

PLATSENTANING PAST JOYLASHUVI BO'LGAN HOMILADORDA TUG'RUQNI BOSHQARISH (ADABIYOTLAR SHARHI)

Magzumova N.M., Norqulova Sh.U., Ahmedova G.A.

Toshkent Tibbiyot Universiteti

Dolzarbligi. “Past joylashgan platsenta” — bu platsentaning bachadon pastki segmentiga qisman joylashgan holati bo‘lib, u ichki bachadon bog‘zidan 1–20 mm masofada joylashadi. Bunday holatdagi ayollarda optimal tug‘ruq usuli hanuzgacha muhokama qilinmoqda, shuning uchun ularning aksariyatida kesarcha kesish bajariladi. Vaginal va kesarcha tug‘ruq hollari chastotasini baholash uchun adabiyotlar tahlili amalga oshirildi.

Kalit so‘zlar: homiladorlik, past joylashgan yo‘ldosh, diagnostika, ultratovush tekshiruvi.

ВЕДЕНИЕ РОДОВ У БЕРЕМЕННЫХ С НИЗКО РАСПОЛОЖЕННОЙ ПЛАЦЕНТОЙ (ОБЗОР ЛИТЕРАТУРЫ)

Магзумова Н.М., Норкулова Ш.У., Ахмедова Г.А.

Ташкентский медицинский Университет

Актуальность. «Низко расположенная плацента» — это когда происходит частичная имплантация в нижний сегмент матки и расположен на расстоянии 1–20 мм от внутреннего цервикального отверстия. Оптимальный способ родоразрешения у женщин с низко расположенной плацентой до сих пор остается спорным и большинству из них проводится кесарево сечение. Проведен анализ литературы для оценки частоты вагинальных родов и кесарева сечения при родах.
Ключевые слова: беременность, низкая плацентация, диагностика, ультразвуковое исследование

MANAGEMENT OF LABOR IN PREGNANT WOMEN WITH LOW-LYING PLACENTA (LITERATURE REVIEW)

Magzumova N.M., Norkulova S.U., Akhmedova G.A.

Tashkent Medical University

Relevance: "Low-lying placenta" refers to partial implantation in the lower segment of the uterus, located at a distance of 1–20 mm from the internal cervical os. The optimal method of delivery in women with low-lying placenta remains controversial, and most of them undergo cesarean section. A literature analysis was conducted to assess the frequency of vaginal delivery and cesarean section during labor.

Keywords: pregnancy, low placenta, diagnosis, ultrasound examination.

“Past joylashgan platsenta” atamasi platsentaning bachadon pastki segmentiga qisman joylashgan holatini ifodalaydi, bu holatda platsentaning pastki cheti ichki bachadon bog‘zidan (internal -os- distance - IOD) 1–20 mm masofada joylashadi [1–3]. Transvaginal skanerlash (TVS) — IOD ni o‘lchashda “oltin standart” hisoblanadi [4]. Ushbu masofani o‘lchash uchun optimal vaqt homiladorlikning uchinchi trimestri oxiri — 36-hafta deb hisoblanadi, chunki shu vaqtda bachadon pastki segmenti to‘liq shakllanadi [6, 7]. IOD ni aniqlash tug‘ruq usulini tanlashda muhim ahamiyatga ega [2, 5, 8].

Platsentaning oldindan joylashuvi holatlarida kesarcha kesish bajarilishi kerakligi borasida ko‘rsatmalar mavjud bo‘lsa-da, platsentaning past joylashuvi bo‘lgan homiladorlarda optimal tug‘ruq usuli hali ham bahsli hisoblanadi, chunki bu borada ishonchli ilmiy ma’lumotlar yetarli emas [9–14].

Izlanishlarga homiladorlikning ikkinchi trimestrida platsentaning past joylashuvi bo‘lgan ayollar kiritilgan. Nazorat guruhi sifatida platsentasi normal joylashgan homiladorlar olingan. Har bir holatda, uchinchi trimestr oxirida IOD >5 mm bo‘lgan 30 nafar ayol tanlab olindi. Platsentaning past joylashuvi holatlari chastotasi ikkinchi trimestrda 2% bo‘lsa, homiladorlik oxiriga kelib 0,4% gacha kamaydi. Agar IOD >5 mm bo‘lgan ayollarda vaginal tug‘ruq chastotasi $\geq 60\%$ bo‘lsa, ularni tug‘ruqqa tayyorlash uchun rejalashtirilgan kasalxonaga yotqizish maqbul hisoblanadi.

Amerika va Buyuk Britaniyaning akusherlik va ginekologiya kollejlari homiladorlikning uchinchi trimestrida simptomlari yo‘q past joylashgan yo‘ldoshli ayollar uchun klinik vaziyat va bemor istagiga asoslangan individual yondashuvni

tavsiya etadi. Niderlandiyaning 2015-yilgi va Kanadaning 2020-yilgi ko'rsatmalarida esa IOD 11–20 mm bo'lgan barcha ayollarga vaginal tug'ruq tavsiya etiladi, chunki bu oraliqda qon ketish xavfi past hisoblanadi [16].

