

MANAGEMENT TACTICS AND COMPLICATIONS OF PREGNANCY AND CHILDBIRTH IN OVERWEIGHT WOMEN

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Abstract

Obesity is one of the most common metabolic disorders. In recent years, its frequency has been increasing and reaches 20-50% in economically developed countries. In Uzbekistan, obesity and overweight are observed in 25.0-37.0% of the female population. The results of numerous studies in recent years confirm that the process of pregnancy and childbirth in overweight women is significantly complicated. Prevention of perinatal problems (hypertension during pregnancy, macrosomia), as well as complications of childbirth that end surgically.

Keywords: obesity, pregnancy, childbirth

Research materials and methods

1. Lipid metabolism disorders (total cholesterol, TG, HDL cholesterol, LDL cholesterol, VLDL cholesterol).

3. Violation of purine metabolism (uric acid). III. Determination of hormones on the 3-5th day of evaluation of hormonal status: release of free cortisol with total testosterone, SHBG (with the calculation of the index of free androgens), prolactin, LH, FSH, daily urine.

Morph functional methods of ultrasound examination of the liver, adrenal glands, pelvic organs, mammary glands and calypermeter (thickness of subcutaneous fat in the region of the anterior abdominal wall and shoulder triceps muscles).

Results. Pregnancy in obese bears is associated with a number of maternal and perinatal risks. The degree and frequency of these risks increases with the severity

of obesity. Weight loss and reduction of these risks in women in planning a pregnancy of reproductive age are important tasks of internationalists and obstetricians.

Obesity is characterized by an excess of adipose tissue in the body. The body mass index (BMI) directly correlates with the mass of adipose tissue and is currently used to determine obesity, where BMI (excluding pregnancy) is $>30 \text{ kg} / \text{m}^2$ [1]. Adipose tissue is an active endocrine organ. With an excess of adipose tissue, leptin levels rise and adiponectin levels decrease, leading to insulin resistance (IR). Obesity is also often associated with hyperandrogenism. These and various other hormonal changes cause anovulation [2].

Whether obesity itself is a factor that increases the risk of adverse pregnancy consequences or is prone to the development of other pathological conditions that increase this risk is still not entirely clear [3]. Adverse pregnancy outcomes are often associated with impaired carbohydrate metabolism, which occurs in a significant proportion of obese women. At the same time, the likelihood of a complex pregnancy is increasing in obese women with normal glucose tolerance [4].

It is believed that various mechanisms of regulation of metabolic, vascular and anti-inflammatory mechanisms of metabolic substances are used in pathogenesis. This assumption confirms that the occurrence of certain complications increases with progression [1,2,6].

Epigenetic changes in the uterus in response to increased levels of glucose, lipids and proinflammatory cytokines affecting the fetus, temporary or permanent changes in metabolic programming, and this manifests itself as an increased risk of developing various diseases during Life [7].

Prevalence of obesity among women of reproductive age varies widely depending on the criterion used, the year of study, and the characteristics of the population

under study, but there is a clear increase in the proportion of these women in line with the increase in prevalence of obesity in the general population [8]. According to a 2011-2012 NHANES (National Health and nutrition investigation study) study, the proportion of obese people between the ages of 20 and 39 was 31% (BMI ≥ 30 kg / m²); the highest prevalence was among African American women (56.6%) [9]. For comparison: in 1980 (before the regular use of BMI) received the first birth

Effects on fertility. Obesity is often associated with polycystic ovary syndrome (PCOS), characterized by anovulation. In PCOS, IR is one of the main pathogenetic mechanisms. Reactive hyperinsulinemia is thought to disrupt normal folliculogenesis. The recovery of ovulation observed in women with PCOS in the treatment of weight loss and metformin supports this concept [11, 12]. However, even in the absence of PCOS, obese women have fertility problems. Pregnancy time increases in proportion to body weight gain [13].

Negative factors associated with obesity disrupt ovarian function and reduce the quality of oocytes, in addition, it can have a sensitive negative effect on the receptor apparatus of the endometrium. Several observational studies have shown that weight loss leads to beneficial hormonal changes and improved fertility in obese women [14, 15]. These initial results were

The effectiveness of infertility treatment using reproductive-assisted technologies (YBT). For infertility in obese women, there is a higher risk of failure compared to women who have normal body weight during ART treatment. In a number of studies, a decrease in the effectiveness of infertility treatment was associated with a lower number and quality of oocytes obtained, as well as a lower quality of embryos [16, 17]. Other studies have shown that women who are obese with comparable rates of clinical pregnancy and live birth require more gonadotropin doses to stimulate ovulation than women with normal body weight [18, 19].

