doppler ultrasound data (lack of diastolic or retrograde blood flow in the umbilical artery);
-The emergence and progression of clinical (rhythm or heart rate with the development of bradycardia, low tones) and/or cardiografic (late decelerations) signs of fetal hypoxia in childbirth (in the absence of the conditions for rapid vaginal birth);
-Drop loop of umbilical cord with cephalic presentation;
-The lateral position of the second fetus from the twins.
Delivery by caesarean section routinely are pregnant in the following clinical situations:
-Delay of the development of the fetus or cause doplerometric symptoms over term blood circulation in its centralization of pregnancy (fetal aorta in a 8.0 and JDO in Middle cerebral artery is less than 2.8);
-Pelvic presentation or lateral position of the fetus;
-Combination(I)-(II)degree of hemodynamic abnormalities in mother-placenta-foetus, early signs of fetal hypoxia with other obstetrical pathology (large fruit, age 30 years older than 1st labor, weighed down by obstetric history, etc.);
-Early signs of fetoplacental insufficiency Progression (worsening of CTG, JDO or signs of increasing centralization of blood circulation in doplerometric research), despite ongoing treatment.
However, the increase in the number of operations cesarean VA section leads to an increase in the number of women having a scar on the uterus, and is accompanied by increased risk of complications in the postoperative period. Therefore, it is important to consider the conditions and contraindicated of the IDB to caesarean section.
Conditions for caesarean section are: a viable fetus, the classification of the qualification of the surgeon, a woman's consent to the operation.
It should be remembered that a scar on the uterus is uterine rupture in perspective (asymptomatic or minor symptoms).
Abdominal pain, lower back pain, across the abdomen, in the region. the scar, on the abdominal wall, the unclear localization during physical exercise, even minor, especially not peel spazmolitikami, analgesics should be interpreted as a threat of uterine rupture of rubcu, not the threat of miscarriage.
In term pregnancy in women with scar at the womb long preliminary period should also be considered as threatening uterine rupture.
At the same time, under the guise of threatening preterm birth in late pregnancy may show clinical failure of the scar on the uterus and thereby threatening uterine rupture. The positive effect of the therapy aimed at preserving the pregnancy (Tocolytic, sedatives), and no local pain in the scar on the uterus, and ultrasound data (evidence about the full lower segment) and cardiotocography (indicating the absence of acute fetal hypoxia) confirm the diagnosis of premature delivery. Persistent local pain in the scar on the uterus, thinning and acoustic heterogeneity ehoplotnost regions (detected at ultrasound of the lower segment of the uterus), and the signs of the deterioration of the fetus (according to CTG) is called the failure of the uterine scar - or rather, to a threatening rupture of the uterus. In these cases, the required emergency abdominal delivery.To develop tactics of pregnancy and delivery method of choice

for women with scar at the womb has an important meaning of NOE, the assessment of the condition of the uterus, which is carried out using a transabdominal and transvaginal ultrasonography in pregnancy.
Ehografic criteria for full healing of the lower uterine segment are:
-U-shaped it with a thickness of not less than 4-5 mm;
-Normal èhogennic′ of the lower segment, similar to the one in the other divisions of the uterus;
-Small areas of low sound transfer on the background of normal acoustic density.
The **èhografic** featured **the insolvent** transverse scar we include:
-Cans-or conical form of the lower segment of the uterus;
-The thickness of the lower segment of less than 3 mm;
-Local thinning of the lower segment of less than 3 mm in the background of normal thickness (4-5 mm);
-Enhanced acoustic density throughout the area of the former.
Many complications that arise in gestational period give reason to treat the scar on the uterus like a disease "after the uterus, cervical incompetence".
Complications during gestation: the threat of termination of pregnancy, placental insufficiency, SZRP, PONRP, wrong position of fetal, perinatal complications, the risk of uterine rupture, uterine rupture of rubcu, coma, lethality.
Complications in childbirth: birth anomalies, bleeding (PONRP, hypotension, etc), perinatal complications, the risk of uterine rupture, uterine rupture of rubcu, coma, lethality.
Recommandations to abdominal′nomu delivery are: intrauterine fetal death or being, incompatible with the existence of intrauterine (Glu-bokaya prematurity, very pronounced degree of hypoxia and fetal malnutrition, foetal malformations, incompatible with life), acute infectious-inflammatory diseases
Criteria for the selection of women with scar at the womb to conduct **spontaneous deliveries** are:
-one c-sections in history, made a cut in the lower uterine segment to a non-repeating (transient) condition: fetal hypoxia, birth abnormalities, pelvic presentation and abnormal position of the fetus, placenta previa and Abruptio, heavy forms hypertensive States;
-No new evidence during this pregnancy to the birth of samoproizvol′;
-satisfactory condition of the mother and fetus.
previa-head sole fruit;
-a full lower cervical segment (clinical and ultrasound data);
-a woman's consent to conduct spontaneous deliveries.
-favourable currents of this pregnancy with no sign of the threat her interruption, signs of fetoplacental insufficiency of gipoksičeskom syndrome of fetus and its placenta location, wasting away, the alleged "scar" on the uterus;
-the biological maturity of the cervix 4th degree;
-preservation of the principle of "triple downward gradient between the divisions, including the lower segment of the uterus; with the start of labour;
-establishing the correct position of the fetus and members head location at the entrance of the pelvis, or centered above the pelvis in the preparatory period for childbirth.
Conservative management of women with scar at the womb is possible only in large hospitals equipped with obstetric enough (or perinatal centres), with 24-hour supervision of highly qualified obstetricians and gynaecologists who endorsed full ext of assistance (including hysterectomy).
Diagnostics of the scar in the out-patient stage:
Visit pregnant women in turn.(I)half of 1 times in 2 weeks, in(II)– 1 time per week.
ULTRASOUND in Dynamics: the I-II trimester 1, III – 3 times.
To èhografičeskim scar at the womb insolvency during pregnancy include thinning of the lower segment of the scar (less than 0, 3 cm), a significant number of acoustically dense inclusions,

indirectly indicating the presence of scar tissue, reshaping the lower segment in the form of niches.
To determine the usefulness of the uterine muscles in the area of the former incision should take into account the objective data obtained by palpation. To do this, pushing aside a skin scar the uterus, pal′piruût when the incision the previous operation. In response to palpation, the uterus is usually reduced. If a scar, then it is not defined and the uterus is uniformly reduced. With nepolnocennom rumen connective tissue is reduced and not pal′piruûŝie fingers feel the deepening (notch) in the uterus.
CTG in Dynamics: from 24 weeks.
Date of hospitalization for women with scar at the womb:
-up to 12 weeks, to assess the condition of the SCAR and to address the issue of pregnancy prolongirovani.
-In 24-26, 30-34 weeks. for the treatment of fetal hypoxia, ÈGZ and attendant complications during gestation.
In a 38-37 weeks for the birth, and when in the rumen nepolnocennom 35-36 weeks.
For delivery, pregnant with scar at the womb State of pitaliziruûtsâ in obstetrical hospitals in 37-38 weeks gestation, where they conducted a full survey of the General and special maternity, childbirth timing TBC, valued the fetoplacental system (using ultrasonic fetometrii, placentografii and dopplerometričeskogo study of blood flow in the umbilical artery and the uterine arteries) and is determined by the estimated weight of the fetus, an assessment of the status of the scar on the uterus (clinically and èhografičeski), be sure to include the data history.
In order to improve the outcomes of repeated Caesarean section for fetal surgery is very significant in the timing, close to childbirth: 39-40 weeks. The transformation of prior years ' arrears, to avoid the risk of uterine rupture is most often coming with the start of labor activity, repeated abdominal delivery were at 38 weeks. The children were born with a birth weight of full-term, but often with gratitude, Kami morfofunkcional′noj immaturity, that in some cases led to the development of respiratory distress syndrome.
Management of pregnancy in women with scar at the womb:
(I)term:
(a) medical-conservative) mode;
b) General recreational activities;
in the laboratory and instrumental examination);
g) treatment of concomitant ÈGZ;
d) treatment complications during gestation;
e) programming follow-up.
(II)term:
(a) medical-conservative) mode;
b) General recreational activities;
in laborotorno)-instrumental examination;
g) treatment of concomitant ÈGZ;
d) treatment complications during gestation;
e) programming follow-up.
(III)term:
(a) medical-conservative) mode;
b) General recreational activities;
in laborotorno)-instrumental examination;
g) treatment of concomitant ÈGZ;
d) treatment complications during gestation;
e) programming of prenatal hospitalization with the traditional preparation for childbirth and with the assessment test readiness indicators.
Concept and types of inappropriate regulations and presentations.

A situation in which the longitudinal axis of the fruit forms a sharp corner or right angle with the longitudinal axis of the mother in the absence of the presenting part.

Causes of the wrong position and fetus.

Excessive fetal movement: when polyhydramnios, gipotrofičnom or nedonošennom fruit, multiple pregnancy, the muscles of the anterior abdominal wall skin flabbiness multiparous. Limited mobility: Fetal malovodii, big fruit, there, you have uterine fibroids, uterine cavity strain, increased uterine tonus, threat of termination of pregnancy. Obstacle vstavleniû head: placenta previa, narrow hips, the presence of uterine fibroids in the lower segment. Abnormalities of the uterus: the uterus dvurogaâ septum, the septum. Fetal anomalies: hydrocephaly, anencephaly.

Diagnosis and incorrect presentations.

-Belly shape: oval or cross-kosooval′naâ; -low standing of seafloor of the uterus; the absence of the presenting part;

-pelvic palpation, head end in the side sections of the uterus fetal heartbeat heard;-in the navel area;-lack of the presenting part of the vaginal examination, and when izlitii amniotic fluid when you can define study vaginal shoulder, handle the umbilical cord, ribs or spine of the fruit; ULTRASOUND study).

--Prevention of constipation; It is recommended for pregnant women to lie on her side, and at the same position on the side of Kos a major part of the fruit;

-admission to 35 weeks;

Complications of pregnancy and childbirth in the wrong position and fetus fetus.

-premature birth by prenatal observing the amniotic fluid in the absence of the belt is tight, may be accompanied by Syncope: small parts (knobs, feet, hinges of the umbilical cord),

-infection of the fetus,

-running lateral position, which threatens to fetal hypoxia, when continuing cuts the uterus may at first, then pererastâženie, and uterine rupture.

Topics № 4: Observance of the Intergenetic Interval

Analysis on step, with teacher, manual to technology of the introduction and removing IUD.

Consultancy on VMS

Steps / problems	
Consultancy before introduction	
1. Greets woman valid and well-disposed	
2. Asks patients about her(its) reproductive purpose	
3. If consultation on IUD was not organized, organizes the consultation before performing the procedure.	
4. Elaborates that chosen patients method to contraceptions - IUD.	
5. Examines the checking list of the estimation patients to define, is she suiting candidacy for use IUD.	
6. Defines the knowledges an patients about side effect when using IUD.	
7. Closely s on necessities and sufferingses patients, connected with using IUD.	
8. Explains the procedure of the introduction IUD and that follows to expect during procedure and after it.	
9. Answer questions an patients if they appeared	
Selection an patients for entering IUD	
1. Asks the patients, has she urinary bladder. Ask woman to urinary bladder and put woman on ginecologic easy chair leg, bent in coxofemoral and knee joint	

3. Explains the patients that will is made, and encourages her(its) assign the questions.	
3. Washes the hands by water with soap and wipe pure, dry towel.	
4. Conducts palpation belly and makes sure in that that no morbidity in the field of basin and pathology of the womb.	
5. Puts on new examination, deeply disinfected or sterile gloves on both hands.	
6. Distributes the instruments and sterile material.	
7. Spends examination by means of gynecologic of the mirror: Take mirror Kusko in shift to the right hand, position of the mirror in hand lock in right or mirror Simpsona handle in right	
8. Big and index fingers of the left hand to divorce the medicine to be taken externally a sexual lips patients and folding mirror to carry in vagina in close type, to indecent slot askew. When using the mirror Simpsona for entering lift delay crotch by mirror and parallel to enter lift	
9. The Advanced mirror before half, careful motion turn the screw part downwards, simultaneously promote the mirror deep into and by means of lock to reveal the casements so that neck turned out to be between casement.	
10. Examine mucous walls vagina, shakes of the womb and nature of the separations of them.	
11. Do the analysis allocation from three points; bak. sowing from vagina and neck (the uretral) of the separations and study on IDBB if there is evidences (HDofPHS).	
12. Delete the mirror Kusko, not closing completely casements if mirrors Simpsona, delete in inverse sequence, decontamination mirrors and gloves.	
13. Conducts the bimanual examination:	
Big and index fingers of the left hand to divorce the medicine to be taken externally a sexual lips patients and carefully enter the middle finger of the right-hand man in vagina, delaying back wall down and then enter the index finger of the same hand.	
14. Produce the examination an vaginal part shakes wombs - is defined length, value, consistency and position for basin.	
15. The Left hand palm by surface, place on front abdominal wall on bosom and palpation the body of the womb - are defined position, sizes, consistency, mobility, morbidity.	
16. Alternately translate the hands on the right and left of womb, examining apurtenance with both sides - define morbidity and presence of the formation.	
17. In the last queue examine parametriy, codes vagina and bone ring of the basin.	
18. Conducts the rectovaginal examination if there is evidences.	
19. Removes the disposable gloves and throws them agreeably to instructions; in the event of reusable of the gloves sinks them in solution of chlorine for disinfection.	
20. Conducts the microscopic study of the dab from three points at presence of the equipment (the colouration on Gram).	
21. Washes the hands by water with soap and wipe pure, dry towel.	
22. After exception IDBB, the infection and formation	
Preparation IUD to introduction to sterile package.	
1.Took IUD in sterile package and has produced checkup on wholeness, validity	
2. Has Revealled package on 1/3 part on the part of opposite to IUD	

3.Took peg and carried in conductor before contiguity with tip IUD	
4. Has Placed package to harden, flat surface and big and index fingers of the left hand have seized clothes hanger IUD on packing	
5. Big and index fingers of the right-hand man have seized for end of the conductor several raise upwards	
6. Bends around clothes hanger IUD having produced propulsion by conductor	
7.After contiguity of the tip clothes hanger on applicatore has moved applicatore several back	
8. Raise other end applicatore has fuelled clothes hanger in conductor	
Introduction VMS	
1. Puts on new examination, deeply disinfected or sterile gloves on both hands.	
2. Enters the vaginale mirror for visualization shakes wombs.	
3. Processes the shake and vagina by antiseptic solution.	
4. Carefully seizes the shake of the womb bullet gable.	
5. Enters the uterine probe, using "noncontact" method, and defines the depth and position of the womb.	
6. Enters IUD, using method "retractions".	
7. Cuts the tendrils and carefully deletes the bullet curling irons and mirror.	
8.Places used instruments in solution of chlorine for disinfection.	
9. Deletes the waste according to instruction.	
10. If they were used reusable of the glove, removes them and sinks in solution of chlorine.	
11. Carefully washes the hands by water with soap.	
13. Does record in medical card patients.	
Consultancy after entering	
1. Explains the patients, either as when check the tendrils.	
2. Discusses that to do in the event of origin side effect or problems.	
3. Convinces the patients that she can delete IUD anytime.	
4. Stakes out condition an patients to say the least 15 minutes, previously than release her(it) home.	
REMOVING IUD	
The Consultancy before removing.	
1. Greets the woman valid and well-disposed.	
2. Asks the patients about reason of the removing and answers the questions.	
3. Discusses with patients her(its) reproductive to purposes at present.	
4. Describes the procedure of the removing and explains that possible to expect.	
Removing VMS	
1. Washes the hands by water with soap and wipe чистым, dry towel.	
2. Puts on new examination, deeply disinfected or sterile gloves on both hands.	
3. Conducts the bimanual examination.	
4. Enters the vaginal mirror for visualization shakes wombs.	
5. Processes the shake and vagina by antiseptic solution.	
6. Seizes the tendrils beside shakes of the womb and pulls carefully, but for removing IUD powerfully.	
7. Places the used instruments and solution of chlorine for disinfection.	
8. Deletes the waste as requested.	

9. If they were used reusable of the glove, removes them and sinks in solution of chlorine.	
10. Carefully washes the hands by water with soap.	
11. Does record about removing IUD in medical card patients.	
Consultation after removing	
1. Discusses that follows to do when arising beside patients what or problems.	
2. Advises on cause of the new method if patient will want this.	
3. Renders aid patient in choice of the new method to contraceptions or advises temporary (barrier) method, before that as chosen method can be begin.	

Exhibit 1: "Numeric play"

For 1 day on each participant is stored up slip with typed вразброс numeral from 1 before 60. Each student distributed on 3 slips.

The Teacher in the beginning asks all student to listen to attentively his(its) instructions. As he only will mark time - 30 seconds, each student must take 1й slip and hand to connect the lines of the numerals on order. As soon as time ends, student dribbles in thin rim last found numeral. Then teacher on board draws the graph and brings the factors all student on 1st column on axis of the abscissas. It Is Chosen arithmetic-mean factor of the group and is noted as "Average mark" on graph. The Play has a repetition 2 times. Thereby, 3 columns are drawn with middle mark. When all results are presented, from graphics is seen that results of the group increased with each at once.

The Conclusion: Play promotes the development of attention, act of concentration at the beginning initially scholastic day, besides, from graphics is seen that drill perfects the result. "Repetition - a mother of the teaching". The Same conclusion possible to do to any newly gained skill.

4.2 Analytical part

Exhibit 2

Problem 1

Patient 20 years, beside it 6-month girl. She with husband does not want to have a child in the following 3-h years. Her(its) girlfriend has said her that her(its) mother and grandmother not become pregnant for 2 years after sort. She heard by radio that IUD is an efficient method to contraceptions. She shoulds like to little more learn of this method, as well as about that that has said the girlfriend and wants his(its) use. The Husband agree that they do not follow to have an childrens during 2-3 years.

- **Tactics DGE**

Consultancy on all method of the contraceptions and on method IUD, tell about that that can become pregnant in the near future.

- **Methods of the study**

Checkup in mirror bimanual checkup, the general blood test, analysis of the separations from 3-h point

- **Interpretation analysis** to Normal factors Hb (as well as at anemias 1 cl.), at degree of the purity vagina 1st and 2 cl.) are an evidence of the introduction IUD o the most

- **Further tactics DGE**

Introduction IUD

Problem 2

Womans 35 years, applied to household polyclinic with complaint on pains and ample and long menstruations in current 3-h months. Objective: skin and visible mucous pale. From anamnesis: mensis on 7-8 days regular, in 28 days. Pregnancy-5, childbirth-3, abortion-2. in mirror: visualized the lower pole and tendrils IUD.

Rv: body of the womb of the normal value, painlessly, area apurtenance - w/f. The Separations with blood moderate.

- Diagnosis

Ekspultion IUD. Anemia

- Methods of the study

General blood test

- Tactics DGE

Removing IUD, antyanemic treatment, protection by other methods to contraceptions after undertaking the consultancy

Themes №5: Determination of early signs of pregnancy.

Most women, wanting to have children, feel the change of their condition. In addition to intuition, there are some signs that appear at a very short gestation period, as well as tests. The first are associated with inevitable changes, including hormonal changes that occur in the body of a woman, not only in the reproductive sphere, but also in others. Therefore, the signs of an early pregnancy are so different in nature. Tests are informative and with a slight delay in menstruation. There are several of them, all based on the definition in the urine of pregnant hCG. Test strips, electronic, inkjet or cassette versions of these means for fidelity should be used 2-3 times. But at the same time they are able to make mistakes both in confirming pregnancy and in denial. This is due to non-compliance with instructions, as well as problems with gynecological health of women.

Termination of menstruation. Actually, the entire menstrual cycle is a preparation for fertilization and subsequent bearing. And monthly ones are needed in order to update the endometrium. When fertilization has occurred, this organ has a looser structure than at other stages of the cycle, such that the fetal egg can easily gain a foothold in the uterus for a long time. It will be 9 months, and this term of the endometrium will not be updated. That is, 36 weeks and menstruation will not have to wait. Yes, and the next 2-3 months, after childbirth, and even more, perhaps, too.

Toxicosis

The symptom appears from the very beginning of pregnancy and is expressed by several signs:

Impairment of appetite;

Nausea;

Increased salivation;

Changing food preferences;

Aversion to some smells,

which had not been annoyed before;

Multiple times a day vomiting.

There is no common opinion about the causes of toxicosis among doctors, but they have learned how to deal with it. A specialist may prescribe a pregnant woman to take medicine: Cerucal;

But the spine;

Hofitol;

Valerian.

But the woman herself must take certain actions to forget about this unpleasant symptom by the 12-13th week:

There are small portions every couple of hours;

To give preference to lean protein,

sour-milk food, fresh vegetables and fruits;

Drink plenty of water, starting to do this before breakfast;

Among the juices to choose non-acidic.

Breast Changes

Mammary glands are also preparing for the appearance of a child, to become for him a source of nutrition and immune protection. The chest slightly increases in size, becomes heavy, more sensitive. To some women, this causes inconvenience, especially in the area of the nipples and areola. The last darkens and also increase in size. To avoid problems with them when feeding, prepare for the process is necessary at an early date. Useful contrast shower with alternating douche of mammary glands with warm and cool water. It also helps to reduce pain. Brassieres will have to be replaced by more spacious and comfortable, so that they do not tighten their breasts. By 10-12 weeks of pregnancy unpleasant sensations will go to loss.

Discharge from the genital tract at an early stage

Months in pregnancy stop, but discharge from the vagina is possible. This is the result of increasing the concentration of progesterone. Healthy secretions are transparent or whitish, without unpleasant odor, do not cause discomfort. They are few and they are quite viscous. At the initial period, in the days when there should be menstruation, there are spotting. If they are too meager, painless, there is nothing to be afraid of. This can be observed a week after conception. This is the moment of introduction of the fetal egg to the wall of the uterus, the allocation is meager and go for a short time. There may be uneven pain, but the process itself is normal. It's worse if the blood goes full and painful. Most likely, this is the rejection of the fetal egg, which requires immediate help.

Changes in basal temperature

If a woman watched the indicator before pregnancy, she would not be hard to notice an increase in basal temperature. In the absence of an embryo in the first days of the cycle, it is 36.7-36.8 degrees, with ovulation rises to 37, and then slightly decreases. The coming conception raises this figure from the middle of the cycle above the last value and keeps it that way. If you do not be lazy and continue to measure basal temperature, then you can track

serious malfunctions during pregnancy. For example, with its fading or localization outside the uterus, the indicator is 37.2-38 degrees. Pain in early pregnancy

Pain in early pregnancy Similar sensations in the lower abdomen are both safe and requiring medical attention. Their intensity and duration are important here. If the pain is weak, it arises from time to time, it is a sign of hormonal changes, the addiction of the body to a new condition. Another of its causes may be increased gassing, characteristic of an early period. Strong, constant sensations should not remain outside of the doctor's office. They can be dangerous for the mother and baby, testify about the disease of the genitourinary sphere, appendicitis. Diarrhea The digestive system of a pregnant woman often presents her with surprises. This is caused by increased nervousness, and a change in diet associated with the novelty of the situation. A woman feels a raspiranie in the intestines, followed by diarrhea, then constipation. If you can not correct the situation with the normalization of the diet in a short time, you should go to the doctor. Diarrhea is also a sign of infection, a gastrointestinal disease, poisoning that during pregnancy at any time, especially at the beginning, is dangerous. From frequent attempts at a woman can develop a tone of the uterus, which creates a threat to the existence of the fetus. And intoxication and the inability to absorb nutrients will adversely affect its development. Until medical aid has arrived, a woman needs to drink plenty of water, broths of chamomile and St. John's wort. But finding out the cause of diarrhea and treatment is a specialist matter. Why go to the doctor?

Pregnancy is not a disease, so some women do not always understand why a gynecologist needs registration, and they are to him when they are about to give birth. But, first of all, it is possible to establish precisely at an early stage, that pregnancy is available, only with the help of medical methods. It is necessary that the future mother beware of everything that is capable of harming her and the baby. And secondly, during the entire process, a woman is observed to be sure of the absence of pathologies in her and the fetus. Required for registration:

Passport;

Policy;

Own presence.

Professional diagnostics It is not enough for a specialist to get a single interview with a woman describing everything that she feels and observes at herself. Similar signs happen and at diseases. Therefore, the diagnosis of pregnancy is also: Inspection and examination of mammary glands, vagina; Studies of blood and urine of a general nature. In both materials, during pregnancy at the initial stage, chorionic gonadotropin is detected. Its number shows not only the state itself, but also its term; Ultrasound of the pelvic organs. Before the expiration of 8 weeks, the future baby has already formed a heart, so you can clearly see not only the pregnancy and the attachment point of the fetal egg, but also the organ reduction. Their absence means a serious pathology called "frozen pregnancy". Analyzes They must be handed over to monitor the condition of the future mother and the proper development of the fetus, as well as timely provision of the necessary care: Blood for the group and Rh factor; Analyzes for infection (HIV, hepatitis, syphilis); General blood analysis; General urine analysis; Blood test

for biochemistry; Ultrasound; Smears on the flora of the genital tract; Triple test. Contains indicators that indicate the condition of the fetus, the length of pregnancy and the number of embryos, as well as the volume of the hormone estriol; Coagulogram. What you can not do This special condition already at the initial stage requires the woman to limit: Forget about coffee and green tea. They contain substances that provoke miscarriage and interfere with the absorption of folic acid;

Do not eat fatty, spicy, salty, fast food, raw fish and meat, hematogen, seafood, do not drink soda.

