ISSN NO: 2770-2936
Date of Publication:11-02-2023

Management of the Reatening Preterm Birth

Shavazi Nargiz Nuralievna
Associate Professor, Head of the Department of Obstetrics and Gynecology №3
Samarkand State Medical University
Akhtamova Nilufar Akbarjonovna
Doctoral resident, Department of Obstetrics and Gyn. No. 1, Samarkand State Medical University
Rayimjanova Nazokat Farkhodovna
Clinical Resident of the 1 years of study of the Department of Obstetrics and Gynecology №3

Annotation: Premature birth (PR) is a complex medical and social problem associated with solving problems to improve the quality of the subsequent life of children born prematurely and associated with material and economic costs. The severity of complications associated with prematurity is proportional to the gestational age of preterm birth. Currently, obstetricians face two main tasks: detection of threatened preterm birth in order to avoid inappropriate interventions and preparation of the fetus for preterm birth with the help of adequate and at the same time safe medications.

Most maternal complications develop during pregnancy, and many of them can be prevented or treated.

These guidelines describe the impact of preterm birth on obstetric complications, diagnostic methods and types of correction of various disorders, as well as the results of the study.

Keywords:

Introduction:

Almost 140 million births occur worldwide every year, and most of them occur without any risks to mother and child, both at the beginning and during labor. Despite this, childbirth is a critical period for the survival of mother and child, since the risk of pathology or death can increase if complications occur.

Preterm birth is a syndrome that can be caused by various factors, such as infection, cervical pathology, uterine hyperdistension, progesterone deficiency, vascular changes (uteroplacental ischemia, decidual bleeding), maternal and fetal stress, allograft reaction, allergic phenomena, and others may be other somewhat unknown factors. These different etiologies can lead to pathological activation of the common decidual/fetal membrane pathway, which causes uterine contractility, cervical ripening, and rupture of the membranes. Moreover, the mechanisms responsible for these processes have been identified, which include receptors, chemokines, and inflammatory cytokines. It is very important to understand the cellular and biochemical pathways responsible for preterm birth in order to detect, treatment and prevention of negative outcome. Clinicians and researchers play a key role in improving the biochemical knowledge of preterm birth, identifying risk factors, and developing interventions to address this complex syndrome.

Material and research methods

Clinical characteristics of pregnant women

The work was performed in the Regional Perinatal Center of the city of Samarkand in the department of pathology of pregnant women, at the Department of Obstetrics and Gynecology No. 3.

A total of 350 pregnant women were examined to assess risk factors for the development of PR. 350 birth histories for 2017-2019 were retrospectively analyzed. Prospectively analyzed the initial clinical characteristics, as well as the features of the course of pregnancy. Under our supervision were 350 pregnant women. Pregnant women were included in the study as they were referred. In accordance with the data obtained from the clinical and laboratory examination, the diagnosis made and the criteria for inclusion in the study developed.

Under our supervision were 350 pregnant women. The main group consisted of 97 pregnant women with a gestational age of 30-34 weeks of pregnancy, who were divided into 3 groups according to the history.

ISSN NO: 2770-2936
Date of Publication:11-02-2023

The control group consisted of 39 pregnant women with a physiological course of pregnancy.

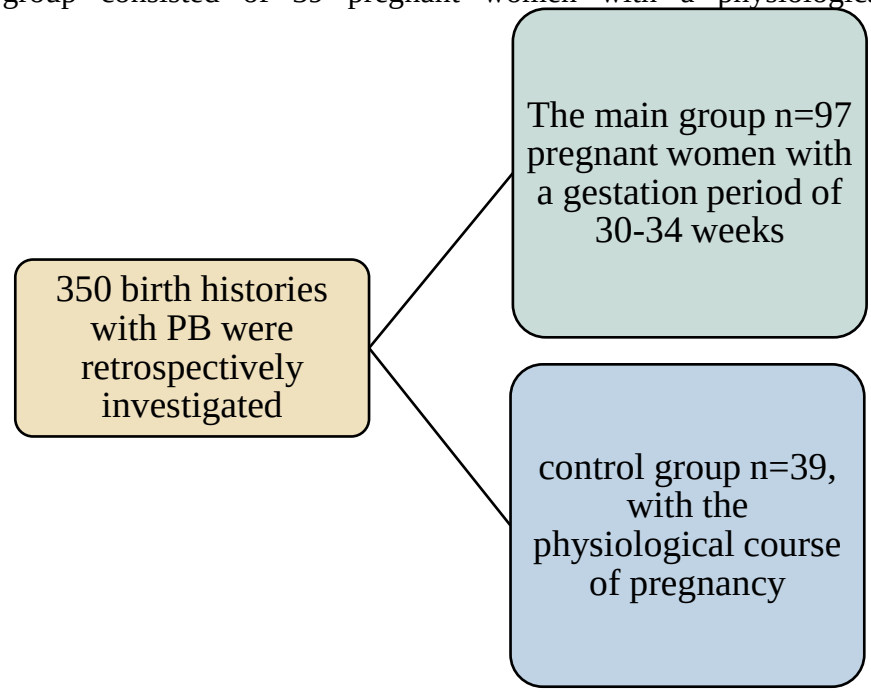


Figure 1– Design of the formation of clinical groups

The criteria for identifying risk factors in preterm birth (PR) based on the materials of the birth histories were the outcomes of the birth of a retrospective group that was collected by us at the Perinatal Center in Samarkand for 2017-2019.

