Практика показывает, что пациентам необходимо какое – то время, чтобы полностью адаптироваться к полным съемным протезам.

В день сдачи полных съемных протезов проблемы с речью наблюдались у 58% пациентов, у 48% через 1 сутки, у 38% через 1-5 дней и у 12% через 5-30 дней (рис. 1).

Вдень сдачи полных съемных протезов проблемы с актом жевания наблюдались у 88% пациентов, через сутки у 78%, через1-5 дней у 72% и через 5-30дней у 42%(рис1). Механизм пережевывания пищи состоит из совокупности взаимосвязанных процессов. Зубы — лишь значительная часть этого процесса. В этот процесс входят язык, губы, щеки и слюнные железы.

При сдачи полных съемных протезы на верхнюю челюсть отмечалось раздражение слизистой протезного ложа у 37% пациентов и 63% на нижней челюсти, по истечении суток жалобы стали 32% в/ч и 58% н/ч, через-5 дней 18% в/ч и 21% н/ч, через 5-30суток 6% в/ч и 9%н/ч.(Рис2) В целом важно, чтобы зубные протезы не вызывали травматических повреждений, т.е. не раздражали слизистую оболочку полости рта. В некоторых случаях пациент с травматическим повреждением или дискомфортом может быть не в состоянии есть, глотать или даже говорить. Ортопеду стоматологу необходимо устранить все эти жалобы, чтобы пациент комфортно пользовался изготовленными протезами. Наше исследование показало, что для возвращения к полноценному функциональному состоянию необходимо от 1 –до 30 дней. Все это сугубо индивидуально, кому-то достаточно 1 дня кому-то значительно больше.

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PRETERM LABOR IN MODERN OBSTETRICS

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ABSTRACT

Data from national and worldwide literature on the study of premature birth problem are presented in the article. The accent is placed on risk factors, modern pathogenetic mechanisms of development, diagnosis and

tactics in premature birth. The frequency of preterm births didn't tend to decrease over the past decade despite all the efforts of scientific and practical obstetricians. The relevance of studying this problem is due not only to medical consequences, as evidenced by the proportion of premature infants in perinatal morbidity and mortality structure, as well as social significance.

Keywords: miscarriage, premature birth, etiopathogenesis, diagnosis, obstetric and perinatal complications.

Labor are considered to be preterm (partuspraematurus) when they happen during period from 22 to 37 full weeks of gestation and lead to the birth of premature babies with unfinished period of normal intrauterine developement [1]. The term «premature babies» was adopted in 1929 and it is recognized worldwide. According to the recommendation of the Ministry of Health, since 1961 all infants whose weight is less than 2,500 grams are defined as newborns with «low birth weight». Since 1974 children, born with a body weight of more than 500 grams with gestational age from 22 full weeks are considered viable. To date, preterm labor (PL) are births that occurred between 22 full to 36 weeks and 6 days from the first day of the last menstrual period.

The urgency of PL takes an important place in modern obstetrics due to the high proportion of premature newborns (PN) in the structure of perinatal morbidity and mortality. On January 1, 2007, Ukraine connected to new standards of the Ministry of Health to define the term of the PN. As a result, perinatal morbidity and mortality rates have increased. In scientific works of B. M. Ventskivsky, V. V. Kaminsky, V. I. Gryshchenko and others (2009) authors emphasized the problem of premature infants, which account for 75% in the structure of neonatal mortality. At 23 weeks of gestation, among those, who were born, only 20% survive (every 5th newborn) at 26 weeks - 60%, at 27-28 weeks - about 80% of PN. Among those, who were born in 32 weeks of gestation and later, almost 100% survival was noted. Approximately 15 million children worldwide are born prematurely each year. From these, 1 million die before the age of 5 (that is 18% of all deaths of children of this age). 35% of cases of early and late neonatal death of newborns (under 28 days of age) are associated with premature birth [2]. Despite all the efforts of scientific and practical obstetrics, the incidence of PL over the past decade has not tended to decrease and varies from 6 to 15% depending on the geographical and demographic situation of the studied population. In recent decades, the number of pregnant women with risk of PL increased, including patients with scar on the uterus, premature rupture of amniotic membranes, extragenital pathology, multiple pregnancies, pregnancies with a help of reproductive technologies (IVF, ICSI, stimulation) [3-6].

The literature presents various statistics on the frequency of spontaneous abortions - from 12-13% to 25-35% of the total number of pregnancies [3, 5]. In lowincome countries, the average incidence of preterm birth is about 12% compared to 9.4% and 9.3% in middle-income and high-income countries, respectively [7]. The lowest rate was recorded in the Netherlands (3.5%) and the highest in India (34%). In the United States, about 7.5% of births are premature. In France – 5%. According to the data of the Department of Health of Ukraine, frequency of premature births in Ukraine in 2019 was 3.4%. The WHO Committee of Experts provides data according to which the frequency of PL and miscarriage tends to increase.

