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Features Of Intensive Therapy For Preeclampsia And Eclampsia

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ABSTRACT

Preeclampsia and eclampsia have always been life-threatening for both mother and fetus. Predisposing factors are hypertension in pregnant women, kidney disease, as well as multiple pregnancies, a history of eclampsia and a family history, age or old age. The cause of convulsions is varying degrees of brain, tumor severity due to increased intracranial pressure or localized vascular spasms leading to cerebral hypoxia of ischemic anoxic genesis.

KEYWORDS

Preeclampsia, eclampsia, hypertension, convulsion, cerebral hypoxia, ischemic anoxic genesis.

INTRODUCTION

Preeklampsia, eclampsia is the cause of 20-40%of maternal deaths and 20%of perinatal deaths. Data on the frequency of preeclampsia cases in different countries are hoghly conflicting. From 357 cases out of 147 births for 1 complication. In developing countries, eclampsia is 20 times more common and average 2,000 cases per 1 birth. Eclampsia most often develops during pregnancy - 48-50%, during pregnancy - 28-29% and in the postpartum period - 22-23%. The purpose of the study. A study and comparision of traditional antihypertensive therapy previously used in women with preeclampsia eclampsia, as well as independent use of E/a and C/A.

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MATERIALS AND METHODS

In 2018-2020, examination and treatment of patients in the therapy department and maternity complex of the SamDTI clinic, as well as archival materials were used.

In total, we studied 80 women with moderate and severe preeclampsia, including 678 patients with eclampsia, of which there were 2 patients with gestosis aged 18 to 40 years.

All patients were divided into 2 groups. basic 1 group and 2 group control, 40 patients each.

All patients underwent complete clinical and diagnostic studies, necessary paraclinical and biochemical studies. To make a diagnosis, we determined anamnesis, age, gestational age, pregnancy, extragenital and background diseases.

The largest number of inquiries on preeclampsia and eclampsia in 80 pregnant women (1 and 2 gr.) On the seasonality of the disease was in the spring and winter. In both groups, 52 pregnant women lived in urban areas and the remaining 28 patients lived in rural areas.

The majority of patients are urban residents, who are associated with changes in the environment, mental stress, and the stresses of urban life.

Blood pressure at admission to the hospital in the primary and control groups was 160/110 mm. rt.article.

(most patients).

Examination of all patients was performed by clinical-analytical method, women were compulsorily examined by a neuropathologist, ophthalmologist, and hardware methods of research were used.

The clinical-analytical method is based on retrospective analysis, anamnestic data, objective and clinical-laboratory data.

Includes laboratory and instrumental research data.

1. Total blood test (hemoglobin, leukocyte count, platelets, etc.);
2. Sukharev, pti and PTV, blood, clinical and biochemical study of total blood protein, urea and creatinine in the blood, liver enzymes (Alt, ast), including blood clotting;
3. General analysis of urine (especially protein), Nechiporenko and Zimnitsky samples;
4. ECG and Echoeg, fetal ultrasound and maternal internal organs;
5. Hemodynamic parameters (blood pressure, heart rate, heart rate);
6. Expert inspection neuropathologist, therapist, optometrist3v
7. Duration of hospital stay.

General blood test.

Determined blood hemoglobin, the number of tronary leukocytes, platelets, ESR, and others. Nia 100% clinical-biochemical blood, including blood clotting, etc. Sukharev, pti and PTV, total protein in the blood, urea and creatinine in the blood, liver enzymes (Alt, ast) cholesterol, fibrinogen content, etc.

Definition and time of prothrombin index (pti, PTV) - true prothrombin Oren (two-stage method)

The prothrombin time (s) reflects the time of plasma coagulation after the addition of the thromboplastic-calcium mixture. Such presentation of the prothrombin test result

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does not allow for a comparative evaluation of the results, as different laboratories use different methods and equipment, most importantly, thromboplastic with different activity and different origins.

The prothrombin index is expressed as the ratio of the coagulation time of the control plasma ("normal") to the patient's plasma coagulation time,%.

