FEATURES OF PROVIDING HIGHLY SPECIALIZED MEDICAL CARE TO PREGNANT WOMEN WITH COVID-19 IN OBSTETRIC PRACTICE

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Abstract: *In pregnant women with COVID-19 a sudden development of a critical condition is possible against the background of a stable course of the disease.*

Keywords: *intranatal amniocentesis preeclampsia detoxification distress premorbid lactation.*

Obstetric tactics is determined by several aspects: the severity of the patient's condition the condition of the fetus gestational age. With a moderate and severe course of the disease before the 12th week of gestation due to the high risk of perinatal complications associated with both the effects of a viral infection and the embryotoxic effect of drugs it is possible to terminate the pregnancy after the infection has been cured. If the patient refuses to terminate the pregnancy a biopsy of the chorionic villi or placenta up to 12-14 weeks or amniocentesis from 16 weeks of gestation is necessary to detect fetal chromosomal abnormalities which are performed at the request of the woman. Termination of pregnancy and delivery at the height of the disease is associated with an increase in maternal mortality and a large number of complications: worsening of the underlying disease and its complications development and progression of respiratory failure occurrence of obstetric bleeding intrapartum fetal death postpartum purulent-septic complications. However if it is impossible to eliminate hypoxia against the background of artificial ventilation of the lungs or with the progression of respiratory failure the development of alveolar pulmonary edema as well as with refractory septic shock for health reasons in the interests of the mother and fetus emergency abdominal delivery (caesarean section) is indicated with all necessary measures to prevent coagulopathy. and hypotonic obstetric bleeding. In pregnancy up to 20 weeks an emergency caesarean section can be omitted since the pregnant uterus does not affect cardiac output at this time. At 20-23 weeks of gestation an emergency caesarean section is performed to save the life of the mother but not the fetus and after 24 weeks to save the life of the mother and fetus. In the case of the development of spontaneous labor activity at the height of the disease (pneumonia) it is preferable to give birth through the natural birth canal under the monitoring control of the state of the mother and fetus. The preferred method of pain relief is regional analgesia in the absence of contraindications. Antiviral antibacterial detoxification therapy respiratory support are carried out according to indications. In the second period to prevent the development of respiratory and

cardiovascular insufficiency efforts should be weakened. In order to speed up the process of delivery in case of fetal distress weakness of labor and or deterioration of the woman's condition it is possible to use vacuum extraction or obstetric forceps. Caesarean section is performed according to standard obstetric indications. However if it is impossible to eliminate hypoxia against the background of artificial ventilation of the lungs or with the progression of respiratory failure the development of alveolar pulmonary edema as well as with refractory septic shock for health reasons in the interests of the mother and fetus emergency abdominal delivery (caesarean section) is indicated with all necessary measures to prevent coagulopathy and hypotonic obstetric bleeding. In severe cases of COVID-19 the preferred approach is the lower midline laparotomy. Anesthesiological provision of caesarean section in severe disease: in the absence of signs of severe multiple organ failure (up to 2 points on the SOFA scale) it is possible to use regional methods of anesthesia against the background of respiratory support with severe multiple organ failure - total intravenous anesthesia with artificial ventilation of the lungs. All patients regardless of the gestational age are shown to prevent bleeding. In all cases the question of the time and method of delivery is decided individually. Clinical discharge criteria for pregnant women and puerperas are: Normal body temperature for 3 days; Absence of symptoms of damage to the respiratory tract; Restoration of disturbed laboratory parameters; Absence of obstetric complications (pregnancy postpartum period). The prognosis for the mother and fetus depends on the trimester of gestation in which the disease occurred the presence of a premorbid background (smoking obesity background diseases of the respiratory system and diabetes mellitus HIV infection) the severity of the infectious process the presence of complications and the timeliness of starting antiviral therapy. Management tactics for newborns in the context of the COVID-19 pandemic The routing of newborns at high risk for developing COVID-19 is based on the identification of risk groups depending on the infection of the mother. A baby is considered potentially infected with SARS-CoV-2 Born to a mother who has a confirmed case of COVID-19 within 14 days before birth; Born to a mother with suspected SARS-CoV-2 infection including those who were in self-isolation (from the group subject to quarantine after contact with infected SARS-CoV-2) Newborn up to 28 days of the postnatal period in cases of contact with infected potentially infected with SARS-CoV-2 (including family members caregivers medical personnel and visitors). A newborn is considered infected if the biomaterial is positive for SARS-CoV-2 RNA RNA regardless of the presence or absence of a clinical picture. To be present at the birth and move the child there must be a pre-allocated medical and nursing team for the newborn which is invited to the delivery room not earlier than the beginning of the straining period or the beginning of anesthesia for caesarean section expects the birth of the child at a distance of at least 2 meters from the woman in labor. The use of personal protective equipment is mandatory. The number of people providing care in the room should be kept to a minimum to reduce patient contact. Delayed cord clamping is not recommended mother-child contact is not recommended;

the child is not applied to the breast to prevent postnatal infection it is taken out of the delivery room as quickly as possible. Depending on the clinical condition of the woman it is possible to maintain lactation for subsequent breastfeeding of the child after the mother has recovered. Primary and resuscitation care for a newborn is provided in a free delivery room or in a specially designated room taking into account the minimization of the use of technologies that contribute to the formation of an external infected aerosol (tracheal sanitation ventilation with an Ambu bag non-invasive administration of a surfactant and others). Diagnostic and treatment items (stethoscope thermometer etc.) and care products must be used individually for each child after his transfer must be processed in accordance with the rules. Doctors nurses and other personnel in contact with the child must wear personal protective equipment. After birth the baby must be removed from the premises intended for pregnant women women in labor and postpartum with COVID-19 and isolated in a dedicated unit (usually a department of a children's hospital). Transportation is carried out in a transport couveuse the personnel uses personal protective equipment. Specially allocated medical vehicles are subject to disinfection in accordance with the rules for working with especially dangerous infections. A newborn baby is swabbed from the nose and oropharynx for COVID-19 immediately after moving from the delivery room or immediately after establishing postnatal contact with COVID-19 positive people from his environment. Further the study for SARS-CoV-2 RNA is repeated after 2-3 days. If both test results are negative then the child is considered not infected with SARS-CoV-2. If a child according to epidemiological indications must be quarantined then control studies of biological material from the nose oropharynx and stool are carried out on the 10-12th day of quarantine in order to decide on the possibility of its termination by 14 days. If one of the results of the SARS-CoV-2 RNA test is positive then the child is considered infected with this virus and further control tests are carried out in accordance with the recommendations for the management of patients with COVID-19. If necessary medical care for the newborn is provided in accordance with clinical recommendations.

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