

CHRONIC ARTERIAL HYPOTENSION IN WOMEN OF REPRODUCTIVE AGE

Kamola X. Abdullayeva

Andijan State Medical Institute Assistant of the Department of Outpatient and
Polyclinic Therapy

Uzbekistan, Andijon region

<https://orcid.org/0009-0009-0991-2165>

Annotation

It is unclear what causes hypotension in expectant mothers. A relative deficiency of the sympatho-adrenal system and adrenal cortex is linked to this condition. The amount of 11-oxycorticosteroids in the blood and their excretion in the urine are decreased in pregnant women in addition to arterial hypotension. However, women who have prenatal hypotension also have the same abnormalities in adrenal function. Inhibition of ovarian function, placenta influence, prostaglandin action, and the immune response to placental and fetal antigens are some of the theories being put forth to explain hypotension in pregnant women. These theories include the reduction or increase of the release of various biological substances, including catecholamines, acetylcholine, serotonin, and histamine.

Many studies distinguish between hypotension in pregnant women that developed earlier in life and that developed during pregnancy (seeing it as a form of toxicosis). It is thought that women who had hypotension before becoming pregnant are more used to it and can handle it more readily during pregnancy. We believe that this distinction between the two types of hypotension is essentially meaningless because the clinical presentation, complications, and course of treatment are identical, and the statistically different incidence of specific symptoms or complications has no bearing on the management strategies used for any given patient.

Key words: pregnancy, arterial hypotension, vascular tone problem

ХРОНИЧЕСКАЯ АРТЕРИАЛЬНАЯ ГИПОТЕНЗИЯ У ЖЕНЩИН РЕПРОДУКТИВНОГО ВОЗРАСТА

Камола Х. Абдуллаева

Андижанский государственный медицинский институт, ассистент кафедры
амбулаторно-поликлинической терапии

Узбекистан, Андижанская область

<https://orcid.org/0009-0009-0991-2165>

Аннотация

Неясно, что вызывает гипотонию у будущих матерей. С этим состоянием связана относительная недостаточность симпатoadреналовой системы и коры надпочечников. У беременных женщин в дополнение к артериальной гипотензии снижается уровень 11-оксикортикостероидов в крови и их экскреция с мочой. Однако у женщин с пренатальной гипотензией также наблюдаются те же нарушения функции надпочечников. Угнетение функции яичников, влияние плаценты, действие простагландинов и иммунный ответ на плацентарные и фетальные антигены - вот некоторые из теорий, которые выдвигаются для объяснения гипотензии у беременных женщин. Эти теории включают уменьшение или увеличение высвобождения различных биологических веществ, включая катехоламины, ацетилхолин, серотонин и гистамин.

Во многих исследованиях проводится различие между гипотонией у беременных, развившейся в раннем возрасте, и гипотонией, развившейся во время беременности (рассматриваемой как форма токсикоза). Считается, что женщины, у которых была гипотония до беременности, более привычны к ней и легче справляются с ней во время беременности. Мы считаем, что это различие между двумя типами артериальной гипотензии, по сути, бессмысленно, поскольку клиническая картина, осложнения и курс лечения идентичны, а статистически различающаяся частота возникновения специфических симптомов или осложнений не имеет никакого отношения к стратегиям ведения каждого конкретного пациента.

Ключевые слова: беременность, артериальная гипотензия, нарушение сосудистого тонуса.

REPRODUKTIV YOSHDAGI AYOLLARDA SURUNKALI ARTERIAL GIPOTENZIYA

Kamola X. Abdullayeva

Andijon Davlat tibbiyot instituti ambulatoriya va poliklinika terapiyasi
kafedrası assistenti

Uzbekiston, Andijon viloyati

<https://orcid.org/0009-0009-0991-2165>

Anotatsiya

Bo'lajak onalarda gipotenzziyaga nima sabab kelib chiqqanligi noma'lum. Simpato-adrenal tizim va buyrak usti bezining nisbiy yetishmovchiligi bu holat bilan bog'liq. Homilador ayollarda arterial gipotenzziyadan tashqari qondagi 11-oksikortikosteroidlar miqdori va ularning siydik bilan chiqarilishi kamayadi. Biroq, prenatal gipotenzziyaga ega bo'lgan ayollarda buyrak usti funktsiyasida ham bir xil anormalliklar mavjud. Tuxumdonlar funktsiyasini bostirilishi, platsenta ta'siri, prostaglandin ta'siri, platsenta va homila antigenlariga immun reaksiyasi homilador ayollarda gipotenzziyani tushuntirish uchun keltirilgan ba'zi nazariyalardir. Ushbu nazariyalar katexolaminlar, atsetilxolin, serotonin va gistamin kabi turli xil biologik moddalarning chiqarilishini kamaytirish yoki ko'paytirishni o'z ichiga oladi.