The low value indicator depends significantly on the sensitivity of the reagents used.

The prothrombin time allows the prothrombin index to assess thrombin formation in the next stage of coagulation, t. e. mainly external Lute plasma heclostasis, and the presence of all the above factors VII and x coagulation I am an increase in blood

Presence of coagulation factors VII and x. An increase in prothrombin time (index) may be due to a deficiency of factors i, I, or v. The study showed PTV, pti 96-100% in 22-24 seconds in our patients. General analysis of urine (especially proteinuria). Of practical importance, proteinuria accumulates in daily urine of 0.3 g / l and more. Urine is collected within a day (for 12–24 h) and the test portion is taken after the initial shaking of the entire volume. This version of the survey shows how fast the disease is progressing and can be an indicator of the lightning speed of the process. In the case of severe preeclampsia, urine can be checked in a short time, e.g. Differential diagnosis can be made based on the presence of proteinuria. According to the ISSHP classification, the diagnosis of proteinuria can be made based on protein detection

using a daily amount of urine (0.3 g per day) or induction series reagents, a purely collected image — at least 4 hours apart ("++" two last measures or "+" if the specific weight of urine when the pH is 1,030 and the pH is 8). High levels of proteinuria not only confirm the diagnosis, but also directly worsen the prognosis for the mother and fetus. The severity of proteinuria has a direct impact on perinatal mortality and the condition of the newborn. A preliminary study of total urine analysis in all patients revealed protein.

If protein secretion in the urine is reduced during treatment, it is likely that pregnancy is spreading. Termination of pregnancy with persistent proteinuria should address the issue of reducing the amount of protein excreted in the urine. In our patients, proteinuria was noted, ranging from 5.8–6.2 g to 1.0 g per day, depending on the degree of disease. In general, 11lotnost of urine was determined by Prsbe Zimnitsky, and Nechiporenko's number of red blood cells and leukocytes was determined.

In addition, ultrasound examination of the kidneys revealed the size of the renal parenchyma, the echo structure, the size of the cup-pelvic system, and the echo signs of inflammation. swelling and decreased echo-positivity. Instrumental research. The general condition of the fetus is determined using ultrasound.

Our ECG patients showed increased symptoms of left ventricular myocardium, tachycardia, and hypoxia.

Hemodynamic parameters (blood pressure, heart rate, pulse) benefit selection. If the shoulder circumference of a pregnant woman is less than 33 cm, a conventional arm (12/23 cm), 15-43 cm around the shoulder of 33-41 cm can be used; a femoral mandible (18/36 cm) is used on the wider shoulder.

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The differential diagnosis between gestational hypertension and preeclampsia can be made based on the presence of proteinuria. According to the ISSP classification, the diagnosis of proteinuria is based on a daily urine volume (0.3 g / day) or a purely collected image using induction series reagents — at least 4 hours ("++" urine specific gravity 1,030 and pH 8, for the last two measurements or "+"). High levels of proteinuria not only confirm the diagnosis, but also directly worsen the prognosis for the mother and fetus.

The severity of proteinuria has a direct impact on perinatal mortality and the condition of the newborn. A preliminary study of total urine analysis in all patients revealed protein. If protein secretion in the urine is reduced during treatment, it is likely that pregnancy is spreading.

Termination of pregnancy with persistent proteinuria should address the issue of reducing the amount of protein excreted in the urine. All of our patients reported proteinuria ranging from 1.0 g to 5.8–6.2 g per day, depending on the degree of disease. The total density of urine was determined by Zimnitsky's sample and Nechiporenko's red blood cell and leukocyte count. In addition, renal ultrasound measurements, echo-structure of the renal parenchyma, size of the cup-pelvic system, and echo signs of inflammation were identified. Swelling and decreased echo-positivity.