All of them badly influence well-being, are not useful for the fetus, and some of the products can cause infection.

It is necessary to limit citrus and chocolate;

Do not dye or curl your hair with chemicals. Their structure is weakened, and hormonal changes can give an unexpected color;

Do not wear synthetic, tight clothes. It can provoke allergy, cystitis and circulatory disorders;

Do not visit the sauna, solarium, be careful of overheating;

Do not use medicines, including plants, without the supervision of a doctor;

Do not use toxic household and personal cosmetics (sprays from mosquitoes, antiperspirants);

To leave your shoes on high heels. It is inconvenient, shifts the center of gravity, can cause loss of balance and falling;

Do not work for more than 2 hours;

As little as possible to use transport because of the danger created by vibration; Do not lift heavy;

Do not be nervous over trifles.

Harmful habits It has long been proven the negative effect of tobacco products on the fetus. Nicotinic resins settle in the blood, which spreads them everywhere, including the placenta. The result of the introduction of poisons into the baby's developing organs are the nervous, respiratory and cardiovascular pathology. He experiences oxygen starvation, which at times increases the likelihood of miscarriage at an early age. Even if the smoking mother managed to deliver the baby to 7 months, the following pathologies may appear:

"The wolf's mouth";

"Hare's lips";

Absence of limbs;

Chronic bronchitis, asthma, severe allergic manifestations; Insulin-dependent diabetes mellitus;

Underdevelopment of the reproductive system in boys;

Renal failure;

Delays in mental development.

Smoking during pregnancy provokes premature birth, respectively, low weight of the baby. A similar action is exerted by alcohol. Few can foresee pregnancy from the moment of conception. Therefore, women often panic when they learn about it, they remember about a recently drunk glass of wine. At this stage of embryo development, it does not hurt. But in principle, alcohol and child in the mother's womb are incompatible. And do not believe in favor of expensive wine and beer for the growth of the baby, even if the pregnant woman really wants to drink. The alcohol it takes will be shared by the baby, for whom it will be a heavy shock. What can be done in the early period Do not think that pregnancy is the absence of any joys. Future moms positive emotions are needed, many pleasures are available to them:

Reasonable physical activity in the form of walking, swimming; Personal care in all types (manicure, pedicure, haircut, cosmetic mask, light massage);

Quality and delicious food;

Relax for fun and sleep, reading, knitting, going to the movies and friends. What for vitamins and trace elements are needed? At the first stage of pregnancy, a sufficient number is of particular importance:

Gland. This is a guarantee of obtaining oxygen for normal development, the possibility of delivery without complications;

Calcium. It is needed to form the baby's bones and preserve the teeth of the mother;

Folic acid. Preserves the possibility of the correct development of the fetus, and if it is deficient, various vices are likely;

Vitamin E. Maintains hormones at the proper level, keeps pregnancy;

Vitamin S. Participates in the formation of immunity, the nervous system of the baby;

Vitamins of group B. Regulate cardiovascular, nervous processes in a child, help a pregnant woman to escape toxemia;

Vitamin A. It ensures the normal functioning of the woman's heart, improves the condition of the skin, mucous membranes, hair, and nails. If there is no possibility to receive what is needed from the products, the doctor will prescribe the reception of pharmaceutical preparations. A woman should take them, not zealous in dosage. Excess of some of them can cause pathology in the child.

Sex up to 13 weeks And this is not unavailable for a pregnant woman. With normal state of health and desire, sex during this period will bring positive emotions that a woman needs so much. If you do not make a love marathon to exhaustion, then in this state they have even advantages:

Do not need to be protected;

Orgasm is achieved more quickly;

Muscles of the vagina are supported in tone.

All this, provided there is no abruption of the placenta, threat of miscarriage or multiple pregnancies. In the latter case, the permission to fulfill the marital debt will have to be asked by the doctor.

Frequent infections Many chronic ailments are exacerbated at this time. Not an exception and thrush, manifested immediately after ovulation. The woman increases the acidity of the vaginal microflora, which is why the wine is hormones. And she notices the symptoms:

Curd;

Redness of the perineum;

Itching of the labia and vagina.

You can not treat candidiasis with usual medications, they create a risk for pregnancy. Help in this case:

Normalization of the diet with the exception of baking, marinades, spices; Treatment of mucous soda solution;

Pimafucin or Gexikon as directed by a physician.

Another danger is cystitis. It can not be treated with the usual methods for other women, they can provoke a miscarriage and damage the baby. This applies to the use of medicinal herbs, so therapy should be chosen by the doctor. Usually this is Monural and Amoxiclav. A woman can speed up recovery by bed rest, a plentiful warm drink. Ectopic pregnancy At the minimum time, it manifests itself almost as normal. And yet it gives itself more severe pain in the area of fixation of the fetal egg, that is, the uterine tube. And also bloody smears. Early diagnosis makes it possible to preserve the organ after normal pregnancy. But you can do this only with a doctor, so it's so important to come to him as soon as possible.

Frozen pregnancy

Termination of fetal development until 13 weeks is called a frozen pregnancy. All that can be done with this is to save the woman from her. The fatal fruit can not be brought back to life. As the reasons are noted:

Defects in embryo development;

Infections;

Rhesus-conflict;

Bad habits of the mother.

Frozen pregnancy manifests itself by a sharp cessation of the signs put to the normal process.

Establish a fact will precisely help ultrasound. Interruption of early pregnancy

If necessary, this early period is the safest in terms of consequences for a woman. Abortion can be carried out in several ways:

Medicamentous. Allowed up to 6 weeks. It consists of taking a remedy that causes rejection of the fetal egg;

Vacuum. Can be applied at 6-12 weeks. This is the exfoliation of the fetal egg with a vacuum pump.

After each method, a woman will have many months of monitoring and rehabilitation, especially if there is an intention in the future to have children. Knowing the nuances of an early pregnancy, the sense of medicine as an ally, will help a woman give birth to a healthy baby, while retaining her own wonderful state of health.

Signs of Pregnancy

Early diagnosis of pregnancy and the determination of its duration is important not only from the point of view of obstetrics, but also because the anatomical, physiological and hormonal changes [1] that occur after conception can have a significant effect on the course of extragenital diseases that are present in anamnesis of the future woman in labor. Determination of the exact period of pregnancy is extremely important for conducting a full-fledged examination and adequate management of pregnancy and childbirth. Diagnosis of pregnancy in the early stages can present significant difficulties, as stresses, medication and some of the endocrine diseases can simulate the state of pregnancy by symptoms. At present, in connection with the widespread introduction of ultrasound diagnosis in obstetric practice, the signs of pregnancy described in classical textbooks on gynecology and obstetrics are no longer so significant. All the signs that make it possible to diagnose pregnancy are divided into suspected (doubtful), probable and reliable. They can be based on subjective or objective data.

Increasing the volume of the abdomen is one of the signs

Content

[hide]

7 References

Doubtful signs of pregnancy

To doubtful signs of pregnancy are those that are based on subjective data:

Vomiting or nausea (especially in the morning), changes in appetite or eating habits

The resulting intolerance of some odors

Violations of the functions of the nervous system (drowsiness, frequent changes of mood, dizziness, malaise, irritability)

Increased urination

Breast engorgement, their hypersensitivity

Change in skin pigmentation on the face, in the area of the nipples, along the white line of the abdomen

The appearance of scars (bands) of pregnancy on the mammary glands, thighs, belly skin

Increase of abdomen in volume

Probable signs (objective signs, determined by examination

Express pregnancy test

Amenorrhea;

Increased mammary glands, the appearance of colostrum;

Cyanosis of the vaginal mucosa and cervix;

Change in the shape, volume, consistency of the uterus;

Uterine enlargement from 5-6 weeks, first in anteroposterior size, then in transverse;

Symptom Gorwitz-Geghar: softening of the uterus, especially in the isthmus. In a two-handed study, the fingers touch the isthmus without resistance. Characteristic for 6-8 weeks from the last menstruation;

Symptom Snegireva: variability of the consistency of the uterus: with mechanical stimulation or two-handed examination, the uterus becomes denser and contractible, then again becomes soft;

Symptom Piskachek: in early terms, there is asymmetry of the uterus, protrusion of one of the corners where the implantation took place. As the term expires, it disappears;

Sign of Gubarev and Gauss: in early terms there is a slight mobility of the neck, which is associated with a significant softening of the isthmus;

Sign of Genter: in early terms, because of the softening of the isthmus, the uterine inflection is marked in front and the comb-shaped thickening on the anterior surface of the uterus along the median line. It is not always determined;

Chadwick's symptom: in the first 6-8 weeks of pregnancy, the cyanoticity of the cervix.

Undoubted (reliable) signs - in the second half of pregnancy

the heartbeat of the fetus is determined (with the aid of an obstetrical stethoscope one can hear the fetal heart contractions);

sensation of wiggling of the fetus (pervorodjashchaya-at 18-20 weeks, moth-borne - at 16-18 weeks;

palpation of large and small parts of the fetus or its movements (starting from the 2nd trimester of pregnancy). When carrying out palpation of the abdomen with Leopold's methods (external methods of obstetric examination) determine the position, position, appearance, presentation of the fetus and the ratio of the presenting part to the small pelvis;

On the roentgenogram and the echogram the skeleton of the fetus is determined.

The positive result of immunological tests for pregnancy refers to the signs likely indicating the onset of pregnancy. Determination of the level of the ß-subunit of chorionic gonadotropin in the blood serum allows to diagnose pregnancy several days after implantation of the embryo.

Reliable or unquestionable signs of pregnancy indicate the finding of the fetus in the uterine cavity. The most reliable information for diagnosis of pregnancy is obtained based on the results of ultrasound (ultrasound). When carrying out transabdominal scanning, pregnancy can be diagnosed at 4-5 weeks, and with transvaginal echography for 3.5-4 weeks. Pregnancy in the early stages is diagnosed on the basis of the determination in the uterus of the fetal egg, yolk sac, embryo and its cardiac contractions. At later dates when the fetus is visualized. Cardiac activity of the fetus is determined at the term of 5-6 weeks of pregnancy, and motor activity at 7-8 weeks.

Themes №6: Methods of Leopold-Levitsky

OF EXTERNAL OBSTETRIC RESEARCH (4 LEOPOLDS - LEVITSKY RECEPTION)

External obstetric examination is carried out with the purpose of determining: position, position, type of position, fetal presentation.

EQUIPMENT:

The pregnant woman lies on her back, the midwife is on her right, face to face with a woman.

1. RECEPTION (for determining the height of the standing of the uterine fundus, the gestational age and part of the fetus located in the bottom of the uterus)

place the palms of both hands on the bottom of the uterus.

push down, bringing your fingers together, determine the height of the standing of the bottom of the uterus and part of the fetus located in the bottom of the uterus.

2. RECEPTION (for determining the position and type of position of the fetus)

place the palms of the hands on the lateral surfaces of the uterus at the level of the navel.

the left hand lies quietly in one place. Fingers of the right hand slide on the left side of the uterus, touch the part of the fruit turned here.

the right hand lies quietly on the wall of the uterus, and the left hand feels a part of the fruit facing the right wall of the uterus (the back is palpated in the form of an even area, small parts in the form of small protrusions).

3. ADMISSION (for determining the fetus's present part)

one arm (usually the right one) lay slightly above the pubic joint so that the thumb is on one side and four fingers on the other side of the lower segment of the uterus.

slow and cautious movement, fingers plunge into the depth and cover the presenting part (the head is palpated in the form of a dense, round part with distinct outlines, and the pelvic end is in the form of an irregularly rounded shape, a soft consistency incapable of balloting).

4. RECEPTION (as an addition to the 3 reception and determination of the level of standing of the presenting part above the entrance to the small pelvis)

stand to the right of the woman face to her feet.

place the palms of both hands on the lower segment of the uterus on the right and left, the ends of the fingers reach the symphysis.

penetrate your elongated fingers, gently inward towards the pelvic cavity.

determine the ends of the fingers of the presenting part and the height of its standing.

Themes №7: Profession of a woman (juvenile, fertile and menopausal)

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HIV and pregnancy

Contents Introduction 1 General information on HIV / AIDS 2 Preparing for pregnancy 4 Questions of conception of a child for HIV-positive couples 5 Planning for pregnancy 7 Starting a pregnancy 8 Monitoring a gynecologist 8 Procedures for conducting medical

For notes

introduction 1

Introduction To date, medicine knows quite a lot about how to prevent the transmission of HIV from mother to child. HIV-infected women can give birth to healthy, uninfected children. According to the World Health Organization, the risk of mother-to-child transmission of HIV without any intervention is 20-45%. In carrying out the same preventive measures, this risk can be reduced to 2% or less. Your desire to have child care, self-care, a conscious attitude towards pregnancy, timely access to a doctor for antenatal care and active participation in the prevention of HIV transmission will allow you to become a happy mom in a healthy baby. Women are most vulnerable to HIV infection, and every year more and more Russians are faced with the need to learn to live with HIV. Most of them are young - they are from 18 to 30 years old. This is the most favorable genital age for women. From year to year, more and more children are born, whose mothers are HIV-positive, to date, about 6,000 such babies have been born. The decision to have a child or interrupt a pregnancy can only be taken by a woman. Most likely, in this situation you will need additional information, advice and support of a loved one. It is very important that future mothers not only know about programs to prevent mother-to-child transmission of HIV, but also actively participate in them, doing everything in their power to ensure that the baby is born healthy.

general information about HIV / AIDS2

Early diagnosis of HIV infection, taking care of one's health, monitoring during pregnancy, and responsible attitude to the recommendations and prescriptions of a doctor are necessary components of success. Look for information, ask questions to doctors, contact public organizations that can be a good source of not only information, but also social and psychological support. Look for communication with other women, the same as you, share experiences, help each other. We view this brochure as the first step that will help you find answers to questions about HIV infection and pregnancy. What will happen next - depends largely on you. General information on HIV / AIDS What is HIV? HIV is the human immunodeficiency virus. HIV weakens the immune system, which protects the body from various infections. HIV affects certain cells of the immune system (CD4-cells). By reducing the

number of CD4 cells, the stage of the disease is judged. People living with HIV are also called HIV-positive or HIV-positive.

general information on HIV / AIDS 3

What is AIDS? AIDS - syndrome of acquired immune deficiency. With the weakening of the immune system, a person becomes vulnerable to various diseases, especially infectious diseases (tuberculosis and pneumonia). Such diseases are called "opportunistic" (able to use favorable circumstances), since they arise when the human immune system is weakened and loses the ability to withstand pathogens. Currently, there are medicines that can stop the rate of HIV infection. Other drugs can prevent or cure some opportunistic diseases. Early diagnosis provides more opportunities for prevention and treatment. When an HIV-infected person is diagnosed with one or more of the opportunistic diseases and / or the number of CD4 cells is reduced to a certain level, he is diagnosed with AIDS. In international practice, doctors prefer to use the terms "late stage" or "advanced stage of HIV infection".

preparation for pregnancy4

How is HIV transmitted? Infection can occur if a sufficient number of HIV has penetrated into the blood. Body fluids that contain enough HIV for infection are: • blood, • semen, • vaginal secretions, • breast milk. Saliva, sweat and urine do not contain enough virus to infect. HIV can not penetrate intact skin or be transmitted through the air, like cold or flu viruses. Preparing for pregnancy For many women living with HIV, the desire to have children can be one of the main ones, especially if they have not yet experienced the happiness of motherhood. It is your choice and the right - to give a new life and continue your kind. Making a decision become a mother, every woman takes responsibility for the life and health of her future baby.

preparation for pregnancy 5

Of course, you will have questions that you should think about and discuss with your partner and / or HIV / AIDS counselor. The main points we will try to cover in this brochure.

Questions of conception of a child for HIV-positive couples Questions of conception of a child for couples in which one or both partners are HIV-infected are very relevant. How and when to do it, in order to protect themselves as much as possible and, first of all, the future child? As we have already said, an HIV-infected mother can transmit the virus to a child during pregnancy, childbirth and breastfeeding. The child can not be infected directly from the father, since the spermatozoids do not contain the virus. The sperm and egg are to a certain extent sterile and do not contain anything other than genetic information and nutrients for the development of the embryo cell. But since the semen contains a high concentration of HIV, the HIV-infected partner can transmit the virus to the woman. If a woman is not infected with HIV, then with unprotected sex, she can become infected with the virus herself and subsequently transmit it to the child. If both partners are infected in a pair, it is important to remember that when engaged in unprotected sex, there is a risk of re-infection with other types of HIV or a drug-resistant virus. This can also increase the risk of mother-to-child transmission of the virus. For pairs in which one or both partners of HIV-infected suschestvu- dissolved conception alternative methods: For pairs in which only the infected female • method of artificial insemination: the procedure is the introduction of semen into the vagina during ovulation which occurs

priblizitelnona 14- th day of the menstrual cycle, when a mature egg leaves the ovary and is ready for fertilization with spermatozoids.

preparation for pregnancy 6

For couples in which the man is infected • timed contact: sexual contact without a condom during ovulation (release a mature egg, ready to oplodotvore- NIJ). When using this method, there is a risk of HIV transmission from one partner to another. Some couples use this method when other methods of conception are unavailable or unacceptable. Before resort to this method, both partners must be screened frames - the ability to detorozhde- NIJ, polovyhorganov chronic diseases, infections, sexually peredayuschi- Esja - and if necessary, to be treated. • Artificial insemination of a woman with the purified sperm of an HIV-positive partner: the method consists in direct insertion of the sperm into the vagina after the process of "purifying" the sperm. This method significantly reduces the risk of transmission of the virus to a woman, and many specialists consider it to be the most preferable for couples in which a man is infected. A woman who wants to conceive a child in this way is under observation, during which the moment of the onset of ovulation is determined, after which the partner provides the sperm for cleaning. Pre-sperm partner is investigated for the ability to fertilize. The limitation to the use of this method is its high cost and the limited number of clinics in which this method is available. • In vitro fertilization (in vitro fertilization) using this method spermatozoa separated from semen- of the liquid, and the woman using the minimally invasive surgical intervention Cesky (laparoscopy) carried fence mature

preparation for pregnancy 7 ovules. Oocytes are fertilized in vitro. A successfully fertilized ovum is placed in the uterine cavity. This method, in view of the high cost and necessity of carrying out procedures related to artificial intrusion into the body, is only applied to couples experiencing problems with conception. • Artificial insemination of female sperm of HIV-negative donor: the method completely excludes the risk of HIV transmission to a woman, but not all couples consider it acceptable for themselves. Before using this method, legal and ethical problems that may arise in the future should be prevented if the donor claims paternity.

Planning pregnancy If you decide to give birth to a child, then a few months before the proposed pregnancy, you should visit a doctor (obstetrician-gynecologist) and tell him about your plans. Experience shows that a well-planned pregnancy gives many advantages for both mother and baby. The risk of mother-to-child transmission of the virus increases significantly if the woman has untreated or chronic forms of sexually transmitted infections (STIs), chronic female genital diseases at the acute stage, diseases of other organs and systems that lead to a deterioration in the general condition of the woman. Of great importance are the stage of development of HIV infection in women, the viral load, immune status, the presence of opportunistic infections. Timely appeal to specialists in preparation for pregnancy will, firstly, determine the state of your immune system and, secondly, identify hidden infections, cure existing ones and prevent their occurrence, which will reduce the risk of mother-to-child transmission of HIV.

beginning of pregnancy8

The beginning of pregnancy When pregnancy comes, you need to contact the AIDS Center. The center's specialists will advise you on further observation and screening during pregnancy and, when necessary, provide drugs to prevent mother-to-child transmission of HIV.

Observation with a gynecologist First, an obstetrician-gynecologist will confirm the onset of pregnancy and put you on the register for pregnancy. During the first visit, you have to answer some questions related to your health. For your part, focus on constructive cooperation, establish good relations with your doctor - you will meet at least once a month during your pregnancy. The doctor will send you to do a series of tests - usually ultrasound, a general blood test and urinalysis. In addition to these procedures, you should be asked to pass blood tests to determine the immune status and viral load. These studies are necessary to assess the state of your health (immunity) and to learn how the virus behaves. Based on these tests, your doctor will decide whether to prescribe antiretroviral therapy for you. Other tests that you should be offered include: tests for sexually transmitted infections (gonorrhea, syphilis, chlamydia, etc.), for hepatitis B and C, for tuberculosis. Also, the doctor will look at the condition of the genitals and make a smear for the study of the vaginal microflora. If you are just planning a pregnancy, it is better to pass these tests in advance and, if necessary, get treatment. Remember that premature pregnancy is one of the additional risk factors for the transmission of the virus to the baby. Therefore, it is necessary to visit a doctor regularly and take care of yourself and your health.

beginning of pregnancy 9

Procedures for conducting medical procedures HIV-positive women should avoid certain medical procedures during pregnancy. Most physicians believe that studies should not be conducted that involve skin disruption and "intrusion" into the uterine cavity, as this poses an additional risk of infection of the child with HIV infection. Often these procedures are aimed at determining hereditary diseases and malformations in the fetus. If you have fears in this regard, you can seek advice from a genetic doctor and conduct special tests before pregnancy. In any case, you have the right to clarify with the doctor the purpose of these procedures and how to perform them. There are also methods that allow you to evaluate the development of the fetus during pregnancy and without penetration into the uterus, for example, ultrasound (ultrasound). If nevertheless these procedures are necessary for medical reasons, before they are carried out, you should make a viral load test to determine the content of the virus in the blood and prescribe antiretroviral therapy to reduce the risk of HIV transmission to the child.

A few tips for maintaining health The healthy way of life of a future mother is the key to successful childbirth and the health of the child, regardless of her HIV status. Recommendations related to diet, day regimen, physical culture, pregnant woman hygiene, described in numerous literature, should also be used by an HIV-infected woman.

beginning of pregnancy10

Here are some general tips: • Pay attention to your diet. Full and balanced food is the guarantee of health for you and your baby. Watch your weight: if you get up to 15 kilograms during pregnancy, this is normal. • Try to abandon alcohol, tobacco and psychoactive substances. • Purchase multivitamins for pregnant women and start taking them daily. Choose the ones that

suit you at a cost. Pay attention to vitamin B and especially folic acid. It is these vitamins that save the fetus from a variety of birth defects. Taking folic acid before conception will support your health and the health of your future baby. • Try to avoid colds. Going to crowded places, drip into the nose of interferon or lay octal ointment; add more onions and garlic to the diet. These activities are harmless to the fetus. More walk in the fresh air, further from the roads. • If you are taking any medications, be sure to tell your doctor about it. Many drugs can be dangerous for the development of the fetus. • Be cautious about radiographic research during pregnancy, especially in the abdomen, pelvis and lungs (fluorography), because irradiation with X-rays can adversely affect the development of the fetus.

beginning of pregnancy 11

• It is better to refrain from "aggressive" sex, especially in the first three months of pregnancy. During this period, there is a high risk of sudden abortion (miscarriage). Always use condoms. This will protect you from various sexual infections, which can be dangerous for you and your future baby. • Special physical exercises (gymnastics for pregnant women) are very useful. They will strengthen your muscle tone and help bear and give birth to a child. Especially good are swimming and walking in fresh air. • It is also important to rest and not overwork. It is recommended to sleep at least eight hours a day, and many women think that they deserve more. • Try to receive only positive emotions - you are preparing for a very important business, and other problems should not greatly exclude you. Stress is unlikely to be useful not only to you, but also to your future child.

What should be paid special attention to mothers with HIV infection? Opportunistic infections. Any infection is a threat to a pregnant woman. However, if a woman is HIV-positive, she has special enemies - opportunistic infections, that is, diseases that usually occur in people with immunodeficiency and are an indicator of the progression of HIV infection. Below are general guidelines for how to avoid contact with pathogens that cause these diseases. Pets. Avoid contact with domestic animals (cats, dogs, exotic pets) - many of them can be a source of infection. If you have a pet, be sure to inspect it from a veterinarian, wash your hands after contact with the pet, instruct others to clean up after him. Environment, nutrition. Use only boiled water, avoid contact with water in natural water bodies, and also with freshly plowed, loosened soil. In addition, if you live in a rural area,

beginning of pregnancy12

Avoid contact with farm animals (cows, sheep). Do not eat raw foods (milk, eggs, sour cream), do not buy food in "spontaneous" markets. And most importantly - try to be as calm as possible, to avoid stressful conditions and not to panic. Stress and fear are the main enemies of a pregnant woman.