In a systematic review and meta-analysis of 33 studies, extracorporeal insemination (IVF) / ICSI (from English ICSI - IntraCytoplasmic Sperm Injection, lit. The introduction of sperm into the cytoplasm, sperm from spermatozoa) has its own 48 thousand treatment cycles

According to a systematic review of the results of treatment cycles in women using Donor eggs (YBT), the clinical pregnancy rate in obese recipients was no different from that of women with body weight (RR 0.97.95% CI 0.83-1.16) [21]. This suggests that decreased fertility associated with obesity is (at least in part) associated with decreased oocyte quality.

At the same time, the studies carried out are mostly retrospective, differing in patient selection criteria, and there is no data on important additional factors (e.g. infertility, smoking, subcutaneous fat distribution or joint endocrinopathies) that can negatively affect fertility. ...

Weight loss before conception improves pregnancy outcomes in obese women involved in eco fertility treatment [22, 23].

There are no random tests that assess the effect of weight loss on the loss of early pregnancy, but

Violation of carbohydrate metabolism. Since obesity undoubtedly contributes to an increase in the incidence of Type 2 diabetes mellitus (DM), impaired carbohydrate metabolism often aggravates the condition of pregnancy in obese women [28].

In addition, the results of various studies clearly show the prevalence of gestational diabetes (GDM) in obese women compared to the general population of similar ages (6-12% and 2-4%, respectively) [29]. The frequency of GDM increases by 0.92% for every 1 kg / m² compared to the ideal body weight [1, 30]. Carbohydrate metabolism can return to normal after birth; in obese women, the duration of diabetes mellitus in the postpartum period is observed 2 times more often than in women with normal body weight [30].

Screening for GDM is usually done at 22-24 weeks. pregnancy, however, if there are dangerous factors for diabetics (severe obesity, GDM or having a large weight in history

Gestational hypertension. Maternal weight and BMI are independent risk factors for the development of preeclampsia and gestational hypertension [28, 36-38].

According to a systematic review of 13 cohort studies covering almost 1.4 million women, the risk of preeclampsia has been shown to increase 2 times for every 5-7 kg / m² above the ideal BMI [36]. This trend remained even after women with persistent hypertension and diabetes were excluded from the analysis or adapted to other diseases. Cohort studies have shown a reduced risk of preeclampsia after weight loss [12].

Induction and spontaneous delivery (PR). Obesity increases the risk of spontaneous and medically indicated PR, primarily hypertension, preeclampsia, and impaired carbohydrate metabolism. The pathogenesis of PR should include vascular and anti-inflammatory factors. Systematic review shun

Postponing pregnancy. Recently, more and more information has appeared about obesity and the association for long-term pregnancy [29, 41-43]. In 4 large population cohort studies, it was shown that the risk of long-term pregnancy in obese women increased by 1.2-1.7 times [29, 30, 41, 43]. It is assumed that hormonal disruptions in obesity can slow down the stimulation of Labor.

Congenital fetal anomalies. Maternal obesity leads to a slight increase in the absolute risk of fetal birth defect development, and this risk increases in proportion to the rate of obesity [45-47].

The pathogenesis of these disorders is not entirely clear, but it is hypothesized to be associated with metabolic and hormonal disorders, primarily hyperinsulinemia. A systematic review and meta-analysis of follow-up studies found that obese mothers had an increased risk of developing neural tube defects (RR1. 87,

Conclusion. Obesity of women of reproductive age is associated with a number of general somatic and reproductive problems, which leads to a decrease in fertility. Adipose tissue is the site of peripheral synthesis of many hormones, and is also actively involved in the work of the vascular system and the formation of immunity, therefore, its excess content is accompanied by metabolic, hormonal, vascular and anti-inflammatory diseases.

Compared to women with normal body weight in obese women, the frequency of spontaneous pregnancy and the effectiveness of infertility treatment in various ways (stimulation of ovulation, ART) decreases. Obese women after pregnancy have an increased risk of congenital fetal abnormalities, macrosomy, stillbirth, gestational hypertension, gestational diabetes, premature birth, and a number of other complications. Weight loss has a positive effect on menstrual function, get pregnant.

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