



IMPACT OF UTERINE MYOMA ON OBSTETRIC AND PERINATAL OUTCOMES

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Article history:	Abstract:
Received: February 28 th 2022 Accepted: March 26 th 2022 Published: May 6 th 2022	The combination of uterine myoma and pregnancy ranges from 0.5% to 6%. The course of pregnancy with uterine myoma, in addition to the growth of nodes and impaired nutrition in them, includes: threat of termination in different gestational periods, development of preeclampsia, fetoplacental insufficiency, delayed fetal development syndrome, placenta detachment, placenta previa, abnormal fetal position. Pregnant women with uterine myoma were found to have one or more extragenital abnormalities, which significantly reduced the immunological status of the pregnant woman and the rate of gestational and perinatal complications.

Keywords: Uterine Fibroids, Gestation, Placenta, Fetus.

INTRODUCTION.

Uterine myoma is the most common benign tumor among women in most countries of the world. Uterine myoma is diagnosed in 30 to 35% of women of reproductive age, more often in late reproductive age, and in 1/3 of patients it becomes symptomatic. The frequency of occurrence of uterine myoma increases every year, and there is a tendency to the rejuvenation of this pathology [1,2,3]. The combination of uterine myoma and pregnancy occurs in 0.5-6% of women. In large obstetric hospitals, the detection rate of uterine myoma in pregnant women reaches 3.9%. To date, both submucosal and intramural nodes have been proven to have a significant negative impact on pregnancy and successful pregnancy. Since the neoplasm is hormone-dependent, myoma undergoes certain changes during pregnancy. Increased production of sex hormones contributes to tumor growth during this period.

Tumor growth causes enlargement and stretching of the muscular membrane of the uterus, increased blood flow in the uterine wall during pregnancy. With the rapid increase of uterine myoma during pregnancy there is a disturbance of node feeding, which leads to (compression) pain syndrome. The situation with myoma during pregnancy, in addition to the growth of nodes and impaired nutrition, blood clotting increases, which can lead to thrombosis. And this in turn leads to impaired nutrition not only in the tumor, but also in the entire fetoplacental system. [2,4,5]. But it happens that pregnancy with uterine myoma can be dangerous. Sometimes node degeneration can occur. Increased amount of progesterone and vascular changes lead to destruction of the formation, which is

accompanied by tissue necrosis, node rejection and bleeding, which can lead to the risk of preterm labor, premature detachment of the normal or low located placenta, especially when the placenta is located partially or completely in the area of myomatous node, improper fetal presentation, placenta previa, spontaneous abortions, abnormal labor, postpartum bleeding, increased indications for cesarean section [6,7]. The peculiarities of pregnancy with uterine myoma, in addition to the growth of nodes and nutritional disorders in them, include fetoplacental insufficiency, fetal retardation syndrome. Myomatous nodes vary in their location in the uterus and the prognosis for pregnancy completion depends on the type of myoma, size, number of nodes, the direction of node growth, background diseases and the immunological state of the pregnant woman.

OBJECTIVE: To study the effect of uterine myoma in pregnancy and childbirth on obstetric and perinatal outcomes

MATERIALS AND METHODS. We retrospectively analyzed 98 labor histories of pregnant, postpartum, and parturient women with uterine myomas, who were divided into two groups. Group I consisted of 50 pregnant women aged 24 to 31 years, and Group II consisted of 48 pregnant women aged 31 to 41 years. The mean age of the study subjects was 33.2. The mean gestational age at which myoma was detected was 18 weeks; there were 12 (12.2%) first-pregnant, 70 (70.1%) second-pregnant, and 16 (16.3%) multiple-pregnant women. Obstetric-gynecological anamnesis was heavy in 72 (70.3%) women, mostly in women of the II retrospective group. Acute and