Toxicosis Toxicosis - a frequent phenomenon associated with hormonal changes in the body. Usually it falls on the first three months of pregnancy and manifests itself in the form of nausea, vomiting, weakness and dizziness. Most often, by the 4th month of pregnancy, the toxicosis passes. If symptoms persist, you should immediately consult a doctor. These are general recommendations that are not necessarily ideal for you. Experiment with food and lifestyle, and you will definitely find your way to overcome the toxicosis.

HIV and Pregnancy 13

HIV and pregnancy Observations about pregnancy in HIV-positive women In the first half of pregnancy, a woman should attend a consultation once a month, after 20 weeks of pregnancy -2 times, after 32 weeks - 3-4 times a month. If necessary, the doctor will appoint more frequent visits. In normal pregnancy, prenatal hospitalization is recommended in 37-38 weeks. If there is a threat of complications, hospitalization can be carried out at any time of pregnancy.

Effect of pregnancy on the course of HIV infection It is known that during pregnancy, the defenses of the mother's body are weakened. Therefore, there were fears that these natural changes could accelerate the development of infection in HIV-positive pregnant women. However, numerous observations of the status of HIV-infected women during pregnancy and after childbirth showed no difference in the progression of the disease compared to non-pregnant HIV-positive women.

When can mother-to-child transmission of HIV occur? The risk of mother-to-child transmission of HIV is between 20% and 45% if no preventive measures are taken. At the same time, the greatest risk is during labor:

HIV and pregnancy14

Infection during pregnancy During pregnancy, the virus from the mother's bloodstream can penetrate the fetus through the placenta. The placenta is the organ that connects the mother and the fetus. Through the placenta, the fetus receives oxygen and nutrients from the mother's body, but the blood of the mother and child does not mix. Normally, the placenta protects the baby from the pathogens of various infections in the maternal blood, including HIV. However, if the placenta is inflamed or damaged, which can occur with abdominal injuries or with infectious diseases, its protective properties are reduced. In this case, HIV infection can be transmitted from the mother to the fetus.

Infection during childbirth can occur in two ways. • When passing through the birth canal (cervix, vagina), the infant's skin contacts the blood and vaginal secretions of the mother that contain HIV. On the skin of the baby there are wounds and sores, through which the virus can get into his body. • When passing through the birth canal, the infant can swallow maternal blood and vaginal discharge. In this case, the virus can enter the body of the child through the mucosa of the mouth, esophagus and stomach.

Infection during breastfeeding can occur: • directly through milk, because it contains HIV; • through blood - if the mother has a damaged skin around the nipple, then along with the milk the child can get blood, which is an additional risk for him. If the mother becomes infected with HIV during breastfeeding, the risk of transmission to the baby increases by 28%.

HIV and Pregnancy 15

Maternal factors: • Viral load in the mother. If the mother has high viral load (> 10 000 copies of the virus in 1 ml of blood), the risk of HIV transmission to the child is significantly increased. • Immune status of the mother. The lower the number of CD4 cells in the blood of a prospective mother, the higher the risk of HIV transmission to the baby. • Smoking, due to its

negative effect on immunity, may increase the risk of mother-to-child transmission of HIV. • The age of the mother (> 30 years) may also be associated with an increased risk of HIV transmission. • Female genital infections, whether untreated or chronic, also increase the risk of mother-to-child transmission of HIV. • Antiretroviral (ARV) therapy, used during pregnancy, and for the newborn reduces the likelihood of HIV transmission (see below: "Prevention of mother-to-child transmission of HIV").

HIV and Pregnancy16

Obstetric and gynecological factors: • Premature discharge of amniotic fluid. • In the anhydrous period of four or more hours (anhydrous period - the time that passes from the passage of amniotic fluid before the birth of a child), the risk of infection increases almost twofold.

Method of labor: • Caesarean section, if done prior to the onset of labor, can significantly reduce the risk of transmission of the virus to the child. In the context of HIV prevention, it makes sense to talk only about the planned CS: before the onset of labor at the 38th week of pregnancy, until the amniotic fluid is reached. Studies have shown that planned CS significantly reduces the risk of mother-to-child transmission of HIV, regardless of the effect of antiretroviral treatment. When the planned CS is performed in combination with antiretroviral therapy, it is possible to reduce the level of HIV transmission to a child up to 2% or less. The decision on the need for caesarean section can only be taken together with a doctor. • Female genital infections, whether untreated or chronic, also increase the risk of mother-to-child transmission of HIV. Fetal factors: • Birth weight less than 2500 grams increases the risk of HIV transmission during childbirth and breastfeeding, because such children often have immature immune system, protective function of skin and mucosa of the gastrointestinal tract. • Premature spontaneous delivery (<38 weeks) increases the risk of transmission, as the child may have an insufficiently developed immune system. • If twins are expected: the twin born first is twice as likely to become infected with HIV than the second. This is due to the fact that the time of passage through the birth canal in the first twin is longer and longer than the contact with infected maternal blood and secretions.

prevention of HIV transmission 17

Preventing mother-to-child transmission of HIV Mother-to-child transmission of HIV is possible during pregnancy, during childbirth and breastfeeding. To prevent infection of the infant during breastfeeding, it is recommended that children born to an HIV-positive woman should not breast-feed or breast-feed. If it is not possible to feed without the mother's milk, it should be boiled. The use of medication prophylaxis during pregnancy and childbirth (with the refusal of subsequent breastfeeding) can reduce the risk of infection of a child to 2% or less.

prevention of HIV transmission18

The most successful results are obtained with all three stages of drug prevention, but if any of them can not be carried out (for example, due to the late detection of HIV infection in a woman), this is not the reason for abandoning the next stage. When prescribing drugs, a woman is informed about the purpose of this activity, the probability of the birth of an infected child during prevention and withdrawal, and the possible side effects of the drugs used. It must be

remembered that antiretroviral drugs during pregnancy are prescribed primarily for the prevention of mother-to-child transmission of HIV, and not for the treatment of HIV infection.

The use of ARV drugs during pregnancy: • Should begin no later than the 28th week of pregnancy. • If HIV infection was detected at a later date, the medication is started as soon as possible (from the moment of diagnosis).

Use of ARVs during labor: • To reduce the risk of mother-to-child transmission of HIV during labor, several prevention strategies have been developed using AZT (retrovir), nevirapine (Viramun) for both intravenous use and tableted formulations.

The use of ARV drugs in a newborn: • This stage begins after birth. Siroparidymidine or nevirapine may be used. • If ARV therapy was not carried out during pregnancy and childbirth and preventive maintenance during the newborn period was not started within the first three days after birth, starting it later is meaningless.

prevention of HIV transmission 19

In order for preventive measures to produce the desired result, that is, for your child to be born healthy, it is very important to follow the drug regimen clearly. If you break this regimen (often miss a dose, take less than the prescribed dose, or do not keep intervals between doses), the risk of transmission of the virus to a child increases.

Effects of ARV drugs on the future child To date, there is no reliable data on the adverse effects of ARV drugs on fetal development. One can say for sure that the effectiveness of AZT and nevirapine for the prevention of mother-to-child transmission of HIV predominates on their side effects. If you follow all of the above, then, according to numerous studies conducted around the world, the risk of mother-to-child transmission of HIV can be reduced to 2% or less.

postpartum period20

Postpartum period • Postnatal care for HIV-positive women does not differ significantly from the care of uninfected patients. • Precautions should be taken when contacting lochia (vaginal discharge in the postpartum period), hygienic pads or materials with traces of blood. • For termination

lactation it is possible to use the method of constriction of dairy wax or drug loss of lactation (as recommended by the doctor). • Care must be taken when caring for the baby, avoiding contact with infected fluids of the HIV-positive mother: blood, milk, vaginal discharge. • After discharge from the maternity hospital, a woman needs to visit a gynecologist in the near future, since HIV-positive women are more susceptible to postpartum infectious complications. • Consult with family planning specialists and methods of contraception. • During this period, some women have a special need for psychological help and emotional support, which can be found in their relatives and friends or in special organizations and services. A good source of support can be a self-help group.

supervision and care of children 21

Observing and caring for children A baby born from an HIV-positive mother needs special attention, and his health will largely depend on how responsible the parents are in approaching medical examinations and performing the necessary procedures. Children born to an HIV positive mother should be: • supervised by a local health center, • by a pediatrician at the AIDS center, • by specialists, • by standard laboratory tests, • by intrauterine infection, • by vaccination, • by prophylaxis pneumocystis pneumonia.

Vaccination (immunization) of children born to HIV-positive mothers Vaccination is an integral part of the medical supervision of children, especially those born from HIV-positive mothers. It should be remembered that immunization with living vaccines is restricted for such children, since living vaccines can cause serious complications and progression of the disease if the child is HIV-infected. Vaccination is carried out according to the vaccination schedule without restrictions.

diagnosis of HIV infection in children22

Prevention of PCP Every child born to HIV-positive mothers should be prevented from pneumocystis pneumonia with biseptol from six weeks. If a child is in the field of vision of medical personnel in a later period, then prevention should begin as early as possible. In a child over 12 months of age, prophylaxis is performed depending on the parameters of the immune status. Most often, pneumocystis pneumonia develops at the age of 3-9 months of the child's life. Diagnosis of HIV infection in children born to HIV-positive mothers It should be noted that all children born to HIV-positive mothers are positive for serological tests for HIV antibodies because all children have maternal antibodies in their blood, which, unlike the HIV virus, is much smaller in size and can penetrate the placental barrier. But antibodies can not cause HIV infection. Maternal antibodies eventually break down, and if the child is not infected with HIV, then by 18 months of life, a negative diagnosis can be made according to the results of serological tests. If the transmission of HIV did occur, the results will remain positive in 18 months. This suggests that the child develops his own antibodies to the human immunodeficiency virus. To know whether the child has been transmitted to HIV, it is possible much earlier, based on the results of tests for the presence of the virus itself (PCR is a polymerase chain reaction). But serological tests are more specific, and the final diagnosis is based on the results of serological reactions, and PCR is used as ancillary research. In addition, PCR is much more expensive than antibodies tests, so few medical institutions can afford them.

diagnosis of HIV infection in children 23

Until the final diagnosis is made, the child will have a diagnosis of "Perinatal contact for HIV infection" and be considered (statistically) positive. For the final diagnosis of a child born to an HIV-positive mother, the following clinical and laboratory studies should be performed: • two or more HIV antibody tests at 12-18 months of age, one study at the age of 18 months ; • two studies by virological methods (PCR) - up to 12 months; Research on the presence of clinical manifestations specific to HIV / AIDS. Based on the results of these studies, a definitive diagnosis will be made.

conclusion24

Conclusion We hope that after reading this brochure you will find the answers to your questions. It is up to you to choose whether or not to have a child, we can only tell you how to make it so that he is healthy. You can give birth to a healthy child if you follow all of the above recommendations and advice of medical personnel! And remember: as the ancient Chinese wisdom says, "The road will be mastered by the going." I wish you success!

Themes №8: Definition of the late term of pregnancy of term berth.

How to listen to the fetal heartbeat

For the first time to hear the heartbeat of your child is an amazing and exciting moment. Listening to the heartbeat can tell the doctor much about the health of the child. For future mothers and fathers, it is extremely important to hear the baby's heartbeat, as they will be able to make sure that the baby is growing correctly. There are several ways in which you can hear the fetal heartbeat. Some of them you can hold at home, while others will be held in the doctor's office. Before using home methods, be sure to consult a doctor.

Method 1

Listen to the heartbeat at home

With the help of a stethoscope. One of the easiest ways to hear the fetal heartbeat at home is by using a conventional stethoscope. At the 18-20th week of pregnancy, the heartbeat should already be strong enough so that you can hear it through the stethoscope. Just attach it to your belly and listen. Perhaps to find a heartbeat, you will have to mute a stethoscope on your stomach. Be patient. [1]

The quality of the stethoscope is very important, so get it only from a reputable seller. In your local pharmacy and even in some office stores, at your disposal stethoscopes of different brands will be available. If you have such an opportunity, you can also borrow a stethoscope from a friend or relative working in the medical field.

Download the application. New technologies allow you to hear the heartbeat of your child without any effort. There are several different applications that you can buy and download to your phone to listen to your heartbeat. Some of them even allow you to record the sound of the heartbeat so that you can reproduce it for your friends and family. [2]

This application is best used in the late stages of pregnancy. With the help of a cardiac monitor. You can buy a relatively inexpensive cardiac monitor for monitoring fetal cardiac activity and use it at home. This is a pretty good choice, if between the trips to the doctor you are inclined to experiencing, and the sound of the heartbeats calms you. However, you should know that these monitors are not as powerful as those used by doctors. He will not be able to catch the child's heartbeat unless you are at least five months pregnant. [3]

Before buying a home cardiomonitor, always consult a doctor. After buying it, follow the instructions for use carefully.

Learn about the factors that affect the sound. Even using the right devices, there are many reasons why you may not hear the fetal heartbeat. It is very important to know that such things

as the position of the fetus and your weight can affect whether you can clearly hear the heartbeat. If you believe that there is cause for concern, immediately consult a doctor

Communicate with your doctor. The relationship between you and your doctor or midwife is very important. When pregnant, make sure that you work with a trusted doctor. Talk with the doctor about the development of the child, as well as the ways by which you can hear his heartbeat at home, and in his office. Give preference to a doctor who thoroughly and patiently answers all your questions.

Prepare for a visit to the doctor. Ask the doctor when you can hear the fetal heartbeat for the first time. Most doctors prescribe a prenatal examination on the ninth or tenth week of pregnancy. Before your visit, you should prepare a list of questions that you want to ask the doctor. This point will be even more special if you understand what is happening and what you should expect. [6]

It will be a very emotional and emotional visit. Ask your partner, a close friend or relative to come with you to the reception and share with you these pleasant experiences.

Fetal doppler. Ask your doctor about what he will use to listen to the heartbeat. Usually the first heartbeat sounds will be heard when a doctor or nurse uses a fetal doppler that uses sound waves to enhance the heartbeat. You lie down on the observation table, after which the doctor will hold a small sensor on your stomach. This procedure is painless. [7]

Although usually the doctor will be able to find the fetal heartbeat on the ninth or tenth week, sometimes it is better to perform the procedure at week 12, so that the search for a heartbeat is not difficult.

Do an ultrasound. If your doctor prescribes an early ultrasound, you will be able to hear the fetal heartbeat through ultrasound at the earliest on the eighth week of pregnancy. Ultrasound is usually prescribed early because of the presence of increased risk factors for pregnancy. Otherwise, ultrasound is carried out not earlier than at 10-12 weeks of pregnancy

Distinguish between devices. Know that to listen to the heartbeat of the fetus, your doctor can use a stethoscope. However, this device is not as powerful as others, so the doctor will use it not earlier than in the second trimester of pregnancy. A doctor or midwife can also use a fetoscope, a device specifically designed to listen to the fetal heartbeat. [9]

Method 3

Palpitation of the fetus

Know about the development of the fetus. Being pregnant, it is very important to know the stages of the child's development. Thus, you will know when you are supposed to be able to hear the heartbeat, and compare this information with other stages of fetal development. For example, it will be useful for you to know that a doctor can hear the child's heartbeat already at the eighth, ninth or tenth week of pregnancy. [10]

Do not forget that the period of fertilization is not always accurate. Do not immediately raise panic if, in your opinion, the development of the child is not fast enough. It is likely that the period of fertilization had a deviation of one or two weeks.

Watch your heart's health. There are many things that you can do to help your child's heart grow strong and healthy. During pregnancy avoid alcohol, smoking and drugs. To help the development of your child, you will need to take folic acid. [11]

Eat healthy foods and avoid caffeine.

Know about the risk factors. Even though you can not wait to hear the fetal heartbeat, it is first worth familiarizing yourself with the risks associated with using a cardiac monitor to monitor the fetal heart activity. The main disadvantage is that the sound of a healthy heartbeat can lead to a false sense of safety in pregnant women. For example, if you feel unwell, but still hear a heartbeat, you can postpone the trip to the doctor. Listen to your body and contact your doctor at the first sign of a malaise. Do not rely too much on home cardio monitors. [12] Moreover, having such a monitor at home can increase your stress level.

Get close to your child. With the permission of the doctor, start listening regularly to the child's palpitation. This feeling will allow you to get closer to your baby. In order to relax, try to take a warm bath and talk to your tummy. In the late stages of pregnancy, the baby will begin to respond to your voice and mood. The child begins to hear sounds at about the 23rd week. [13]

Advice

Share this experience with your partner. It will be an exciting moment for both of you.

Try several methods to find the most suitable for yourself.

Edit Warnings

Before trying to listen to the heartbeat of your child, first consult with your doctor.

Themes №9: Signs of the selection and birth of the afterbirth

The consecutive period begins immediately after the birth of the fetus and ends with the birth of the afterbirth. This is the shortest period of labor, but it is very dangerous because of the possibility of bleeding from the uterus.

The follow-up period is actively awaiting. Constantly observe the condition of the parturient woman, the coloring of the skin and visible mucous membranes, pulse, arterial pressure; take into account the complaints of the parturient woman (dizziness, headache).

In order not to disrupt the processes of uterine contractions and placental abruption, empty the bladder immediately after the birth of the child by means of its catheterization. A woman is placed on a sterile vessel or a kidney-shaped basin is substituted to account for blood loss.

The doctor or midwife is constantly monitoring the appearance of signs that indicate the separation of the placenta from the uterine wall. There are a number of symptoms associated

with changes in the shape and position of the uterus and with the condition of the umbilical cord.

A sign of Schroeder. Immediately after the birth of the fetus, the shape of the uterus is rounded and the bottom of it is at the level of the navel. After the placenta is separated, the uterus is flattened, its bottom rises above the navel and deviates to the right. Often above the pubis, a soft pillow protrusion is formed (due to the lowering of the postpartum into the lower segment of the uterus). Uterus looks like an hourglass.

A sign of Kyustner-Chukalov. When pressing the edge of the palm over the pubis umbilical cord, hanging from the genital slit, with the unplaced placenta drawn into the vagina. If the placenta has separated from the uterine wall, the umbilical cord remains immobile (Figure 60). '

A sign of Alfeld. Ligature, imposed on the umbilical cord at the sexual slit, with the separated placenta falls 8-10 cm or more.

Sign of Strassmann. In the unseparated placenta, beating on the bottom of the uterus is transmitted by a blood-filled umbilical vein. This wave can be felt with the fingers of the hand located on the umbilical cord above the ligature (clamp). If the placenta is separated from the uterine wall, this symptom is absent.

Sign of Dovzhenko. The parturient is offered to breathe deeply. If the umbilical cord does not retract into the vagina, the placenta separates from the uterine wall.

A symptom of Klein. The mother is offered to labor. If the placenta has separated from the uterine wall, after the termination of the attempt, the umbilical cord remains in place. If the placenta does not separate, it is drawn into the vagina.

Sign of Mikuliga-Radetsky. After detachment of the placenta, the latter can descend into the vagina, and the maternity patient feels the urge to exert pressure.

Sign of Hohenbichler. When the placenta is not separated, during the contraction of the uterus, the umbilical cord hanging from the genital slit can rotate around its axis due to overflow of the umbilical vein with blood.

a - the placenta did not separate: when pressing the palm of the hand over the suprapubic region, the umbilical cord is drawn into the vagina; b - the placenta separated: when pressing on the suprapubic region, the umbilical cord is not drawn into the vagina

Fig. 60. Sign of separation of the placenta Kustner-Chukalov:

Fig. 61. The method of isolating the Aboladze afterbirth

If monitoring of the woman in labor can not detect signs of separation of the placenta, the expectant management tactics of period III should not exceed 30 minutes, despite the absence of bleeding and the condition of the woman in childbirth. To avoid possible complications

leading to a large loss of blood, you have to resort to manual removal of the placenta and removal of the placenta.

Active follow-up period is also started in those cases when bleeding started, blood loss reached 250-300 ml, and there are no signs of placenta separation. Active measures (manual removal of the placenta) are necessary even with a slight external blood loss, but with deterioration of the maternity.

Attempts to accelerate the process of expelling the afterbirth by massaging the uterus, pulling at the umbilical cord are unacceptable, since they disturb the physiological process of detachment of the placenta from the uterine wall, change the rhythm of its contractions and only contribute to increased bleeding.

After the birth of the afterburn in front of the doctor is a responsible task - to inspect it. The latter, facing the mother's surface upwards, is placed on a smooth tray and carefully inspects the integrity of the placental tissue. Fissures between the lobes of the placenta are clearly visible (Figure 64). The surface of the placenta should be smooth, covered with a thin layer of decidua and have a grayish-blue color. Pay special attention to the edges of the placenta, since pieces of tissue often come off in the peripheral parts of the placenta. When viewed from the placenta, attention is drawn to the change in its tissue: the presence of calcification, areas of fatty degeneration, old blood clots. Having convinced of the integrity of the placenta, it is necessary to see whether the vessels leave the edges of the vessel into the shells. If there is a break in the vessel in the shells, it is concluded that there is an additional lobule remaining in the uterine cavity. When the lobes of the placenta are delayed in the uterine cavity and even if there is a suspicion of a defect in the placental tissue, it is immediately necessary to conduct a manual examination of the uterine cavity and remove the lagging lacuna of the placenta.

The samples proposed by a number of authors to determine the integrity of the placenta (milk, air, swimming) are of little informative and are not currently applied.

After examination, the placenta is inspected. Clarify the place of rupture of the shells and whether they were all born. The closer to the edge of the placenta the rupture of the membranes occurred, the lower it was located in the uterine cavity. If it turns out that most of the shells are missing, the doctor must remove them from the uterine cavity, making a manual examination of the latter. If only small fragments of shells have lingered in the uterine cavity and there is no bleeding, there is no need for their artificial removal. They will stand out in the first days of the postpartum period. The placenta after examination is measured and weighed. All data of the examination of the afterburn is recorded in the history of childbirth.

Themes №10: Postpartum hemostasis

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a is a general view; 6 - mother's surface; Large and small lobules - cotyledons, on the periphery of the placenta, shells are visible; c - the fruit surface covered with the amniotic membrane, the umbilical cord is visible, its vessels, at the periphery of the placenta - the membranes

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Themes № 11: Personal hygiene

To wash it is necessary to use not soap, but only warm water or special compositions for intimate hygiene, containing substances that do not violate the acidity of the vaginal environment and create conditions for the growth of lactobacilli. You need to wash yourself with cleanly washed hands, at least twice a day.

The direction of the water jet when washing and moving the hands should be directed from the front back, so as not to infect the vagina from the anus of the anus (by the way, after the natural needs have been dispensed, the toilet paper movement should be directed in the same way). I do not wipe off the moisture after washing, but get wet, so as not to accidentally scratch the soft covers.

The area around the anal opening should be washed with a usual toilet soap, because gels for intimate hygiene do not provide the disinfection necessary for this zone.

The towel should be clean, soft, and should be used only by its owner.

During menstruation, do not take a bath, swim in the pool or water. It is better to avoid sexual contact. Hygienic pads during menstruation should be changed at least four to five times a day.

If you use vaginal hygiene tampons, remember that you need to change the tamp every two hours. In most developed countries, doctors do not recommend using tampons regularly.

It is advisable not to use constantly daily sanitary napkins, if there are no special reasons for this. The daily excretions in women are so low that they do not require the use of pads. If you are concerned about increased vaginal discharge in the period between menstruation - it is better to consult a gynecologist.

Douching (rinsing the vagina from the inside with various solutions) should be done only if they are prescribed by a gynecologist. For regular hygiene, they are not only not needed, but can seriously damage the microflora of the vagina.

Why it is necessary to pay so much attention to such seemingly simple things?

The point is that the "center" of the female reproductive system - the uterine cavity - should normally be sterile, so that the developing embryo does not get injured by bacteria or viruses.

The exit of the vagina is anatomically located near the anus, so it is necessary to pay special attention to the characteristics of feminine hygiene, in order to avoid infection into the female's internal genitalia. Also, it is necessary to avoid creating favorable conditions for multiplying pathogenic microorganisms in the perineal region.

Especially vulnerable to infection is the uterus in a period such as menstruation, since during the months there is no protective plug from the mucus in the cervix.

In addition to the mucus barrier in the cervix, the pathway to microorganisms is closed by bacteria that inhabit the vagina. The normal microflora of this organ is 90% composed of lactobacilli, which secrete lactic acid. The acidic environment of the vagina depresses most pathogenic bacteria. If, for some reason, the environment in the vagina becomes alkaline rather than acidic, the number of lactobacilli greatly decreases, and the vacant space can take other microbes. This condition is called dysbacteriosis, and if anaerobic flora predominates, bacterial vaginosis.

The simplest and most common cause of a violation of the acid-base balance in the vagina is the ingress of alkaline soap bubbles into it during washing. Do not be scared if this happens once. But constant alkaline "strokes" lead to serious disturbances in microflora, reproduction of pathogenic bacteria, and, accordingly, an inflammatory disease of the female sexual sphere.

The protective capabilities of the genital organs depend on the age of the woman. Up to 17-18 years, that is, before puberty, the microflora of the vagina of a girl is easily disturbed in any adverse effects. Its resistance is also decreasing in women who have reached menopause.