Shuningdek, kanadalik tadqiqotchilar IOD ≤ 10 mm bo'lgan ayollarda ham, agar boshqa xavf omillari bo'lmasa (masalan, 29 haftagacha qon ketish holatlari yoki marginal sinus belgilarining mavjud emasligi), vaginal tug'ruqni sinab ko'rishni tavsiya etadilar [17].

Retrospektiv tadqiqotda IOD 11–20 mm bo'lgan ayollarda vaginal tug'ruq 69% hollarda, IOD 1–10 mm bo'lganlarda esa 25% hollarda kuzatilgan [10]. Shu asosda 2009-yilda maxsus protokol ishlab chiqilgan: IOD ≤ 10 mm bo'lsa — rejalashtirilgan kesarcha kesish, IOD 11–20 mm bo'lsa — vaginal tug'ruq tavsiya qilinadi.

2009–2018-yillar mobaynida protokol qo'llanilganda, IOD 11–20 mm bo'lgan ayollarda vaginal tug'ruq 77%, shoshilinch kesarcha hollari esa 16,3% ni tashkil etdi [18]. Bu Jansen va boshqalar tomonidan olib borilgan sistematik tahlil natijalari bilan mos keladi [19]. IOD 1–10 mm bo'lgan ayollarda vaginal tug'ruq 43%, shoshilinch kesarcha esa 45% ni tashkil etgan. Ikkala guruhda ham onalik kasalliklari bo'yicha farq aniqlanmagan. Shunga o'xshash natijalar Wortman va boshqalar tomonidan o'tkazilgan retrospektiv tadqiqotda olingan. [13] Ular IOD > 5 mm bo'lgan ayollarda vaginal tug'ruq ehtimoli < 5 mm (mos ravishta 58% va 0%) bilan solishtirgandasezilarli darajada yuqori ekanini aniqladilar, IOD kichik guruhlari o'rtasida sezilarli farqlar yo'q(6-10mm, 11-15mm, 15-20mm)

Ishonchli ilmiy dalillar va o'z navbatida, o'ziga xos milliy tavsiyalar yo'qligi sababli Italiyada platsenta past joylashgan ko'pchilik ayollarga odatda kesarcha kesish taklif qilinadi [10, 18]. Biroq, uchunchi trimestrda IOD > 20 mm ga yetgan ayollarda ham qon ketish xavfi yuqori bo'lishi aniqlangan.

Kesarcha kesish keyingi homiladorliklarda platsenta oldindan joylashuvi ehtimolini oshiradi, ayniqsa ilgari bunday holat kuzatilgan bo'lsa [21]. Bu xavf avvalgi kesarcha soni ortgani sayin oshadi [5]. Avvalgi kesarcha va yo'ldoshning oldindan joylashuvi — platsenta o'sib kirishi (placenta accreta) rivojlanishining asosiy omillari hisoblanadi [22]. Ushbu holat og'ir qon ketish, gistorektomiya, qon quyish va onalik-perinatal o'lim xavfi bilan kechadi [23].

JSST 2015-yildan boshlab ayniqsa birinchi homiladorlikda kesar kesish usulidagi tug'ruqlarni kamaytirishni tavsiya qilgan [24]. Bu tavsiyalar ayniqsa Yevropa davlatlari uchun dolzarb, chunki bu mamlakatlarda eng yuqori ko'rsatkichlarga ega [25].

Italiya tadqiqotlari (2021-2024) uchunchi trimestr oxirida trasvaginal ultratovush tekshiruvini asosida platsenta past va IOD >5mm bo'lgan barcha ayollarga vaginal tug'ishni sinovdan o'tkazishni taklif qiladi. Tadqiqotchilar homiladorlikning ikkinchi trimestrida normal va past joylashgan yo'ldoshli ayollarni solishtirgan. Maqsad: IOD 6–20 mm bo'lgan ayollarda vaginal tug'ruq va shoshilinch kesarcha holatlarini baholash.

Oxirgi yillarda olingan ma'lumotlar past joylashgan yo'ldoshli ayollarda vaginal tug'ruq xavfsizligini tasdiqlamoqda [12]. Shu bilan birga, kesar kesish usulidagi tug'ruqlar ortib borayotgani fonida placenta accreta xavfi ham ortmoqda [22].

Shuning uchun homiladorlikning 19–23 haftalari oralig'ida UTT orqali past joylashgan yo'ldosh aniqlanib, placenta accreta holati istisno qilinishi kerak. 37-haftada qayta baholab, tug'ruq usulini aniqlash tavsiya etiladi.

Adabiyotlar tahlili shuni ko'rsatmoqdaki, past joylashgan yo'ldoshni erta aniqlash va TVS orqali IOD ni aniqlash, placenta accreta ni istisno qilish orqali har bir homilador ayolga individual yondashuv asosida tug'ruq rejasini tuzish mumkin bo'ladi.