We studied 350 birth histories of pregnant women who had a preterm birth at 30-34 weeks gestation. When detecting PR, it was found that more often pregnant women complained of the following: frequent stress, bad habits, occupational hazards, age from 18 to 37, a history of a threatened miscarriage, a history of early gestosis, a history of preeclampsia, a history of eclampsia, oligohydramnios, polyhydramnios, PR in history in the short term, and extragenital diseases (EGD) ..

All pregnant women included in the study underwent a standard set of examinations. In the course of the work, general clinical and special research methods were used: laboratory, instrumental.

Methods of research of pregnant women

General clinical research methods: in all patients included in the study, the data of the somatic and obstetric-gynecological anamnesis were analyzed. Particular attention was paid to past infectious and inflammatory diseases, the conduct or absence of pregravid preparation, the course and outcomes of previous pregnancies. We took into account the presence in the anamnesis of cases of non-developing pregnancies, spontaneous miscarriages, premature births, premature rupture of amniotic fluid, polyhydramnios. An objective examination included a general examination, which assessed the state of the cardiovascular, respiratory, nervous, digestive and urinary systems.

During an external obstetric examination, the position, presentation, position of the fetus, the nature of its motor activity were determined, the heart rate of the fetus, uterine tone, the degree of tension of its walls, and the size of the uterus corresponding to the gestational age were determined. During a gynecological examination, attention was paid to the nature of the discharge, the presence of rashes or papillomas on the skin and mucous membranes of the labia, perineum, vagina, the presence of pathology of the cervix, the length of the cervix, consistency, and the state of the inguinal lymph nodes were assessed. All patients additionally underwent a number of standard studies: determination of the blood group and Rh factor, clinical and biochemical blood tests, hemostasiogram, general urinalysis, vaginal and cervical canal smear analysis for flora.

Laboratory examination was carried out in the laboratory of the MedSI clinic (head of lab. Ilkhomova Sh.).

Functional research methods:

ISSN NO: 2770-2936
Date of Publication:11-02-2023

Ultrasound procedure. Using ultrasound (cervicometry), the state of the cervix was assessed, as well as the dynamics of changes in the cervix: length and width, the state of the placenta and its blood circulation. In addition, the thickness, degree of maturity, location and structure of the placenta, the presence of amniotic fluid were taken into account. The studies were carried out using the apparatus), "Mindray" (China). In a prospective study, complaints were analyzed at admission, the causes contributing to preterm labor and delivery, the state of the birth canal, concomitant diseases. In diseases of the kidneys and liver, an additional ultrasound examination was performed to control the size, structure and condition of the renal-pelvic system, the presence of calculi, as well as the structure of the liver, etc.

Results of the Study

A retrospective analysis of pregnant women with premature rupture of amniotic fluid and preterm labor.

The criteria for identifying risk factors for preterm birth and premature rupture of amniotic fluid based on the materials of the birth histories were the outcomes of the birth of a retrospective group that was collected by us at the Perinatal Center in Samarkand for 2016-2019. We studied 350 birth histories of pregnant women who had undergone preterm labor and premature discharge of amniotic fluid at 30-34 weeks of gestation. The age of women is shown in the table (3.1)

Table 1

Age of women in the retrospective group.

Age	350 pregnant women with R.G.	
	abs.	%
18-20 years old	eleven	3.1
21-24 years old	127	36.2
25-29 years old	115	32.8
30-33 years old	82	23.4
34-35	fifteen	4.2
social status		
Housewives	196	56
Employees	103	29.4
Students	51	14.5

The age of women ranged from 18 to 34 years. More common were 20-24 years old 36.2%, as well as 25-29 years old 32.8%, and less common over 35 years old 4.2% and less than 19 years old 3.1%.

According to the social status employees 29.4%, housewives 56.0%, students 14.5% prevailed.