During these periods of life, the rules of intimate hygiene should be observed especially carefully.

Introduction

Hygiene is a medical science that studies the impact of the environment and production activities on human health and develops optimal, scientifically sound requirements for the living and working conditions of the population.

The most precious gift that a person receives from nature is health. It's not for nothing that people say: "Everything is healthy for a healthy person!" It is always worth remembering this simple and clever truth, and not only when the body starts to malfunction and we are forced to turn to doctors, sometimes demanding impossible from them.

No matter how perfect medicine is, it can not save everyone from all diseases. Man himself is the creator of his health! Instead of dreaming about "living water" and other miraculous elixirs, it is better to lead an active and healthy life from an early age, to temper, exercise and sports, to observe the rules of personal hygiene - in a word, to achieve in reasonable ways the true harmony of health.

The main thing - a healthy lifestyle - a set of recreational activities that ensure the harmonious development and strengthening of health, improving the working capacity of people, prolonging their creative longevity.

The main elements of a healthy lifestyle are productive work, optimal motor conditions, personal hygiene, rational nutrition, hardening, rejection of bad habits.

General Hygiene

1.1. Hygiene and its main tasks

Hygiene, as well as natural environmental conditions (exposure to sunlight, air, water) are means of physical education. Physical culture should not be exhausted only by physical exercises in the form of sports, gymnastics, outdoor games and other things, but must embrace both public and personal hygiene of work and life, the use of natural forces of nature, the correct mode of work and rest.

Hygiene is the science of health, the creation of conditions favorable to human health, the proper organization of work and leisure, and the prevention of disease. Its purpose is to study the impact of living and working conditions on human health, prevent diseases, ensure optimal conditions for human existence, preserve its health and longevity. Hygiene is the basis of disease prevention.

The main tasks of hygiene are studying the influence of the external environment on the health and working capacity of people; scientific substantiation and development of hygienic norms, rules and measures for improving the environment and eliminating harmful factors; scientific

substantiation and development of hygienic standards, rules and measures to increase the body's resistance to possible harmful environmental influences in order to improve health and physical development, improve efficiency.

Sanitation - the practical implementation of hygiene requirements, the implementation of the necessary hygiene rules and measures.

During the development of hygiene, a number of hygiene disciplines were formed: occupational hygiene, social hygiene, hygiene of children and adolescents, hygiene of physical culture and sports

The hygiene of physical culture and sports, which studies the interaction of the organism engaged in physical culture and sports with the environment, plays an important role in the process of physical education. Hygienic regulations, norms and rules are widely used in the physical culture movement.

Hygienic regulations are so important because without them it is impossible to fulfill the basic tasks of comprehensive and harmonious development of people, to maintain strong health and creative activity for many years, to prepare the population for high-performance work and protection of the Motherland.

Young specialists graduating from the country's universities should know the basic provisions of personal and public hygiene and apply them skillfully in everyday life, in studies, in production.

Hygiene of physical culture and sports includes sections: personal hygiene, hardening, hygiene of the home, hygienic requirements for sports facilities and places for exercising, auxiliary hygienic means of recovery and increase of efficiency.

1.1.1. Communal Hygiene

Communal hygiene is a section of hygiene that studies the impact of environmental factors on health and the sanitary conditions of life of the population. Based on the study of these factors, hygienic standards and sanitary measures are developed to ensure healthy and favorable living conditions for the population.

Research in the field of communal hygiene is aimed at studying the adverse chemical, physical and biological factors of the environment and the development of sanitary rules, hygienic regulations and standards for the hygiene of air, water and water supply hygiene, sanitary protection of water bodies, soil hygiene and sanitary cleaning of inhabited places, and public buildings, hygiene of planning and development of populated areas. Control over the observance of sanitary rules, hygienic recommendations and standards is carried out by the sanitary-epidemiological surveillance service of the Russian Federation through sanitary-epidemiological stations.

Construction, reconstruction and commissioning of public facilities, treatment and other facilities are allowed only with the permission of sanitary inspection bodies. To solve the problems of municipal hygiene, plumber engineers, builders, architects are also involved.

1.1.2. Food Hygiene

Hygiene of nutrition - a section of hygiene, which studies the problems of full and rational nutrition healthy person. Nutrition issues of patients and the principles of therapeutic nutrition are developed by dietology.

Studies on food hygiene are aimed at justifying the optimal mode and nature of nutrition of the population, as well as preventing diseases that occur when foodstuffs are deficient in food or due to the ingestion of microorganisms capable of causing disease, toxins and various chemicals.

The study of the nutrition of a healthy person is made taking into account age, profession, physical and neuropsychic load in the process of labor, living conditions and public utilities, as well as national and climatographic features. Hygiene of nutrition develops nutrition norms, preventive measures for beriberi and hypovitaminosis. An important problem of food hygiene is the study of the energy costs of the organism and its needs in proteins, fats, carbohydrates, mineral salts, vitamins from various prof. Groups of the population, for example, in workers of industrial enterprises with various degrees of mechanization and automation of labor, people of intellectual work, etc. The increase in the number of elderly people put forward the task of scientific substantiation of nutrition for the elderly in front of nutrition hygiene. Nutrition hygiene is engaged in the development of methods for controlling the quality of products in public catering establishments, the food industry and the trade network aimed at timely preventing the penetration or entry into the food of strangers, including harmful substances, and the development of measures to prevent food poisoning, toxic infections, intoxications . Food hygiene deals with the study of the biological value, chemical composition and calorie content of both traditional and new foods. The results of these studies are published in the form of official calorie tables and the chemical composition of the products. The tasks of the SES food hygiene departments include preventive and current sanitary supervision over the design, construction and operation of food industry enterprises, trade, public catering.

1.1.3. Hygiene of work, or occupational hygiene

Occupational hygiene or occupational hygiene is a section of hygiene that examines the impact of the work process and the environment on the body of workers working to develop sanitary and hygienic and therapeutic and preventive standards and activities aimed at creating more favorable working conditions, ensuring health and a high level of the person's ability to work.

In industrial production conditions, people are often exposed to low and high air temperatures, strong heat radiation, dust, harmful chemicals, noise, vibration, electromagnetic waves, and a wide variety of combinations of these factors that can lead to various health problems , to a decrease in efficiency. To prevent the elimination of these adverse effects and their consequences, the study of the specifics of production processes, equipment and processed materials (raw materials, auxiliary, intermediate, by-products, waste products) from the point of view of their effect on the working organism; sanitary conditions of work (meteorological factors, air pollution by dust and gases, noise, vibration, ultrasound, etc.); character and organization of labor processes, changes in physiological functions in the process of work. The health status of workers (general and occupational diseases), as well as the state and hygienic

efficiency of sanitary and technical devices and installations (ventilation, lighting), sanitary and household equipment, personal protective equipment are thoroughly investigated.

In Russia, as well as in some other countries (USA, England, etc.), the system of hygienic rationing of the maximum permissible concentrations of unfavorable chemicals in the air of the working area and certain physical factors (air temperature, humidity, noise, vibration, etc.) is widely used.). Hygienic standards established in Russia guarantee the preservation of the health of workers. The implementation of these standards is mandatory for the administration of enterprises, farms and institutions, which is enshrined in legislation.

Embedded streaming and conveyor-assembly lines, mechanization and automation of labor processes, freeing the worker from heavy physical strain, make high demands, especially to the state of the nervous system and vision. When performing such work, it is extremely important to establish such a mode of work and rest, so that it ensures high labor productivity without disrupting the physiological reactions of the organism throughout the entire working shift.

Specialists in industrial ventilation and industrial lighting, machine and tool designers, construction technologists and production organizers are also involved in solving occupational health problems.

1.1.4. Hygiene of children and adolescents

Hygiene of children and adolescents is a section of hygiene that studies the problems of protecting and promoting the health of children and adolescents, developing hygienic recommendations for setting up the teaching and upbringing and labor process in schools, vocational schools and children's institutions.

In our country, the hygiene of children and adolescents has a fundamentally different, new direction compared to school hygiene, which exists in a number of other countries and deals with the solution of private problems of schools. Our research in the field of hygiene of children and adolescents is aimed at the hygienic justification of the organization of the educational and labor process, the study of the complex influence of environmental factors on the organism of children and adolescents, on the rationale for the sanitary standards for the construction of children's institutions. An important place in the work of physicians working in the field of hygiene of children and adolescents is given to measures to prevent fatigue and fatigue, to develop the most favorable modes of study and production for students studying in secondary educational institutions of various industries.

Doctors of school departments of SES and doctors working in schools monitor the physical condition and development of children and adolescents, monitor the correct organization of physical education, the training load, as well as the sanitary regime of schools and children's institutions.

Themes №12: School of Meteor

Composition of milk. General Provisions

The composition of female milk fully corresponds to the needs of the fast growing body of the child and is as balanced as possible;

Milk is individually in composition, which is regulated by the child; that is, in two mothers the composition of milk is different, in addition it changes during one feeding, and also during the entire lactation period;

All nutrients are contained in an optimal form for assimilation. No, even the best mixture, is not a full-fledged substitute for breast milk.

In addition to the optimal balance of fats, proteins and carbohydrates for the child, breast milk contains substances that promote digestion (auto-enzymes), immune bodies to various types of diseases, the ideal composition of vitamins and enzymes.

Themes №13: Insertion and removal of the IUD

IUD- small bending device, carried in cavity of the womb. The Modern varieties are made from plastic arts and contains the medicinal preparation (slowly liberate the small quantities coopers or progestine). The Development intrauterus to contraceptions is connected with offer R. Richter (1909) carry in cavity of the womb ring, made from gut silk hearts.

The Categorization modern IUD:

- Inert:Lippes Loop
- (copper): Copper T 380A, Nova T and Multiload 375
- Selecting progestine: Progestaserd and Levo Nova (LNG), MIRENA

Mechanism kontraseptional actions IUD definitively not studied, exists several theories:

- theory semen-toksic of the action ion cooper;
- theory of the abortion action;
- theory of the speed peristalsis of the uterine pipes;
- theory of the aseptic inflammation;
- theory of the enzymatic breaches;
- theory of the suppression to functional activity endometrial cover.

The Evidences to using VMS:

9. Woman any reproductional age and with any amount of pregnancy in anamnesis, wanting high effection of the long-term method to contraceptions, not requiring daily action.
10. Woman successfully used IUD in past
11. Feeding mother, needing for contraceptions
12. Woman after sort, not feeding bosom
13. Patients after abortion, not having sign to pelvic infection
14. Woman, who can not remember the tablets about daily receiving.
15. Womans having one constant partner (since is absent the risk of the arising the diseases, sent sexual by way).
16. Woman, preferring not to use hormonal of the facility, or one, must not their use (for instance, active smokers senior 35 years)

Advantage

12. High efficiency (0,5-1,0 pregnancy on 100 womans for first year of the use for Copper T 380A)
13. Efficient immediately
14. Long-term method (IUD Copper T 380A efficient up to 10 years)
15. is Not connected with sexual by act
16. does Not influence upon nursing by bosom
17. Immediate return фертильности after removing
18. Little side effects

19. Except послеустановочного of the visit, patients follows be shown physician only in the event of arising the problems
20. Patientse no need nothing buy or keep in stock
21. Can be entered by special nurse or midwife
22. Inexpensive method (Copper T 380A)

Nekontraceptivnye advantage

4. Reduction of the menstrual pains (only progestiv)
5. Reduction of the menstrual bleeding (only progestiv)
6. Reduction of the risk ectopic to pregnancy (with the exclusion of Progestaserd)

Defect:

10. Before entering is required pelvic checkup and is recommended examination on IPP
11. Required presence prepared medical worker for entering and removing
12. Need of the check tendril to spirals after menstruation, being accompanied pain, fight or smearing blooding by separations
13. Woman can not itself stop use (depends on medical worker)
14. Reinforcement of the menstrual bleedings and pains in first several months (only for copper IUD)
15. Possible spontaneous ekspultion
16. Seldom <1/100 events) happens perforation of the womb during introduction
17. Does Not prevent all extrauteral to pregnancy
18. Can enlarge risk of the inflammatory diseases organ basin (IDOP) with following sterility beside womans, falling into group of the risk of the contamination IST and other DST (for instance, VGV, VICH/AIDS DISEASE)

When begin

6. Anytime, when there is confidence that patient not pregnant
7. With 1-go on 7-y day of the menstrual cycle
8. After sort (right after; at the first 48 hours or after 4-6 weeks; after 6 months if uses MOTHER)
9. After abortion (immediately or for 7 days) if no sign to pelvic infection
10. After cessation of the use of other method

Explanation way of the using

Act as follows

1.After inserting IUD plan together with woman her(its) repeated visit through 3-6 weeks - for instance, after menstruation - for checking and ginecological of the checkup. To be certified, on place IUD and no infections. The Visit possible to appoint to any suitable time for women(woman), but not at period of the menstruations. Hereon the repeated visit other visits are not required.

2.Make sure that woman knows:

- What type VMS she uses and as this type IUD looks.
- When she follows to delete or change IUD. Date card with writing the month and year of the installation IUD
- When visit the medical institutions woman must report medical workman on that that beside it is installed IUD

Instructions

The Woman must know that after installing IUD:

1. Beside it can be:
   - Painful spasms during 1-2 days following installing. Possible take NAIP (the ibuprofen, nimesil)
   - Vaginal separations during several weeks after installing. This orderly.
   - More Ample menstruations. The Possible bleedings between menstruation, particularly during the first several months after installing IUD.
2. Checking the position IUD.

- Once at week for the first month after installing
- after menstruation Now and then.

For checking the position IUD woman must:

1. To wash up hands.
2. Sit down on skatting.
3. As possible deeper ca66rry in vagina 1 or 2 fingers while she will not find the threads IUD. If woman seems that IUD was displaced, necessary once again to apply to medical institution.

It is impossible pull for thread - can bring about output IUD from cavity of the womb

4. Once again wash up hands

When installing IUD after sort of the threads not always are beyond the scope of shakes of the womb so their possible not to find.

The Conditions requiring precautionary measure (the contraindications)

Absolute:

- Pregnancy (known or suspected) HOofPHS class 4
- Unexplained vaginal bleeding (before clarification of the reasons) HOofPHS class 4
- IDBB (at present or the last 3 months) HOofPHS class 4
- Strong festering (the purulent) of the separation HOofPHS class 4
- Deformed cavity of the womb (the fibroid or anatomical anomalies such as double womb) HOofPHS class 4
- Tuberculosis (the known pelvic tuberculosis) HOofPHS class 4
- Cancer of genitalis (the shakes of the womb, endomeyrial or gonad) HOofPHS class 4
- Woman, having more one partner or whose partner has more one sexual of the partner HOofPHS class 3

Relative:

- Cervikal stenosis.
- Diseases shelters, anemia
- Painful menstruations
- Erosion shakes wombs
- Ekstragenital diseases
- Residiv inflammatory processes of the womb and her(its) apurtenance
- allergy on copper

Side effects

1. Amenoreya - exclude pregnancy and генитальную pathology More
- typical of progestin IUD
2. Irregular bleedings - conduct ginecological checkup to exclude:
- pregnancy uterine or extrauterine
- a disease shakes wombs
- IDBB

If required conduct treatment revealled to pathology

- becalm woman, these change the nature of the menstrual bleedings Normal phenomena and since time they, probably, decrease
- If there is anemia to conduct course of the treatment

3. Bleeding

Conduct ginecological checkup to exclude:

- pregnancy uterine or extrauterine
- a disease shakes wombs
- IDBB

If required conduct the treatment revealled pathology to ask the woman. Wants leave IUD

- If yes, give NAIP, ferriferous preparations and repeated consultancy in 3 months
- If no, delete VMS and help to choose other method to contraceptions

4. Pains
- A TIE position IUD in cavities of the womb
- a checkup organ small basin to exclude pregnancy, IDBB.
- fix NAIP
5. Partner complains of sensation tendril during sexual of the act - a threads possible to cut shorter

Themes № 14: Sex education

In recent years, work has been carried out in our country to create a family planning service and to eliminate the negative consequences associated with underestimation of its importance. Such consequences include a high incidence of induced abortions, which have traditionally been the leading method of limiting unplanned pregnancies. The long-term consequences of abortions underlie such types of obstetric and gynecological pathology as miscarriage, obstetric hemorrhages, abnormalities of the contractile activity of the uterus, genital endometriosis, pelvic inflammatory disease, and secondary infertility. Complications of abortions account for about a third of the causes of maternal mortality. Thus, limiting the frequency of abortion can significantly reduce both obstetric and gynecological morbidity, and the maternal mortality rate. Achievement of these results is possible only with the wide use of modern highly effective methods and means of contraception.

Unplanned pregnancies are often observed in women of young (under 18 years) and late reproductive (over 35 years) age. In both cases, there is a significant frequency of pregnancies with a high risk of obstetric pathology, which increases the rates of perinatal and maternal mortality. A small interval between pregnancies (less than 2 years), as well as the presence of a large number of pregnancies (including births) in the history are among the factors of high risk for the development of complications of pregnancy and childbirth. Thus, assisting the population in family planning helps reduce the number of high-risk pregnancies and, consequently, the level of maternal and perinatal mortality.

The organization of a family planning service and the widespread introduction of effective contraception are the most cost-effective means of reducing maternal mortality. According to experts, the use of effective contraception 30% of women of childbearing age will reduce the maternal mortality rate by half. In this case, one should not expect a negative impact on fertility, since contraception prevents abortion, and not childbirth.

The family planning service can be represented by specialized agencies where only family planning services are provided or integrated with various medical institutions as their functional unit. In the latter case, the range of services provided to the population is usually broader and includes the management of women with various gynecological pathologies, habitual miscarriage, infertility, abortion, laparoscopic interventions, including sterilization.

At the present stage, the family planning service is an important part of the preventive direction of reproductive medicine. Priority in the work of centers, clinics and family planning offices is the protection of the reproductions

Themes №15: Hygiene of pregnant women and puerperas, dietology

The point is that the "center" of the female reproductive system - the uterine cavity - should normally be sterile, so that the developing embryo does not get injured by bacteria or viruses.

The exit of the vagina is anatomically located near the anus, so it is necessary to pay special attention to the characteristics of feminine hygiene, in order to avoid infection into the female's internal genitalia. Also, it is necessary to avoid creating favorable conditions for multiplying pathogenic microorganisms in the perineal region.

Especially vulnerable to infection is the uterus in a period such as menstruation, since during the months there is no protective plug from the mucus in the cervix.

In addition to the mucus barrier in the cervix, the pathway to microorganisms is closed by bacteria that inhabit the vagina. The normal microflora of this organ is 90% composed of lactobacilli, which secrete lactic acid. The acidic environment of the vagina depresses most pathogenic bacteria. If, for some reason, the environment in the vagina becomes alkaline rather than acidic, the number of lactobacilli greatly decreases, and other microbes may occupy the vacated space. This condition is called dysbacteriosis, and if anaerobic flora predominates, bacterial vaginosis.

The simplest and most common cause of a violation of the acid-base balance in the vagina is the ingress of alkaline soap bubbles into it during washing. Do not be scared if this happens once. But constant alkaline "strokes" lead to serious disturbances in microflora, reproduction of pathogenic bacteria, and, accordingly, an inflammatory disease of the female sexual sphere.

The protective capabilities of the genital organs depend on the age of the woman. Up to 17-18 years, that is, before puberty, the microflora of the vagina of a girl is easily disturbed in any adverse effects. Its resistance is also decreasing in women who have reached menopause. During these periods of life, the rules of intimate hygiene should be observed especially carefully.

Introduction

Hygiene is a medical science that studies the impact of the environment and production activities on human health and develops optimal, scientifically sound requirements for the living and working conditions of the population.

The most precious gift that a person receives from nature is health. It's not for nothing that people say: "Everything is healthy for a healthy person!" It is always worth remembering this simple and clever truth, and not only when the body starts to malfunction and we are forced to turn to doctors, sometimes demanding impossible from them.

No matter how perfect medicine is, it can not save everyone from all diseases. Man himself is the creator of his health! Instead of dreaming about "living water" and other miraculous elixirs, it is better to lead an active and healthy life from an early age, to temper, exercise and sports, to observe the rules of personal hygiene - in a word, to achieve in reasonable ways the true harmony of health.

The main thing - a healthy lifestyle - a set of recreational activities that ensure the harmonious development and strengthening of health, improving the working capacity of people, prolonging their creative longevity.

The main elements of a healthy lifestyle are productive work, optimal motor conditions, personal hygiene, rational nutrition, hardening, rejection of bad habits.

Chapter 1. General Hygiene

1.1. Hygiene and its main tasks

Hygiene, as well as natural environmental conditions (exposure to sunlight, air, water) are means of physical education. Physical culture should not be exhausted only by physical exercises in the form of sports, gymnastics, outdoor games and other things, but must embrace both public and personal hygiene of work and life, the use of natural forces of nature, the correct mode of work and rest.

Hygiene is the science of health, the creation of conditions favorable to human health, the proper organization of work and leisure, and the prevention of disease. Its purpose is to study the impact of living and working conditions on human health, prevent diseases, ensure optimal conditions for human existence, preserve its health and longevity. Hygiene is the basis of disease prevention.

The main tasks of hygiene are studying the influence of the external environment on the health and working capacity of people; scientific substantiation and development of hygienic norms, rules and measures for improving the environment and eliminating harmful factors; scientific substantiation and development of hygienic standards, rules and measures to increase the body's resistance to possible harmful environmental influences in order to improve health and physical development, improve efficiency.

Sanitation - the practical implementation of hygiene requirements, the implementation of the necessary hygiene rules and measures.

During the development of hygiene, a number of hygiene disciplines were formed: occupational hygiene, social hygiene, hygiene of children and adolescents, hygiene of physical culture and sports,

The hygiene of physical culture and sports, which studies the interaction of the organism engaged in physical culture and sports with the environment, plays an important role in the process of physical education. Hygienic regulations, norms and rules are widely used in the physical culture movement.

Hygienic regulations are so important because without them it is impossible to fulfill the basic tasks of comprehensive and harmonious development of people, to maintain strong health and creative activity for many years, to prepare the population for high-performance work and protection of the Motherland.

Young specialists graduating from the country's universities should know the basic provisions of personal and public hygiene and apply them skillfully in everyday life, in studies, in production.

Hygiene of physical culture and sports includes sections: personal hygiene, hardening, hygiene of the home, hygienic requirements for sports facilities and places for exercising, auxiliary hygienic means of recovery and increase of efficiency.

1.1.1. Communal Hygiene

Communal hygiene is a section of hygiene that studies the impact of environmental factors on health and the sanitary conditions of life of the population. Based on the study of these factors, hygienic standards and sanitary measures are developed to ensure healthy and favorable living conditions for the population.

Research in the field of communal hygiene is aimed at studying the adverse chemical, physical and biological factors of the environment and the development of sanitary rules, hygienic regulations and standards for the hygiene of air, water and water supply hygiene, sanitary protection of water bodies, soil hygiene and sanitary cleaning of inhabited places, and public buildings, hygiene of planning and development of populated areas. Control over the observance of sanitary rules, hygienic recommendations and standards is carried out by the sanitary-epidemiological surveillance service of the Russian Federation through sanitary-epidemiological stations. Construction, reconstruction and commissioning of public facilities, treatment and other facilities are allowed only with the permission of sanitary inspection bodies. To solve the problems of municipal hygiene, plumber engineers, builders, architects are also involved.

1.1.2. Food Hygiene

Hygiene of nutrition is a section of hygiene that studies the problems of a full and rational nutrition of a healthy person. Nutrition issues of patients and the principles of therapeutic nutrition are developed by dietology.

Studies on food hygiene are aimed at justifying the optimal mode and nature of nutrition of the population, as well as preventing diseases that occur when foodstuffs are deficient in food or due to the ingestion of microorganisms capable of causing disease, toxins and various chemicals.

The study of the nutrition of a healthy person is made taking into account age, profession, physical and neuropsychic load in the process of labor, living conditions and public utilities, as well as national and climatographic features. Hygiene of nutrition develops nutrition norms, preventive measures for beriberi and hypovitaminosis. An important problem of food hygiene is the study of the energy costs of the organism and its needs in proteins, fats, carbohydrates, mineral salts, vitamins from various prof. Groups of the population, for example, in workers of industrial enterprises with various degrees of mechanization and automation of labor, people of intellectual work, etc. The increase in the number of elderly people put forward the task of scientific substantiation of nutrition for the elderly in front of nutrition hygiene. Nutrition hygiene is engaged in the development of methods for controlling the quality of products in

public catering establishments, the food industry and the trade network aimed at timely preventing the penetration or entry into the food of strangers, including harmful substances, and the development of measures to prevent food poisoning, toxic infections, intoxications . Food hygiene deals with the study of the biological value, chemical composition and calorie content of both traditional and new foods. The results of these studies are published in the form of official calorie tables and the chemical composition of the products. The tasks of the SES food hygiene departments include preventive and current sanitary supervision over the design, construction and operation of food industry enterprises, trade, public catering.

