

Scientific and international conference on medical education, health science and patient care <https://doi.org/10.5281/zenodo.6388225> New Delhi, India 2022 ISBN 987-93-86954-56-5 29 New Delhi, India 2022 ISBN 987-93-86954-56-5 ORCID 0000-0001-6156-3630 OPEN ACCESS

### **Pregnancy in patients with chronic kidney disease**

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#### Annotation

The article is characterized by the prevalence of chronic kidney disease among women of reproductive age.

The features of preconception preparation, pregnancy management, tactics of delivery and postpartum follow-up of patients with chronic kidney disease are considered. Keywords: pregnancy, chronic kidney disease, chronic renal failure, obstetric and perinatal complications. The prevalence of CKD in the general population is high, while signs of kidney damage are often detected in women in the reproductive period. According to foreign authors, the prevalence of CKD of the first - second stage in women of childbearing age (20-39 years) is at least 3%, and CKD of the third - fifth stage is approximately 0.6-0.7% [1,2]. In this regard, an urgent question arises: how does CKD affect the course and outcomes of pregnancy, and pregnancy itself - on the prognosis of kidney disease? It is known that pregnancy in women with kidney disease, even with intact renal function (CKD of the first stage), is accompanied by serious problems: an increased frequency of obstetric and perinatal complications and preterm birth compared to the general population, the need for abdominal delivery, the need for newborns to intensive care. It should be noted that the real frequency of pregnancy complications in patients with CKD can be significantly underestimated. As kidney function deteriorates, the frequency of these complications increases, that is, the stage of CKD, along with arterial hypertension and proteinuria more than 1 g / day, increases the risk of an adverse outcome for both the mother and the child. These factors, to a greater extent than the nosological diagnosis, affect the prognosis of pregnancy, of course, with some exceptions [3,4]. For example, pregnancy should definitely be avoided in case of nodular periarteritis, kidney damage as part of systemic sclerosis, and renal amyloidosis [5]. For other diseases, specific risks and features of the course of pregnancy are determined. Establishing a diagnosis of CRF during pregnancy can be difficult and requires doctors to have certain experience and knowledge about the features of functional changes in renal blood flow and renal function during gestation. The norms of some laboratory parameters during pregnancy change, which complicates the differential diagnosis of the norm and pathology. Thus, due to the specifics of hemodynamic changes during pregnancy and an increase in GFR, normal GFR values in the earliest stages of gestation increase, averaging 120–150 ml/min/1.73 m<sup>2</sup>, so the normal serum creatinine level is lower

than before pregnancy. Therefore, indicators that are considered the upper limit of the norm of creatinine (80-96  $\mu\text{mol} / \text{l}$ ) and the lower limit of normal GFR values (80-90  $\text{ml} / \text{min} / 1.73 \text{ m}^2$ ) for non-pregnant women during pregnancy may indicate a violation kidney function. To accurately determine the stage of CKD, it is necessary, of course, to have data on the level of creatinine and GFR before pregnancy, which in practice is not always possible. It should be remembered: known formulas for calculating GFR are not intended for use in pregnant women. That is why the assessment of renal function in pregnant women is based on the study of serum creatinine in dynamics and GFR by endogenous creatinine clearance (Rehberg's test with the collection of daily urine). Pregnancy can be planned in the absence of an exacerbation of the underlying disease and arterial hypertension (or with adequate control of blood pressure with drugs allowed during pregnancy), stable renal function (without its rapid decrease), CKD of the first and second stages. At the third stage of CKD, pregnancy is possible, but the decision is made by a consultation of specialists individually in each case. Certainly, stage 3a (GFR 45– 59  $\text{ml}/\text{min}/1.73 \text{ m}^2$ ) is more favorable in terms of pregnancy outcome than stage Scientific and international conference on medical education, health science and patient care <https://doi.org/10.5281/zenodo.6388225> New Delhi, India 2022 ISBN 987-93-86954-56-5 31 New Delhi, India 2022 ISBN 987-93-86954-56-5 ORCID 0000-0001-6156-3630 OPEN ACCESS 3b (GFR 30–44  $\text{ml}/\text{min}/1.73 \text{ m}^2$ ). In stage 4 and 5 CKD, the risks are very high and it is best to advise the woman not to become pregnant. If the pregnancy in such patients is prolonged, then, as a rule, a further decrease in GFR in time with gestational gestation necessitates urgent renal replacement therapy (dialysis treatment). In some cases, a woman should be persuaded to postpone pregnancy for some time until a stable remission of the disease is obtained with a possible improvement in renal function, for example, if pathogenetic therapy is carried out and the deterioration in kidney function is at least partially reversible. Women with stage 5 CKD treated with dialysis (programmed or perineal) typically experience anovulatory cycles and infertility. Nevertheless, the pregnancy rate in women of childbearing age who are on dialysis treatment is about 0.5% per year, and not all pregnancies end successfully. LITERATURE 1. Mukhin N.A., Tareeva I.E., Shilov E.M. etc. Diagnosis and treatment of kidney diseases. Guide for doctors. M.: GEOTAR-Media, 2008. 2. Guide to nephrology / ed. R.V. Schreyer, trans. from English. ed. ON THE. Mukhin. M.: GEOTAR-Media, 2009. 3. Shilov E.M., Kozlovskaya N.L., Bobkova M.Yu. et al. Chronic kidney disease and the program of saving the people of the Russian Federation // Clinical Nephrology. 2010. No. 3. S. 29-38. 4. Bakker R., Steegers E.A., Hofman A. et al. Blood pressure in different gestational trimesters, fetal growth, and the risk of adverse birth outcomes: the generation R study // Am. J. epidemiol. 2011 Vol. 174. No. 7. P. 797-806. 5. Davison J.M., Lindheimer M.D. Chronic renal disease // Clin. obstet. Gynecol. 1984 Vol. 27. No. 4. P. 891-901. Scientific and international conference on medical education, health science and patient care <https://doi.org/10.5281/zenodo.6388225> New Delhi, India 2022 ISBN 987-93-86954-56-5 32 New Delhi, India 2022 ISBN 987-93-86954-56-5 ORCID 0000-0001-6156-3630 OPEN ACCESS 6. Leshchinskii L.A., Gaisin I.R., Maksimov N.I... Basic and metabolic therapy of hypertensive disease in pregnant women // Klin. Med. (Mosk.). 2008 Vol. 86. No. 9. P. 25-28

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