When collecting an anamnesis, it was found that more often pregnant women complained of the following: frequent stress, bad habits, occupational hazards, age up to 18 after 30, a history of the threat of interruption, a history of toxicosis, a history of preeclampsia, a history of eclampsia, oligohydramnios, polyhydramnios, PR in the anamnesis in small terms, and extragenital pathology. An important role in the development of complications was played by the presence and frequency of EHD in the examined women. Thus, 61 women had a history of inflammatory diseases in childhood, SARS, diseases of the respiratory system, ear, throat and nose, kidney disease, which could have a negative impact on the state of various organs and systems during the formation of the reproductive function of the future woman. When collecting a gynecological history, the main pathology was revealed - inflammatory diseases of the genital tract, colpitis (61.4%), inflammatory diseases of the uterus (39.3%), and menstrual disorders (16.2%) prevailed among them. By parity, among the surveyed primiparas there were 32.3% of multiparous 67.7%. Of no small importance for the current pregnancy are the outcomes of previous pregnancies in the examined women. A distinctive feature of the obstetric history in pregnant women with PR is the high frequency of spontaneous abortions (29.3%), induced abortions (21.4%), the threat of preterm birth (57.3%), hypertensive disorders (39.7%), preterm birth history (31.3%), postpartum diseases (17.3%). Taking into account all risk factors, Table 2 was compiled. 3% multiparous 67.7%. Of no small importance for the current pregnancy are the outcomes of previous pregnancies in the examined women. A distinctive feature of the obstetric history in

ISSN NO: 2770-2936
Date of Publication:11-02-2023

pregnant women with PR is the high frequency of spontaneous abortions (29.3%), induced abortions (21.4%), the threat of preterm birth (57.3%), hypertensive disorders (39.7%), preterm birth history (31.3%), postpartum diseases (17.3%). Taking into account all risk factors, Table 2 was compiled. 3% multiparous 67.7%. Of no small importance for the current pregnancy are the outcomes of previous pregnancies in the examined women. A distinctive feature of the obstetric history in pregnant women with PR is the high frequency of spontaneous abortions (29.3%), induced abortions (21.4%), the threat of preterm birth (57.3%), hypertensive disorders (39.7%), preterm birth history (31.3%), postpartum diseases (17.3%). Taking into account all risk factors, Table 2 was compiled. 7%), a history of preterm birth (31.3%), postpartum diseases (17.3%). Taking into account all risk factors, Table 2 was compiled. 7%), a history of preterm birth (31.3%), postpartum diseases (17.3%). Taking into account all risk factors, Table 2 was compiled

Table 2
Prognostic card for a comprehensive assessment of risk factors for 350 women from a retrospective group

Risk factors	Noted	Doesn't mark	Notes in history	Didn't mark in anam	Total quantity we take
Stress	105	245	Not op	Not op	350
Bad habits	eleven	339	28	322	350
Prof. harmfulness	98	252	128	222	350
Age under 18 after 30	25	325	36	314	350
Gynecological goiter	340	ten	340	0	350
History of abortion	147	203	101	249	350
Threat of interruption	347	3	Not op	Not op	350
Early gestosis	350	0	348	2	350
Preeclampsia ber	45	305	Not op	Not op	350
Eclampsia in temp.ber	eight	342	Not op	Not op	350
Ultrasound oligohydramnios	153	197	Not op	Not op	350
Ultrasound Polyhydramnios	29	331	Not op	Not op	350
Ultrasound of FPN and NK	147	203	Don't remember	Don't remember	350
PR up to 22 weeks	3	347	Not op	Not op	350
PR up to 36 weeks	169	181	Not op	Not op	350
Acute NRP detachment	5	345	one	349	350
Diseases n.p.	7	343	9	341	350
SS diseases	fourteen	336	Can't cancel	Can't cancel	350
Hypertensive drugs	33	327	37	313	350
Kidney pathology	28	332	31	329	350
Anemia	205	145	215	135	350

As can be seen from Table 3.2, many anamnestic criteria for risk factors remained unexplored: the doctor of the admission department did not pay attention to the EG, the anamnesis did not interrogate the pregnant woman and, therefore, may not have assessed her condition.

In our opinion, the causes of PR and PR are late admission to the hospital, comorbidities, insufficiently collected anamnesis,untimely identification of risk factors and lack of prevention of preterm birth.

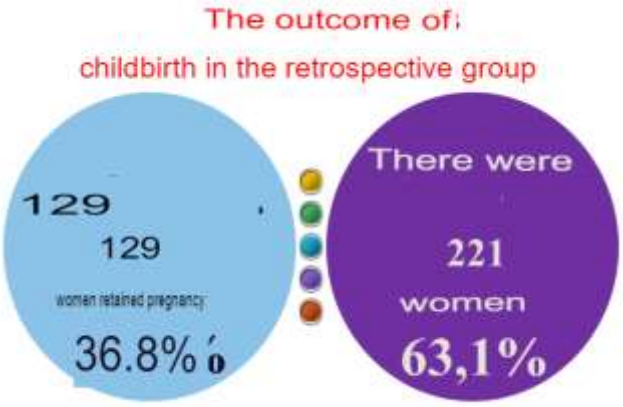
As the results of the study showed, not timely identification of risk factors and prevention of preterm birth lead to preterm birth in 63.1% of cases

ISSN NO: 2770-2936
Date of Publication:11-02-2023

Table 3
The outcome of childbirth in 350 pregnant women of the retrospective group