1.1.3. Hygiene of work, or occupational hygiene

Occupational hygiene or occupational hygiene is a section of hygiene that examines the impact of the work process and the environment on the body of workers working to develop sanitary and hygienic and therapeutic and preventive standards and activities aimed at creating more favorable working conditions, ensuring health and a high level of the person's ability to work.

In industrial production conditions, people are often exposed to low and high air temperatures, strong heat radiation, dust, harmful chemicals, noise, vibration, electromagnetic waves, and a wide variety of combinations of these factors that can lead to various health problems , to a decrease in efficiency. To prevent the elimination of these adverse effects and their consequences, the study of the specifics of production processes, equipment and processed materials (raw materials, auxiliary, intermediate, by-products, waste products) from the point of view of their effect on the working organism; sanitary conditions of work (meteorological factors, air pollution by dust and gases, noise, vibration, ultrasound, etc.); character and organization of labor processes, changes in physiological functions in the process of work. The health status of workers (general and occupational diseases), as well as the state and hygienic efficiency of sanitary and technical devices and installations (ventilation, lighting), sanitary and household equipment, personal protective equipment are thoroughly investigated.

In Russia, as well as in some other countries (USA, England, etc.), the system of hygienic rationing of the maximum permissible concentrations of unfavorable chemicals in the air of the working area and certain physical factors (air temperature, humidity, noise, vibration, etc.) is widely used.). Hygienic standards established in Russia guarantee the preservation of the health of workers. The implementation of these standards is mandatory for the administration of enterprises, farms and institutions, which is enshrined in legislation.

Embedded streaming and conveyor-assembly lines, mechanization and automation of labor processes, freeing the worker from heavy physical strain, make high demands, especially to the state of the nervous system and vision. When doing such work it is extremely important to establish such a mode of work and rest, so that it ensures high labor productivity without violating the physical In our country, the hygiene of children and adolescents has a fundamentally different, new direction compared to school hygiene, which exists in a number of other countries and deals with the solution of private problems of schools. Our research in the field of hygiene of children and adolescents is aimed at the hygienic justification of the organization of the educational and labor process, the study of the complex influence of environmental factors on the organism of children and adolescents, on the rationale for the sanitary standards for the construction of children's institutions. An important place in the work

of physicians working in the field of hygiene of children and adolescents is given to measures to prevent fatigue and fatigue, to develop the most favorable modes of study and production for students studying in secondary educational institutions of various industries.

Doctors of school departments of SES and doctors working in schools monitor the physical condition and development of children and adolescents, monitor the correct organization of physical education, the training load, as well as the sanitary regime of schools and children's institutions.

Topics №16: Family counseling

IUD- small bending device, carried in cavity of the womb. The Modern varieties are made from plastic arts and contains the medicinal preparation (slowly liberate the small quantities coopers or progestine). The Development intrauterus to contraceptions is connected with offer R. Richter (1909) carry in cavity of the womb ring, made from gut silk hearts.

The Categorization modern IUD:

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- (copper): Copper T 380A, Nova T and Multiload 375
- Selecting progestine: Progestaserd and Levo Nova (LNG), MIRENA

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18. Woman successfully used IUD in past
19. Feeding mother, needing for contraceptions
20. Woman after sort, not feeding bosom
21. Patients after abortion, not having sign to pelvic infection
22. Woman, who can not remember the tablets about daily receiving.
23. Womans having one constant partner (since is absent the risk of the arising the diseases, sent sexual by way).
24. Woman, preferring not to use hormonal of the facility, or one, must not their use (for instance, active smokers senior 35 years)

Advantage

23. High efficiency (0,5-1,0 pregnancy on 100 womans for first year of the use for Copper T 380A)
24. Efficient immediately
25. Long-term method (IUD Copper T 380A efficient up to 10 years)
26. is Not connected with sexual by act
27. does Not influence upon nursing by bosom
28. Immediate return фертильности after removing
29. Little side effects
30. Except послеустановочного of the visit, patients follows be shown physician only in the event of arising the problems
31. Patientse no need nothing buy or keep in stock

32. Can be entered by special nurse or midwife
33. Inexpensive method (Copper T 380A)

Nekontraceptivnye advantage

7. Reduction of the menstrual pains (only progestiv)
8. Reduction of the menstrual bleeding (only progestiv)
9. Reduction of the risk ectopic to pregnancy (with the exclusion of Progestaserd)

Defect:

19. Before entering is required pelvic checkup and is recommended examination on IPP
20. Required presence prepared medical worker for entering and removing
21. Need of the check tendril to spirals after menstruation, being accompanied pain, fight or smearing blooding by separations
22. Woman can not itself stop use (depends on medical worker)
23. Reinforcement of the menstrual bleedings and pains in first several months (only for copper IUD)
24. Possible spontaneous ekspultion
25. Seldom <1/100 events) happens perforation of the womb during introduction
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When begin

11. Anytime, when there is confidence that patient not pregnant
12. With 1-go on 7-y day of the menstrual cycle
13. After sort (right after; at the first 48 hours or after 4-6 weeks; after 6 months if uses MOTHER)
14. After abortion (immediately or for 7 days) if no sign to pelvic infection
15. After cessation of the use of other method

Explanation way of the using

Act as follows

1.After inserting IUD plan together with woman her(its) repeated visit through 3-6 weeks - for instance, after menstruation - for checking and ginecological of the checkup. To be certified, on place IUD and no infections. The Visit possible to appoint to any suitable time for women(woman), but not at period of the menstruations. Hereon the repeated visit other visits are not required.

2.Make sure that woman knows:

- What type VMS she uses and as this type IUD looks.
- When she follows to delete or change IUD. Date card with writing the month and year of the installation IUD
- When visit the medical institutions woman must report medical workman on that that beside it is installed IUD

Instructions

The Woman must know that after installing IUD:

1. Beside it can be:
   - Painful spasms during 1-2 days following installing. Possible take NAIP (the ibuprofen, nimesil)
   - Vaginal separations during several weeks after installing. This orderly.
   - More Ample menstruations. The Possible bleedings between menstruation, particularly during the first several months after installing IUD.
2. Checking the position IUD.
   - Once at week for the first month after installing
   - after menstruation Now and then.

For checking the position IUD woman must:

1. To wash up hands.
2. Sit down on skatting.
3. As possible deeper ca66rry in vagina 1 or 2 fingers while she will not find the threads IUD. If woman seems that IUD was displaced, necessary once again to apply to medical institution.

It is impossible pull for thread - can bring about output IUD from cavity of the womb

4. Once again wash up hands

When installing IUD after sort of the threads not always are beyond the scope of shakes of the womb so their possible not to find.

Themes №17: Importance of contraception

Analysis on step, with teacher, manual to technology of the introduction and removing IUD.

Consultancy on VMS

Steps / problems	
Consultancy before introduction	
1. Greets woman valid and well-disposed	
2. Asks patients about her(its) reproductive purpose	
3. If consultation on IUD was not organized, organizes the consultation before performing the procedure.	
4. Elaborates that chosen patients method to contraceptions - IUD.	
5. Examines the checking list of the estimation patients to define, is she suiting candidacy for use IUD.	
6. Defines the knowledges an patients about side effect when using IUD.	
7. Closely s on necessities and sufferingses patients, connected with using IUD.	
8. Explains the procedure of the introduction IUD and that follows to expect during procedure and after it.	
9. Answer questions an patients if they appeared	
Selection an patients for entering IUD	
1. Asks the patients, has she urinary bladder. Ask woman to urinary bladder and put woman on ginecologic easy chair leg, bent in coxofemoral and knee joint	
3. Explains the patients that will is made, and encourages her(its) assign the questions.	
3. Washes the hands by water with soap and wipe pure, dry towel.	
4. Conducts palpation belly and makes sure in that that no morbidity in the field of basin and pathology of the womb.	
5. Puts on new examination, deeply disinfected or sterile gloves on both hands.	
6. Distributes the instruments and sterile material.	
7. Spends examination by means of gynecologic of the mirror: Take mirror Kusko in shift to the right hand, position of the mirror in hand lock in right or mirror Simpsona handle in right	
8. Big and index fingers of the left hand to divorce the medicine to be taken externally a sexual lips patients and folding mirror to carry in vagina in close type, to indecent slot askew. When using the mirror Simpsona for entering lift delay crotch by mirror and parallel to enter lift	
9. The Advanced mirror before half, careful motion turn the screw part	

downwards, simultaneously promote the mirror deep into and by means of lock to reveal the casements so that neck turned out to be between casement.	
10. Examine mucous walls vagina, shakes of the womb and nature of the separations of them.	
11. Do the analysis allocation from three points; bak. sowing from vagina and neck (the uretral) of the separations and study on IDBB if there is evidences (HDofPHS).	
12. Delete the mirror Kusko, not closing completely casements if mirrors Simpsona, delete in inverse sequence, decontamination mirrors and gloves.	
13. Conducts the bimanual examination:	
Big and index fingers of the left hand to divorce the medicine to be taken externally a sexual lips patients and carefully enter the middle finger of the right-hand man in vagina, delaying back wall down and then enter the index finger of the same hand.	
14. Produce the examination an vaginal part shakes wombs - is defined length, value, consistency and position for basin.	
15. The Left hand palm by surface, place on front abdominal wall on bosom and palpation the body of the womb - are defined position, sizes, consistency, mobility, morbidity.	
16. Alternately translate the hands on the right and left of womb, examining apurtenance with both sides - define morbidity and presence of the formation.	
17. In the last queue examine parametriy, codes vagina and bone ring of the basin.	
18. Conducts the rectovaginal examination if there is evidences.	
19. Removes the disposable gloves and throws them agreeably to instructions; in the event of reusable of the gloves sinks them in solution of chlorine for disinfection.	
20. Conducts the microscopic study of the dab from three points at presence of the equipment (the colouration on Gram).	
21. Washes the hands by water with soap and wipe pure, dry towel.	
22. After exception IDBB, the infection and formation	
Preparation IUD to introduction to sterile package.	
1.Took IUD in sterile package and has produced checkup on wholeness, validity	
2. Has Revealled package on 1/3 part on the part of opposite to IUD	
3.Took peg and carried in conductor before contiguity with tip IUD	
4. Has Placed package to harden, flat surface and big and index fingers of the left hand have seized clothes hanger IUD on packing	
5. Big and index fingers of the right-hand man have seized for end of the conductor several raise upwards	
6. Bends around clothes hanger IUD having produced propulsion by conductor	
7.After contiguity of the tip clothes hanger on applicatore has moved applicatore several back	
8. Raise other end applicatore has fuelled clothes hanger in conductor	
Introduction VMS	
1. Puts on new examination, deeply disinfected or sterile gloves on both hands.	
2. Enters the vaginale mirror for visualization shakes wombs.	
3. Processes the shake and vagina by antiseptic solution.	

4. Carefully seizes the shake of the womb bullet gable.	
5. Enters the uterine probe, using "noncontact" method, and defines the depth and position of the womb.	
6. Enters IUD, using method "retractions".	
7. Cuts the tendrils and carefully deletes the bullet curling irons and mirror.	
8.Places used instruments in solution of chlorine for disinfection.	
9. Deletes the waste according to instruction.	
10. If they were used reusable of the glove, removes them and sinks in solution of chlorine.	
11. Carefully washes the hands by water with soap.	
13. Does record in medical card patients.	
Consultancy after entering	
1. Explains the patients, either as when check the tendrils.	
2. Discusses that to do in the event of origin side effect or problems.	
3. Convinces the patients that she can delete IUD anytime.	
4. Stakes out condition an patients to say the least 15 minutes, previously than release her(it) home.	
REMOVING IUD	
The Consultancy before removing.	
1. Greets the woman valid and well-disposed.	
2. Asks the patients about reason of the removing and answers the questions.	
3. Discusses with patients her(its) reproductive to purposes at present.	
4. Describes the procedure of the removing and explains that possible to expect.	
Removing VMS	
1. Washes the hands by water with soap and wipe чистым, dry towel.	
2. Puts on new examination, deeply disinfected or sterile gloves on both hands.	
3. Conducts the bimanual examination.	
4. Enters the vaginal mirror for visualization shakes wombs.	
5. Processes the shake and vagina by antiseptic solution.	
6. Seizes the tendrils beside shakes of the womb and pulls carefully, but for removing IUD powerfully.	
7. Places the used instruments and solution of chlorine for disinfection.	
8. Deletes the waste as requested.	
9. If they were used reusable of the glove, removes them and sinks in solution of chlorine.	
10. Carefully washes the hands by water with soap.	
11. Does record about removing IUD in medical card patients.	
Consultation after removing	
1. Discusses that follows to do when arising beside patients what or problems.	
2. Advises on cause of the new method if patient will want this.	
3. Renders aid patient in choice of the new method to contraceptions or advises temporary (barrier) method, before that as chosen method can be begin.	

Themes №18: Family Planning

IUD- small bending device, carried in cavity of the womb. The Modern varieties are made from plastic arts and contains the medicinal preparation (slowly liberate the small quantities coopers

or progestine). The Development intrauterus to contraceptions is connected with offer R. Richter (1909) carry in cavity of the womb ring, made from gut silk hearts.

The Categorization modern IUD:

- Inert:Lippes Loop
- (copper): Copper T 380A, Nova T and Multiload 375
- Selecting progestine: Progestaserd and Levo Nova (LNG), MIRENA

Mechanism kontraseptional actions IUD definitively not studied, exists several theories:

- theory semen-toksic of the action ion cooper;
- theory of the abortion action;
- theory of the speed peristalsis of the uterine pipes;
- theory of the aseptic inflammation;
- theory of the enzymatic breaches;
- theory of the suppression to functional activity endometrial cover.

The Evidences to using VMS:

25. Woman any reproductional age and with any amount of pregnancy in anamnesis, wanting high effection of the long-term method to contraceptions, not requiring daily action.
26. Woman successfully used IUD in past
27. Feeding mother, needing for contraceptions
28. Woman after sort, not feeding bosom
29. Patients after abortion, not having sign to pelvic infection
30. Woman, who can not remember the tablets about daily receiving.
31. Womans having one constant partner (since is absent the risk of the arising the diseases, sent sexual by way).
32. Woman, preferring not to use hormonal of the facility, or one, must not their use (for instance, active smokers senior 35 years)

Advantage

34. High efficiency (0,5-1,0 pregnancy on 100 womans for first year of the use for Copper T 380A)
35. Efficient immediately
36. Long-term method (IUD Copper T 380A efficient up to 10 years)
37. is Not connected with sexual by act
38. does Not influence upon nursing by bosom
39. Immediate return фертильности after removing
40. Little side effects
41. Except послеустановочного of the visit, patients follows be shown physician only in the event of arising the problems
42. Patientse no need nothing buy or keep in stock
43. Can be entered by special nurse or midwife
44. Inexpensive method (Copper T 380A)

Nekontraceptivnye advantage

10. Reduction of the menstrual pains (only progestiv)
11. Reduction of the menstrual bleeding (only progestiv)
12. Reduction of the risk ectopic to pregnancy (with the exclusion of Progestaserd)

Defect:

28. Before entering is required pelvic checkup and is recommended examination on IPP
29. Required presence prepared medical worker for entering and removing
30. Need of the check tendril to spirals after menstruation, being accompanied pain, fight or smearing blooding by separations
31. Woman can not itself stop use (depends on medical worker)
32. Reinforcement of the menstrual bleedings and pains in first several months (only for copper IUD)

33. Possible spontaneous ekspultion
34. Seldom <1/100 events) happens perforation of the womb during introduction
35. Does Not prevent all extrauteral to pregnancy
36. Can enlarge risk of the inflammatory diseases organ basin (IDOP) with following sterility beside womans, falling into group of the risk of the contamination IST and other DST (for instance, VGV, VICH/AIDS DISEASE)

When begin

16. Anytime, when there is confidence that patient not pregnant
17. With 1-go on 7-y day of the menstrual cycle
18. After sort (right after; at the first 48 hours or after 4-6 weeks; after 6 months if uses MOTHER)
19. After abortion (immediately or for 7 days) if no sign to pelvic infection
20. After cessation of the use of other method

Explanation way of the using

Act as follows

1.After inserting IUD plan together with woman her(its) repeated visit through 3-6 weeks - for instance, after menstruation - for checking and ginecological of the checkup. To be certified, on place IUD and no infections. The Visit possible to appoint to any suitable time for women(woman), but not at period of the menstruations. Hereon the repeated visit other visits are not required.

2.Make sure that woman knows:

- What type VMS she uses and as this type IUD looks.
- When she follows to delete or change IUD. Date card with writing the month and year of the installation IUD
- When visit the medical institutions woman must report medical workman on that that beside it is installed IUD

Instructions

The Woman must know that after installing IUD:

1. Beside it can be:
   - Painful spasms during 1-2 days following installing. Possible take NAIP (the ibuprofen, nimesil)
   - Vaginal separations during several weeks after installing. This orderly.
   - More Ample menstruations. The Possible bleedings between menstruation, particularly during the first several months after installing IUD.
2. Checking the position IUD.
   - Once at week for the first month after installing
   - after menstruation Now and then.

For checking the position IUD woman must:

1. To wash up hands.
2. Sit down on skatting.
3. As possible deeper ca66rry in vagina 1 or 2 fingers while she will not find the threads IUD. If woman seems that IUD was displaced, necessary once again to apply to medical institution.

It is impossible pull for thread - can bring about output IUD from cavity of the womb

4. Once again wash up hands

When installing IUD after sort of the threads not always are beyond the scope of shakes of the womb so their possible not to find.

Themes № 19: The ability to work

Recommandations to abdominal′nomu delivery are: intrauterine fetal death or being, incompatible with the existence of intrauterine (Glu-bokaya prematurity, very pronounced

degree of hypoxia and fetal malnutrition, foetal malformations, incompatible with life), acute infectious-inflammatory diseases

Criteria for the selection of women with scar at the womb to conduct **spontaneous deliveries** are:

-one c-sections in history, made a cut in the lower uterine segment to a non-repeating (transient) condition: fetal hypoxia, birth abnormalities, pelvic presentation and abnormal position of the fetus, placenta previa and Abruptio, heavy forms hypertensive States;

-No new evidence during this pregnancy to the birth of samoproizvol′;

-satisfactory condition of the mother and fetus.

previa-head sole fruit;

-a full lower cervical segment (clinical and ultrasound data);

-a woman's consent to conduct spontaneous deliveries.

-favourable currents of this pregnancy with no sign of the threat her interruption, signs of fetoplacental insufficiency of gipoksičeskom syndrome of fetus and its placenta location, wasting away, the alleged "scar" on the uterus;

-the biological maturity of the cervix 4th degree;

-preservation of the principle of "triple downward gradient between the divisions, including the lower segment of the uterus; with the start of labour;

-establishing the correct position of the fetus and members head location at the entrance of the pelvis, or centered above the pelvis in the preparatory period for childbirth.

Conservative management of women with scar at the womb is possible only in large hospitals equipped with obstetric enough (or perinatal centres), with 24-hour supervision of highly qualified obstetricians and gynaecologists who endorsed full ext of assistance (including hysterectomy).

Diagnostics of the scar in the out-patient stage:

Visit pregnant women in turn.(I)half of 1 times in 2 weeks, in(II)– 1 time per week.

ULTRASOUND in Dynamics: the I-II trimester 1, III – 3 times.

To èhografičeskim scar at the womb insolvency during pregnancy include thinning of the lower segment of the scar (less than 0, 3 cm), a significant number of acoustically dense inclusions, indirectly indicating the presence of scar tissue, reshaping the lower segment in the form of niches.

To determine the usefulness of the uterine muscles in the area of the former incision should take into account the objective data obtained by palpation. To do this, pushing aside a skin scar the uterus, pal′piruût when the incision the previous operation. In response to palpation, the uterus is usually reduced. If a scar, then it is not defined and the uterus is uniformly reduced. With nepolnocennom rumen connective tissue is reduced and not pal′piruûŝie fingers feel the deepening (notch) in the uterus.

CTG in Dynamics: from 24 weeks.

Date of hospitalization for women with scar at the womb:

-up to 12 weeks, to assess the condition of the SCAR and to address the issue of pregnancy prolongirovani.

-In 24-26, 30-34 weeks. for the treatment of fetal hypoxia, ÈGZ and attendant complications during gestation.

In a 38-37 weeks for the birth, and when in the rumen nepolnocennom 35-36 weeks.

For delivery, pregnant with scar at the womb State of pitaliziruûtsâ in obstetrical hospitals in 37-38 weeks gestation, where they conducted a full survey of the General and special maternity, childbirth timing TBC, valued the fetoplacental system (using ultrasonic fetometrii, placentografii and dopplerometričeskogo study of blood flow in the umbilical artery and the uterine arteries) and is determined by the estimated weight of the fetus, an assessment of the status of the scar on the uterus (clinically and èhografičeski), be sure to include the data history.

In order to improve the outcomes of repeated Caesarean section for fetal surgery is very significant in the timing, close to childbirth: 39-40 weeks. The transformation of prior years '

arrears, to avoid the risk of uterine rupture is most often coming with the start of labor activity, repeated abdominal delivery were at 38 weeks. The children were born with a birth weight of full-term, but often with gratitude, Kami morfofunkcional′noj immaturity, that in some cases led to the development of respiratory distress syndrome.

Management of pregnancy in women with scar at the womb:

(I)term:
(a) medical-conservative) mode;
b) General recreational activities;
in the laboratory and instrumental examination);
g) treatment of concomitant ÈGZ;
d) treatment complications during gestation;
e) programming follow-up.
(II)term:
(a) medical-conservative) mode;
b) General recreational activities;
in laborotorno)-instrumental examination;
g) treatment of concomitant ÈGZ;
d) treatment complications during gestation;
e) programming follow-up.
(III)term:
(a) medical-conservative) mode;
b) General recreational activities;
in laborotorno)-instrumental examination;
g) treatment of concomitant ÈGZ;
d) treatment complications during gestation;
e) programming of prenatal hospitalization with the traditional preparation for childbirth and with the assessment test readiness indicators.

Concept and types of inappropriate regulations and presentations.

A situation in which the longitudinal axis of the fruit forms a sharp corner or right angle with the longitudinal axis of the mother in the absence of the presenting part.

Causes of the wrong position and fetus.

Excessive fetal movement: when polyhydramnios, gipotrofičnom or nedonošennom fruit, multiple pregnancy, the muscles of the anterior abdominal wall skin flabbiness multiparous. Limited mobility: Fetal malovodii, big fruit, there, you have uterine fibroids, uterine cavity strain, increased uterine tonus, threat of termination of pregnancy. Obstacle vstavleniû head: placenta previa, narrow hips, the presence of uterine fibroids in the lower segment. Abnormalities of the uterus: the uterus dvurogaâ septum, the septum. Fetal anomalies: hydrocephaly, anencephaly.

Diagnosis and incorrect presentations.

-Belly shape: oval or cross-kosooval′naâ; -low standing of seafloor of the uterus; the absence of the presenting part;
-pelvic palpation, head end in the side sections of the uterus fetal heartbeat heard;-in the navel area;-lack of the presenting part of the vaginal examination, and when izlitii amniotic fluid when you can define study vaginal shoulder, handle the umbilical cord, ribs or spine of the fruit; ULTRASOUND study).
--Prevention of constipation; It is recommended for pregnant women to lie on her side, and at the same position on the side of Kos a major part of the fruit;
-admission to 35 weeks;

Complications of pregnancy and childbirth in the wrong position and fetus fetus.

-premature birth by prenatal observing the amniotic fluid in the absence of the belt is tight, may be accompanied by Syncope: small parts (knobs, feet, hinges of the umbilical cord),
-infection of the fetus,

-running lateral position, which threatens to fetal hypoxia, when continuing cuts the uterus may at first, then pererastâženie, and uterine rupture.

Prevention activities:

-polupostel′nyj mode;

-prophylaxis of constipation;

-It is recommended to pregnant women lying on the side of the position, and when the situation on the side of Kos a major part of the fruit;

-admission to 35 weeks;

-combined fetal rotation on foot;

-the best method of delivery is by caesarean section;

Tactics of fetal pelvic presentation in redležanii..

. Pelvic presentation requires an expectant observation.

From 29-30 weeks are recommended: gymnastic exercises (pregnant lies on the right and left side perevoračivaâs′, every 10 minutes, repeat 3-4 times a day).

Republic Uzbekistan Ministry of Health

Bukhara medical institute of name Абу Али ибн Сино

Obstetrics and gynecology chair

« I Confirm»

It is registered by the educational Department the Pro-rector on study

№ _____ the senior lecturer_____

S.S.Olimov

«___» _____ 2017 «_____» _____ 2017

THE CURRICULUM

IN THE SUBJECT OBSTETRICS AND GYNECOLOGY

Knowledge branch: 500000 Public health services and social security

Training branch: 510000 Public health services

Training direction: 5510100 Medical business

5111000 Vocational training

COURSE 6

VOLUME OF HOURS: 360

Including:

LECTURES: 12

PRACTICAL TRAINING: 55

CLINICAL EMPLOYMENT: 66

INDEPENDENT WORK: 227

БУХАРА-2017

The working program is made on the basis of the Typical program on obstetrics and gynecology for students of VII course of medical and mediko-pedagogical faculties the Medical High school, confirmed in M3 РУ in 2013 in directions: medical business - 5510100 and professional training - 5511100.

