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EPIDEMIOLOGY AND FEATURES OF ESSENTIAL THERAPY HYPERTENSION IN PREGNANT WOMEN

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Abstract

The article analyzes the prevalence of arterial hypertension in pregnant women and complications of antihypertensive therapy based on the materials of the 1st clinic of the SAMMI

In the VIII Work Program of the World Health Organization, hypertensive conditions during pregnancy are called "one of the leading problems of world health" [4]. According to WHO, hypertensive syndrome is the second cause of maternal mortality after embolism. The frequency of hypertensive conditions in pregnant women in various regions of Russia ranges from 7 to 29% [6]. Such ambiguity of the statistical assessment is due to the lack of a complete and exhaustive classification of hypertensive conditions during pregnancy, since there are no uniform criteria and classification signs, there is no single terminological base (for example, to denote the same process in Russia, many European countries use the term gestosis, in the USA and Great Britain – preeclampsia, in Japan – toxemia).

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Keywords: arterial hypertension, antihypertensive therapy, pregnancy, pregnancy complications, prognosis in pregnant women with arterial hypertension.

Introduction

More than 100 classifications of hypertensive conditions during pregnancy have been proposed. In particular, the International Classification of Diseases X revision (ICD X) all pregnancy-related similar manifestations are combined in the II obstetric unit. In Russia, all diseases are encrypted in accordance with this classification, although due to different terminology, encryption is ambiguous. The classification of arterial hypertension (AH) in pregnant women, published by the U.S. Department of Health and Human Services in 1990, is now widely used abroad:

1. Hypertension that is not specific to pregnancy (chronic):

a)Primary (essential hypertension) – hypertension (GB);

b)Secondary (symptomatic) hypertension, including endocrine, renal, cardiovascular, neurogenic.

2. Transient (transient, gestational) hypertension.

3. Pregnancy–specific hypertension:

a) Preeclampsia - eclampsia;

b)Preeclampsia, combined with chronic hypertension that occurred earlier ("imposed" preeclampsia).

The diagnosis of hypertension causes great difficulties, since it is carried out by the method of excluding many diseases accompanied by symptomatic hypertension. During pregnancy, essential hypertension (GB) is considered to be hypertension, which is characterized by a persistent increase in blood pressure to a level exceeding 140/90 mmHg, detected even before pregnancy and detected during the first 20 weeks of gestation and persisting 42 days after delivery [1].

Currently, the problem of treating hypertension in pregnant women is far from being resolved, and onlythe joint efforts of obstetricians, cardiologists and clinical pharmacologists can bring success closer. Over the past more than 30 years, seven international studies have been conducted that compared the management of pregnant women with mild chronic hypertension with the appointment of antihypertensive agents and in the absence of treatment. It was found that treatment of mild hypertension does not reduce the frequency of layered gestosis, premature birth, placental abruption and perinatal mortality, while the absence of adequate hypotensive therapy in women with severe chronic hypertension leads to fetal loss in 50% of cases and significant maternal mortality.

The choice of the drug and the duration of the administration of antihypertensive drugs to pregnant women with chronic hypertension are the subject of discussion. One of the key points of the problem is the probability of deterioration of uteroplacental blood flow under the influence of hypotensive therapy. In addition, in Russia there is no classification of medicines according to the criteria of safety for the fetus. When choosing a drug, doctors are guided by the criteria of the American Classification of Safety of Medicines and Food Products (FDA, 2002) and prefer methyldopa as a drug of the first stage (category B). The basis for this approach is reports on the stability of uteroplacental blood flow in pregnant women receiving methyldopa. In addition, 7.5-year follow-up with a limited number of children did not reveal any delayed adverse developmental effects after their mothers received methyldopa during pregnancy. Other drugs offered for the treatment of hypertension belong to category C or are not recommended in accordance with the instructions of the Pharmaceutical Committee of the Russian Federation, because adequate and strictly controlled studies on them it was not carried out. Nevertheless, the use of calcium antagonists and beta blockers in the treatment of chronic hypertension in pregnant women is allowed, although a number of studies have shown that the patient's health benefits from their therapy are minimal, and the possible risk tothe fetus is quite high.

The Purpose of the Work

To study the prevalence of chronic essential hypertension among pregnant women of the Samarkand district of Samarkand and the actual medical practice of treating this category of patients.

Research Methodology

In accordance with the tasks set, we conducted a retrospective pharmacoepidemiological descriptive study of 541 individual cards of pregnant women taken into account by the women's consultation Samarkand district in the period from January 2018 to January 2020.

Research Results and Their Discussion

For two years, 76 pregnant women with chronic GB were registered by the women's consultation, which amounted to 0.9% of the total. The age of women is from 20 to 37 years, of which every fourth woman was first pregnant (25 %). In 77.5% (59), the diagnosis of first-stage GB was detected or confirmed, in 25.5% (17), second-stage GB was detected with damage to target organs (local or generalized narrowing of the

retinal arteries; left ventricular hypertrophy detected by EchoCG). Verification of the diagnosis was carried out according to the order
of the Ministry of Health of the Uzbekistan "On industry standards for the volume of obstetric and gynecological care" with the mandatory participation of a cardiologist and an endocrinologist. All women included in the study were examined by cardiologists of district polyclinics, 68% were hospitalized once or
repeatedly in cardiological hospitals of the city, 18% of pregnant women were consulted in the regional cardiological dispensary. The criteria for excluding patients from the study were "white coat hypertension" or neurocirculatory dystonia of the hypertensive type, if no daily monitoring of blood pressure, confirming the presence of chronic hypertension.
The cards of pregnant women with chronic kidney disease or endocrinopathy were also excluded from the study.
By the time of registration, all pregnant women, regardless of the period of pregnancy, the stage of the disease and awareness of their disease, received hypotensive therapy sporadically or were not treated at all. When performing a retrospective pharmacoepidemiological study, it was revealed that in 100% of cases, dopegit was prescribed as antihypertensive therapy. When taking methyldopa in therapeutic dosages, 12% had side effects as pronounced sedation and orthostatic hypotension, which served as a reason to reduce the dosage of the drug or its cancellation, followed by the appointment of nifedipine. The appointment of the calcium antagonist verapamil in a small number of pregnant
women were episodic in nature and aimed at leveling the side effect caused by taking the tocolytic ginipral (tachycardia). Analysis of 76 individual charts of pregnant women showed that in all cases, pregnancy outcomes were complicated by gestosis of various degrees of severity.

Conclusion

The conducted study clearly shows that in real clinical practice, 100% of all prescriptions for the treatment of GB in pregnant women are represented by a drug of central action – methyldopa. The use of this drug in chronic hypertension in pregnant women makes it possible to achieve the target blood pressure, but does not affect the frequency of gestosis. To improve the prognosis for the mother and fetus, as well as to reduce the risk of acute vascular catastrophes in women in the future, it is advisable conducting rational pre-gravidar preparation using combinations of antihypertensive drugs and psychopharmacological agents.

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