chronic inflammatory diseases of the uterus and appendages in 68 (69.3%) women in this group, endocervicitis, cervical erosions in 21 (21.2%), ovarian cysts in 14 (14.2%), abnormal uterine bleeding in 21 (21.2%), uterine endometriosis in 12 (12.2%) were among the survived gynecological diseases, primary and secondary infertility in 8 (8.1%), nodal uterine myoma before pregnancy was detected in 15 (15.3%), conservative myomectomy of two subserosal nodes was performed in 1 (1.02%) 3 years before the pregnancy, ovarian cysts were removed in 4 (4.08%), ectopic pregnancy was performed in 3 (3.06%). The obstetric history was aggravated by formal abortions (including multiple abortions) in 35 (35.7%) women, spontaneous miscarriages in 26 (26%), premature labor in 14 (14.2%), hysterical pregnancy in 11 (11.2%), scarring after cesarean section in 19 (1.9%) women. In addition, 90 pregnant women were found to have one or another extragenital pathology: in the first place was chronic iron deficiency anemia of various degrees 78 (86.6%), diffuse and nodular toxic goiter 15 (1.5%), acute and chronic pyelonephritis 21 (2.3%), rheumatic disease 4 (4.4%), congenital and acquired heart defect 6 (6, We found out that the main causes of these diseases were chronic hepatitis 5 (5,5 %), chronic gastritis 9 (10 %), vegetative-vascular functional disorders 9 (9,1 %), bronchial asthma 2 (2,2 %), chronic tonsillitis 7 (7,7 %), obesity 11 (12,2 %). The serious pathological changes were mostly observed in women of the II group, which can be explained by the fact that the immunological reactivity of the organism in both groups was decreased against the background of chronic inflammatory diseases of the genitals, chronic somatic diseases. The study of the course of gestation in patients with myoma showed that in 65 (66.3%) cases the study subjects' pregnancy had complications of the gestational period. Thus, high parameters of the threat of termination of pregnancy were observed in 51 (52%) during all II trimesters, early toxemia of pregnancy in 30 (30.6%), mild preeclampsia in 19 (19.3%), severe preeclampsia in 7 (7 placenta previa (complete, partial, low) in 8 (8.2%), chronic fetoplacental insufficiency in 39 (39.7%), chronic fetal hypoxia in 28 (28.5%), abundant water in 17 (17.3%), water shortage in 5 (5.1%). This once again confirms deeper changes in the fetoplacental system in pregnant women with uterine myoma. The analysis of labor in women with uterine myoma showed that 20 (20.4%) women delivered prematurely, 78 (78.5%) at term, 31 (30.1%) by cesarean section, 9 (9.08%) cases had total

hysterectomy by concomitant indications, and 4 (4.08%) cases had one-stage conservative myomectomy, 21 (21, The incidence of premature placenta previa was registered in 17 (17.1%), oblique and transverse position of the foetus in 5 (5.1%), premature detachment of placenta in 4 (4.08%), abnormal labors in 9 (9.01%), intrapartum death in 1 (1.02%), bleeding in early postpartum period in 14 (14.1%). Postpartum uterine subinvolution occurred in 29 (29.3%) and systemic inflammatory response syndrome in 11 (11.2%). The birth outcomes for the fetus and the newborn were as follows: the newborn weight was 1,500 g to 3,700 g, various degrees of intrauterine fetal retardation in 25 (25.3%), severe asphyxia in 3 (3.3%), mild and moderate asphyxia in 13 (13.2%) newborns, and congenital malformation (palate malformation and palatation) in 1 (1.02%) newborn.

CONCLUSIONS: An in-depth study of the history, pregnancy, labor and postpartum, fetal and neonatal conditions showed that uterine myoma during pregnancy is a frequent cause of gestational complications, increased perinatal complications, disability, and reduced quality of life, and therefore these pregnant women should be assigned to a high risk group for the development of obstetric and perinatal pathology. A differential approach to the preservation and management of pregnancy, labor, and the postpartum period in women with uterine myoma and preventive measures aimed at the prevention of placental insufficiency, improvement of pelvic circulation, and reduction of uterine hypertension can significantly reduce the number of maternal and fetal complications, the number of surgical interventions, perinatal pathology and mortality rates, and the risk of delivering a sick newborn.

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