



Prevention and Treatment of Postpartum Hemorrhage

1. Jasur Rizayev Alimjanovich
2. Larisa Rubenovna Agababyan
3. Anvar Ibragimovich Kamalov

Received 27th Apr 2021,
Accepted 09th Jun 2021,
Online 28th Aug 2021

¹ Professor Doctor of Medical Science. Rector of Samarkand State Medical Institute

² PhD Candidate of medical Sciences, Head of the department of obstetrics and gynecology Samarkand State Medical Institute

³ Assistant at the department of obstetrics and gynecology Samarkand State Medical Institute

Abstract: The article discusses many methods for controlling postpartum hemorrhage, determining the most effective methods and indicators for maintaining anemia and organs in the life and health of a woman, preventing postpartum hemorrhage in maternity hospitals, and Recommendations for the implementation of standard treatment protocols and protocols. to transfer patients to a higher-level institution. In addition, simulation training on postpartum haemorrhage will be conducted as part of educational programs for medical staff at all levels of care, the use of standard protocols for the prevention and treatment of postpartum haemorrhage in medical institutions. In all maternity wards, it is recommended to conduct periodic simulation training in the management of PPH as part of training programs designed for all conditions of health care workers.

Keywords: postpartum hemorrhage, uterine anatomy, uterotonic agent, waiting tactics.

Postpartum hemorrhage (PPM) is one of the leading causes of severe illness and chronic disability in postpartum women, as well as a number of other serious conditions that develop as a result of more pronounced blood loss, usually including shock and polyorganism insufficiency. [5]. Although there are no clear clinical or anamnestic risk factors in many women who have developed PPMD, the presence of six or more births in their anamnesis and an overly prolonged uterus increase the risk of postpartum hemorrhage. It is necessary to reconsider the recommendations of the WHO on the emergence of new scientific evidence in the field of prevention and treatment of STIs and adapt them to the conditions of our country.

The use of uterotonics is the main method in the active conduct of the third stage of childbirth. Oxytocin is also a recommended intra-tonic agent for the prevention of CKD during cesarean section.

Postpartum hemorrhage (PSC) is usually defined as the loss of at least 500 ml of blood within 24 hours after delivery, and severe PTSD is defined as the loss of at least 1000 ml of blood during this period. About 2% of women who give birth suffer from STIs: they not only account for almost a quarter of all maternal deaths worldwide, but are the leading cause of maternal mortality in many developed countries. Uterine atony is the most common cause of CKD, but birth injuries (i.e., rupture of the vagina or cervix), uterine rupture, placental abruption, or impaired blood coagulation can also lead to CKD. may come.

PPMD can be complicated by existing anemia in the body, and in such cases, even a small amount of blood loss can lead to undesirable clinical consequences [1-2]. The second half of the twentieth century marked the beginning of a complex of treatments for the third stage of childbirth. This procedure is known as "active delivery in the third stage of childbirth" and consists of the following components: prophylactic use of postpartum uterotonics, early contraction and cutting of the umbilical cord, controlled umbilical cord pulling. Uterine massage is a common component of the active third trimester. In contrast to active exercise, the waiting tactic seeks to wait for signs of placental abruption, either independently or by stimulating the suckers or by placing a weight on the abdomen to allow the satellite to separate. Compared with the waiting tactic, active delivery in the third trimester is characterized by a significant reduction in the incidence of IBD [3]. It is generally assumed that deaths from UHF can be prevented primarily through prevention and treatment. For this reason, prevention and treatment are important steps in improving health care for women who have given birth. To do this, health care providers need to be given access to the necessary medications and trained in how to provide care in the ICU. Institutions need to be provided with evidence-based guidelines to formulate health strategies and improve the outcome of health interventions. The main task of these recommendations is to develop measures that have proven to be effective in reducing ICS. Most TB-related deaths occur within the first 24 hours after birth; many of which can be prevented.

Recommendations for the treatment of CKD. The use of uterotonics (oxytocin as a monotherapy is the tool of choice). PPMK plays an important role in treatment. Uterine massage is recommended to relieve UFO after direct diagnosis; in addition, intensive infusion therapy with isotonic crystalloid solutions is also recommended. The use of tranexamic acid is recommended for refractory atonic bleeding or persistent bleeding due to soft tissue injury of the birth canal. Cylindrical tamponade of the uterus is recommended in the absence of refractory or uterotonics. Bimanual compression of the uterus is recommended as a temporary measure until an external compression of the aorta can be performed. Embolization of the uterine arteries should be considered in cases of persistent bleeding and in the absence of the necessary reserves. If bleeding does not stop with the use of uterotonics and other conservative treatments, surgery should be performed immediately. If the third stage of labor lasts more than 30 minutes, NKT should be used for placental abruption and oxytocin should be administered intravenously or intravenously. If the satellite is not separated and bleeding occurs, the satellite must be separated manually. It is recommended to administer a single dose of prophylactic antibiotics for manual separation of the placenta.