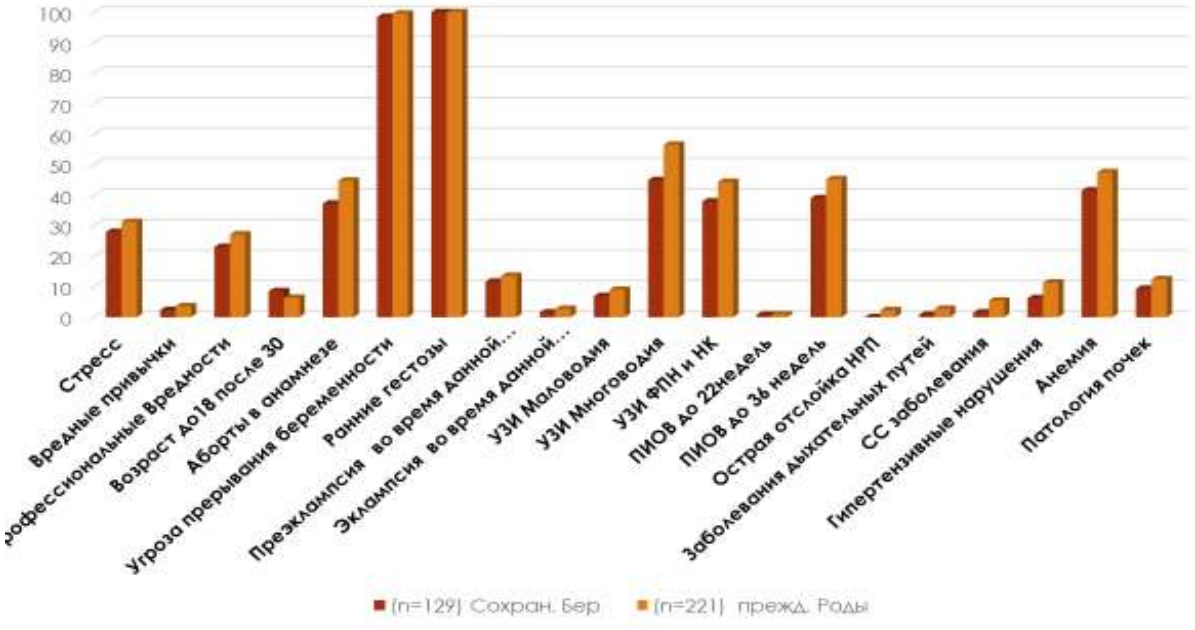
Number of patients	Saved the pregnancy		OL happened	
350 - 100%	129	36.8%	221	63.1%

Taking into account the outcome of the birth of 221 pregnancies ended in preterm birth, we decided to re-examine the history of childbirth and identify risk factors and determine methods for maintaining pregnancy in 129 pregnant women whose pregnancy continued (Fig. 3.). Apparently, 129 pregnant women who survived the pregnancy were hospitalized in a timely manner and received maintenance therapy according to the standards.



Rice. 3 Birth outcomes in the retrospective group

An analysis of the retrospective group showed (Table 4, Fig. 3) that a distinctive feature of the obstetric anamnesis in those examined with a preserved pregnancy was such factors as: stress (27.9%), bad habits (2.3%), age up to 18 after 30 years (8.5%), history of abortion (37.2%), gynecological diseases (44.9%), threatened miscarriage (98.4%), early preeclampsia (100%), preeclampsia up to 22 weeks (0.77%), PR up to 36 weeks (53.4%), cardiovascular diseases (1.5%), hypertensive disorders (6.2%).



Rice. four Risk factors in pregnant women with premature rupture of amniotic fluid and preterm labor

ISSN NO: 2770-2936
Date of Publication:11-02-2023

At the same time, in those examined with preterm birth, an increase in the frequency of risk factors was observed in comparison with women with a preserved pregnancy: stress (31.2%), bad habits (3.6%), age under 18 after 30 years (6.33%), history of abortions (44.7%), gynecological diseases (56.5%), threatened miscarriage (99.5%), early preeclampsia (100%), preeclampsia up to 22 weeks (0.90%), preeclampsia up to 36 weeks (45.2%), cardiovascular diseases (5.4%), hypertensive disorders (11.3%).

Table 4

Prognostic chart for assessing risk factors in women who have continued pregnancy and experienced preterm birth in a retrospective group

Risk factors	Save ber (n=129)		before Childbirth (n=221)	
	abs	%	abs	%
Stress	36	27.9	69	31.2
Bad habits	3	2.3	eight	3.6
Professional Hazards	38	23	60	27.1
Age under 18 after 30	eleven	8.5	fourteen	6.33
History of abortion	48	37.2	99	44.7
DPR	127	98.4	220	99.5
Early gestosis	129	100	221	100
Preeclampsia c. e.b.	fifteen	11.6	thirty	13.5
Eclampsia	2	1.5	6	2.7
Ultrasound oligohydramnios	9	6.9	twenty	9.0
Ultrasound Polyhydramnios	58	44.9	125	56.5
Ultrasound of FPN and NK	49	37.9	98	44.3
PR up to 22 weeks	one	0.77	2	0.90
PR up to 36 weeks	69	53.4	100	45.2
NRP detachment	0	0	5	2.26
Respiratory diseases	one	0.77	6	2.7
SS diseases	2	1.5	12	5.4
Hypertensive drugs	eight	6.2	25	11.3
Anemia	100	77.5	105	47.5
Kidney pathology	12	9.3	16	12.4

We were faced with the following questions: What activities could save the pregnancy? Could timely hospitalization and ongoing therapy in 129 pregnant women in whom pregnancy persisted be the reason for maintaining pregnancy, and what methods of treatment were performed for them?

