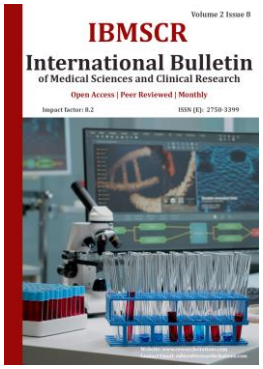

MATERNAL MORTALITY - A PROBLEM OF MODERN MEDICINE

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Annotation: Maternal mortality is an indicator that characterizes the activities of the health service for women and children. The article analyzes the maternal mortality in the Samarkand region of the Republic of Uzbekistan over the past 5 years and gives ways to reduce it.
Key words: Maternal mortality, Samarkand region, obstetric bleeding, hypertensive conditions during pregnancy, purulent-septic diseases, extragenital diseases

Relevance. Mortality of pregnant women, women in childbirth and puerperas, called maternal mortality (MM) is one of the main indicators of the country's civilization, which is difficult to overestimate in the modern world community. Every day, 830 women die from acquired causes related to pregnancy and childbirth. 99% of all maternal deaths occur in developing countries. Between 2016 and 2030, in line with the Sustainable Development Agenda, the goal is to reduce the global MI to less than 70 per 100,000 live births(1,2,5,6). For the period from 1990-2015. MM in the world has decreased by almost 44%. The problem of prevention and reduction of maternal morbidity and mortality is being actively addressed in our country and abroad; numerous WHO studies are devoted to it. At the same time, the study of the clinical aspects of MM, mortality from individual causes in dynamics requires scientific analysis.

Improving women's health, preventing MM, reducing mortality and searching for new directions for solving organizational, treatment-and-prophylactic, tactical tasks is one of the urgent problems of healthcare in the Republic of Uzbekistan. In strategic documents, the President of the Republic of Uzbekistan Sh.M. Mirziyoyev identified the health of mother and child as the main priority for the present and future development of our country, pointed out the need to reduce maternal and perinatal morbidity and mortality.

Purpose of the study: An in-depth study of the clinical aspects of the causes of MM in the Samarkand region. Development and implementation of a set of measures for the prevention of MM, justification of the reserves for its further reduction.

Research objectives:

1. To establish social and clinical and anamnestic risk factors for MM, characteristic of the Samarkand region
2. Conduct a quality assessment and analysis of errors in the provision of medical care.
3. Explore the possibility of preventing MM.
4. Substantiate and implement a system of measures to reduce MM.

Research material: The primary medical documentation of 70 pregnant women, women in childbirth and puerperas who died in the Samarkand region of the Republic of Uzbekistan was

analyzed, the structure of MM was studied, quality assessment and analysis of errors were carried out, shortcomings were identified at all stages of medical care that led to death.

The structure of MS in the Samarkand region. The problem of reducing MM and the search for new directions for solving organizational, medical, diagnostic, and tactical tasks dictates the need to analyze the structure of MM. The structure of MM in Samarkand region in 60.0% consists of controlled causes. Dominated obstetric bleeding (34.3%), hypertensive conditions (24.3%). Subsequent places are occupied by thromboembolism, EGP, EOV and complications of anesthesia, i.e. causes that are difficult to regulate. In two cases, the cause of death remained unspecified due to the short stay in the hospital and the lack of an autopsy.

MM structure

1. Bleeding - 24 (34.3%)
2. Hypertensive conditions during pregnancy - 17 (24.3%)
3. Thromboembolism of the Pulmonary Artery - 10 (14.3%)
4. Extragenital diseases - 7(10.0%)
5. Other reasons - 7 (10.0%)
6. Amniotic fluid embolism - 2 (2.9%)
7. Unspecified - 2 (2.9%)
8. Purulent-septic disease - 1 (1.3%)
9. Direct obstetric causes - 42 (60%)

Obstetric bleeding as a cause of MM. Obstetric bleeding has led to a poor outcome in cases of impaired hemostasis (2,3,4). The most common cause of death in pregnancy and childbirth from bleeding was PONRP (11-45%), as well as bleeding in the afterbirth and early postpartum periods (24.2%). DIC was observed in 7 weeks (10.0%), massive bleeding could be predicted, they occurred against a certain clinical background. In most cases, there were risk factors and the possibility of preventing bleeding and hemorrhagic shock (correct organization of monitoring of pregnant women with known high-risk groups threatened by the development of bleeding, adherence to the stages of hospitalization, timeliness and completeness of the volume of therapeutic measures, timely provision of emergency surgical care. Analysis of MM from bleeding showed that the algorithm for stopping bleeding given in national guidelines is relevant, the system of measures to combat bleeding, the introduction of a unified protocol for the treatment of obstetric bleeding, safe and effective means in the prevention of complications reduce the incidence of multiple organ, cardiovascular, cerebral dysfunction, coagulopathy, reduce the proportion of massive blood loss. Prophylactic or early use of factors that affect hemostasis, in cases where massive bleeding is predicted, in some cases makes it possible to avoid hysterectomy. The main defects in the provision of medical care were: underestimation of the severity of the condition of the pregnant woman; wrong choice of method of delivery; violation of the birth protocol; unskilled management of the postoperative period, underestimation of the true blood loss.