Basic organizational measures.

1. It is recommended that medical institutions have and use standard protocols for the prevention and treatment of STIs.
2. It is recommended that women in medical institutions have access to and use transcripts.
3. During pre-diploma and post-graduate training, it is recommended to conduct simulation trainings on the treatment of STIs as part of educational programs for medical staff.
4. It is recommended to monitor the use of postpartum uterotonics as an indicator of the process in the evaluation of the program for the prevention of STDs.

Uterotonics. The use of third-generation auterotonics for the prevention of STDs is recommended in all births. Oxytocin (10 ME, v / or m / oga) is the recommended uterotonic agent for the prevention of STDs. In the absence of oxytocin, it is recommended that other injectable inerotonics (i.e., ergometrine / methylegometrine or an established combination of oxytocin and ergometrine) or oral misoprostol (600 mcg) be used. In the absence of qualified midwives and oxytocin for the prevention of TB, it is recommended that unqualified health care providers use misoprostol (600 mcg p / o).

The number of materials available for comparison is limited, but it is unlikely that there is a significant difference between the positive effects of oxytocin and ergometrine. In our opinion, great attention should be paid to the prevention of side effects of ergometrine, with similar benefits to the use of oxytocin and ergometrine for the prevention of CKD.

Recommendations for the prevention and treatment of STIs and the organization of medical care for health care systems.

It is recommended that medical institutions use standard protocols for the prevention and treatment of IBD. There should be standard protocols for the transfer of women to higher institutions. It is recommended that all maternity hospitals conduct periodic simulation trainings on the treatment of STIs as part of training programs for medical staff for all states. It is recommended to monitor the use of uterotonics as an indicator of the process in evaluating the program for the prevention of postpartum TB.

The generally accepted and partial assessment of uterine tone remains an important element of urgent care in the postpartum period, especially for the optimization of early diagnosis of CKD. However, the implementation of standard protocols is a complex process that requires international standards to be adapted to local conditions. Some programs are high-tech and computerized, costly, while others are characterized by lower costs and are more likely to be suitable for organizations with limited resources. Improving communication between health care providers, patients, and their families is an important task in training health care providers to provide care in the ICU. It is also important to monitor the prophylactic use of uterotonics. This recommendation is based on the experience of other areas of health care, including pediatrics, in which the health status indicator is based on the proportion of satisfied and dissatisfied patients and is considered effective for general and programmatic purposes. is calculated as the ratio of the number of women who received prophylactically uterotonic agent after childbirth to the total number of women who gave birth.

Evidence-based prevention and treatment of TBS can be successfully accomplished using relatively inexpensive tools. However, before applying the recommendations in this guide, consider the following:

- During the first few hours after the birth of the baby and the placenta, the woman should be under constant medical supervision.
- The use of oxytocin should monitor the continuity of the cold chain (ie, compliance with the requirements for temperature control in the delivery room).
- Neonatal jaundice detection (and treatment if necessary) should also be used in the health care system where late umbilical cord contractions are performed.

The implementation of these recommendations should be monitored at the health system level. Clinical audits can be performed on intermittent time series or audits based on specific principles to obtain important information about the treatments used in the ICU. It is necessary to use certain criteria and indicators that may be related to locally approved target parameters. We strongly recommend the use of full coverage with prophylactic uterotonics as an indicator of the prophylaxis and monitoring process.

Complete coverage with prophylactic uterotonics: The proposed indicator is calculated as the ratio of the number of women receiving prophylactic uterotonics in the third trimester to the total number of women giving birth. This indicator allows you to assess the level of implementation of the main recommendations included in this guide. A more complete assessment of the quality of care associated with the prevention and treatment of TB may require the use of other locally approved specialized indicators (e.g., assessment of the use of certain uterotonics). The WHO is based on concepts such as the audit of possible events and the audit of certain criteria (World Health

Organization. Evaluating the quality of care for severe pregnancy complications: the WHO near-miss approach for maternal health. Geneva: WHO; 2011). has developed a special manual for assessing the quality of medical care in severe complications of rheumatism (including PPMK).Critical guidelines and consequences.

PPMK prevention. Critically significant results;

Decreased maternal mortality;

Decrease in the number of severe CKD cases (blood loss > 1000 ml);

Decreased number of blood transfusions;

Decreased number of admissions to the intensive care unit;

Blood loss ≥ 500 ml;

Sending additional uterotonics;

Moderate blood loss;

Postpartum anemia;

Breastfeeding;

Decreased severity of anemia in newborns;

Any side effects of the mixture;

Any side effects that require treatment;

Nausea, Vomiting, Diarrhea, Headache, Abdominal Pain;

High blood pressure;

Varaja, mother's body temperature $\geq 38^{\circ}\text{C}$;

The mother's body temperature is $\geq 40^{\circ}\text{C}$.