Instrumental research. The general condition of the fetus is determined using ultrasound. Our ECG showed that our patients had increased symptoms of left ventricular myocardium, tachycardia, and hypoxia. Hemodynamic parameters (blood pressure, heart rate, pulse) benefit selection. If the shoulder circumference of a pregnant woman is less than 33 cm, a conventional arm (12/23 cm) can be used, 15-43 cm around the shoulder of 33-41 cm; B uses the femoral arm (18/36 cm) on the wider shoulder. There are some differences in the method of measurement with the Korotkov method during pregnancy. Since the armpit of the sphygmomanometer is located at the level of the heart, the source should be in the left hand if it is located on the left side of the pregnant woman. To judge the beat — the diastolic pressure of a pregnant woman is taken from the beginning of Korotkov's sounds, while non-pregnant women are judged since these sounds are completely lost. In this regard, for neobho-Dimo maternity homes, select such monitor systems for automatic measurement of blood pressure that record Korotkov's 1 and v sound phases.

Traditional IV-phase tone recurrence increases the frequency of misdiagnosis of diastolic pressure and can significantly distort our understanding of the diagnosis and assessment of the severity of preeclampsia.

Since Korotkov's tones are better heard during auscultation, a membrane-free stethoscope surface should be used. It is preferable to use a mercury sphygmomanometer instead of an aneroid manometer. Each of the sphygmomanometers should be fine and adjustable. Particular attention should be paid to the health of manometers-aneroids, the accuracy of which is comparable to that of reference mercury sphygmomanometers. The sphygmomanometer should have a set of benefits. The small size of the cuff can lead to high blood pressure readings. On the contrary, its magnitude is so large that it can lead to an evaluation of the results (to a lesser extent). Ideally, the length of the stuffed rubber pear is 80% of the arm circumference and its width is

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40%. By auscultation, an additional pressure increase is required in the manhole above 20 mm Hg above the systolic pressure level determined by b. palpation time.

Systo-lic pressure readings are recorded when the first periodic noise (1 ton for Korotkov) occurs (sounds appear round, povьishayuschie, in the range of 2 mm Hg). Diastolic pressure readings are recorded by sensing these noises (V tones in Korotkov) (appearing at the same interval at 2 mm Hg).

blood pressure was dependent on the severity of preeclampsia and eclampsia in the main group of patients. Bp 140 / 80-90mm HG with mild preeclampsia. Nine patients with 150-160 / 100 mm HG were admitted. Eclampsia occurred in 22 critically ill patients with blood pressure 160/100 mm HG, 6 patients, 3 patients.

Tachycardia was frequently noted at 10–11 min in 90 min. Women are the main group with an increase in A / D for 160/110 mmHg.st., With ineffectiveness of treatment (reduction of blood pressure to 10-5mm HG) .art. and only high blood pressure was stable) performed a cesarean section for 12-48 hours. Antihypertensive therapy occupies one of the leading positions in the intensive care complex. In a combination of antihypertensive drugs we used. B-blockers (atenolol, metaprolol, bisoprolol) are used to treat arterial hypertension in patients with hypertrophic cardiomyopathy, migraine headache and arrhythmia.

Pregnancy is necessary in pregnant women with bronchial asthma or chronic lung pathology. In this group, we mainly used atenolol. Atenolol-cardioselective Beta1-blocker. Sympathetic innervation reduces the excitatory effect of catecholamines circulating in the heart and blood.

Labetolol combined α-Vadrenoblocker is particularly useful for intravenous administration in the treatment of acute hypertensive conditions during pregnancy and childbirth. Nifedipine is a drug from the group of dihydropyridines, which has little effect on the heart, mainly acts as a vasodilator. It is widely used for pre-modern complications because it does not adversely affect the fetus. Extensive research, however, has not been carried out in pregnant women with chronic arterial hypertension y treatment with this drug, but the drug is gradually gaining popularity, especially since its medication can be taken once a day, slow-expelling intestinal "retard" form. Doses used to treat arterial hypertension (30 to 60 mg per day) are higher than those used for tocolysis. Short-term doses of nifedipine (an antagonist of the dihydropyridine group) lead to vasodilatation, which is formed with 10 mg of the drug, which is rapidly absorbed in the stomach. You can also use nifedipine sublingually. Blood pressure decreases after 10-20 minutes, the effect of the drug lasts 4-6 hours. If the drug does not work, give a second dose of 10 mg in 20 minutes, then taking the drug is repeated every 4-8 hours.

