Liver Diseases in Pregnant Women, Principles of Treatment

Author	Affiliation
Munira Khusainova Alisherovna	Samarkand State Medical Institute, Samarkand, Uzbekistan
Zarrina Khaydarova Erkinovna	Samarkand State Medical Institute, Samarkand, Uzbekistan
Suvon Yarmatov Tatlibayevich	Samarkand State Medical Institute, Samarkand, Uzbekistan

ABSTRACT

This article is devoted to the problem of liver pathology in pregnant women. In the period from 2017-2021, 168 pregnant women with liver pathology were treated at the clinic. The pathological condition of the liver in pregnant women is characterized by a variety of etiological forms, variants of the course and prognosis. The article highlights cholestatic jaundice, acute fatty hepatosis of pregnant women, chronic hepatitis, cirrhosis of the liver. The results of treatment in pregnant women with liver pathology depend on the timing of admission of patients, the presence of complications, concomitant pathology, timely diagnosis and adequate surgical intervention, prolonged hepatotropic therapy.

Keywords: Cholestasis, Hepatitis, Cirrhosis Of The Liver In Pregnant Women, HELLP Syndrome

Relevance of the topic:

Liver pathology occurs in 3-5% of pregnant women and is one of the most common and prognostically significant forms of gestational pathology. With these diseases, the frequency of preeclampsia and eclampsia, the threat of termination of pregnancy, spontaneous abortions and premature birth, labor anomalies, bleeding in the postpartum period increases markedly, which is one of the important causes of perinatal mortality.

The purpose of the work.

Improving the results of treatment of liver diseases in pregnant women. During pregnancy, the red function of organs, including the liver, changes. In healthy women, changes in liver activity are associated with the adaptation of pregnancy and does not negatively affect their well-being. Their blood tests reveal a change in liver function: the activity of acetylcholinesterase, lipase decreases, the activity of alkaline aminotransferase, phosphatase increases, the content of cholesterol and fibrinogen increases. With late toxicosis of pregnant women, significant liver disorders are observed: disorder of detoxification, protein-forming function. One of the leading clinical symptoms of liver disease is jaundice. The genesis of jaundice is very important. According to the classification of A.F. Bluger, E.Z.Krupnikova (1967), there are 3 types of jaundice: suprahepatic, hepatic and subhepatic. During pregnancy, childbirth and the postpartum period, one of these types of jaundice occurs. Of the women who have a manifestation of jaundice, jaundice is directly related to pregnancy they are detected in 35%, and

jaundice developing independently of pregnancy - in 60%.
Jaundice caused by the actual pathology of pregnancy includes cholestatic hepatosis of pregnant women (CGB) and acute fatty hepatosis of pregnant women.

Cholestatic jaundice in most cases is detected in the 3rd trimester of pregnancy and usually passes after childbirth. The general condition of the pregnant woman does not suffer significantly. Rarely, patients complain of loss of appetite, nausea, vomiting, diarrhea and abdominal pain. The liver is not enlarged, the leading symptom is a widespread itching of the skin throughout the body, which always appears before jaundice. Jaundice is weakly expressed. The tests reveal moderate leukocytosis, an increase in ESR, an increase in alkaline phosphatase, moderate hyperbilirubinemia. HCG does not have a markedly negative effect on the condition of the mother and fetus. Clinical and laboratory manifestations are quickly eliminated after childbirth. It is relatively rare that there is a need for termination of pregnancy.

Acute fatty hepatosis of pregnant women (AFHPW) is one of the most severe forms of hepatic pathology. It is rare in 1.9%. Clinically characterized by acute onset and rapid progression of the disease, progressive development of jaundice, development of hepatic-renal insufficiency, DIC of blood complicated by bleeding from the uterus, other organs and tissues, the development of hepatic coma. At any stage AFHPW shows immediate termination of pregnancy against the background of complex therapy. Maternal mortality in this pathology reaches 80-90%.
Chronic hepatitis (ChH) is a polyetiological diffuse inflammatory liver lesion lasting more than 6 months with a progressive course and development of fibrosis up to cirrhosis. anamnesis of previously transmitted viral hepatitis B, C or D,occupational, chemical harmful factors, drug intoxication, alcohol abuse, subhepatic cholestasis, etc. is important for diagnosis. Clinically manifested by hepatolienal, dyspeptic, asthenovegetative, cholestatic syndrome, itching, acholic feces, dark brown urine staining, jaundice - a frequent but optional syndrome; hemorrhagic syndrome – hemorrhages and bruises on the skin, bleeding gums, nosebleeds, hematuria, spotting from the vagina; portal hypertension syndrome: persistent dyspepsia, flatulence, periodic diarrhea, weight loss, varicose veins of the cardia, with bleeding, splenomegaly.