Treatment of PPM.

Critical Important Consequences;

Extra blood loss ≥ 500 ml;

Extra blood loss ≥ 1000 ml;

Hemotransfusion;

Sending additional uterotonics;

Non-invasive interventions;

Surgical interventions (including hysterectomy);

Mother's body temperature $\geq 40^{\circ}\text{C}$;

Complications with treatments;

Infections;

Serious illnesses;

Transfer the mother to another department or medical facility;

Reducing the time between decision making and implementation;

Availability of drugs and therapies.

Significant results: accuracy of blood loss assessment, average blood loss; postpartum anemia; additional non-surgical interventions (eg, external compression of the aorta, bimanual compression of the uterus).

Consequences:

Nausea, vomiting, or fever;

Mother's body temperature $\geq 38^{\circ}\text{C}$;

Delayed breastfeeding;

Hospital bedtime.

Quality of care and postpartum hemorrhage.

The quality of medical care is one of the main conditions for the development of healthcare in our country. At the same time, scientific research in various areas of health care is not given due attention. The state of medical care in the Republic of Uzbekistan, a clear definition of its quality, criteria for its evaluation and ways to improve it are not yet available. Many modern studies have shown that the quality of care provided to a woman is a key factor in determining the outcome of pregnancy and childbirth [1-2]. Therefore, the focus is not on the quality of the doctor, but on the satisfaction of the patient and the medical care provided to him. However, in the course of the study, it became clear that quality management analysis or quality management is more important than quality assessment. It is clear that our perceptions of quality are far behind world standards, and in essence, we are lagging behind in the first stage, and our main efforts are still focused on the assessment, examination and control of medical dampness. Implementation of quality management includes the introduction of modern evidence-based medical technologies, medical standards, clinical guidelines and local clinical protocols, licensing of doctors and accreditation of medical institutions, as well as training and skills of medical staff with continuous monitoring and monitoring of quality of care. should be carried out by way of increase. Only such an approach can reduce the likelihood of errors made by physicians and increase patient satisfaction. Because of this, we believe that postpartum obstetric hemorrhage can be a reliable tool for assessing, monitoring, and managing the quality of care in reducing obstetric care defects. Unfortunately, there are very few studies on the organization of emergency care for pregnant women with obstetric and vasomotor pathology, and in many cases, admission to the hospital independently, rather than on the basis of a doctor's referral, increases the risk of adverse consequences. According to various Russian authors, the main factors reducing the quality of medical care in perinatal centers are insufficient funding (35.5%), low material and technical base (23%), insufficient qualification of doctors. is not (6.6%) [3-4].

The lack of assessment of health care quality management is a sign of a lack of understanding of the role of organization in ensuring the quality of work in maternity hospitals. In the practice of obstetrics in the Republic of Uzbekistan, evidence-based medical information is used, the needs of the patient, as well as the need to take into account the knowledge of the nurse, along with continuous professional development. the number was only 59% and the number of women giving birth was 62.2%. It is well known that patient satisfaction is the leading criterion for emergency care. The vast majority of complaints from patients and their relatives are related to unhealthy behaviors. The cause of the remaining complaints was not related to the activities of the medical staff providing medical care. However, the obstetric hospital's medical commission is not involved in the review of complaints, and its opinion is not taken into account at the level of justification of this or that statement. In assessing the inadequate quality of care in obstetric practice, it was found that more than half of the deficiencies identified in these cases were in most cases primary primary deficiencies; diagnostic defects are slightly superior to treatment defects, which is also often primary, but treatment defects lead to three

times more adverse outcomes [3-4]. The role of perinatal education in the satisfaction of health care in the obstetric system deserves further research and study.

Literature

1. National standards for improving the quality of perinatal care in the health care system of the Republic of Uzbekistan. Tashkent, 2017
2. Collection of clinical protocols on obstetrics. Tashkent, 2019
3. Luzanova I. –Medical legal conflicts as an indicator of the quality of medical services / IM Luzanova // Legal issues in health care - 2012. - № 1. - P. 48-54.
4. Romodanovsky P.O. Study of unfavorable conditions in obstetric-gynecological practice / P.O. Romodanovsky, E. Barinov // Medical Management. - 2012. - No. 6. - S. 44-49.
5. World Health Organization. World Health Organization multicountry survey on maternal and newborn health. Geneva: WHO; 2012
6. World Health Organization. Evaluating the quality of care for severe pregnancy complications: the WHO near-miss approach for maternal health. Geneva: WHO; 2011. Available from: http://whqlibdoc.who.int/publications/2011/9789241502221_eng.pdf

CENTRAL ASIAN
STUDIES