In our studies, it was found that women received the following therapy: to threaten and eliminate tone, they were prescribed nifedipine tablets 10 mg 3 times a day under the control of A / D for 4-5 days, hormone therapy, depending on the threat, indomethacin suppositories 100 mg 2 times per day 4 days rectally, antibiotics were prescribed for the kidneys 2 times a day, tutukon 30 ml 3 times a day, Canephron 1 tablet 3 times a day, kidney tea, panangin, riboxin, tivortin, cocarboxylase were prescribed for the pathology of cardiovascular pathology.

As can be seen from Table 5, therapeutic measures were carried out for all pregnant women, but the above treatment measures did not give the expected effect.

Table 5

Table of therapy according to ICD standards

D.Z	Was held		Not prov.		Treatment effect (+)		effect from treatment (-)	
	350	%	350	%	350	%	350	%
Threatening PR	127	36.2	87	24.8	127	36.5	87	124.8

ISSN NO: 2770-2936
Date of Publication:11-02-2023

Preeclampsia	53	15.1	0	0	45	12.8	eight	2.28
Hyp. violations	33	9.4	0	0	27	7.1	6	1.7
SS diseases	fourteen	4.0	0	0	eleven	3.14	3	0.85
Anemia	205	58.5	0	0	185	52.8	twenty	5.7

Almost all pregnant women were at risk of premature birth, in particular, 87 pregnant women did not receive adequate therapy, due to the fact that these pregnant women went to the hospital too late, often with labor activity already started.

If we pay attention to the fact that many somatic pathologies did not respond to therapy, which probably could also affect the development of PR. Fetoplacental disorders were not treated separately, which, in our opinion, could also lead to PR.

Other laboratory tests, such as a general blood test, urine, flora smear, blood clotting did not provide accurate diagnostic information.

Thus, a clinical analysis of a retrospective study of preterm birth and premature rupture of amniotic fluid showed that the risk factors for this pathology include a history of preterm birth, threats of spontaneous miscarriage, inflammatory diseases of the uterus, colpitis, abortion, hypertensive disorders.

Lately identified risk factors for the development of PR in 63.1% (out of 350) cases ended in PR. At the same time, the question arises why more than half of the women studied still had PR.

In our opinion, under such circumstances, biochemical markers of premature rupture of water and preterm labor, which can play a major role in the development of the above conditions, remain unexplored.

In connection with the data obtained, we decided, based on risk factors, to draw up a prognostic map of the retrospective group, to study the biochemical aspects of the development of PR.

Assessment of the functional state (prospective analysis) of pregnant women at risk for preterm birth

To determine the optimization of the management of pregnant women with the threat of preterm birth, we observed 128 women at a gestational age of 30-34 weeks, whose pregnancy was complicated with the threat of preterm birth. All pregnant women who were under our supervision were hospitalized in the department of pathology of pregnant women in the Regional Perinatal Center of Samarkand, as well as in the department of the clinical base of the Department of Obstetrics and Gynecology of SamMI for the period from 2016 to 2019.

All pregnant women included in the study were comparable in age and somatic health.

To collect anamnesis, we used "***Prognostic matrix for identifying risk factors"***(according to the computer program created by us (DGU 06117 dated January 25, 2019; Fig. 3.3).