COMPOSERS:

Managing chair, senior lecturer Ihtijarova **of And**

The senior lecturer, к.м.н. **Hotamova M. T.**

The senior teacher, к.м.н. **Ashurova N.G.**

The senior teacher, к.м.н. **Rahmatullaeva M. M.**

The senior teacher **Hamdamova M. T.**

REVIEWERS:

Облокулов A.R.-zav.kafedry infectious diseases, эпидемиологии and kozhno - venereologic illnesses, д.м.н.доцент

Акрамов Century of the River the-manager. Chairs of traumatology, orthopedy, neurosurgery and the general surgery, к.м.н., the senior lecturer

The working program is discussed and confirmed on faculty meeting of obstetrics and gynecology the report № 1 from 28.08.2017

MANAGING CHAIR: the senior lecturer Ihtiyarova G. A----------

CHAIRMAN ММК: **the senior lecturer Ihtiyarova G. A**----------

The working program is discussed and confirmed in central methodological council Buh MI

The report № - «-------»----------2017

The methodologist: Jumaeva S.B.----------

INTRODUCTION

The working program in a subject «Obstetrics and gynecology» for students of 7th course of medical and mediko-pedagogical faculties is developed on State standard for preparation of bachelors and confirmed by the Order the Ministry of the higher and sredne - the Republic Uzbekistan vocational education № 26 from 22.01.2016 years.

The obstetrics and gynecology trains: rational conducting pregnancy and sorts, diagnostics and to scientifically proved treatment of widespread gynecologic diseases the most widespread gynecologic diseases, to a formulation of command spirit for finding-out and the decision of medical problems which are present at patients, rehabilitation and prophylactic medical examination at urgent conditions.

The purposes and science problems

The purpose of teaching of a subject - independent conducting women with physiological and pathological pregnancy, studying, diagnostics and preventive maintenance of complications during pregnancy, sorts and the postnatal period. To the hospital help at the complicated conditions, rehabilitation after gynecologic frustration, planning of a family and protection of reproductive health.

Subject problems:

- Conducting беременностей, sorts and the postnatal period with a physiological current and complicated against экстра генитальных diseases;
- To define risk factors for акушерской and перинатальной pathologies;
- Training to criteria of hospitalisation of patients with difficult экстра генитальными pathologies;
-Training to principles диспансерного supervision.
-Training to criteria out-patient and hospitalisation.
-Urgent initial estimation of pregnant women.
-Timely and safe hospitalisation
To carry out diagnostics of difficult gynecologic diseases;

- Development of knowledge on skills of consultation on all methods of contraception, family planning.

Requirements to knowledge, skills and abilities of pupils in a subject

Within the limits of a subject «Obstetrics and gynecology» the bachelor **should know:**

- Clinic of the basic акушерских and gynecologic diseases, conducting women with physiological and pathological pregnancy, diagnostics and preventive maintenance of complications during pregnancy, sorts and the postnatal period, revealing of risk factors for mother and the child, an estimation of a condition of a fruit, the pre-hospital help at the complicated conditions, rehabilitation after gynecologic frustration, questions of planning of a family and protection of reproductive health.

Within the limits of a subject «Obstetrics and gynecology» the bachelor **should own skills:**

- Definition of term of pregnancy and sorts.
-Definition of prospective weight of a fruit.
-Survey in mirrors.
-manualnyj survey of a uterus and appendages.
-External акушерское inspection.
-Auscultation of palpitation of a fruit.
Dab-capture on cytology.
-Definition of degree of cleanliness влагалищного dab.
-Exhibitings and removals of Naval Forces.
-Definition and interpretation of tests of functional diagnostics.
The-emergency help at heavy преэклампсии, эклампсии and акушерских bleedings

The bachelor **should own qualifying skills on:**

-To conducting physiological pregnancy,
-Conducting pregnant women with not complicated экстра генитальной a pathology, early toxicoses, гипертензивными infringements, лактостазом, гипогликемией, not complicated mastitis and with an anaemia of pregnant women,
-Conducting women with предменструальным, a climacteric syndrome, with sharp and chronic diseases of bodies of genitals, with infringements менструального a cycle.

Interrelation of a subject with other disciplines and methodological integration

The obstetrics and gynecology is a clinical subject and are taught on 11, 12, 13 and 14 semestre. For curriculum development it is required knowledge on clinical and fundamental disciplines. (Normal and pathological anatomy, physiology and патофизиология, therapy, surgery, anesthesiology and intensive therapy, дерматовенерология, clinical pharmacology, oncology, эндокринология, urology).

Value of a subject in a science and manufactures

The subject Obstetrics and gynecology is important for formation of a basis of medical knowledge at doctors of the general practice. Together with other sciences provides development of clinical thinking in the training.

Modern information and pedagogical technologies in subject teaching

Crucial importance for mastering by an obstetrics and gynecology subject has use of the advanced methods of training for students, introduction of new information and pedagogical technologies. The course is focused on textbooks, teaching materials, texts of lectures, distributing materials, computer programs, electronic materials, phantoms and breadboard models. The advanced pedagogical technologies successfully use in lectures and a practical training.

The training focused on the person. This formation, as a matter of fact, provides an all-around development of all participants of educational process.

The regular approach. The technology of formation should possess all features of system: logic of process, its sequence and integrity.

The training focused on activity. In it the training directed on formation of creative qualities of the person, activization and strengthening of activity of the trainee, opening of all its abilities and possibilities in the course of training is described.

The dialogue approach. Such approach demands development of the academic relations. Creative activity, such as self-activation and a self-estimation as a result increases.

Co-education creation. Democracy, equality, formation and vocational training should be underlined at a formulation of the maintenance of work and realisation of teamwork according to the reached results.

Problem formation. The way of the decision of problems in the formation maintenance, stirs up activity of the trainee. At the same time the objective contradiction of scientific knowledge and creative use of methods of its decision forms a dialectic phenomenon and as a result creates independent student's creative activity.

Application of modern information and communication methods - introduction of new computer and information technologies in educational process.

Training methods. Lecture (introduction, a subject, visualisation), problematic training, cases-herds and designing methods, practical work.

Communications methods: direct interaction with trained, based on an operative feedback.

Methods and feedback means: diagnostics of training on the basis of supervision, a blitz-interrogation, intermediate, flowing and control end results.

Methods and control devices: planning of educational actions in the form of a technological card which defines stages of educational activity, cooperation of the teacher and the pupil in achievement of the purposes, not only in audiences, and also the control over independent work out of an audience.

Monitoring and estimation: Regular monitoring of results of training throughout all training course. Upon termination of a cycle estimate knowledge of listeners by means of ОСКЭ.

During training «the Obstetrics and gynecology» are developed computer technologies, the curriculum software, distributing materials on themes. The estimation of knowledge of students is carried out in the oral, computerised test forms

Technique «the Tree of decisions»

1. Technique use «a tree of decisions» allows to seize skills of a choice of an optimum variant of the decision, action, etc.

2. Construction of "a tree of decisions» - a practical way to estimate advantage and lacks of various variants. The tree of decisions for three variants can look as follows:

Problem: …

Variant 1: …	Variant 2: …	Variant 3: …

Pluses	Minuses	Pluses	Minuses	Pluses	Minuses

Business and role games

Business game – the form of a reconstruction of the subject and social maintenance of professional work, modelling of systems of relations, various conditions of professional work, characteristic for the given kind of practice.

In business game training of participants occurs in the course of joint activity. Thus everyone solves the separate problem according to the role and function. Dialogue in business game it is not simple dialogue in the course of joint mastering of knowledge, but first of all – the dialogue simulating, reproducing dialogue of people in the course of real studied activity.

Discussion

Discussion (from an armour. discussion — research, consideration) is an all-round discussion of a question at issue in public meeting, in private conversation, dispute. In other words, discussion consists in collective discussion of any question, a problem or comparison of the information, ideas, opinions, offers. The purposes of carrying out of discussion can be very various: training, training, diagnostics, transformation, change of installations, stimulation of creativity, etc.

The round table is a method of the active training, one of organizational forms of informative activity of the pupils, allowing to fix received before knowledge, to fill the missing information, to generate abilities to solve a problem, to strengthen positions, to learn to culture of conducting discussion. Characteristic line of "a round table» is the combination of thematic discussion to group consultation.

Method «three этапного interview»

The purpose: to Train students in the correct psychological approach at revealing and the decision of problems.

Main principles: the group is subdivided into 2-3 subgroups and appointed to a role of students: the doctor, the patient, the expert. The patient who plays a role of the patient, is secretly diagnosed. The patient should know about painful complaints, development of illness, epidemiological history, and the doctor should know about changes which can occur because of illness and illness. Each doctor will accept the patient with council within 10-15 minutes. Experts estimate activity of the patient (the patient and the doctor) in following three categories:

1. What was correct?
2. What was wrong?
3. What it was necessary to make?

3. The discipline maintenance

Hours	**Distribution of academic loads**				**Independent work**
	In total	Lecture	Practical training	Clinical employment.	
360	133	12	55	66	227

№	Lecture theme	Но
1.	Physiological childbirth. The physiological postnatal period.	2
2	The complicated pregnancy	2
3	Head be ill. Sight deterioration. Consciousness loss. The high arterial	2
4	Protection of reproductive health	2
	In total	8

The maintenance of a lecture course.

Theme: Physiological childbirth. The physiological postnatal period

Deepenings of knowledge and skills on tactics of conducting pregnant women and lying-in women at physiological sorts at level of a primary link and the house. Development of ability of an estimation, the analysis of a situation, a choice of tactics of conducting, to diagnostics, rendering of the urgent help, rational transportation at physiological sorts and after comes from the period at level of a primary link.

About: 1,2,3,4,5,8,9,10,13,14 Д: 6,10,11,14,17, the Internet - sites

Theme: Akushersky bleedings as the reason of parent death rate.

The purpose: to Learn students to rational tactics of conducting pregnant women with risk on акушерские bleedings, urgent actions at акушерских bleedings at a pre-hospital stage.

Expected results: the Spent lecture will help ВОП to reveal risk group on акушерские bleedings, to spend at them preventive treatment, to render the rational help at a pre-hospital stage.

The maintenance: Introduction. Risk factors ПОНРП and software. ПОНРП. Placenta prelying. Bleedings in III and the early postnatal period. Uterus rupture.

Equipment: the Computer for multimedia display of slides.

Independent work: Work in library, the Internet.

Control questions:

- Risk group on акушерские bleedings
- ПОНРП. Tactics ВОП
- Software, Tactics ВОП.
- Hypotonic bleedings. Tactics ВОП.

About: 1,2,3,4,5,6,7,8,9,10,11,14 Д: 6,10,11,14,17,19,20, the Internet - sites

Theme: «Infringement менструальной functions. ДМК. Conducting tactics».

The purpose: to Learn to diagnose and spend treatment of the basic forms of infringements менструальной functions.

Expected results: the Spent lecture will help students to have algorithm of inspection and treatment of the given pathology.

The maintenance: Introduction. Classification of infringements менструальной functions. Algorithm of inspection.

ДМК: Патогенез, algorithm of inspection, clinic, treatment.

Метроррагия: the Reasons, algorithm of inspection, conducting tactics.

Lecture equipment: the Computer for multimedia display of slides.

Independent work: Work in library, the Internet.

Control questions:

- Classification of infringements менструального a cycle

- Inspection in the conditions of rural medical point (СВП) and family polyclinics (joint venture)
- Treatment in СВП and the joint venture
- ДМК – патогенез
- Inspection in СВП and the joint venture
- Treatment

About: 1,2,3,4,5,6,7,8,9,10,14 Д: 6,10,11,14,17, the Internet - sites

Theme: «Tactics ВОП at diagnostics and conducting pregnant women with background and before cancer diseases of a neck and a uterus body».

The purpose: to Learn to diagnose, carry out differential diagnostics, timely hospitalisation and treatment background and before cancer diseases.

Expected results: the Spent lecture will help ВОП to have algorithm of inspection and treatment in the conditions of a polyclinic and carrying out of timely hospitalisation in a hospital.

The maintenance: Introduction. Risk factors. Classification. Clinic. Treatment.

Equipment: the Computer for multimedia display of slides.

Independent work: Work in library, the Internet.

Control questions:

- The reasons background and before cancer diseases of a neck and a uterus body.
- Risk groups.
- Treatment.

About: 1,2,3,4,5,6,7,8,9,10,14 Д: 6,10,11,14,17, the Internet - sites

The maintenance of a practical training

THE KALENDARNO-THEMATIC PLAN OF PRACTICAL AND CLINICAL EMPLOYMENT

№	Practical training	Практ.зан.	Wedge. Зан.	Hours
1	Physiological childbirth. Conducting tactics. Ургентная the help at physiological sorts ВОП. Chest feeding. Physiological послеродовый the period. Conducting tactics.	2	2	4
2	Conducting pregnancy at healthy women. Антенатальный leaving. The order №137 МЗ РУЗ. Personal hygiene.	2	4	6
3	Conducting pregnant women with a hem on a uterus. A Cesarean section in modern obstetrics. Diagnostics. Conducting pregnant women.	3	3	6
4	Premature birth. Diagnostics. Conducting tactics.	2	2	4
5	Перенашивание. Diagnostics. Conducting tactics. An induction of sorts. Mediko-genetic consultations.	3	3	6
6	Pregnancy conducting at the restretched uterus (at многоплодии, многоводии). Diagnostics. Conducting tactics. Observance интергенетического an interval.	2	3	5
7	Estimation of a condition of a fruit during pregnancy and sorts. Menacing conditions of a fruit. ЗВУР. ФПН.	3	3	6
8	Гипотензивные infringements during pregnancy and sorts. Diagnostics. Conducting tactics (the Chronic hypertensia. A hypertensia induced by pregnancy).	3	3	6

9	Гипертензивные infringements during pregnancy and sorts (преэклампсия, эклампсия). Diagnostics. Conducting tactics.	**3**	**3**	6
10	Вагинальное кровотчение in late terms of pregnancy and in sorts. ПОНРП, placenta prelying. Diagnostics. Conducting tactics. Вагинальное a bleeding in early terms of pregnancy	**3**	**2**	5
11	Rhesus factor-immunization. ABO the conflict. (A jaundice of newborns). Diagnostics. Conducting tactics. Дистресс a fruit syndrome. Diagnostics of urgent conditions of newborns and their tactics of conducting.	**2**	**2**	4
12	**Heat after родаразрешения. Postnatal septic diseases. A peritonitis after кесарева sections. Diagnostics. Conducting**	**3**	**3**	6
13	**Вагинальное a bleeding in early terms of pregnancy. Abortions and their complications. Diagnostics. Conducting tactics.**	**3**	**3**	6
14	Infringement менструального a cycle. ДМК. Diagnostics. Tactics of conducting Вагинальное a bleeding in early terms of pregnancy. Abortions and their complications. Diagnostics. Conducting tactics	**3**	**3**	6

The maintenance of a practical training

The maintenance of clinical employment

№	Clinical employment
1	**Physiological childbirth. Conducting tactics. Ургентная the help at physiological sorts ВОП. Chest feeding. The physiological postnatal period. Conducting tactics.** Deepenings of knowledge and skills on tactics of conducting pregnant women and lying-in women at physiological sorts at level of a primary link and the house. Development of ability of an estimation, the analysis of a situation, a choice of tactics of conducting, to diagnostics, rendering of the urgent help, rational transportation at physiological sorts and after comes from the period at level of a primary link.
2	**Physiological pregnancy, childbirth and the postnatal period. Conducting pregnancy at healthy women. Антенатальный leaving. The order №137 М3 Ouse. Personal hygiene**. To train students ВОП independent антенатальному in leaving (АНУ) at healthy women, to a capture on the account, to carrying out of consultation and training of the future parents, and also screening of pregnant women on diagnostics of deviations from a normal current of pregnancy
3	**The complicated pregnancy. Conducting pregnant women with a hem on a uterus. A Cesarean section in modern obstetrics. Diagnostics. Conducting pregnant women.** To train student ВОП to develop risk groups under indications on a Cesarean section and terms of hospitalisation of pregnant women with a hem on a uterus. To generate knowledge and abilities of timely diagnostics, differential diagnostics of wrong positions of a fruit, to carry out at them preventive actions, a primary estimation of a condition of the patient, to render the emergency help at level of a polyclinic and timely transportation in a medical institution, to carry out rehabilitation actions after sorts and to features of methods of contraception

4	**Premature birth. Diagnostics. Conducting tactics.** Premature birth. Diagnostics. Conducting tactics. Перенашивание pregnancy. Diagnostics. Conducting tactics. An induction of sorts. Mediko-genetic consultation.
5	**Перенашивание. Premature birth. Diagnostics. Conducting tactics. Diagnostics. Conducting tactics. An induction of sorts. Mediko-genetic consultations.** Premature birth. Diagnostics. Conducting tactics. Перенашивание pregnancy. Diagnostics. Conducting tactics. An induction of sorts. Mediko-genetic consultation.
6	**Pregnancy conducting at the restretched uterus (at многоплодии, многоводии). Diagnostics. Conducting tactics. Conducting pregnancy at young and elderly первородящих. Diagnostics. Conducting tactics. Observance интергенетического an interval.** Uzbekistan is considered one of regions with high percent young and adult первородящих women. Correct statement of the diagnosis, development of tactics of conducting, both during time, and out of pregnancy will lower indicators parent and перинатальной death rates. To learn to diagnostics, features of conducting pregnancy с the restretched uterus (многоплодии and многоводии) and also at old, young первородящих women and to preventive maintenance and actions for protection of reproductive health and family planning.
7	**Estimation of a condition of a fruit during pregnancy and sorts. Menacing conditions of a fruit. ЗВУР. ФПН.** To fix and deepen knowledge of actions and diagnostics methods at threatened conditions of a fruit, an estimation small for гестационного age of a fruit, ЗВУР, ФПН. To develop abilities of the analysis and an estimation of a condition of a fruit during pregnancy and sorts. To generate skills of early diagnostics, tactics of conducting, treatment and preventive maintenance of menacing conditions of a fruit at акушерской and экстрагенитальной pathologies.
8	**Гипертензивные infringements during pregnancy and sorts. Diagnostics. Conducting tactics (the Chronic hypertensia. A hypertensia induced by pregnancy).** Development of ability of an estimation and the situation analysis at receipt of pregnant women with гипертензивными conditions, including a chronic hypertensia, a hypertensia the induced pregnancy, эклампсию and эклампсию. Working off of skills of a choice of tactics of conducting, to diagnostics, rendering of the urgent help and rational transportation of patients with гипертензивными infringements at level of a primary link with application of data of demonstrative medicine.
9	**Headache. Sight infringement. Spasms. Consciousness loss. High arterial pressure. Гипертензивные infringements during pregnancy and sorts. Diagnostics. Conducting tactics (Преэклампсия and эклампсия).** Development of ability of an estimation and the situation analysis at receipt of pregnant women with гипертензивными conditions, including a chronic hypertensia, a hypertensia the induced pregnancy, преэклампсию and эклампсию. Working off of skills of a choice of tactics of conducting, to diagnostics, rendering of the urgent help and rational transportation of patients with гипертензивными infringements at level of a primary link with application of data of demonstrative medicine.
10	**Вагинальное a bleeding in late terms of pregnancy and in sorts. ПОНРП, placenta prelying. Diagnostics. Conducting tactics. Вагинальное a bleeding in early terms of pregnancy**. Akushersky bleedings win first place in structure of parent death rate and to this day they remain a global problem in obstetrics. For correct treatment of a syndrome: вагинальное a bleeding, a short wind, loss consciousness, a pain in a stomach, a hypotension and a hypertensia, infringement of consciousness with геморрагическим a shock, themes – ПОНРП, placenta prelying are necessary for studying for students ВОП.
11	**Rhesus factor-immunization. ABO the conflict. (A jaundice of newborns). Diagnostics. Conducting tactics.** To train in diagnostics, preventive maintenance of complications иммуноконфликтной and

	ABO to disputed pregnancy, principles of out-patient treatment, indications to hospitalisation, a post to hospitalisation, realisation of actions for protection of reproductive health and family planning. To train in diagnostics of early toxicoses of pregnancy, to estimate severity level of vomiting of pregnant women, to principles of out-patient treatment, indications to hospitalisation and posthospitalization.
12	**Heat after родоразрешения. Postnatal septic diseases. A peritonitis after кесарева sections. Diagnostics. Conducting** Timely diagnostics of infections at pregnant women, working out of correct tactics of conducting pregnancy, carrying out of adequate treatment-and-prophylactic actions will allow to lower перинатальную disease and death rate, will promote also to reduction of postnatal is purulent-septic diseases.
13	**Вагинальные кроветечения in early term of pregnancy. Abortion and its complications. Diagnostics and conducting patients.** Training to consultation and conducting the patient with вагинальными bleedings, диф. To diagnostics.
14	**Infringement менструального a cycle. ДМК. Diagnostics. Conducting tactics. Routine inspection of children and teenagers.** Deepening and expansion of knowledge on tactics of conducting women with дисфункциональными маточных bleedings. Development of ability of an estimation, the analysis of a situation, a choice of tactics of conducting, to diagnostics, rendering of the urgent help, rational transportation and poststationary rehabilitation of women with ДМК at level of a primary link.
15	**Кисты and кистомы яичников (good-quality and malignant). Diagnostics. Conducting tactics.** Deepening of knowledge on revealing of risk factors of development and diagnostics кист and кистом яичников. Development of ability of an estimation of severity level and a current of disease, differential diagnostics, a choice of tactics of conducting and treatment, and also a measure of rehabilitation after surgical treatment at level of a primary link with application of data of demonstrative medicine.
16	**Sharp stomach in gynecology: extra-uterine pregnancy; апоплексия яичника; перекрут legs кистомы яичника. Diagnostics. Conducting tactics. Traumas of genitals. Diagnostics. Conducting tactics. Employment.** Because signs of "a sharp stomach» in clinic meet both in gynecologic, and in surgical practice, it is necessary to know accurately a clinical picture of some diseases at which arises ОЖ. The fast estimation of the general condition and rendering of the emergency help at symptoms of "a sharp stomach» is one of sections of the urgent gynecologic help at ВОП. The knowledge of this material will help ВОП to correct statement of the diagnosis эктопической to pregnancy, апоплексии яичника and перекрута legs кистомы яичника, and as a result, to a choice of correct algorithm of actions.
17	**Traumas and anomaly of genitals. Diagnostics. Conducting tactics.** Because signs «травми genitals» in clinic meet both in gynecologic, and in surgical practice, it is necessary to know accurately a clinical picture of some diseases at which there is a trauma гениталия. The fast estimation of the general condition and rendering of the emergency help at symptoms «травми гениталия» is one of sections of the urgent gynecologic help at ВОП.
18	**Protection of reproductive health.** **Reproductive health. Consultation. Marriage consultation.** Protection of reproductive health (РЗ) includes a number of mediko-social actions spent in СВП and ГВП doctors of the general practice that plays the important role in decrease parent and перинатальной pathologies. For formation of a healthy family and improvement of reproductive health it is necessary to learn to consultation principles on methods of contraception, preventive maintenance ЗППП.

19	**Contraception kinds. Family planning.** It is established, that too early, frequent and late childbirth, and also abortions are one of principal causes parent and перинатальной death rates. Quite often it is result of unsuccessful application of a contraceptive, and in most cases absence of access to services in reproductive health. For formation of a healthy family and improvement of reproductive health rational application of modern contraceptive means taking into account individual selection is necessary.

7.1. Themes of independent works (medical faculty)

№	Themes	Hours
1.	Prophylactic medical examination of pregnant women and methods research.	12
2.	The periods of sorts	12
3	Kinds a Cesarean section.	12
4	Observance интергенетического an interval	12
5	Definition of early term of pregnancy	12
6	Leopold-Levitsky's methods	12
7	The Prof. survey of the woman (ювенил, фертил. And climacteric age)	12
8	Опред.позднего term ber.	12
9	Signs allocation and a birth последа	12
10	Послеродовый a hemostasis	12
11	Personal hygiene	
12	School метерей	12
13	Insertion and removal of Naval Forces	12
14	Sexual education	12
15	Hygiene of pregnant women and women in childbirth, dietology	12
16	Family consultation	12
17	Value of contraception	12
18	Family planning	12
19	Work capacity	12
	жами	227

The list of practical skills

1. Definition of term of pregnancy and sorts
2. Definition of prospective weight of a fruit
3. Survey in mirrors
4. Бимануальный survey
5. External акушерский survey
6. Dab capture on Папаниколау.
7. Measurement базальной temperatures.
8. Definition of a symptom of "pupil"
9. Definition of an extensibility of slime of a neck of a uterus
10. Introduction of Naval Forces
11. Removal of Naval Forces
12. Definition of cleanliness of a vagina.
13. The urgent help at эклампсии
14. Pressing of a belly aorta
15. Active conducting 3 periods of sorts
16. Preprocessing культи umbilical cords
17. Processing of eyes of the newborn

18. Primary applying of the newborn to a breast.

The list of practical skills

Obstetrics and Gynecology ВОП chairs

1. Definition of term of pregnancy and sorts
2. Definition of prospective weight of a fruit
3. Survey in mirrors
4. Мануальный survey
5. External акушерский survey
6. Dab capture on Panicking.
7. Measurement базальной temperatures.
8. Definition of a symptom of "pupil"
9. Definition of an extensibility of slime of a neck of a uterus
10. Introduction of Naval Forces
11. Removal of Naval Forces
12. Definition of cleanliness of a vagina.
13. The urgent help at эклампсии
14. Pressing of a belly aorta
15. Active conducting 3 periods of sorts
16. Preprocessing культи umbilical cords
17. Processing of eyes of the newborn

The first applying of the newborn to a breast.