The main factors of PL are: biological (age, anthropometric data, ethnic characteristics of parents, genetic and chromosomal abnormalities); ecological (unfavorable ecological environment increases the frequency of miscarriage by 1.7-2.2 times); infection (acute, chronic, systemic, ascending; bacterial and / or viral); mechanical factors (multiple births, polyhydramnios, abnormalities of uterine development, infantilism, isthmic-cervical insufficiency, intrauterine synechiae); endocrine; genetic; thrombosis and placental abruption occur because of thrombophilic disorders; maternal and fetal stress, which leads to hormonal changes [8].

According to the literature, one of the leading factors among miscarriages is the inflammatory disease of the ovum, placenta and its membranes, as well as internal genitals [9, 10]. Thus, the frequency of the detected inflammatory process in the placenta after a long period of intrauterine miscarriage is 76.5%, and without signs of threat – 20.2% [11-13]. Chronic infection also plays a specific role, namely: brucellosis, toxoplasmosis, rickettsiosis, as well as mumps viruses, herpes and cytomegalovirus [14, 15]. There are disorders in the reproductive system that cause chronic endometritis, followed by abortion thanks to the long-term persistence of infectious agents in the endometrium. Thus, in pregnant women with anamnesis of inflammatory miscarriage, the incidence of asymptomatic persistence of opportunistic pathogens in the endometrium is 68.3%, while in patients with a stillborn pregnancy in anamnesis of mixed infection with two or more pathogens in 26.7%. The main risk factors for obstetric and perinatal complications in women with a history of sexually transmitted infections (STIs) are: presence of a high infectious index in anamnesis (76.0% and 72.0%), chronic and acute inflammatory processes of the urinary tract (48.0% and 40.0%), STIs before pregnancy (32.0% and 28.0%), as well as reproductive losses of infectious origin (21.0% and 28.0%): miscarriages, fetal growth retardation and history of placental dysfunction, ante- and intranatal fetal death [16-19].

It was found that the risk of abortion is 5 times more common in women with abortion in anamnesis than in primiparous women, and its frequency is about 20% [20, 21]. An unfavorable prognostic factor is the presence of a history of medical abortions, which contribute to the growth of PL during the next pregnancy in 22.3-69.4% of cases [22]. In turn, inflammatory diseases of the uterine appendages, which often occur after an abortion, in 80% are the cause of spontaneous abortion. This fact is confirmed by studies of AV Kuznetsova and co-authors (2002). Concomitant endocrinopathies and autoimmune disorders, even acting indirectly on the pregnant woman, lead to fetal developmental disorders and abortion. These indicators, according to various authors, range from 21.3% to 44.7% of cases [23-25].

Today, sexually transmitted diseases are also relevant and lead to the termination of a desired pregnancy and PL. According to the literature the increase in the incidence of AIDS in pregnant women, chlamydial infection (12-42%), herpes virus type II and cytomegalovirus (8-30%), bacterial vaginosis (20-65%) are the reasons of PL in 34-65% of cases [26-31]. In 80% of cases, the infection is mixed viral-bacterial or viral-viral, often in combination with candidiasis. As a result in a pregnant woman's body develops secondary immuno-deficiency, which is clinically manifested by symptoms of abortion [32-36].

There are many reasons that can lead to the development of PL. However, it is advisable to focus on more detailed disorders of the functional state of the feto-placental complex (FPC), that leads to a high incidence of prenatal mortality [37], as well as the problem of vitamin D deficiency, which can not only cause dysregulation of phosphorus-calcium metabolism during pregnancy (impaired mineralization of the fetal bone system), but also increases the risk of preeclampsia, gestational diabetes, neonatal hypocalcemia, type 1 diabetes, metabolic syndrome, cardiovascular disease, etc. [38, 39].

According to MM Chernyak and OO Korchynska, PL remain the most common complication of pregnancy, which significantly increases the level of perinatal morbidity and mortality. However, it is undeniable that the prediction and prevention of PL is one of the main areas of prevention of perinatal losses [40].

PL in 64-74% of cases is caused by hormonal disorders. First of all, hormonal insufficiency of the ovaries and placenta on the background of infantilism of the reproductive system (70-75%). The state of hormone-producing function in PL is quite fully described in the works of R. L. Goldenberg, O. J. Rouse (2012). In miscarriage, the formation of the placenta occurs against the background of disruption of the synthesis of sex steroids, which is a significant imbalance of all metabolic changes in 75%. An important factor that determines the level of hormones in blood is the intensity of uteroplacental circulation, which determines the rate of estrogen precursors to the placenta and the rate of estriol produced in the placenta into a maternal circulation [41]. Persistent estrogen deficiency and placental progesterone are caused by activation of the androgenic spectrum of steroid hormones. During first months of pregnancy, despite the relative activity of some hormones, such as estradiol, the level of total estrogen and progesterone decreases progressively [42, 43]. Steroid imbalance in miscarriage leads to persistent changes in hormonal balance in the hypothalamic-pituitary system, impaired synthesis and secretion of gonadotropins, which are manifested in acyclic peaks of luteinizing and follicle-stimulating hormones with low total gonadotropic activity in urine [44-46]. Decreased estriol production on the background of high blood levels of 17-B estradiol may be one of the diagnostic criteria, which, according to FF Burmunolova (1998), helps to increase the contractile activity of the uterine muscles.

