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TREATMENT AND PROPHYLAXIS IN PREGNANT WOMEN WITH CHRONIC ARTERIAL HYPERTENSION

Siusiuka V.G.

Doctor of Medical Sciences, Professor, Head of the Department of Obstetrics and Gynecology, Zaporizhzhia State Medical and Pharmaceutical University

Onopchenko S.P.

Candidate of Medical Sciences, Assistant of the Department of Obstetrics and Gynecology, Zaporizhzhia State Medical and Pharmaceutical University

Kyryliuk O.D.

Candidate of Medical Sciences, Associate Professor at the Department of Obstetrics and Gynecology, Zaporizhzhia State Medical and Pharmaceutical University

Shevchenko A. O.

Candidate of Medical Sciences, Assistant of the Department of Obstetrics and Gynecology, Zaporizhzhia State Medical and Pharmaceutical University

Chronic arterial hypertension (CHAH) occurs before pregnancy or in the first 20 weeks of pregnancy, or if a woman is already taking antihypertensive drugs. Usually, it persists for more than 42 days after delivery and may be associated with proteinuria. Therapeutic and preventive measures in pregnant women with CHAH are determined by the characteristics of the pathogenesis of the disease during pregnancy and differ from those recommended in the general population of patients with AH. The goal of treatment for patients is to prevent complications of pregnancy, especially combined preeclampsia (PE), particularly its early and severe forms, as well as to protect the baby before birth. Timely prescription of adequate drug therapy in patients with CHAH leads to a slowdown in the progression of the disease, a decrease in the frequency of severe PE, perinatal and neonatal complications, as well as a reduction in maternal mortality. For initial treatment of CHAH, first-line antihypertensive drugs with proven efficacy in reducing the risk of complications are used. These drugs include methyldopa (Dopegit) (250-750 mg), dihydropyridine calcium channel antagonists (Nifedipine),

beta-blockers (Bisoprolol), and their combinations. If it is not possible to normalize blood pressure with first-line drugs or in the event of a hypertensive crisis, second-line drugs are additionally prescribed (Urapidil – 10-50 mg slowly under blood pressure control). Clonidine (75-300 mg) or glycerol trinitrate (Nitroglycerin – 0.5 mg sublingually or 2 ml IV) may be used for resistant hypertension. When conducting antihypertensive therapy, excessive reduction of blood pressure (no more than 25% of maximum blood pressure) should be avoided. In pregnant women with hypertension, it is contraindicated to use: ACE inhibitors, ARBs, direct renin blockers, diuretics, and Reserpine. The target BP should be 130-150/80-100 mmHg in pregnant women with uncomplicated CHAH. Women with target organ damage should be offered treatment that will keep BP below 140/90 mmHg. Subsequently, it is necessary to ensure that the patient complies with the recommendations for taking medications, monitor blood pressure, and adjust therapy.

Pregnant women with CHAH at 28, 32, and 36 weeks undergo ultrasound fetometry, amniotic index determination, and Doppler ultrasound of the umbilical arteries. The optimal term for delivery in women with uncomplicated CHAH is 38+0 to 39+6 weeks of pregnancy. Women with CHAH who have blood pressure below 160/110 mmHg, with or without antihypertensive treatment, are not recommended to deliver before 37 weeks of pregnancy. If early delivery (before 34 weeks) is necessary, a course of glucocorticoids is recommended to prevent fetal respiratory distress syndrome. In pregnant women up to 32 weeks of gestation with a high probability of preterm delivery (within the next 24 hours), magnesium sulfate administration is indicated for fetal neuroprotection.

During labor, blood pressure should be monitored hourly in cases of moderate hypertension and continuously in cases of severe hypertension, with a target range of 140-159/90-109 mmHg. If blood pressure remains stable, the duration of the second stage of labor is not usually limited. Pain relief (epidural analgesia) is advisable. If blood pressure cannot be corrected with antihypertensive therapy, the question of

operative delivery should be considered. In the postpartum period, treatment with antihypertensive drugs prescribed before delivery should be continued, except for Methyldopa. The use of this drug is discontinued within 2 days after delivery, and Captopril or Enalapril is prescribed until the end of breastfeeding.

Recommendations are provided after the patient is discharged from the hospital. Further blood pressure checks are not necessary if the blood pressure is 140/90 mmHg or lower and the woman feels well. The patient should visit her family doctor two weeks after giving birth. If blood pressure is 141-150/91-100 mmHg, it should be measured every 2 days. If blood pressure is above 150/100 mmHg, the patient should consult an obstetrician-gynecologist to determine further management. It should be noted that this group of women has an increased risk of CVD in the long term and a higher prevalence of hypertensive disorders in subsequent pregnancies compared to women without such disorders. Therefore, women should be advised about future risks and provided with appropriate recommendations for care and lifestyle modification.