ISSN NO: 2770-2936
Date of Publication:11-02-2023

Rice. 5.Predictive matrix to identify risk factors

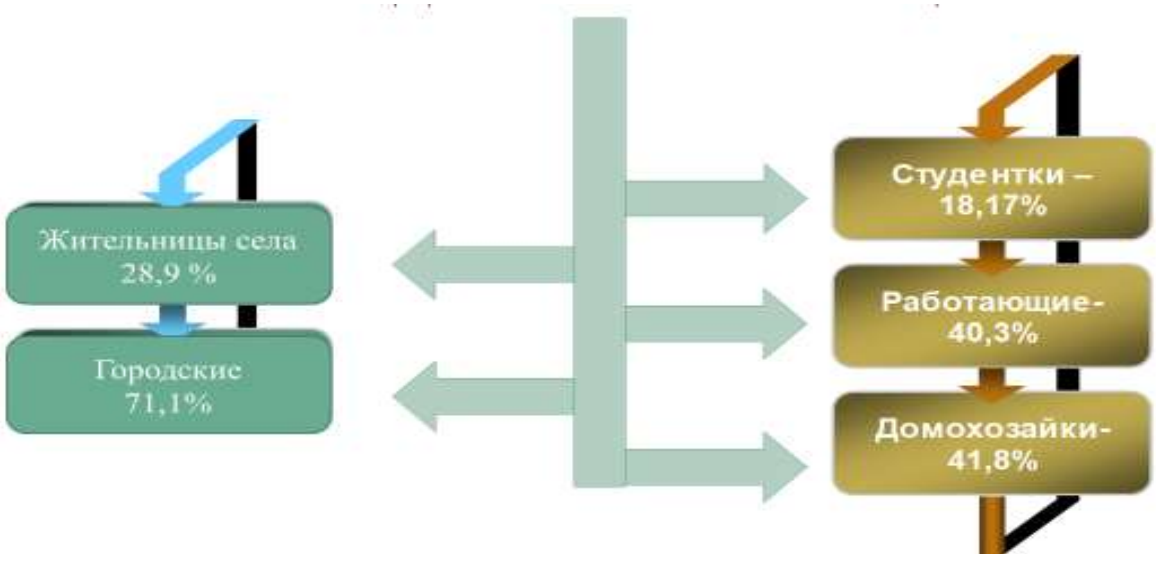
A prognostic matrix was developed according to the anamnesis and clinical symptoms, using the method of normalization of intensive indicators (NIP) (E.N. Shigana 2008), which will allow dividing 93 subjects into three groups (the method is described in the fifth chapter).

Women were divided into 3 groups:

- ✓ group 1 - low probability of developing PR;
- ✓ group 2 - medium, the probability of developing PR;
- ✓ Group 3 - high probability of developing PR and PR

The age of women ranged from 19 to 38 years. The youngest age at the onset of preterm birth is 18 years, and the later is 38 years, averaging 27 ± 2.9. The main group consisted of every second woman of reproductive age from 25 to 32 years in all groups. In the high-risk group, every third woman was aged 28-35 years (Table 3.6).

In all 3 groups, women were mostly Uzbeks. Residents of the village - 37 (28.9%); urban - 91 (71.1%). According to the social status of those surveyed (Fig. 6): students - 18.17%, working - 40.3%, housewives - 41.8%.



Rice. 6. Social status of the surveyed women

ISSN NO: 2770-2936
Date of Publication:11-02-2023

An analysis of the weight-height ratios in the examined pregnant women did not reveal any deviations from the population norms. The average body weight was 71.1±2.1, 78.3±2.2, 79.8±2.0 kg, the average height was 166.1±3.2, 165.4±3.9 and 167, 9±4.6 cm in groups 1, 2 and 3, respectively.

Strictly healthy women were included in the control group by selection; if a pathology of the obstetric or EG anamnesis was detected, further observations were stopped.

✓ The onset of menarche varied from 10 to 18 years, the average for the entire group of patients was 13.1±0.3 years.

- 4 women had early menarche (before 11 years of age)
- Belated - older than 16 years in 8 women.

✓ In the general group of examined women, menstrual dysfunction (oligomenorrhea, algomenorrhea) was 15 women (16.1%)

Table 6
Gynecological history of the examined pregnant women

Nosological forms	**Main group n=93 (%)**
Menstrual disorders	15 (16.1%)
cervicitis	21 (45.7)
Cervical erosion	7 (7.5%)
Chronic endometritis	43 (46.2)
Inflammation of the appendages	36 (38.7%).
uterine fibroids	6 (6.4%).
Infertility I and II	13 (14%)

✓ Of the gynecological diseases, inflammation of the uterus and appendages occurred in history in 36 women out of 93 pregnant women (38.7%).

✓ 7 (7.5%) of the 93 women studied had cervical erosion.

✓ Uterine fibroids were diagnosed before the onset of this pregnancy in 6 women out of 93 studied (6.4%).

✓ Of the surveyed 93 - pregnant women.

- Primiparous 46 (49.4%)
- multiparous47(50.6%)

As can be seen from Table 6, stress was 38.7%, bad habits up to 25.8%, occupational hazards 30.1%, allergic background 24.7%, stomatitis 12.9%, antibiotic use 26.8%. It can be assumed that the above background can also lead to PR.

ISSN NO: 2770-2936
Date of Publication:11-02-2023

Table 7
Table for assessing the risk of developing PR by collecting general data during a given pregnancy (n=93)

Risk factors	Celebrated	%	Not noted	%
Stress	36	38.7	57	61.2
Bad habits	24	25.8	69	74.1
Occupational hazards	28	30.1	65	69.8
Age under 18 after 30	12	12.9	81	87.0
Allergic background	23	24.7	70	75.2
Stomatitis	12	12.9	81	87.0
Use of antibiotics	25	26.8	68	73.1

The obstetric anamnesis was also studied in the main group according to the survey matrix.As can be seen from table 8, the study and identification of anamnesis has a lot of information for determining and identifying PR. The highest numbers rest on the threat of interruption and preeclampsia 100% of cases, abortions 36.5%, gynecological diseases 23.6%, spotting 56.9%, preeclampsia 15.0%, eclampsia 1.07%, PR up to 22 weeks 19 , 3%, PR up to 36 weeks 7.5%, PONRP 2.1%, uterine scar 11.8%.