Литература.

- 1.Reddy UM, Abuhamad AZ, Levine D, et al. Fetal imaging: Executive summary of a joint Eunice Kennedy Shriver National Institute of child health and human development, Society for Maternal-Fetal medicine, American Institute of ultrasound in medicine, American College of obstetricians and Gynecologists, American College of radiology, Society for pediatric radiology, and society of radiologists in ultrasound fetal imaging workshop. J Ultrasound Med 2014;33:745–57.
- 2.Oppenheimer L, Armson A, Farine D, MATERNAL FETAL MEDICINE COMMITTEE . Diagnosis and management of placenta previa. J Obstet Gynaecol Can 2007;29:261–6.
- 3.Dashe JS. Toward consistent terminology of placental location. Semin Perinatol 2013;37:375–9.
- 4.Farine D, Fox HE, Jakobson S, et al. Vaginal ultrasound for diagnosis of placenta previa. Am J Obstet Gynecol 1988;159:566–9.
- 5.Jauniaux E, Alfirevic Z, Bhide AG, et al. Placenta praevia and placenta accreta: diagnosis and management: Green-top guideline No. 27a. BJOG 2019;126:e1-e48.

6. Fukuda M, Fukuda K, Shimizu T, et al. Ultrasound assessment of lower uterine segment thickness during pregnancy, labour, and the postpartum period. *J Obstet Gynaecol Can* 2016;38:134–40.
7. Ginsberg Y, Goldstein I, Lowenstein L, et al. Measurements of the lower uterine segment during gestation. *J Clin Ultrasound* 2013;41:214–7.
8. Silver RM. Abnormal placentation: placenta previa, vasa previa, and placenta accreta. *Obstet Gynecol* 2015;126:654–68.
9. Bronsteen R, Valice R, Lee W, et al. Effect of a low-lying placenta on delivery outcome. *Ultrasound Obstet Gynecol* 2009;33:204–8.
10. Vergani P, Ornaghi S, Pozzi I, et al. Placenta previa: distance to internal os and mode of delivery. *Am J Obstet Gynecol* 2009;201:266.e1–266.e5.
11. Nakamura M, Hasegawa J, Matsuaka R, et al. Amount of hemorrhage during vaginal delivery correlates with length from placental edge to external os in cases with low-lying placenta whose length between placental edge and internal os was 1-2 cm. *J Obstet Gynaecol Res* 2012;38:1041–5.
12. Al Wadi K, Schneider C, Burym C, et al. Evaluating the safety of labour in women with a placental edge 11 to 20 MM from the internal cervical os. *JOGC* 2014;36:674–7.
13. Wortman AC, Twickler DM, McIntire DD, et al. Bleeding complications in pregnancies with low-lying placenta. *J Matern Fetal Neonatal Med* 2016;29:1367–71.
14. Taga A, Sato Y, Sakae C, et al. Planned vaginal delivery versus planned cesarean delivery in cases of low-lying placenta. *J Matern Fetal Neonatal Med* 2017;30:618–22.
15. ACOG Committee opinion no. 764: medically indicated late-preterm and early-term deliveries. *Obstet Gynecol* 2019;133:e151–5.
16. Derks J. Modus partus bij placenta praevia marginalis. *NVOG*, 2015. [Google Scholar]
17. Jain V, Bos H, Bujold E. Guideline No. 402: diagnosis and management of placenta previa. *J Obstet Gynaecol Can* 2020;42:906–17.
18. Ornaghi S, Tessitore V, Vergani P. Pregnancy and delivery outcomes in women with persistent versus resolved low-lying placenta in the late third trimester. *J Ultrasound Med* 2021:1–11
19. Jansen C, Mooij YM, Blomaard CM, et al. Vaginal delivery in women with a low-lying placenta: a systematic review and meta-analysis. *BJOG: Int J Obstet Gy* 2019;126:1118–26.
20. Ogueh O, Morin L, Usher RH, et al. Obstetric implications of low-lying placentas diagnosed in the second trimester. *Int J Gynaecol Obstet* 2003;83:11–17.

21. Gurol-Urganci I, Cromwell DA, Edozien LC, et al. Risk of placenta previa in second birth after first birth cesarean section: a population-based study and meta-analysis. *BMC Pregnancy Childbirth* 2011; 11:95.
22. Eshkoli T, Weintraub AY, Sergienko R, et al. Placenta accreta: risk factors, perinatal outcomes, and consequences for subsequent births. *Am J Obstet Gynecol* 2013;208:219.
23. Farquhar CM, Li Z, Lensen S, et al. Incidence, risk factors and perinatal outcomes for placenta accreta in Australia and New Zealand: a case-control study. *BMJ Open* 2017;7:e017713.
24. World Health Organization. WHO statement on caesarean section rates, 2015.
25. Euro-Peristat Project. European perinatal health report. core indicators of the health and care of pregnant women and babies in Europe in 2015.