4.1. The list of textbooks and manuals.

The basic literature

1. Gynecology. Ajupova F.M., Жаббарова J.K.Toshkent, 2006.
2. Obstetrics. Савельевича G.M.Moskva. 2002.
3. Clinical lectures on Obstetrics and Gynecology. A.N.Strizhena. M.Meditsina 2000г.
4. Obstetrics. Bodjazhina V. I, Семенченко. M. 2004.
5. A short management on infection preventive maintenance. The first edition. Tashkent. 2004. 236c.
6. The urgent help in акушерской to practice. The CART. 2004.
7. Not operative gynecology. Smetnik V. N, тумилович V.P.Meditsinskoe the Inform. Agency. Moscow. 2005. 440c.
8. Gynecology. Ajupova F.M., Жаббарова J.K.Toshkent. 2006.
9. Gynecology. Under the editorship of Vasilevsky M. 2007.
10. Obstetrics and gynecology. Under the editorship of Савельевой of M. of M. 2007
11. A Klininchesky management on conducting patients with кровотечениеми in sorts and the postnatal period. T. 2008.
12. A Klininchesky management on conducting patients with a sepsis / a septic shock during pregnancy and the postnatal period. T. 2008.
13. A Klininchesky management on conducting patients with гипертензивным a syndrome at берременности. T. 2008.
14. Гинеокология. The textbook. Under the editorship of Савельевой G.M.Moskva. ГЭОТАР. MEDICAL 2009 480c.

Дополнительная the literature

1. Экстрагенитальная a pathology and pregnancy. Шехтман M.M.Meditsina. 2005г.
2. The decision of problems of newborns a management for doctors, nurses And midwifes. A management the CART. UNFPA 2007.
3. Effective перинатальная the help and leaving. A management the CART. UNFPA 2007.
4. Thermal protection of the newborn. Practical guidance the CART. UNFPA 2007.
5. Неонатология the Management the CART. UNFPA 2007.

6. Obstetrics. A management the CART. UNFPA 2007
7. Экстагенитальная a pathology and pregnancy. Шехтман M.M.Meditsina. 2005.
8. Перинатальная an infection. Questions патогенеза, morphological diagnostics and kliniko-morphological соспоставлений. A management for doctors. V.A.Tsinzerling., V.F.Melnikova "ЭЛБИ" SPb 2002

Abu Ali Ibn Sina and Bukhara State Medical Institute, an obstetrician and a gynecologist DEPARTMENT

Midwives have won and Gynecology 6 - course on the subject of treatment, medical and educational f akultet for students

calendar - thematic plan

Bukhara - 201 7 year
Schedule of lectures

No	M avzu	So horse	Sa na	Interdisciplinary and interconnected	Education engine lors	Benefit the literature s
1	Physiological pregnancy and postnatal period	2		normal and pathological anatomy, physiology and pathophysiology, Turpin, surgery, anesthesiology and critical care, dermatoveneralogiya, clinical pharmacology, oncology, endocrinology, urology)	slides to multime computer for demonstration of dialogue	A: 1,2,3,5,6,7,8, 9,10,14 Q1,6,10,11,13,14, 15,16,17,19
2	Complicated pregnancy	2		normal and pathological anatomy, physiology and pathophysiology, Turpin, surgery, anesthesiology and critical care, dermatoveneralogiya, clinical pharmacology, oncology, endocrinology, urology,	computer for multimedia presentation of slides	A: 1,2,3,4,5, 6,7,8,9, 10,11,14 Q: 6,10,11, 14,17, 19,20,

3	Left on the head. Infringement of the structure. Troubleshooting. High arterial pressure	2		normal and pathological anatomy, physiology and pathophysiology, Turpin, surgery, anesthesiology and critical care, dermatoveneralogiya, clinical pharmacology, oncology, endocrinology, urology,	computer for multimedia presentation of slides	A: 1,2,3,4,5,8,9, 10,13,14 Q: 6,10,11,14,17,
4	High temperature after the hawk	2		normal and pathological anatomy, physiology and pathophysiology, Turpin, surgery, anesthesiology and critical care, dermatoveneralogiya, clinical pharmacology, oncology, endocrinology, urology,	computer for multimedia presentation of slides	A: 1,2,3,5,6,7,8,9, 10,12,14 Q: 1,6,10,11,13,14, 15,16,17,19
5	Cut off the henna	2		normal and pathological anatomy, physiology and pathophysiology, Turpin, surgery, anesthesiology and critical care, dermatoveneralogiya, clinical pharmacology, oncology, endocrinology, urology,	a computer for multimedia slide show	A: 1,2,3,5,6,7,8,9, 10,12,14 Q: 1,6,10,11,13,14, 15,16,17,19
6	Kindergartens	2		normal and pathological anatomy, physiology and pathophysiology, Turpin, surgery, anesthesiology and critical care, dermatoveneralogiya, clinical pharmacology, oncology, endocrinology, urology,	computer for multimedia presentation of slides	A: 1,2,3,5,6,7,8,9, 10,12,14 Q: 1,6,10,11,13,14, 15,16,17,19
	Total:	12				

Obstetrics and Gynecology practical training calendar -tematik plan

No	subject	Sohorse	Sana	Fellowship and intercourse within	Teaching Methods	Education engine lors	Benefit the literatures	Mustado business

1	Physiologic knot	6		normal and pathological anatomy, physiology and pathophysiology, Turpin, surgery, anesthesiology and critical care, dermatovenerologiya, clinical pharmacology, oncology, endocrinology, urology)	***Around the "gallery tour".***	Computer multimedia c ideofilmlar, or zuv panels, shelves models, g e slate	A, 1.3, 4, 6,7.8,14, 18.Q- 20, 24, 27	**Methods of dispensing and examination of pregnant women.** .
2	Soglom goodbye pregnancy bring to go. Check. WAC tactics.	6		normal and pathological anatomy, physiology and pathophysiology, Turpin, surgery, anesthesiology and critical care, dermatovenerologiya, clinical pharmacology, oncology, endocrinology, urology,	***Assisment method.***	Computer Multimedias / history of the disease, Oscar, a textbook educational materials, D-stand, flipchart, wearing models	**A** 1,3.4,5,6, 7,13 **Q,** 19 2, 3, 20, 24, 27 29, 3, 4.35, 36.37	1. Seizures
3	Vaccination of pregnant women with uterine fibroids. Cutting cutaneous obstetrics.	7		normal and pathological anatomy, physiology and pathophysiology, Turpin, surgery, anesthesiology and critical care, dermatovenerologiya, clinical pharmacology, oncology, endocrinology, urology,	***The "T-scheme" method.***	Computer multimedia disease history, distribution material, practical delusions feet, models, flipchar	**A** 1,3,4,5,6, 7,14 **Q, 2,** 0, 23, 24,27,28, 29, 30, 34,35,37	Types of Kesar cutting operations.

						t.		
4	Pregnancy with an earlier pregnancy.	7		normal and pathological anatomy, physiology and pathophysiology, Turpin, surgery, anesthesiology and critical care, dermatovenerologiya, clinical pharmacology, oncology, endocrinology, urology,	***"Three-stage interview (patient, doctor, expert)".***	Computer Multimedias / history of the disease, Oscar, a textbook educational materials, D-stand, flipchart, wearing models	**A,** 1.3, 4, 6,7.8,14, 18 **Q-2,** 0, 23, 24,27,28, 29, 30, 34,35,37	Compliance with intergenetic interval
5	Adult pregnancy. Induction of tugruk.	7		normal and pathological anatomy, physiology and pathophysiology, Turpin, surgery, anesthesiology and critical care, dermatovenerologiya, clinical pharmacology, oncology, endocrinology, urology,	***The "cluster" method***	Computer Multimedias / history of the disease, Oscar, a textbook educational materials, D-stand, flipchart, wearing models	**A,** 1.3, 4, 6,7.8,14, 18 **Q-2** 0, 23, 24,27,28, 29, 30, 34,35,37	Early detection of pregnancy
6	Pregnancy with aborted uterus (multiple fetal, acute abundance). Diagnostics.Differential diagnostics.Tactics.	7		normal and pathological anatomy, physiology and pathophysiology, Turpin, surgery, anesthesiology and critical care, dermatovenerologiya, clinical pharmacology, oncology,	***"Acute attack".***	Computer Multimedias / history of the disease, Oscar, a textbook educational	**A,** 1.3, 4, 6,7.8,14, 18 **Q** 48,49, 50, 52.53, 55, 56, 58.63	Leopold-Levitsky Methods

				endocrinology, urology,		materials, D-stand, flipchart, wearing models		
7	Hamilton distress syndrome. Diagnosis and management of emergency situations in chakalok.	7		normal and pathological anatomy, physiology and pathophysiology, Turpin, surgery, anesthesiology and critical care, dermatovenerologiya, clinical pharmacology, oncology, endocrinology, urology,	***"Round table".***	Computer Multimedias / history of the disease, Oscar, a textbook educational materials, D-stand, flipchart, wearing models	**A 1.3,** 4, 6,7.8,14, 17, 18 **Q, 2** 0, 23, 24,27,28, 29, 30, 34,35,37	Prophylaxis of women (in rabbit, fertile age and climacteric period)
8	Hypertensive infringement during pregnancy and laparotomy. (Chronic hypertension, pregnancy-induced hypertension) Control. Differential diagnostics.	7		normal and pathological anatomy, physiology and pathophysiology, Turpin, surgery, anesthesiology and critical care, dermatovenerologiya, clinical pharmacology, oncology, endocrinology, urology,	***"Discussion".***	Computer Multimedias / history of the disease, Oscar, a textbook educational materials, D-stand, flipchart, wearing models	**A,** 1.3, 4, 6,7.8,14, 18 **Q, 2,** 0, 23, 24,27,28, 29, 30, 34,35,37	Definition of late pregnancy. X confused to hear the heartbeat on ultrasound
9	Hypertensive infringement during pregnancy and laparotomy. (Preeclampsia, eclampsia) Control. Differential diagnostics.	7		normal and pathological anatomy, physiology and pathophysiology, Turpin, surgery, anesthesiology and critical care, dermatovenerologiya,	***"SWOT"***	Computer Multimedias / history of the disease, Oscar, a textbook	**A,** 1.3, 4, 6,7.8,14, 18 **Q, 2,** 0, 23, 24,27,28, 29, 30, 31, 32, 33 34,35,37	Symptoms of spinal cord and divorce.

				clinical pharmacology, oncology, endocrinology, urology,		educational materials, D-stand, flipchart, wearing models		
10	Bone marrow in the second half of the pregnancy: NPVP, placement of the spinal cord. Check. Differential diagnostics.	6		normal and pathological anatomy, physiology and pathophysiology, Turpin, surgery, anesthesiology and critical care, dermatovenerealogiya, clinical pharmacology, oncology, endocrinology, urology,	***. Role-playing game "clinical".***	Computer Multimedias / history of the disease, Oscar, a textbook educational materials, D-stand, flipchart, wearing models	**A,** 1.3, 4, 6,7.8,14, 18 **Q, 2,** 0.23, 24,27,28, 29, 30, 31, 32,33,34,35,37	Hemostasis after Coma
11	Rheumatic Immunization. AVO conflict. Diagnosis. of tactics to go. Check. Differential diagnostics.	6		normal and pathological anatomy, physiology and pathophysiology, Turpin, surgery, anesthesiology and critical care, dermatovenerealogiya, clinical pharmacology, oncology, endocrinology, urology,	**BEHH diagram**	Computer Multimedias / history of the disease, Oscar, a textbook educational materials, D-stand, flipchart, wearing models	**A,** 1.3, 4, 6,7.8,14, 18 **Q-2** 0,23, 24,27,28, 29, 30, 31, 32,33,34, 35, 37	Personal hygiene
12	Sputum Septic Diseases. Peritonitis after Caesarean cutting. Check. Differential diagnostics.	6		normal and pathological anatomy, physiology and pathophysiology, Turpin, surgery, anesthesiology and critical	***"Demonstration" method***	Computer Multimedias / history of the disease, Oscar, a	**A,** 1.3, 4, 6,7.8,14, 18 **Q, 2,** 0.23, 24,27,28, 29, 30, 31, 35,37	Mother's school

				care, dermatovenerologiya, clinical pharmacology, oncology, endocrinology, urology,		textbook educational materials, D-stand, flipchart, wearing models		
13	Pregnancy first half of the bleeding. and abortion T ashxis complications. Check. Tactics. Differential diagnostics.	7		normal and pathological anatomy, physiology and pathophysiology, Turpin, surgery, anesthesiology and critical care, dermatovenerologiya, clinical pharmacology, oncology, endocrinology, urology,	***The problem of "problem solving"***	Computer Multimedias / history of the disease, Oscar, a textbook educational materials, D-stand, flipchart, wearing models	**A,** 1.3, 4, 6,7.8, 9, 14, 1 6 **Q, 2,** 0.23, 24,27,28, 29, 30, 31, 32,33,34,35,37	Early detection of pregnancy.
14	Menstrual cycle violation. DBK. Diagnosis. Check. Tactics. Differential diagnostics.	6		normal and pathological anatomy, physiology and pathophysiology, Turpin, surgery, anesthesiology and critical care, dermatovenerologiya, clinical pharmacology, oncology, endocrinology, urology,	***"Working in a small group"***	Computer Multimedias / history of the disease, Oscar, a textbook educational materials, D-stand, flipchart, wearing models	**A,** 1.3, 4, 6,7.8, 9, 14, 16, **Q, 2** 0.23 24,27,28, 29, 30, 31, 32,33,34,35,37	Sexual education
15	Ovarian cyst and cystoma (dangerous and safe). Detection. Getting off.	6		normal and pathological anatomy, physiology and pathophysiology, Turpin, surgery,	***"Moychechak"***	Computer Multimedias / history of the	**A** 1,3,4,6,7.8,14, 16 **Q 2,** 0,23, 24,27,28, 29, 30, 31, 32,33,34,35.37	Pregnant and sucker women hygiene and dietology

				anesthesiology and critical care, dermatovenerologiya, clinical pharmacology, oncology, endocrinology, urology,		disease, Oscar, a textbook educational materials, D-stand, flipchart, wearing models		
16	Acute abdomen in gynecology: ovarian pregnancy, ovarian apoplexy, twitching of ovarian cysts. Check. Differential diagnostics. .	6		normal and pathological anatomy, physiology and pathophysiology, Turpin, surgery, anesthesiology and critical care, dermatovenerologiya, clinical pharmacology, oncology, endocrinology, urology,	***The "tree of trees"***	Computer Multimedias / history of the disease, Oscar, a textbook educational materials, D-stand, flipchart, wearing models	**A** 3,12,13,18 **Q,** **2** 0.23 24,27,28, 29, 30, 31, 32,33,34,35,37	Family counseling
17	Wound and anomalies of the genital organs. Check. Differential diagnostics.	6		normal and pathological anatomy, physiology and pathophysiology, Turpin, surgery, anesthesiology and critical care, dermatovenerologiya, clinical pharmacology, oncology, endocrinology, urology,	***"Discussion"***	Computer Multimedias / history of the disease, Oscar, a textbook educational materials, D-stand, flipchart, wearing models	**A** 3,12,13,18 **Q,** 28, 29.33, 34,38,39	Contraceptive the importance of
18	Bepusht divorce. Diagnosis. Check. Differential	6		normal and pathological anatomy, physiology and	***The "fish skeleton"***	Computer Multimedias /	**A** 3,12,13,18 **Q,** 28,	Family planning

19	Diagnostics and GP Tactics. Types of contraception Total:	6 12 1		pathophysiology, Turpin, surgery, anesthesiology and critical care, dermatovenerologiya, clinical pharmacology, oncology, endocrinology, urology, normal and pathological anatomy, physiology and pathophysiology, Turpin, surgery, anesthesiology and critical care, dermatovenerologiya, clinical pharmacology, oncology, endocrinology, urology,	***"Working in a small group"***	history of the disease, Training manuals, training materials, D Oscar-stand, flipchart, kulkop models Computer Multimedias / history of the disease, Training manuals, training materials, D Oscar-stand, flipchart, kulkop models	29.33, 34,38,39 **A** 3,12,13,18 **Q,** 28, 29.33, 34,38,39	Workability **227**

Literature:

1. Gynecology. Show Mullazhanova, Jabbarovich Yu.K. Tashkent, 2006.
2. Obstetrics. Savelyevich GM Moscow. 200 2 .
3. Klinicheskie lektsii PO gynecologist and obstetrician. AN Strijakova. M.Meditsina 2000.
4. Obstetrics. Bodyajina VI, Semenchenko. M. 2004.
5. Kratkoe fin PO prevention of infection. Pervoy izdanie. Tashkent. 2004. 236s.
6. Neotlojnaya assistance akusherskoy practices. WHO. 2004.

7. Neoperativnaya Gynecology. Smetnik VN, tumilovich VP Medical Inform. Agency. Moscow. 2005. 440S.
8. Gynecology. Show Mullazhanova, Jabbarovich Yu.K. Tashkent. 2006.
9. Gynecology. pod red. Vasilevskoy M. 2007.
10. Obstetrics and gynecology. pod red. Savelevoy GM M. 2007
11. Klinincheskoe fin PO vedenie bolnyx s krovotecheniemi v Roda poslerodovom period. T. 2008.
12. Klinincheskoe fin PO vedenie bolnyx s / septicheskim sepsis, shock vo Vremya beremennosti poslerodovom period. T. 2008.
13. Klinincheskoe fin PO vedenie bolnyx s syndrome gipertenzivnym Prix berermennosti. T. 2008.
14. Gineokologiya. Uchebnik. Pod red. Savelevoy GM Moscow. Geothe. MED. 2009 480s.

More Posts:

1. Ekstragenitalnaya Pathology beremennost. Shextman MMIsakova Medical. 2005.
2. Find RESHENIE problem novorojdennyx fin vrachey, medsestra I akusherok. WHO supervision. UNFPA in 2007.
3. Effektivnaya Perinatal assistance Uxod. Supervision of WHO. UNFPA in 2007.
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Zav.kafedroy : k.m.n. Assoc. : Ixtiyarova G.A.

Kalendarno - tematicheskiy plan lektsiy PO gynecologist and obstetrician - za 6 201 7 201 8 uchebnyy god dlya course lechebnogo pedagogicheskogo Department

No	Nazvanie temy	chasy	data	Vnutrimejdistsiplinarnaya svyaz	Naglyadnye Posobia	**l** iteratura
1	Physiologicheskie rody. Physiological poslerodovyy period.	2		normal and pathological anatomy, physiology and pathophysiology, Turpin, surgery, anesthesiology and critical care, dermatoveneralogiya, clinical pharmacology, oncology, endocrinology, urology)	Lazerny projector, visual material, informative obespechenie	A: 1,2,3,5,6,7,8, 9,10,14 Q1,6,10,11,13,14 , 15,16,17,19
2	Oslojnennaya veremennost	2		normal and pathological anatomy, physiology and pathophysiology, Turpin, surgery, anesthesiology and critical care, dermatoveneralogiya, clinical pharmacology, oncology, endocrinology, urology)	Lazerny projector, visual material, informative obespechenie	A: 1,2,3,4,5, 6,7,8,9, 10,11,14 Q: 6,10,11, 14,17, 19,20,
3	Golovnaya b narushenie zreniya, sudorogo, obmorok, vysokaya A / D	2		normal and pathological anatomy, physiology and pathophysiology, Turpin, surgery, anesthesiology and critical care, dermatoveneralogiya, clinical pharmacology, oncology, endocrinology, urology)	Lazerny projector, visual material, informative obespechenie	A: 1,2,3,4,5,8,9, 10,13,14 Q: 6,10,11,14,17,

4	V ysokaya temperature poslerodovoy period	2		normal and pathological anatomy, physiology and pathophysiology, Turpin, surgery, anesthesiology and critical care, dermatoveneralogiya, clinical pharmacology, oncology, endocrinology, urology)	Lazerny projector, visual material, informative obespechenie	A: 1,2,3,5,6,7,8,9, 10,12,14 Q: 1,6,10,11,13,14, 15,16,17,19
5	Vlagalishchnie krovotechenie			normal and pathological anatomy, physiology and pathophysiology, Turpin, surgery, anesthesiology and critical care, dermatoveneralogiya, clinical pharmacology, oncology, endocrinology, urology)	Lazerny projector, visual material, informative obespechenie	A: 1,2,3,5,6,7,8,9, 10,12,14 Q: 1,6,10,11,13,14, 15,16,17,19
6	Vlagalishchnie vydelenie			normal and pathological anatomy, physiology and pathophysiology, Turpin, surgery, anesthesiology and critical care, dermatoveneralogiya, clinical pharmacology, oncology, endocrinology, urology)	Lazerny projector, visual material, informative obespechenie	A: 1,2,3,5,6,7,8,9, 10,12,14 Q: 1,6,10,11,13,14, 15,16,17,19
	Itogo:	12				

Kalendarno - tematicheskiy Planning Tools zanyatiy PO gynecologist and obstetrician za 2017 -2018 uchebnyy god dlya 6-year lechebnogo pedagogicheskogo Department

No	The Nazvanie Temy	Chasy	Data	Vnutri, mejdis..vzaimosvyaz	Metody Obucheniyya	Naglyadnye poobiya	Lite Ratura	Samostoyatelnaya rabota
1	Physiologicheskie rody. The tactics are veneiya. Urgentnaya assistance Prix fiziologicheskix Carlos VOP.	6		normal and pathological anatomy, physiology and pathophysiology, Turpin, surgery, anesthesiology and critical care, dermatoveneralogiya, clinical	Tour po gallery	Find cabinet VOP SVP, audience, imeyushchaya Terms of Rabat groups, models and tools - stethoscope,	A, 1.3, 4, 6,7.8,14, 18.Q- 20, 24, 27	Dispensaries beremennyx techniques issledovanie.

				pharmacology, oncology, endocrinology, urology)		santimetrovaya tape, zerkala, perchatki prisoner wakes standard Shag PO vypolneniyu Tools navykov. ,		
2	Vedenie beremennosti zdorovyx jenshch in. Antenatalny uxod. Prick №137 MZ resolution. Lichnaya hygiene.	6		normal and pathological anatomy, physiology and pathophysiology, Turpin, surgery, anesthesiology and critical care, dermatovenerologiya, clinical pharmacology, oncology, endocrinology, urology,	assisment	Computer Oscar multimedia, D-stand, flipchart, perchatki models Istoriya rodov stethoscope, centimeter tape, zerkala	**A** 1,3.4,5,6, 7,13 **Q,** 19 2, 3, 20, 24, 27 29, 3, 4.35, 36.37	2. Periody rodov
3	Vedenie beremennyx s rubtsom na matke. Kesarevo sechenie v sovremennom akusherstve. Diagnostics. Vedenie beremennyx.	7		normal and pathological anatomy, physiology and pathophysiology, Turpin, surgery, anesthesiology and critical care, dermatovenerologiya, clinical pharmacology, oncology, endocrinology, urology,	T-scheme			Vydy kesarevo sechenie i texnika
4	Predecessional rody. Diagnostics. The tactics are veneiya	7		normal and pathological anatomy, physiology and pathophysiology, Turpin, surgery, anesthesiology and critical care, dermatovenerologiya, clinical pharmacology, oncology, endocrinology, urology 7	3 stepenny y interview	Go Uchebnye posobiya, materials, istorii Boles, slaydovye prezentatsii, razdatochnye materials, standard Shag PO vypolneniyu Tools navykov	**A,** 1.3, 4, 6,7.8,14, 18 **Q-2** 0, 23, 24,27,28, 29, 30, 34,35,37	Soblyudenie intergenetich eskogo intervala

						models, the Rules Internet back dokazateln oy Medicine, markers, scotch, flipchart.		
5	Perenashivani e. Diagnostics. The tactics are veneiya. Induction rod. Mediko-geneticheskie konsultatsii.	7			Cluster			Diagnostics rannyy Sroki beremennos ty
6	Vedenie beremennosti pererastyanut oy Matko Grand Prix (Grand Prix mnogoplodii, mnogovodii). Diagnostics. The tactics are veneiya. Vedenie beremennosti u yunyx i pojilyx pervorodyash chix. Diagnostics. The tactics are veneiya. Soblyudenie intergenetiche skogo intervala.	7		normal and pathological anatomy, physiology and pathophysiolo gy, Turpin, surgery, anesthesiology and critical care, dermatovenera logiya, clinical pharmacology , oncology, endocrinology , urology,	storming devoted	Go Uchebny e posobiya , material s, istorii Boles, razdatoc hnye material s, standard Shag PO vypolne niyu Tools navykov , models, flipchart	**A,** 1.3, 4, 6,7.8,14, 18 **Q-2,** 0 , 23, 24,27,28 29, 30, 34,35,37	The method Leopolda-Levitt
7	Distress syndrome novorojdenny x. Emergency novorojdenny x	7			round table			Profilaktiche skoe osmotic ginseng (YUVENTA, fertile, klimaktericheskogo vozrasta)