Table 8
Table for assessing the risk of developing PR by collecting an obstetric history during a given pregnancy (n=97).

sk factors	Celebrated	%	Didn't notice	%
abortion	34	36.5	59	63.4
Gynecological diseases	22	23.6	71	79.5
Bloody discharge from the genital tract I trimester II trimester III trimester	53 53 23 9	56.9 56.9 24.7 9.6	40	43.0
We take the threat of interruption I trimester II trimester III trimester	93 93 39 9	100 100 41.9 9.6	- - 54 84	- - 58.0 90.3

ISSN NO: 2770-2936
Date of Publication:11-02-2023

Gestosis during pregnancy I trimester II trimester	93 93 41	100 100 44.0	- - 52	- - 55.9
Preeclampsia Mild degree Severe degree	fourteen 9 5	15.0 9.6 5.3	79	84.9
Eclampsia	one	1.07	92	98.9
PR up to 22 weeks	eighteen	19.3	75	80.6
PR up to 36 weeks	7	7.5	86	92.4
Acute NRP detachment	2	2.1	91	97.8
Scar on the uterus	eleven	11.8	82	88.1

The results of Table 3.10 showed that CVD amounted to 6.4%, hypertensive disorders - 13.9%, kidney disease - 16.2%, respiratory diseases 11.8%, liver pathology 21.5%, anemia 60.2% , metabolic disorders 25, 8%, Rh negative blood 2 cases.

Table 9

Table for assessing the risk of developing PR by determining extra-genital pathology (n=97)

Risk factors	Celebrated	%	Not noted	%
Cardiovascular diseases	6	6.4	87	93.5
Hypertensive Disorders -Gestational hypertension -Chronic hypertension	13 7 6	13.9 7.5 6.45	80	86.0
kidney disease - Gestational pyelonephritis -Chronic pyelonephritis	fifteen eleven four	16.2 11.8 4.3	78	83.8
Respiratory diseases	eleven	11.8	82	88.1
Liver pathology - hepatitis B, C -cholecystitis -hepatosis	twenty 2 13 5	21.5 2.1 13.9 5.3	73	78.4
Anemia - mild degree - severe degree	56 37 9	60.2 39.7 9.6	37	39.7
Obesity -I degree -II degree	24 fourteen ten	25.8 15.0 10.5	69	74.1
Rhesus (-) blood not immunized	2	2.1	91	97.8

ISSN NO: 2770-2936
Date of Publication:11-02-2023

Thus, there was no significant difference in the frequency of gynecological pathology in the examined groups in pregnant women.

Based on the study of the reproductive history, it was found that every second was primiparous. One birth in history was in 46 women (42.78%), 2 births - in 32 (29.76%), 3 births - in 8 (7.44%), and in 7 women (6.51%) before the onset of this pregnancy was 4 births.

In all the studied groups, women had a history of different outcomes of a previous pregnancy, the main share of which is occupied by the combined outcomes of several pregnancies, which could later cause PR. Women who previously had the above factors are at risk for the development of PR pregnancy.

Summing up, we can say the appointment of antibiotic therapy (in the presence and absence of premature rupture of the membranes). Routine antibiotics are not recommended for women with preterm labor and intact membranes without clinical signs of infection (Strong recommendation based on moderate-quality evidence). Prescribing antibiotics is recommended for women with preterm rupture of membranes (Strong recommendation based on moderate-quality evidence) . Erythromycin is the antibiotic of choice for prophylaxis in women with preterm rupture of membranes (Strong recommendation based on moderate-quality evidence)

The optimal method of delivery in preterm labor. Delivery by caesarean section is not recommended to improve outcomes in preterm infants, regardless of the type of presentation of the fetus (cephalic or breech). (Conditional recommendation based on very low quality evidence)

Bibliography

1. Aghababyan L. R., Azimova Sh. T. Obstetric bleeding as a leading cause of maternal mortality in the works of academician from Zakirov // Journal of Reproductive Health and Uro-Neprological Research. - 2021. - Vol. 2. - No. one.
2. Akhtamova N. A., Shavazi N. N. PREDICTION OF OBSETRIC BLOOD LOSS IN WOMEN WITH PRETERM BIRTH (LITERATURE REVIEW) // UZBEK MEDICAL JOURNAL. - 2022. - Vol. 3. - No. 5.
3. Bazirete O, Nzayirambaho M, Umubyeyi A, Karangwa I, Evans M. Risk factors for postpartum haemorrhage in the Northern Province of Rwanda: A case control study. //PLoS One. 2022 Feb 15;17(2):e0263731.
4. Fazilova M., Sultanov S. ASSESSMENT OF THE STATE OF THE COAGULATION LINK OF HEMOSTASIS IN WOMEN WHO TERMINATED NON-DEVELOPING EARLY PREGNANCY WITH MEDICATION //Science and innovation. – 2022. – T. 1. – №. D7. – C. 259-263.
5. Guljannat Isroilova, Pardabaevna, I. G., & Khayrillayevich, S. A. (2021, April). Optimization of the outcome of pregnancy and childbirth in women with the threat of premature childbirth. In E-conference globe (pp. 52-54).
6. Islomovna A. K., Ergashevna J. G., Pardabaevna I. G. Prevention of Vertical Transmission of Infection in Pregnant Women with Hepatitis B //JournalNX. – C. 141-144.

