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MODERN VIEW ON THE RATIONALE FOR WAY TO PREVENT EARLY NEONATAL INFECTION

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For the fetus, the source of infection of any etiology is a pregnant woman in whom the disease can manifest itself with clinical symptoms or be in a latent form. There is a close link between the colonization of the mother's organism and her child. The frequency of infection during vaginal delivery composes 50-60%. [1]

Purpose: the reason for writing this work was the necessity to analyze the causes of early neonatal infection cases in the maternity hospital and substantiate the main ways of preventing it. For this, we carried out a retrospective clinical and statistical analysis of 49 case histories and childbirth histories, newborns histories in the maternity hospital № 3 (Zaporizhzhia), who were diagnosed with intrauterine infection, intrauterine pneumonia within 24-48 hours. These newborns, due to the deterioration of their condition, were transferred by the children's intensive care team to the intensive care unit of the city children's clinical hospital № 5 (Zaporizhzhia), where they were examined and the clinical diagnosis was clarified.

Materials and methods: A bacteriological study was carried out and, then, based on the data received, a statistical analysis of the data was also carried out. According to the results we received, among the dedicated pathological microflora and microbial associations, the first place took *Streptococcus haemolyticus* (*Streptococcus agalactiae*, GBS). Group B streptococci are one of the main causes of morbidity and mortality among newborns, causing pneumonia, sepsis, meningitis, less often-osteomyelitis, septic arthritis. Streptococcal infection is also the etiological factor of postnatal sepsis (30-50% of cases).

By carrying out a retrospective clinical and statistical analysis of 49 case histories and childbirth histories, newborns histories in the maternity hospital № 3 (Zaporizhzhia) the following results were obtained.

Results: According to the data obtained by retrospective analysis of the histories of pregnancy and childbirth of 49 women in the maternity hospital - women aged 18-35-85,7% (42 women) years predominated, women aged 36-40 years- 14,3% (7 women). Extragenital pathology occurred in 65.3% (32 women), the presence of cases of primary pyelonephritis was observed in 20.4% cases (10 women).

The main source of group B streptococcus, which causes infections in newborns, are the mother's genitourinary tract, diseases of the gastrointestinal tract (chronic gastritis, chronic cholecystitis, duodenal ulcer, viral hepatitis A, B, C) noted in 11 cases (22.4%). Gynecological history was burdened in 61.5% (30) cases of medical abortions and miscarriages, among which 38.5% of cases were complicated by the presence of chronic inflammatory diseases of the genitals. In 36.7% (18) cases, pathology of the cervix was noted. The course of this pregnancy was complicated by: in 30.6% (15) cases bacterial vaginosis, 18.4% (9) cases asymptomatic bacteriuria. According to the latest data - diagnosed with asymptomatic bacteriuria, is a symptom of bacterial vaginosis in pregnant women. [3]

The more intense the infection in the mother's vaginal tract, the more often the child is infected, the frequency reaches 50-60%. Polyhydramnios, as an amnion infection, was observed in 14.3% (11) cases in the 3rd trimester of pregnancy (after 32 weeks). Dehydration was noted in 8.2% (4) cases, accompanied by placental dysfunction in combination with dysfunction of uteroplacental circulation in 12.2% (6) cases. Intrauterine fetal growth retardation was noted in 6.1% (3 cases). Grade 1 anemia was noted in 10.2% (5) cases. Premature rupture of membranes occurred in 14.3% (7) (max. 118 hours at 28 weeks, 30 hours 25 minutes at 38-39 weeks). Ultrasound described US-markers of the infectious process in the form of: 16.3% (8) cases recorded low placentation (in the history of these women 2 abortions or more). The high 63.2% (31) percentage of placental calcifications is noteworthy. Births in term predominated in 75.5% (37) cases, whereas in 24.5% (12) cases occurred preterm births. In 3 cases (6.1%) was dichorionic diamniotic pregnancy (2-term pregnancy, 1-35 weeks premature birth). Early discharge of amniotic fluid was observed in 37.4% of cases of childbirth. Meconium, odorless amniotic fluid is described in 4 cases (8.2%), in 2 (4.1%) - meconium, with odor. It is noteworthy that in 87.8% of births amniotic fluid was light. In a study of premature rupture of amniotic membranes, scientists found that for GBS-infected women, induction of labor reduces the risk of neonatal infection.[2] Childbirth by cesarean section 44.9% (22 women): routinely - 11 (3 - twins with pelvic presentation of 1 fetus, scar on the uterus - 6, scar on the uterus in combination with pelvic presentation of the fetus - 1, incapable scar on uterus 1); urgently: for acute fetal distress in 1 period of childbirth - 8 (16.3%), clinically narrow pelvis - 1 (2%), premature detachment of the normally located placenta 1 (2%), weakness of labor - 1 (2) %). Delivery through the natural birth canal occurred in 27 women (55.1%). In 5 (10.2%) cases of these 27 the second period of childbirth was accompanied by acute fetal distress, so, that's why the vacuum extraction of the fetus was used. The weight of newborns was 2530.0 - 3900.0 in 33 (65%) cases; up to 2500.0 - in 14 (28.6%) cases; 4000.0 and more - 4.1% (2) cases. Without asphyxia, according to the generally accepted Apgar score, 42 infants were born (85.7%) in a good condition, in moderate asphyxia 3 (6.1%), severe - 4 (8.2%).

Conclusion: It is important to note the fact that in the vast majority of cases, the carriage of the pathogen is asymptomatic. At the same time, pregnant women identified as carriers of GBS have a 25-fold higher risk of having a baby with early onset of neonatal sepsis. Every second child born by vaginal delivery to a mother who is a carrier of GBS is also contaminated. Sepsis caused by GBS is the leading cause of the

neonatal death in developed countries (mortality consists 60%). Therefore, in 2002, the expediency of antenatal screening (in order to identify carriers of GBS) and intrapartum antibiotic prophylaxis (when referring these patients to the risk group) was justified .[1,3]

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