According to R. L. Goldenberg (1998), the processes of biosynthesis of sex steroids during the formation of placenta are not fully normalized even under the influence of therapy, which can have negative consequences during pregnancy.

Pathogenetic relationship of morphological structure, features of feto-placental barrier and ovarian hypofunction was proved [47-51]. This leads to the premature occurrence of persistent placental insufficiency. The state of ovarian hypofunction and genital infantilism is prognostically unfavorable, which, according to EK Ailamazyan (2004), leads to involuntary premature termination of pregnancy in 32-34% of cases. Risk factors of PL include endocrine forms of infertility. According to V. M. Sidelnikova and co-authors (2010), the high-risk group of miscarriage and PL includes women whose pregnancies occurred after induced ovulation. The evaluation of functional diagnostic tests plays a leading role [52-54]. PL can be caused by disorders not only of ovarian function and fetoplacental complex, but also by an adrenal cortex. However, I. S. Sidorova and I. O. Makarov (2000) proved that in a mechanism of miscarriage or premature birth, the change in glucocorticoid function of the adrenal cortex is not so significant. At the same time, one of the reasons for abortion, especially after the 20th week of pregnancy, may be hyperandrogenic adrenal genesis.30-40% of women with a threat of preterm labor (TPL) have functional insufficiency of the thyroid gland and a predisposition to hypothyroidism, while clinical manifestations are absent or have an erased character. It was proved that a decrease in production of thyroid hormones leads to conformational changes in protein composition of molecules, followed by a decrease in a number of sulfhydryl groups in blood serum of pregnant women [55-57]. Violation of hormonal homeostasis can be caused by a number of other immediate factors. The leading role among them belongs to neuroendocrine pathology, in particular diabetes mellitus [58-60].

An important place among the causes of PP belongs to isthmic-cervical insufficiency (ICF), as well as malformations of the uterus. ICF may be functional, depending on endocrine disorders, including ovarian hypofunction. However, the most common cause of ICF is internal os injuries during instrumental abortion (up to 42%), less often – in large fetuses, rapid births, surgical manipulations (obstetric forceps, vacuum extraction of the fetus), unrecovered cervical ruptures [61-69].

Today the dominant is opinion that there is a natural selection at a high initial level of creation of chromosomal-abnormal embryos which is aimed on eliminating of chromosomal mutations carriers [70, 71]. Therefore, couples with more than two miscarriages in anamnesis need a thorough medical and genetic counseling, which includes genealogical research with analysis of the couple's family, including not only anamnestic data about miscarriages, but also all cases of premature births, stillbirths, fetal growth retardation (FGR), congenital anomalies, mental retardation and infertility [72-74]. A number of Ukrainian scientists, such as V. A. Potapov, T. V. Demchenko, M. V. Medvedev (2004), proved the role of preeclampsia in pregnant women as one of the causes, which can provoke PL (10,9-24%), polyhydramnios (16.6%), abnomal location and premature detachment of placenta (22.8%), as well as extragenital diseases (15.7–26.2%) [75-77]. The share of these diseases and complications of gestation in the structure of PL is about 40% [78-80].

Pregnant women with even one involuntary termination of pregnancy in anamnesis belong to the risk group for miscarriages and PL at different termines of pregnancy. A. Bocking and co-authors (1999) indicate that if there is at least one preterm birth in anamnesis, the risk of developing them during the next pregnancy is 37%, and in case of two or more births – more than 70%.

Literature data indicate the teratogenic effects of smoking and alcohol on the pregnant woman as a possible cause of complications during pregnancy and its premature termination [81-83].

Among researchers, the question of the influence of age on the likelihood of TPL remains controversial. According to Yu. P. Vdovichenko, A. V. Tkachenko (2002), TPL are more common (up to 67.3%) at the age of 21-30 years, ie during the heyday of a woman's reproductive function. At the same time, O. V. Salamin (2001) emphasizes that miscarriages and PL are more common in women under 18 and over 35 (50.4%).

It should be noted that there is a category of women in whom, despite all the studies, the cause of preterm termination of pregnancy can not be determined and the frequency of idiopathic PL is from 27.5 to 63.7% [84-86]. In a number of cases it has been stated that empirical drug therapy may be ineffective, while the use of psychocorrection methods gives a positive result [87, 88].

The variety of causes of PL dictates the need to know mechanisms of childbirth, which will individualize therapy for the threat of premature birth and save the lives of women and unborn children. The general level of health decreases, the fertile function of women worsens. Considering polyetiological nature of premature birth, the quality of outpatient and inpatient care of this cohort of women is of great importance. Since causes of abortion occur long before pregnancy, it is obvious that patients with this pathology in anamnesis should be examined and treated before pregnancy or from the moment of registration.

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