8	Gipertenzivnye narusheniya vo Vremya beremennosti Rhodes. Diagnostics. The tactics of Vedeno (Xronicheskaya hypertension. Hypertension, indutsirovannaya beremennostyu).	7		normal and pathological anatomy, physiology and pathophysiology, Turpin , surgery, anesthesiology and critical care, dermatovenerologiya , clinical pharmacology , oncology, endocrinology , urology,	Discussion	Go Uchebnye posobiya, materials, istorii Boles, slaydovye prezentatsii, razdatochnye materials, standard Shag PO vypolneniyu Tools navykov models, the Rules Internet back of Medicine, markers, scotch, flipchart .	**A,** 1.3, 4, 6,7.8,14, 17, 18 **Q, 2** 0 , 23, 24,27,28 29, 30, 34,35,37	Diagnostic pozdn sroki beremennosty
9	Gipertenzivnye narusheniya vo Vremya beremennosti Rhodes. Diagnostics. Ah, tactics, write down (preeclampsia , eclampsia)	7		normal and pathological anatomy, physiology and pathophysiology, Turpin , surgery, anesthesiology and critical care, dermatovenerologiya , clinical pharmacology , oncology, endocrinology , urology,	' SWOT '	Go Uchebnye posobiya, materials, istorii Boles, slaydovye prezentatsii, razdatochnye materials, standard Shag PO vypolneniyu Tools navykov models, the Rules Internet back of Medicine, markers, scotch, flipchart .	**A,** 1.3, 4, 6,7.8,14, 17, 18 **Q, 2** 0 , 23, 24,27,28 29, 30, 34,35,37	Priznaki ogtdelenie vydelenie plantsenti
10	Krovotechenie vo vtoroy polovine beremennosti. PONRP.PP. The tactics of Vedeno. Dif h	6		normal and pathological anatomy, physiology and pathophysiology, Turpin , surgery, anesthesiology	**Rolevaya Igra**	Go Uchebnye posobiya, materials, istorii	**A,** 1.3, 4, 6,7.8,14, 18 **Q, 2,** 0 , 23, 24,27,28 29, 30,	Poslerodovyy hemostasis

	iagnostika .			and critical care, dermatovenera logiya , clinical pharmacology , oncology, endocrinology , urology,		Boles, razdatoc hnye material s, standard Shag PO vypolne niyu Tools navykov , models, flipchart .	31, 32.33 34,35,37	
11	Rh immunization . AVO conflict D iagnostika. The tactics of Vedeno.	6		normal and pathological anatomy, physiology and pathophysiolo gy, Turpin , surgery, anesthesiology and critical care, dermatovenera logiya , clinical pharmacology , oncology, endocrinology , urology,	Venn diagram	Go Uchebnye posobiya, materials, istorii Boles, slaydovye prezentatsi i, razdatoch nye materials, standard Shag PO vypolneni yu Tools navykov models, the Rules Internet back of Medicine, markers, scotch, flipchart .	**A,** 1.3, 4, 6,7.8,14, 18 **Q, 2 ,** 0.23, 24,27,28, 29, 30, 31, 32,33,34,35 ,37	Lichnaya hygiene
12	Septicheskie zabolevaniya After the Rhodes .P eritonit After the Caesarean unofficial . The tactics of Vedeno.	6		normal and pathological anatomy, physiology and pathophysiolo gy, Turpin , surgery, anesthesiology and critical care, dermatovenera logi ya , clinical pharmacology , oncology, endocrinology , urology,	demonstr ation	Go Uchebnye posobiya, materials, istorii Boles, slaydovye prezentatsi i, razdatoch nye materials, standard Shag PO vypolneni yu Tools navykov models, the Rules Internet	**A,** 1.3, 4, 6,7.8,14, 18 **Q 2** 0.23 24,27,2 8, 29, 30, 31, 32,33,34, 35, 37	Shkola ma Teresa

						back of Medicine, markers, scotch, flipchart .		
13	Krovotechenie pervoy polovine beremennosti. I-ix oslojneniya abortions.	7		normal and pathological anatomy, physiology and pathophysiology, Turpin , surgery, anesthesiology and critical care, dermatovenerologiya , endocrinology , urology,	RESHENIE problems	Go Uchebnye posobiya, materials, istorii Boles, slaydovye prezentatsii, razdatochnye materials, standard Shag PO vypolneniyu Tools navykov models, the Rules Internet back of Medicine, markers, scotch, flipchart .	**A,** 1.3, 4, 6,7.8,14, 18 **Q, 2 ,** 0.23, 24,27,28, 29, 30, 31, 35.37	diagnostic rannyy sroki beremennosty
14	NMOTs D MK.Diagnostika . Dif h iagnostika	6			Rules v Maly groups			Polovoe vospitanie
15	Over i kistomy yaichnika . (Dobrokachestvennye zlokachestvennye) diagnostics. techniques lecheniya	6			chamomile			Hygiene diontologiya beremennyx kormyashix jenshinax
16	Ostryy gynecologist LiveJournal	6			dereva resheniy			Konsultirovanie fat
17	Trauma and abnormal JPO	6			Discussion			matter kontratseptsie
18	Reproduktivnoe to come with me. Konsultirovan	6		normal and pathological anatomy, physiology and pathophysiolo	Skeleton ryby	Uchebnye Go posobiya, materials, istorii	**A** 3,12,13,18 **Q,**	Planirovanie Family

	ie. Konsultirovanie brake.			gy, Turpin , surgery, anesthesiology and critical care, dermatovenerologiya , clinical pharmacology , oncology, endocrinology , urology,		Boles, razdatochnye materials, standard Shag PO vypolneniyu Tools navykov, models, flipchart .	**2** 0.23, 24,27,28, 29, 30, 31, 32,33,34,35 ,37	
19	Vidya contraception . I vedenie pobochnyx preventive effects.	6		normal and pathological anatomy, physiology and pathophysiology, Turpin , surgery, anesthesiology and critical care, dermatovenerologiya , clinical pharmacology , oncology, endocrinology , urology,	Rules v Maly groups	Uchebnye Go posobiya, materials, istorii Boles, razdatochnye materials, standard Shag PO vypolneniyu Tools navykov, models, flipchart .	**A** 3,12,13,18 **Q,** 28, 29.33, 34,38,39	Rabotaspo sobnost

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Zav.kafedroy : k.m.n. Assoc. : Ixtiyarova G.A.

Glossary.

ABORTION	During the first 22 weeks of living of fetal abilities,gestation is dropped through uterus or have a an abortion.
ALPHAFETOPROTEIN	(AFP) TEST: Maternal serum blood test performed during pregnancy to detect various fetal abnormalities. For more
ABORTION RATE	The number of abortions obtained by women of childbearing age (15 to 44) over a given period. This rate is usually expressed in terms of abortions per 1,000 women annually.
AMENORRHEA	:Absence or extreme modification of the usual menstrual cycle. Amenorrhea is a generally temporary condition that may be caused by disease, excessive exercise, or breastfeeding. Not related to menopause
AMNION	A thin membrane enclosing the preborn child, containing the amniotic fluid in which the child is immersed. This is the gossamer membrane depicted surrounding the preborn baby in some photographs of midterm pregnancy development.
ANTENATAL	A term used to describe any event before birth.
ARTIFICIAL INSEMINATION	Procedure by which the sperm donor masturbates to collect sperm, which is then introduced into the woman's vagina
BAG OF WATERS	The double-walled fluid-filled sac that encloses and protects the preborn baby in the uterus. The bag of waters is frequently mechanically ruptured at the end of pregnancy to induce hard labor.
BASAL TEMPERATURE	The body temperature of a person who has been at complete rest long enough for the temperature to stabilize at a low point.
BIOPSY	

CHORION	The surgical removal of a tissue sample for analysis.
CONTRAGESTION	The outer embryonic membrane associated with the allantois, which is the vascular fetal membrane that is initially formed in the shape of a pouch
EMBRYO	The process of inducing an abortion.
Allantois	Preborn baby in the early stages of development that are characterized by the laying down of fundamental tissues, cleavage, and the initial formation of organs and organ systems
Regulation of reproductive function in athletic women	The hollow sac-like structure filled with clear fluid that forms part of a developing amniote's conceptus (which consists of all embryonic and extra-embryonic tissues). It helps the embryo exchange gases and handle liquid waste.
CONTRAGESTION	an investigation of the roles of energy availability and body composition
CRYOPRESERVATION	The process of inducing an abortion.
CORPUS LUTEUM	The preservation of embryos, sperm, or other biological matter by freezing at extremely low temperatures.
CONTRACEPTION	The temporary structure that emits hormones from within a ruptured ovarian follicle (after the egg is released during ovulation). The purpose of the hormones is to sustain pregnancy until the placenta matures to the point where it can assume this role.
Apgar Score	The practice of using drugs, procedures or devices intended to prevent conception by one or more of three modes of action
Braxton Hicks contractions	The meternal period before delivery

Gestation	(false labour) Relatively painless contractions , which may be present throughout the pregnancy, or just prior labour
Grand multipara	The period from fertilization of the ovum until brith
Menarche	A woman who has had deliveries or more
Ovulation	The first menstruation and the commencement of cyclic menstrual function
Perinatal	Release of an ovum secondary oocyte from the vesicular follicle
Multigravida	Occuring at or near the time of birth
Premature Labour	A voman has hadtwo or more pregnancies
Term	Onset of Labour less than 35 cmpleted weeks of gestation
Trimestrer	A pregnancy that has reached 40 weeks gestation
ABORTIFACIENT	One of three periods of approximately 3 month into which pregnancy is divided
ACCIDENTAL A BORTION	An agent whose sole or primary purpose is to cause abortions. Such agents include low-close birth control pills, minipills, 'morning-after' pills, NORPLANT
AFEBRILE ABORTION	An unintentional abortion (usually termed a miscarriage) caused by a fall, blow, or any other accidental injury.
ABORTION RATE	A natural or spontaneous abortion resulting from a tubal or abdominal pregnancy. Does not refer to a procedure designed to remove the fetus from the Fallopian tube or abdomen.

	The number of abortions obtained by women of childbearing age (15 to 44) over a given period. This rate is usually expressed in terms of abortions per 1,000 women annually.

The system for assessing students' knowledge

№	Assimilation in (%) and points	Score	Level of knowledge of students
1.	86 - 100	Excellent «5»	Draws conclusions and conclusions Logical thinking Independent thinking Applies in practice Understands the meaning Knows, tells Has deep knowledge
2.	71 - 85	Good "4"	Independent thinking Applies in practice Understands the meaning Knows, tells Has the concept of
3.	55 - 70	Satisfactory «3»	Understands the meaning Knows, tells Has the concept of
4.	0 - 54	Unsatisfactory "2"	Does not have a definite notion Does not know the subject of training

TESTS

1. The hormone responsible for the development of the ovum during the menstrual cycle is?

a. Estrogen
b. Progesterone
c. Follicle Stimulating hormone (FSH)
d. Luteneizing hormone (LH)

2. Which hormone is not responsible for differentiation of male reproductive organs during fetal life?

a. Mullerian duct inhibitor (MDI)
b. Dyhydrotestosterone
c. Dehydroepiandosterone sulfate
d. Testosterone

3. Which principal factor causes vaginal pH to be acidic?

a. Cervical mucus changes
b. Secretion of the Skene's gland
c. The action of the doderlein bacillus
d. Secretion of the bartholins gland

4. Family centered nursing care for women and newborn focuses on which of the following?
a. Assisting individuals and families achieve their optimal health
b. Diagnosing and treating problems promptly
c. Preventing further complications from developing
d. Conducting nursing research to evaluate clinical skills

5. When reviewing the ethical dilemmas facing maternal and newborn nurses today, which of the following has contributed to their complexity?
a. Limitation of available options
b. Support for one viable action
c. Advancement in technology
d. Consistent desirable standards

6. The frenulum and prepuce of the clitoris are formed by the?

a. Fossa Navicularis
b. Mons veneris
c. Labia majora
d. Labia minora

7. The vas deferens is a:

a. storage for spermatozoa
b. Site of spermatozoa production
c. Conduit of spermatozoa
d. Passageway of sperm

8. Cremasteric visits the clinic and is told that his sperm count is normal. A normal sperm count ranges from:

a. 20 to 100/ml
b. 100, 000 to 200, 000/ml
c. 100 to 200/ml
d. 20 to 100 million/ml

9. During which of the following phase of the menstrual cycle is it ideal for implantation of a fertilized egg to occur?

a. Ischemic phase
b. Menstrual phase
c. Proliferative phase
d. Secretory phase

10. Variation on the length of menstrual cycle are due to variations in the number of days in which of the following phase?

a. Proliferative phase
b. Luteal phase
c. Ischemic phase
d. Secretory phase

Situation: Mrs. Calamares G2P1 1001, comes out of the labor and delivery room and reports ruptured amniotic membranes and contractions that occur every 3 minutes lasting 50-60 seconds. The fetus is in LOA position

11. The nurse's first action should be to:

a. Check the FHR
b.Call the physician
c. Check the vaginal discharge with nitrazine paper
d.Admit Mrs. Calamares to the delivery area

12. When asked to describe the amniotic fluid, Mrs. Calamares states that it is "brown-tinged". This indicates that:

a. The fetus had infection
b. At some point, the fetus experienced oxygen deprivation
c. The fetus is in distress and should be delivered immediately
d. The fetus is not experiencing any undue stress

13. The nurse established an IV line, and then connects Calamares to an electronic fetal monitor. The fetal monitoring strip shows FHR deceleration occurring about 30 sec after each contraction begins; the FHR returns to baseline after the contraction is over. This type of deceleration is caused by:

a. Fetal head compression
b. Umbilical cord compression
c. Utero-placental insufficiency
d. Cardiac anomalies

14. With this type of deceleration, the nurse's first action should be to:

a. Do nothing, this is a normal occurrence
b. Call the physician
c. Position the patient on her left side
d. Continue monitoring the FHR

15. Which of the following methods would be avoided for a woman who is 38 years old, has 3 children and smokes a pack of cigarette per day?

a. Oral contraceptives
b. Cervical cap
c. Diaphragm
d. IUD (Intra-uterine device)

16. A woman using diaphragm for contraception should be instructed to leave it in place for at least how long after intercourse?

a. 1 hour
b. 6 hours
c. 12 hours
d. 28 hours

17. When assessing the adequacy of sperm for conception to occur, which of the following is the most helpful criterion?

a. sperm count
b. sperm motility
c. Sperm maturity
d. Semen volume

18. A couple with one child had been trying, without success for several years to have another child. Which of the following terms would describe the situation?

a. Primary Infertility
b. Secondary Infertility
c. Irreversible infertility
d. Sterility

Situation: Melanie a 33y/o G1P0 at 32 weeks AOG is admitted to the Hospital with the diagnosis of PIH.

19. Magnesium Sulfate is ordered per IV. Which of the following should prompt the nurse to refer to the obstetricians prior to administration of the drug?

a. BP= 180/100
b. Urine output is 40 ml/hr
c. RR=12 bpm
d. (+) 2 deep tendon reflex

20. The nurse knows that Melanie is knowledgeable about the occurrence of PIH when she remarks:

a. "It usually appears anytime during the pregnancy"
b. "Its similar to cardio-vascular disease"
c. "PIH occurs during the 1st trimester"
d. "PIH occurs after the 20th wks AOG"

21. After several hours of MgSO4 administration to Melanie, she should be observed for clinical manifestations of:

a. Hyperkalemia
b. Hypoglycemia
c. Hypermagnesemia
d. Hypercalcemia

22. The nurse instructs Melanie to report prodromal symptoms of seizures associated with PIH. Which of the following will she likely identify?

a. Urine output of 15ml/hr
b. (-) deep tendon reflex
c. sudden increase in BP
d. Epigastric pain

Situation: The following questions pertain to intrapartum complications:

23. Which of the following may happen if the uterus becomes over stimulated by oxytocin during induction of labor?

a. Weak contractions prolonged to more than 70 sec
b. Titanic contractions prolonged for more than 90 sec
c. Increased pain with bright red vaginal bleeding
d. Increased restlessness

24. Which of the following factors is the underlying cause of dystocia?

a. Nutritional
b. Environmental
c. Mechanical
d. Medical

25. When Umbilical cord is inserted at the edge of the placenta is termed:

a. Central insertion
b. Battledore insertion
c. Velamentous insertion
d. Lateral insertion

26. When fetal surface of the placenta presents a central depression surrounded by a thickened grayish white ring, the condition is known as:

a. Placenta succenturiata
b. Placenta marginata
c. Fenestrated placenta
d. Placenta Circumvallata

27. Which of the following is derived form mesoderm?

a. lining of the GI tract
b. liver
c. brain
d. skeletal system
28. The average length of the umbilical cord in human is:

a. 35 cm
b. 55 cm
c. 65 cm
d. 45 cm

29. Urinary excretion of HCG is maximal between which days of gestation?

50-60
40-50
60-70
30-40

30. Which of the following is not a part of conceptus?

a. deciduas
b. amniotic fluid
c. fetus
d. membranes

31. Protection of the fetus against syphilis during the 1st trimester is attributed to:

a. amniotic fluid
b. langhan's layer
c. syncitiothrophoblast
d. placenta

Situation: Diane is pregnant with her first baby. She went to the clinic for check up.

32. To determine the clients EDC, which day of the menstrual period will you ask?

a. first
b. last
c. third
d. second

33. According to Diane, her LMP is November 15, 2002, using the Naegle's rule what is her EDC?

a. August 22, 2003
b. August 18, 2003
c. July 22, 2003
d. February 22, 2003

34. She complained of leg cramps, which usually occurs at night. To provide relief, the nurse tells Diane to:

a. Dorsiflex the foot while extending the knee when the cramps occur
b. Dorsiflex the foot while flexing the knee when the cramps occurs
c. Plantar flex the foot while flexing the knee when the cramps occur
d. Plantar flex the foot while extending the knee when the cramp occur

Situation: Marita is a nurse working in a STD clinic (question 36-45)

35. The main symptom of gonorrhea in male is:

a. Maculopapular rash
b. Jaundice
c. Urinary retention
d. Urethral discharge

36. In providing education to your clients, you should take into account the fact that the most effective method known to control the spread of HIV infection is:

a. Premarital serological screening
b. Prophylactic treatment of exposed person
c. On going sex education about preventive behaviors
d. Laboratory screening of pregnant woman

37. You counseled one of your clients who developed herpes genitalis concerning follow up care. Women who have developed the disease are at risk of developing:

a. Heart and CNS damage
b. Cervical cancer
c. Infant Pneumonia and eye infection
d. Sterility

38. Cremasteric, 19 y/o states that he has Gonorrhea. In performing assessment, the nurse should expect to identify which of the following symptoms?

a. Lesion on the palms and soles
b. A pinpoint rash on the penis
c. Urinary dribbling
d. Dysuria

39. The nurse should explain to Rhone, 15 y/o that untreated Gonorrhea in the female frequently leads to:

a. Obstruction of the Fallopian tubes

b. Ovarian cysts
c. Ulceration of the cervix
d. Endometrial polyps

40. Diane, a 16 y/o female high school student has syphilis. Treatment is initiated. Before the client leaves the clinic, which of the following actions is essential for the nurse to take?
a. Advice the client to avoid sexual contact for 2 months
b. Ask the client to identify her sexual contacts
c. Arrange for the client to have hearing and vision screening
d. Have the client to return to the clinic weekly for blood test

41. Kris complains of fishy smelling, white cheeslike vaginal discharge with pruritus. You suspect that Kris may have:

a. Moniliasis
b. Trichomoniasis
c. Syphilis
d. Gonorrhea

42. Demi who has history of repeated Trichomonas infections was advised to have Pap-smear by her physician. She asked you what the test is for. Your appropriate response is:

a. It's a screening for cervical cancer
b. It's a screening test for presence of cancer in the female reproductive tract
c. It is a diagnostic test for the presence of Trichomonas infection
d. It is a test that will show if she has cervical cancer or not.

43. The result of the pap-test is class II. This means that:

a. Presence of malignant cells
b. Presence of benign or possible malignancy
c. Normal finding
d. Possible inflammation or infections

44. You should be aware that a major difficulty in preventing spread of gonorrhea is that many women who have the disease:

a. Is un aware that they have it
b. Have milder form of the disease than most men
c. Are more reluctant to seek health care than men
d. Acquire the disease without having sexual contact

Situation: Mrs. Rhona Mahilum was admitted to the hospital with signs and symptoms of pre-eclampsia

45. Because of the possibility of convulsive seizures, which of the following should the nurse have available at the client's bed side?
a. Oxygen and nasopharyngeal suction
b. leather restraints
c. cardiac monitor
d. venous cutdown set

46. One morning, Rhona tells the nurse that she think she is having contractions. Which of the following approaches should the nurse use to fully assess the presence of uterine co tractions?

a. Place the hand on opposite side of the upper part of the abdomen, and curve them somewhat around the uterine fundus.
b. Place the heel of the hand on the abdomen just above the umbilicus firmly

c. Place the hand flat on the abdomen over the uterine fundus, with the fingers apart and press lightly
d. Place the hand in the middle of the upper abdomen and then move hand several times to different parts of the abdomen

47. Exposure of a woman pregnant of a female offspring to which of the following substance increases the risk of the offspring during reproductive years to cervical and uterine cancer

steroids
thalidomides
diethylstilbestrol
tetracyclines

48. In which of the following conditions is vaginal rugae most prominent?
a. multiparous women
b. before menopause
c. after menopause
d. nulliparous waman

49. The deepest part o the perineal body surrounding the urethra, vagina and rectum that when damaged can result to cystocele, rectocele and urinary stress incontinence is the?

a. Pubococcygeus muscle
b. Spinchter of urethra and anus
c. Bulbocavernous muscle
d. Ischiocavernous muscle

Situation: Review of concepts of parturition was made by the clinical instructor to a group of nursing students preliminary to their assignment to Labor and delivery room
50. Which plays an important role in the initiation of labor?

a. maternal adrenal cortex
b. fetal adrenal cortex
c. fetal adrenal medulla
d. maternal adrenal medulla

51. Which is not considered an uteroronin?

a. Prostaglandin
b. Endothelin-1
c. Oxytocin
d. Relaxin

52. Which is a primary power of labor?

a. uterine contractions
b. pushing of the mother
c. intrathoracic pressure
d. abdominal contraction

53. The lower uterine segment is formed from the:

a. cervix
b. isthmus and cervix
c. body of the uterus
d. isthmus

54. Ripening of the cervix occurs during the:

a. first stage
b. second stage
c. third stage
d. fourth stage

55. In the second stage of labor, uterine contraction last:

a. 20 seconds
b. 30 seconds
c. 60 seconds
d. 120 seconds

56. The time between uterine contractions is:

a. intensity
b. interval
c. duration
d. frequency

57. Midpelvic capacity may be precisely determined by:

a. imaging studies
b. clinical measurement of the sidewall convergence
c. clinical measurement of the ischial spine prominence
d. sub pubic angel measurement

58. The inanimate bone of the pelvis is not composed of the:

a. sacrum
b. ilium
c. Pubis
d. Ischium

59. Which does not refer to the transverse diameter of the pelvic outlet?

a. Bi-ischial diameter
b. Bi-spinous diameter
c. Bi-tuberous diameter
d. Intertuberous diameter

60. The Antero-posterior diameter of the pelvic inlet where the fetus will likely most difficulty during labor is the:

a. Diagonal conjugate
b. True conjugate
c. conjugate Vera
d. obstetric conjugate

1-c. 2-c.3-c.4-a.5-c.6-d.7-c.8-d.9-d.10-a.11-a.12-b.13-c.14-c.15-a.16-b.17-b.18-b.19-c.20-d.21-d.23-b.24-c.25-c.26-d.27-d.28-b.29-c.30-a.31-b.32-a.33-a.34-a.35-d.36-c.37-b.38-d.39-a.40-b.41-a.42-a.43-d.44-a.45-a.46-c.47c.48-d.49-a.50-b.51-d.52-a.53-b.54-a.55-c.56-b.57-a.58-a.59-b.60-d.

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