Hypertensive conditions during pregnancy as a cause of MM. Hypertensive conditions during pregnancy remain one of the main causes of MS (4,7,8,9). Due to delayed diagnosis of complications, the development of multiple organ failure, inadequate therapy and irrationally chosen term and method of delivery, 17 women (24.3%) died. Late diagnosis of preeclampsia, lack of proper attention to generalized edema, including the liver, persistent arterial hypertension that is not relieved by medication, the growth of liver enzymes and urea levels in the postpartum period, the development of multiple organ failure and early extubation of

patients contributed to the lethal outcome. Particularly difficult were the forms caused by autoimmune pathology - HELLP syndrome, antiphospholipid syndrome, hepatosis. At the heart of the antiphospholipid syndrome, DIC was a systemic inflammatory response syndrome that caused multiple organ failure.

Purulent-septic diseases (PSD) as a cause of MM. Peritonitis after caesarean section was observed in 1 (1.4%) case, the lethal outcome was associated with the development of sepsis, with the growth of leukocytes and leukocyte infectious index, progression of disorders of the hemostasis system with a decrease in the prothrombin index against the background of intensive therapy, including sanitation of the focus of infection, antibacterial therapy. Obstetric practice should be built on modern ideas about the systemic inflammatory response syndrome, autoimmune pathology, genetically determined and acquired thrombophlebia (3,6,11,12)

Extragenital diseases (EGD) as a cause of MM. Recently, among the causes of MS, the number of EGD has increased. MS largely depends on the state of health of pregnant women, and first of all, their somatic status. 72.8% of the deceased were accompanied by EHD, pregnancy was contraindicated (4,7,13) for women, death occurred in 7 cases (10.0%), the dominant causes of death of mothers were viral hepatitis and cardiovascular diseases. Improving the living conditions and health of pregnant women is our task and the task of the state, and when it is fulfilled, the MS indicators will decrease. Autopsy was performed in 30 (42.9%) women. One of the main tasks of the pathoanatomical service is to ensure the reliability of data on the causes of MS. We noted some discrepancies in the formulations of the final clinical and pathoanatomical diagnoses, finding out the true cause of death was difficult in some cases, which, accordingly, reduces the informative value of MS statistics.

Conclusions: The structure of MS in the Samarkand region has not changed over the past 5 years:

1. The leading place is occupied by direct obstetric causes 44 (62.8%), indirect - 7 (10.0%) and others - 7 (10.0%) . MM is highest among women living in rural areas - 59 (84.3%).
2. MM risk factors were:
- social (low level of education),
- unsatisfactory intra-family relationships,
- living away from large medical institutions), - clinical and anamnestic (late registration for pregnancy, severity of condition, chronic anemia in history, anemia of pregnant women, CHD, infections of the vagina and genital organs, etc.). - tactical (qualification of a doctor and paramedical staff) - organizational determinants
3. MM largely depends on the state of health of pregnant women, and first of all, their somatic status. 84.2% of the deceased women had concomitant EG pathology.
4. The main causes of MM are preventable, the leading risk factors are realized with an incomplete and insufficiently high-quality medical care, with a lower significance of diagnostic errors.

Practical recommendations:

Reserves for reducing MC are:

Pre-conception training of girls, adolescent girls and women with the allocation of a special group of patients at high risk of adverse outcomes of pregnancy and childbirth, improving the living conditions and health of pregnant women.

Priority attention should be given to the development of primary health care, to increase the role of nurses, social workers, psychologists, to financially stimulate district doctors and paramedical workers for the results achieved.

This will contribute to the prevention and timely detection of diseases in girls, adolescents and women, the coverage of medical examinations, the birth of desirable healthy children.

The prospect of further reduction of MC is to use new scientific achievements.

Timely diagnosis, differentiated and pathogenetic treatment of major emergency conditions in obstetric practice (bleeding, prerecepsia, decompensation of extragenital diseases), provision of planned and emergency monitoring as a means of effectively identifying risk groups and monitoring the effectiveness and subsequent medical care in level III institutions will reduce maternal morbidity and mortality.

Modern achievements in medical science, the introduction of advanced practices and technologies, compliance with national standards and emergency care algorithms, intensive care of critical conditions and continuous training of medical personnel are quite sufficient to prevent women from dying from causes of the “Complications of pregnancy, childbirth and the postpartum period” class.

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