Ko'pgina tadqiqotlar homilador ayollarda hayotning boshida rivojlangan va homiladorlik paytida rivojlangan gipotenzziyani ajratib turadi (uni toksikoz shakli sifatida ko'rish). Homilador bo'lishdan oldin gipotenzziyadan aziyat chekkan ayollarda Arterial gipotoniya nisbatan yengil kichadi degan fikr bor. Gipotenzziyaning ikki turi o'rtasidagi bu farq mohiyatan ma'nosiz, deb hisoblaymiz, chunki klinik ko'rinish, asoratlari va davolash kursi bir xil va o'ziga xos alomatlar yoki asoratlarning statistik jihatdan har xil holatlari har qanday bemor uchun qo'llaniladigan boshqaruv strategiyasiga ta'sir qilmaydi..

Kalit so'zlar: homiladorlik, arterial gipotenzziya, qon tomir tonusi buzilishi

Introduction

If blood pressure (BP) is less than 100/60 mm Hg, arterial hypotension is a sign of vascular tone violation. Pregnant women experience this pressure much more frequently (on average, 12%), with 5-7% of both sexes in the 20–40 age

range experiencing it. They shouldn't all be regarded as ill, though. Physiological or constitutional hypotension is the term used to describe the condition in which many women do not react to lower blood pressure, keep excellent health, have normal working ability, and do not complain. Others have trouble performing their regular tasks because they feel ill. major and symptomatic hypotension are differentiated because hypotension may be the major symptom of the disease or one of the symptoms of another illness (e.g., stomach ulcer, infectious disease, allergy disorders, hypothyroidism, adrenal insufficiency, etc.).

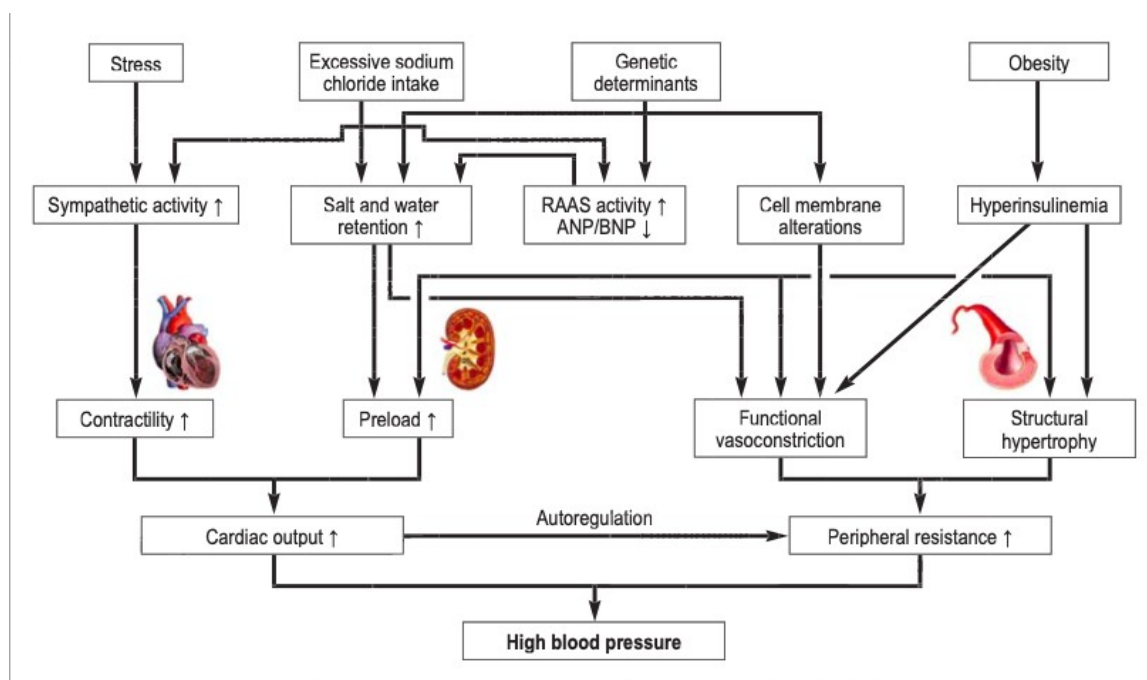
One common vascular neurosis is primary arterial hypotension, which is a hypotonic form of neurocirculatory dystonia. Overwork, emotional strain, and neuropsychiatric injuries are frequently linked to the disease's beginnings. It is known as a stable (compensated) stage of the illness when arterial hypotension is only characterized by a drop in blood pressure. Numerous objective and subjective symptoms manifest during the disease's unstable (subcompensated) stage.

Hypotonic crises, readily occurring fainting, sleep disturbances, the onset of acrocyanosis, and incapacity are all signs of decompensated arterial hypotension. The most common complaints from patients are headache, lightheadedness, weakness, palpitations, heart discomfort and other unpleasant feelings, perspiration, memory loss, reduced productivity, cold hands and feet, and meteosensitivity. When getting out of bed, some women suffer orthostatic symptoms, such as lightheadedness, darkening of the eyes, and even fainting. Non-orthostatic syncope can occur against a backdrop of health or during a disease aggravation. Patients frequently experience mood swings, emotional instability, and irritation. Colaptoid states that co

Patients experience a sudden weakness, a sense of ear congestion, pale skin and mucous membranes, cold sweats, headaches, dizziness, and vomiting when their blood pressure falls below 80/50 mm Hg or lower during a crisis. Blood pressure may not always stay consistently low; on occasion, it may rise to normal or even higher levels, as in the case of agitation or hospitalization.

