

THE INCIDENCE OF ANEMIA IN PREGNANT WOMEN DURING PREGNANCY AND MODERN CLINICAL DIAGNOSIS

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Relevance of the problem: It should also be remembered that a balanced diet alone cannot cure anemia. The fact is that the total amount of iron that enters the body with food (even if it is red meat or beef liver) is ultimately absorbed to a maximum of 2.5 mg per day. At the same time, iron-containing preparations can provide 15-20 times more trace elements. Iron preparations are usually taken for a long time, since the hemoglobin concentration often increases by the end of the 3rd week of treatment, and other blood parameters decrease after about 5-8 weeks. At the same time, the body's iron supply may still not be restored, so WHO recommends continuing to take the drug even after the main indicators have normalized, first reducing its amount by half (for 3 months), and then leaving it at a very small dose (for 6 months). Experts recommend continuing to take oral iron supplements for another 3 months after the anemia is corrected. In addition, your doctor may prescribe copper, manganese, vitamin B12, vitamin C, and folic acid supplements to help improve iron absorption.

Research methods and materials: The fetus receives iron from the mother through active transport through the placenta, mainly in the third trimester of pregnancy. Iron deficiency anemia during this period can lead to premature birth, bleeding during or after childbirth, and also complicates the subsequent recovery process: inflammation often develops in women with anemia who have recently given birth. If the hemoglobin concentration in a woman's blood at the 28th week of pregnancy is less than 100 g / l, the risk of stillbirth or death of the child during childbirth increases threefold.

In addition, newborns whose mothers suffer from iron deficiency anemia have significantly reduced levels of ferritin, transferrin, and the iron saturation coefficient of transferrin. This can lead to complications: such children are often born prematurely, have low birth weight, may lose weight after birth, suffer from physiological jaundice for a long time, and are at increased risk of

infections. And with severe anemia during pregnancy, the newborn may also develop anemia or latent iron deficiency, and he may lag behind his peers in psychomotor development in the first years of life. Folic acid deficiency anemia in the third trimester of pregnancy is no less dangerous. Studies have shown that the birth weight of the baby is directly related to the concentration of folic acid in the mother's body. Shortly before birth, the fetus actively consumes folic acid from the mother's reserves: thanks to this substance, the future baby gains weight; In addition, his body forms its own vitamin reserves. If a pregnant woman has a folic acid deficiency, there is a high risk of giving birth to a low birth weight (normal height) baby.

Research findings: Anemia in pregnancy is a major public health problem, and the World Health Organization estimates that 37% of pregnancies are anemic (1). Globally, the prevalence of anemia during pregnancy is highest in low- and middle-income countries. A study of nearly 4 million births in the United States found that prenatal anemia was more common in women who were black (22%) or Pacific Islander (18%) and less common in women who were Asian (11%) or white (10%) (2).

Anemia in pregnancy is associated with adverse maternal outcomes (e.g., preterm birth, placental abruption, intensive care unit admission) and adverse neonatal outcomes (e.g., stillbirth, growth restriction, neurodevelopmental defects) (3 , 4 , 5).

During pregnancy, bone marrow erythroid hyperplasia develops, and the red blood cell (RBC) count increases by 15–25% in a singleton pregnancy (6). At the same time, a disproportionate increase in plasma volume (by 40–50%) leads to hemodilution (gestational hydremia) and, consequently, an increased need for iron. Physiological anemia occurs in healthy nonpregnant women, with a decrease in the mean hematocrit (Hct) from 38–45% in late singleton pregnancy to approximately 34% in late multiple pregnancy and to 30% in late multiple pregnancy.

Despite hemodilution, oxygen-carrying capacity remains normal throughout pregnancy.

Hematocrit usually increases immediately after birth due to the return of maternal blood to the maternal circulation in the placental vessels.

Discussion: Pregnant women with normal hemoglobin or ferritin levels usually do not require additional iron supplements to prevent anemia. However, WHO recommends that pregnant women take 60 mg of iron supplements and 400 mcg of folic acid in the second and third trimesters. In addition, a pregnant woman should adjust her diet: food should be rich in easily digestible iron (meat and offal, fish, eggs). Timely prevention is especially important for women at risk of developing anemia.

Abstract: Anemia in pregnancy is a major public health problem, and the World Health Organization estimates that 37% of pregnancies are anemic (1). Globally, the prevalence of anemia during pregnancy is highest in low- and middle-income countries. A study of nearly 4 million births in the United States found that prenatal anemia was more common in black (22%) or Pacific Islander (18%) women and less common in Asian (11%) or white (10%) women (2). Anemia in pregnancy is associated with adverse maternal outcomes (e.g., preterm birth, placental abruption, admission to the intensive care unit) and adverse neonatal outcomes (e.g., stillbirth, growth restriction, neurodevelopmental defects) (3 , 4 , 5). During pregnancy, bone marrow erythroid hyperplasia develops, and the red blood cell (RBC) count increases by 15–25% in a singleton pregnancy (6). At the same time, a disproportionate increase in plasma volume (by 40–50%) leads to hemodilution (gestational hydremia) and, consequently, an increased need for iron. Physiological anemia occurs in healthy nonpregnant women, with a decrease in the mean hematocrit (Hct) from 38–45% in late singleton pregnancy to approximately 34% in late multiple pregnancy and to 30% in late multiple pregnancy. Despite hemodilution, oxygen-carrying capacity remains normal throughout pregnancy. Hematocrit usually increases immediately after birth due to the return of maternal blood to the maternal circulation in the placental vessels.

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