

**CLASSIFICATION AND DIAGNOSIS OF HYPERTENSIVE CONDITIONS
DURING PREGNANCY**

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Abstract: Hypertensive disorders of pregnant women remain one of the current problems in obstetrics practice with surgical procedures and indications. Hypertensive disorders are the 2nd-3rd cause of maternal death, complicating the course of pregnancy and childbirth. Affecting the development of the fetus in the mother's womb, it leads to an increase in the percentage of perinatal diseases and death.

Key words: hypertensive conditions, disorders, pregnant women, death, problems.

According to the World Health Organization, pregnancy the occurrence of hypertensive conditions during the period varies from 7% to 16% and it is especially common in developing countries. Mothers cases of hypertension during pregnancy as a cause of death Independent In the Commonwealth of States, it exports 24%, for example, in Russia - 26.3%, In Uzbekistan, it has reached 15.4% and occupies the third place. It is known that it is long Obstetric hemorrhages are among the causes of maternal death and externalized 12.5-18.2%, but bleeding is the cause of maternal death half of the total number of women who died during the analysis (46.7%) were pregnant. It was found that it was related to the state of hypertension during the period. Uzbekistan maternal death in hypertensive cases during pregnancy is the first among birth mothers — 27.5%, in the Russian Federation - 54.8%; again among pregnant women, this indicator exceeded 17.1% and 38.7%, frequent and 33.2% among those with multiple births.

Perinatal death during pregnancy 5.3% (18-30%) in cases of hypertension, and morbidity is 30% (640-780%), retardation of fetal development - 40%. In recent years cases of hypertension during pregnancy are increasing in the world, acceleration of the process and rapid development of complications are noted is being done. Nowadays, the quality of disease diagnosis has improved together with an increase in the risk group of hypertensive conditions during pregnancy caused¹

Chronic hypertension is high blood pressure that either precedes pregnancy, is diagnosed within the first 20 weeks of pregnancy, or does not resolve by the 12-week postpartum checkup. Two categories of severity are recognized: mild (up to 179 mm Hg systolic and 109 mm Hg) and severe (≥ 180 systolic or 110 diastolic). Chronic hypertension complicates about 5% of all pregnancies, and prevalence rates are increasing due to delayed childbearing. Medications should be reviewed when pregnancy is first diagnosed. We cannot recommend

¹ Axmedova R. Obstetrics and in genealogy nursing work. from science a set of teaching materials. Sh- 2021, p-175-176

with certainty to either stop, start, or continue antihypertensive medications: evidence is mixed whether such actions improve outcome. Methyldopa is the most studied of all antihypertensive medications and is generally the first choice in pregnancy because it has a limited effect on uteroplacental blood flow. Sometimes an alternative must be found because of elevated liver enzymes or complaints of headache. Labetalol, a combined alphablocker and beta-blocker, is the first alternative to methyldopa and is becoming a first-line choice as experience with the drug during pregnancy increases. It is generally well tolerated and has an easier (twice-a-day) dosing schedule than methyldopa. Calcium channel blockers, particularly nifedipine, are being used more frequently, probably because doctors have become familiar with their use to stop premature labor. They seem to be safe and effective, but evidence is sparse. Diuretics have been used in pregnancy despite the theoretical risk of preventing normal blood volume expansion.

Most studies have not found adverse pregnancy outcomes. Nonetheless, caution should be used in cases of impaired uteroplacental perfusion, such as preeclampsia or intrauterine growth restriction. Atenolol and other pure beta-blockers should be avoided: they have been associated with babies born small for their gestational age. Angiotensin-converting enzyme (ACE) inhibitors are contraindicated in the second and third trimester because they are associated with a myriad of congenital anomalies, including renal failure, oligohydramnios, renal dysgenesis, reduced ossification, pulmonary hypoplasia, and fetal and neonatal death. Patients presenting in the first trimester on an ACE inhibitor should either be taken off antihypertensive medications or switched to another agent. Exposure during this time is not an indication for pregnancy termination, however. Angiotensin II receptor antagonists are considered guilty by association because of their similarity to ACE inhibitors, but there are no data to confirm this. Chronic hypertension accounts for a disproportionate amount of maternal and perinatal morbidity and mortality, mostly because of an increased risk of superimposed preeclampsia. There is an increased risk of prematurity, birth of infants who are small for their gestational age, intrauterine death, placental abruption, and cesarean delivery.

Complication rates are directly related to the severity and duration of elevated blood pressures. For instance, patients with severe hypertension in the first trimester have a greater than 50% risk of developing superimposed preeclampsia. All hypertensive patients should undergo increased surveillance, serial laboratory tests throughout pregnancy, serial ultrasound scans to follow growth, and antenatal testing. The baby should be delivered vaginally if possible.

Gestational hypertension, formerly known as pregnancy-induced hypertension or PIH, is the new onset of hypertension after 20 weeks of gestation. The diagnosis requires that the patient have:

- Elevated blood pressure (systolic ≥ 140 or diastolic ≥ 90 mm Hg, the latter measured using the fifth Korotkoff sound)
- Previously normal blood pressures
- No protein in the urine
- No manifestations of preeclampsia/eclampsia.

Also known as transient hypertension, gestational hypertension is actually diagnosed retrospectively when the patient does not develop preeclampsia and if blood pressure returns to normal by the 12-week postpartum visit. Fifty percent of women diagnosed with gestational hypertension between 24 and 35 weeks develop preeclampsia² The diagnosis of gestational hypertension mandates increased surveillance. Women who progress to severe gestational hypertension based on the degree of blood pressure elevation have worse perinatal outcomes than do women with mild preeclampsia, and require management similar to those with severe preeclampsia

Cells during the development of hypertensive state during pregnancy. There is a violation of the function of the membranes, which are membrane proteins (with transport, enzyme, hormone receptors, antibodies and immunity related proteins) is considered to be in the change of the mechanism of action or to be incorrect, this, in turn, leads to a change in the activity of cellular structures.

Hypertensive condition during pregnancy is always related to kidney function accompanied by severe disorders, they are earlier than other members and more injured. The main changes in the kidney are microcirculation level of kidney hemodynamic disorders, blood in the kidney parenchyma decreased perfusion, decreased filtration rate in the renal glomeruli, The permeability of the ball filter increases for proteins, concentration and water is represented by a violation of the activity of excretion. Areas of microthrombosis with ischemic, edematous and dystrophic changes in tubes and balls together.

In conclusion, although many pregnant women with high blood pressure have healthy babies without serious problems, high blood pressure can be dangerous for both the mother and the fetus. Women with pre-existing, or chronic, high blood pressure are more likely to have certain complications during pregnancy than those with normal blood pressure. However, some women develop high blood pressure while they are pregnant (often called gestational hypertension).

The effects of high blood pressure range from mild to severe. High blood pressure can harm the mother's kidneys and other organs, and it can cause low birth weight and early delivery. In the most serious cases, the mother develops preeclampsia-or "toxemia of pregnancy"-which can threaten the lives of both the mother and the fetus.

References:

1. Axmedova R. Obstetrics and in genealogy nursing work. from science a set of teaching materials. Sh- 2021, p-175-176
2. Report of the National High Blood Pressure Education Program Working Group on High Blood Pressure in Pregnancy. Am J Obstet Gynecol. 07;183(1):S1–S22
3. Ailamazyan E.K. Emergency care in extreme conditions in obstetric practice. // Assoc. ROSMEDPOLIS", 2000, pp. 29-52

² Report of the National High Blood Pressure Education Program Working Group on High Blood Pressure in Pregnancy. Am J Obstet Gynecol. 07;183(1):S1–S22