

relief of symptoms of miscarriage. Thus, according to the obtained result, the values of the CPS of the embryo are the most informative for the prediction of the course and outcome of the gestational process in the first trimester of pregnancy. When assessing the heart rate of the embryo in the group of pregnant women with habitual pregnancy loss in most cases (70%), the dynamics of changes in heart rate (HR) of the embryo corresponded to the parameters of physiological pregnancy. Thus, the heart rate of the embryo gradually increased from 6 weeks of gestation (107 ± 12 beats / min) to 9-10 weeks (176 ± 11 beats / min), then to 12 weeks decreased to 159 ± 6 beats / min. The highest heart rate (180 beats / min; $p < 0.05$) was also observed at 9 weeks of pregnancy. However, in 3 (5.71%) cases with CPS of the embryo of 14 mm and more (14-26 mm) no cardiac activity of the embryo was registered, which allowed to diagnose a non-developing pregnancy.

The ultrasound picture in pregnant women with miscarriage in the first trimester of pregnancy is an important prognostic sign.

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NEW GESTOSIS PREVENTION METHODS IN PREGNANT WOMEN WITH MISCARRIAGE

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Late gestosis is one of the most common complications of pregnancy and is accompanied by significant hemodynamic and metabolic disorders, which are largely determined by changes in renal function and water-salt homeostasis.

Aim of study: to study pathogenesis and development of new methods of corrective therapy for late toxicosis of pregnant women is the most important task of modern obstetrics. The study of the kidneys function, water and mineral balance in pregnant depending on the form of late toxicosis and those transformations was conducted. 377 pregnant women with late toxic goat aged 18 to 48 years were examined, of which 221 were first-born and 156 were reborn. All pregnant women, depending on the lane Eden therapy were divided into two groups: the control included 161 pregnant women, who treated according to the classical scheme, the main group - 216 pregnant women, among whom was applicable anomalies targeted to corrective therapy in 153, and maintenance in 63.

A study of these indicators was also conducted in 40 healthy non-pregnant women and 48 pregnant women. All women underwent a general clinical examination, the dynamics of the level of electrolytes and trace elements in plasma and erythrocytes of blood and urine was determined. The content of natriuretic factor was expressed in conventional units, which were calculated by the change in sodium excretion (in μ / mol / h) in test rats after administration of appropriate amounts of blood plasma of the examined women. The results of our studies indicate a profound disorder of renal function, water-mineral balance and acid-base balance in severe forms of late toxicosis of pregnant women and dictate the need for targeted correction of these disorders. It was also found that after the main course of effective therapy remained reduced until discharge from the hospital glomerular filtration in the kidneys (84.84 ± 3.34 ml / min), their excretion of sodium and potassium (respectively 101.6 ± 5.11 and $64, 13 \pm 1.78$ mmol / s) and increased excretion of calcium and magnesium (6.45 ± 0.08 and 4.38 ± 0.21 mmol / s, respectively). Osmotic pressure of urine, as well as total blood protein (57.2 ± 1.8 g / l) and disturbed - the ratio of protein fractions in the direction of coarse (albumin-globulin ratio -0.9 ± 0.04) remained underestimated. The above material convincingly shows that the reversibility of clinical, functional and biochemical changes under the influence of treatment is not the same and in clinical recovery the function of some organs and metabolic processes are not normalized and clearly indicate trace pathogenetic disorders that require constant monitoring and continuation of therapy.

The consequence of underestimation of these data is recurrence of toxicosis, and in more severe forms. Thus, in the control group they were observed in 23.4% discharged after recovery from the hospital. These facts made it possible to review existing regulations on the management of patients with toxicosis and to outline treatment measures for early and more complete regression of

late toxicosis and clinical recovery of pregnant women. The use of targeted and corrective and supportive treatment of late toxicosis of pregnant women is not only justified but also necessary. Naturally, the proposed principles of treatment and rehabilitation measures do not solve this problem, but attempts to accelerate the regression of toxicosis, prevent recurrence and achieve more complete rehabilitation of impaired functions during pregnancy seem appropriate to us. It is in this that we see the reserves for a possible improvement at the end of pregnancy and childbirth for mother and fetus.

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PLACENTAL MORPHOMETRIC INDICES IN WOMAN WITH PLACENTAL DYSFUNCTION

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Placental dysfunction (PD) is a key problem of obstetrics, neonatology and pathological anatomy, diseases of ante- and perinatal period, since functional failure of this organ leads to threatening miscarriage, fetal growth and developmental retardation (FGDR) or its death.

A morphometric study of placentas from 30 lying-in women, who had the background of placental dysfunction (study group) and 25 lying-in women with physiological pregnancy (control group) in gestation period of 36-40 weeks was carried out. Methodical recommendations on placental morphometry methods, introduced by A.P. Milovanov and A.I. Brusylovsky, were used in the study.

Having assessed the form of placentas, we found out that in women with placental dysfunctional complications the placentas were round in shape in 7 (28%) cases, whereas in women with physiological pregnancy this morphological parameter was observed in 19 (63.3%). 18 (72%) placentas in the main group were oval; it's twice higher than the same parameter in control group – 11 (36.7%).

Studying the umbilical attachment variations we researched that in women with placental dysfunction central attachment occurred only in 8 (32%) lying-in women, and in women with physiological pregnancy course it was noted in 18 (60%). Lateral umbilical cord attachment was observed in 13 (52%) pregnant of the main group, but in physiological pregnancy only 10 (33,3%) pregnant had this variation of umbilical attachment. The marginal attachment rate is rather high in women with PD in comparison with the control group – 4 (16%) to 2 (6.8%). According to the literature data, such umbilical cord attachment anomalies are accompanied by dysplastic changes of bloodstream and restriction of compensatory-adaptive reactions of the placenta.

An average weight of the placenta in patients with placental dysfunction was 388.58 ± 12.4 , in the control group – $492.8 \pm 24.4\%$ ($p < 0.05$). Difference between an average weight indices and gestation norm probably may occur due to the fact that the effective implementation of the placenta compensatory-adaptive reactions is possible only with adequate functioning of the utero-placental vessels. An average area of the placenta in the lying-in women of the main group was 241.21 ± 5.16 cm, in the control group – 234.8 ± 5.2 cm. The tendency of the placentas to become thinner was also observed – 1.77 ± 0.2 cm and 1.9 ± 0.4 cm. Macroscopically the afterbirth flattening and thinning was observed in this pathology.

Placental-fetal index (PFI) in the main group was $0,138 \pm 0,003$, and in the control group 0.159 ± 0.009 , that indicates a reduction in the volume of placental tissue per weight unit of a newborn with the placental dysfunction. External examination of placentas of the main group of patients showed the isolated bleeding centers on the maternal surface, frequent calcifications, deep cotyledon divisions.

The analysis of placentas morphometric peculiarities showed that in women with placental dysfunction placentas differ in shape, among which oval is dominant. The eccentric umbilical cord attachment is more frequent; flattening and thinning of the afterbirth occurs, it indicates reduction of weight, size and thickness of the placenta.