1. Ease of access-under the tongue, through the mouth;
2. The drug mainly affects the arterioles 3;
3. Normalizes blood pressure, arterial hypertension is rarely observed;
4. Dilates coronary arteries and increases blood flow in the subendocardial parts of the myocardium.

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With an increase in blood pressure, we chose doses of antihypertensive drugs (atenolol, nifedipine). If the blood pressure is 130/80 - 140/80 mm. Rt.atenolol (50mg) 1 Tab x2 times, nifedipine (10mg) (under tongue or reg os) 1 tabx2 once a day. If the blood pressure is 150/90 -160/90 mmHg.article. Atenolol (50mg) 1tab x2-3 times, nifedipine (10mg) 2-3 times a day in combination with magnesium therapy (according to the Zuspan scheme). BP 170/100 and then atenolol (50mg) 1 Tab x3 times, nifedipine 10mg x3 once a day + magnesium therapy (instilled on saline or reopoliglucin). Magnesium therapy was continued until the 120-130 mm HG regimen was reduced. st., 0.8-1.0 gr. Dry matter per body weight up to 65 kg up to 75 kg - 1.5-2 g / h, over 75 kg - up to 2.5 g / h.

In addition, attention should be paid to the use of magnesium sulfate in the treatment of severe ketosis and eclampsia. The pharmacological effect of magnesium sulfate is as follows. Magnesium sulfate suppresses the centers of pathological activity of the central nervous system by blocking N-methyl-D-aspartate-glutamate receptors. Due to its anticonvulsant effect, the drug is superior to diazepam and phenytoin. Sulfate uteroplacental magnesium improves blood flow, increases prostacyclin concentrations by increasing production by endothelial cells. The next very important property of magnesium sulfate is its ability to remove arteriolospasm and thereby improve microcirculation. Currently, the plasma activity of the drug angiotensin-converting enzyme reduces renin b levels, leading to bronchodilator. Thus, magnesium sulfate has antihypertensive, sedative, antispasmodic, anticonvulsant, diuretic properties, reduces intracranial pressure.

Anticonvulsant treatment performed before and after delivery is clear to prevent recurrent seizures in patients with severe preeclampsia and eclampsia. In such cases, parenteral administration of magnesium sulfate is a priority of the appointment. However, the appointment of magnesium in patients with mild forms of pregnancy hypertension and preeclampsia does not have a proven advantage. Magnesium therapy during childbirth is indicated at a blood pressure level of 160/105 mm HG. In an emergency, the goal of antihypertensive therapy is to gradually reduce blood pressure to normal values. Magnesium therapy schemes Intravenous infusions (according to Zuspan). In 4 minutes (20ml 25% p-ra) a loading dose of xnumxg dry matter is injected intravenously. Then continuous infusion at a rate of 1-2G / h. If eclampsia occurs against the background of magnesium therapy, then 2-4G magnesium sulfate should be used instead of the loading dose. Traditionally, treatment with magnesium sulfate lasts 24 hours after delivery or after the last convulsive seizure (in cases of eclampsia).

DISCUSSION RESULTS

We followed 678 patients aged 18 to 40 years (mean age 20–26 years). All patients were divided into 2 groups. 1 group and basic control 2 group. The total number of patients in the first group (primary) was 40 women. The total number of patients in the second (control) group was also 40 women. The first group of pregnant women underwent complex intensive care. Blockers (atenolol, bisoprolol, metaprolol), Ca ++ (nifedipine, corinfar), amlodipine antagonists, magnesium therapy, if necessary, neurometabolic L-lysine essinate, as well as infusion therapy (reform, stabizol, etc.). The second group of pregnant women was treated according to the standard. Conclusion.

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As a result of the study, the effect of antihypertensive drugs in combination with neurometabolic drugs was studied; B chose a safe optimal therapy for the mother and the newborn.

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