From laboratory indicators - detection of markers of viral hepatitis B, C, bilirubinemia, moderate leukocytosis, increased ALT, AST, alkaline phosphatase, decreased prothrombin. Ultrasound data have a certain diagnostic value: signs of chronic hepatitis.

Tactics of pregnancy management: establishing a diagnosis jointly by a therapist with a gynecologist, resolving the issue of the possibility of pregnancy. Contraindications are: pronounced activity of the inflammatory-necrotic process, pronounced fibrosis of the liver parenchyma, portal hypertension, cholestasis syndrome, cytolytic syndrome.

In the treatment of HCG, hepatotropic, detoxification therapy, and disaggregants are used. Essentiale is prescribed 2 capsules 3 times a day, aevit 2 capsules 2-3 times a day, ascorbic acid, glutamic acid, vitamins B1, B6. Diet No. 5, nutrition should be balanced, complete, animal fats are excluded. For anemia, toxicosis, the purpose of infusion therapy: essentiale 5-10 ml intravenously, vitamin E 100-300 mg, vitamin C intravenously 1000-1500 mg, glutamic acid 1% 200-400 ml intravenously, riboxin 10ml intravenously, cocarboxylase 100mg intravenously, intravenously reopoliglyukin, trental, glucose-potassium-insulin mixture 200-400 ml, with hypoalbuminemia albumin 10% 200.0 intravenously, plasma, enterosorption.
Cirrhosis of the liver: the most severe pathology of the liver in pregnant women, the examination should be carried out by hepatologists in a specialized hospital. Pregnancy can trigger the development of acute liver failure, ascites, bleeding from varicose veins of the esophagus. The presence of portal hypertension in patients with cirrhosis of the liver creates an increased risk of bleeding from Varicose veins, which reaches 18-32%. Therefore, pregnancy with cirrhosis of the liver must be interrupted in the early

stages, the terms are agreed by the obstetrician with the hepatologist.

Materials and methods of research

In 2017-2021, 168 women with surgical diseases in combination with pregnancy were observed in the clinic, of which 6 patients with acute cholecystitis, 4 with acute biliary pancreatitis, 1 with echinococcosis of the liver, 3 with chronic hepatitis had liver pathology.

6 pregnant women with a period of 16-24 weeks were observed with acute cholecystitis. Clinically, they had moderate leukocytosis, bilirubinemia - 25-65 mmol/l, an increase in ALT, AST to 100-150 IU / l, calculous cholecystitis on ultrasound. They were conducted mostly conservatively with the supervision of a surgeon and gynecologist. 1 patient was operated on for acute calculous phlegmonous cholecystitis, choledocholithiasis: cholecystectomy, choledocholitotomy, CDA, drainage of the choledochus according to Pikovsky, drainage of the abdominal cavity. Discharged with recovery for 15day.

Four pregnant women with acute biliary pancreatitis pregnant women with 7-24 weeks' gestation, managed were treated conservatively. Clinically there was a moderate Leukocytosis, elevated amylase up to 50-115 units, ALT and AST increased moderately. Diffuse changes on ultrasound investigation Diffuse changes in parenchyma of pancreas and liver, signs of Cholecystitis.

One patient was diagnosed with echinococcosis of the right lobe of the liver with perforation, widespread Peritonitis, 5-6 weeks pregnant. Echinococectomy was performed, sanation, drainage She was discharged on the 14th day of treatment day.

In 3 patients with acute appendicitis, clinical mild gastric hemorrhage with a diagnosis of Erosive gastritis, chronic hepatitis in combined with a 16-32 week pregnancy. The treatment of the main pathology was combined with the treatment of liver. Premature delivery and mortality was avoided in all our patients.

Conclusions:

1. A differentiated approach in determining indications for surgical intervention, the use of non-invasive diagnostic studies, the decision of the tactics of management of pregnant women with liver pathology together with gynecologists allowed to avoid premature delivery.
2. The results of treatment in pregnant women with liver pathology depend on the timing of admission of patients, the presence of complications, concomitant pathology, timely diagnosis and adequate surgical intervention.
3. To prevent the development of liver failure in pregnant women with liver diseases, preventive administration of hepatotropic drugs and disaggregants under clinical and laboratory control is necessary.

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