ISSN NO: 2770-2936
Date of Publication:11-02-2023

7. Mousa HA, Blum J, Abou El Senoun G, Shakur H, Alfirevic Z. Treatment for primary postpartum haemorrhage. The Cochrane database of systematic reviews. 2014(2):CD003249
8. Nuriddinovna K. I., Nuriddinovna K. M. MODERN ASPECTS OF REHABILITATION OF WOMEN WITH POSTNATAL PERINEAL INJURIES //American Journal of Interdisciplinary Research and Development. – 2022. – Т. 9. – С. 261-265.
9. Shavazi N.N., Alimova P.B. MODERN ASPECTS OF OBSTETRIC BLEEDING (REVIEW OF LITERATURE) // JOURNAL OF REPRODUCTIVE HEALTH AND DAMAGE-NEPHROLOGICAL RESEARCH. - 2022. - Issue. 3. - No.5.
10. Yunusova A., Zakirova F. THE EFFECTIVENESS OF OZONE THERAPY IN THE TREATMENT OF CHRONIC ENDOMETRITIS //Молодой исследователь: вызовы и перспективы. – 2020. – С. 443-445.
11. Абдуллаева Л. С. К вопросу профилактики акушерских кровотечений при синдроме перерастянутой матки //Yangi o'zbekistonda milliy taraqqiyot va innovasiyalar. – 2022. – С. 338-342.
12. Амонова М. Ф. ДЕФИЦИТ ВИТАМИНА Д У ЖЕНЩИН В МЕНОПАУЗЕ (ОБЗОР ЛИТЕРАТУРЫ) //ЖУРНАЛ РЕПРОДУКТИВНОГО ЗДОРОВЬЯ И УРО-НЕФРОЛОГИЧЕСКИХ ИССЛЕДОВАНИЙ. – 2022. – Т. 3. – №. 2.
13. Доброхотова Ю.Э., Кузнецов П.А., Оленев А.С., Джохадзе Л.С. Управляемая баллонная тампонада при послеродовых кровотечениях у женщин с многоплодной беременностью // Хирург. – 2018. – №3-4. – С. 80-85.
14. Жаркин Н. А. Кровотечения в акушерской практике //Вестник Волгоградского государственного медицинского университета. – 2013. – №. 3 (47). – С. 3-8.
15. Искаков С. С. и др. Современные факторы риска акушерских кровотечений //Астана медициналық журналы. – 2020. – Т. 105. – №. 3. – С. 184-189.
16. Каменских Г. В., Новикова В. А. Возможности прогнозирования кровотечения у женщин с преждевременными родами //Научное обозрение. Медицинские науки. – 2019. – №. 2. – С. 63-73.
17. Каменских Г.В. Прогнозирование патологической кровопотери у женщин с преждевременными родами: Автореф. Дис… канд.мед.наук.-Челябинск, 2020.-25 с.
18. Махмудова С. Э., Атаева Ф. Н. Опыт применения модульной системы для овладения педагогическими навыками в подготовке резидентов магистратуры по специальности" акушерства и гинекологии" //ЛУЧШАЯ НАУЧНАЯ СТАТЬЯ 2018. – 2018. – С. 290-293.
19. Пчелинцева А. А. Проблемы преждевременных родов в современном акушерстве //Бюллетень медицинских интернет-конференций. – Общество с ограниченной ответственностью «Наука и инновации», 2016. – Т. 6. – №. 5. – С. 430-431.
20. Радзинский В.Е. Способ остановки гипотонического маточного кровотечения / В.Е. Радзинский, А.Н. Рымашевский, Н.А. Красникова, А.И. Лукаш, А.А. Оразмурадов, А.С. Оленев, С.В. Апресян // Патент на изобретение № 2386407, зарегистрировано 20 апреля 2010 г.

ISSN NO: 2770-2936
Date of Publication:11-02-2023

21. Тезиков Ю. В. и др. Факторы риска акушерских кровотечений //ГБУЗ СО" Самарская городская клиническая поликлиника№ 15" г. о. Самара: 70 лет созидания и развития-к новым достижениям. – 2018. – С. 473-475.
22. Тугизова Д. И., Каримова М. Н., Рахимов Н. М. ТАКТИКА ВЕДЕНИЯ БЕРЕМЕННЫХ С ИНВАЗИВНЫМ РАКОМ ШЕЙКИ МАТКИ (ЛИТЕРАТУРНЫЙ ОБЗОР) //ЖУРНАЛ БИОМЕДИЦИНЫ И ПРАКТИКИ. – 2022. – Т. 7. – №. 3.