But it is dwindling quickly. Women with hypotension are more likely to have acrocyanosis, pale complexion, and an asthenic build. Varicose veins are present in about half of them. Cold hands and feet, a labile pulse, decreased filling and tension, bradycardia, an enlarged left ventricle, and a systolic murmur at the apex are all common symptoms. continue for many minutes are the result of hypotonic crises.

Picture 1



The pathophysiology of essential arterial hypertension. Multiple hemodynamic, neural, humoral, and renal mechanisms lead to increased cardiac output and/or peripheral vascular resistance. The product of these two hemodynamic variables determines the blood pressure. ANP, atrial natriuretic peptide; BNP, B-type natriuretic peptide; RAAS, renin-angiotensin-aldosterone system

However, pathological alterations are not seen in the majority of patients with cardiac percussion and auscultation. The ECG also shows no particular alterations. Blood pressure drops as a result of an increase in the minute volume of blood and an insufficient reduction in peripheral blood flow resistance. 91% of women saw an increase in their pre-existing hypotension symptoms when they became pregnant. The majority of the time, the decline happened early in pregnancy.

As pregnancy went on, all women had an increase in permanent paroxysmal autonomic abnormalities. The presence and severity of early toxicosis during pregnancy had a detrimental impact on the dynamics of hypotension in 85% of cases. The first background factor causing early toxicosis in pregnant women is violations of suprasegmental autonomic control, of which hypotension is one specific manifestation. It's unclear what causes pregnant women to have hypotension. This syndrome is linked to a relative deficiency of the sympatho-adrenal system and adrenal cortex.

Along with arterial hypotension, pregnant women had lower blood levels of 11-oxycorticosteroids and lower urine excretion of these hormones. Nonetheless, women with prenatal hypotension have the same alterations in adrenal function. The immune response to placental and fetal antigens, the placenta's influence, prostaglandin action, and inhibition of ovarian function are some of the theories being put forth to explain hypotension in pregnant women. These theories include decreased or increased release of various biological substances, including

catecholamines, acetylcholine, serotonin, and histamine. It is incorrect to think of inferior vena cava syndrome as a sign of hypotension in expectant mothers. It appears while a lady is resting on her back during the second half of her pregnancy.

As a result of compression of the inferior vena cava by the pregnant uterus, blood flow to the heart is disrupted and fainting develops with a drop in blood pressure, a weakening of the pulse, and often loss of consciousness. When the uterus is moved, the lady turns over on her side or sits down, and the situation rapidly returns to normal. Many studies distinguish between hypotension in pregnant women that developed earlier in life and that developed during pregnancy (think of it as a form of toxicosis).

It is thought that pregnant women who has had hypotension are more accustomed to it and can handle it more readily. We believe that the distinction between the two types of hypotension is essentially meaningless because the clinic picture, complications, and treatment are the same, and a statistically different frequency of a particular symptom or complication has no bearing on the management strategies used for any given patient. As with other vascular illnesses, gestosis is common among pregnant women with arterial hypotension (in 25% of cases).

When people with nephropathy have hypotension, their blood pressure may not rise over normal (120/80 mmHg), but it will be 30% higher than it was before; this is regarded as pathology. Compared to healthy women with arterial hypotension, pregnant women are more likely to develop early toxicosis. Spontaneous abortion is one of the primary consequences of pregnancy with arterial hypotension. It is five times more common than in healthy women at different points during pregnancy.

The reverse impact is also observed: blood pressure gradually drops in women who remain bedridden for an extended period of time because of a threatened miscarriage, presumably as a result of muscular inactivity. Because of decreased uteroplacental blood flow, arterial hypotension plays a role in the development of fetal growth retardation syndrome.

Calcium chloride, glucose, and estrogens should be utilized to reduce the lengthy prenatal period in women with arterial hypotension, but do not seek an emergency prescription for medication to induce labor. Primary weakness of labor may be confused with the sluggish rate of labor development seen in women experiencing arterial hypotension during labor.

Because women with arterial hypotension have slow-moving metabolisms, this disease is linked to a severe depletion of the body's energy resources.

Rhodostimulation in these situations involves a disarray of general forces. Sedatives, antispasmodic medications, and paracervical anesthesia are used to treat disorganized labor, which is characterized by extremely painful contractions and a delayed opening of the uterine pharynx. Women should be given relaxation and sleep in order to effectively recover from this disease.

Conclusion

Among women of reproductive age, idiopathic arterial hypotension is a prevalent but frequently underdiagnosed disease. Its many clinical symptoms and complex origins have a substantial impact on quality of life and may make pregnancy and childbirth more difficult. IAH raises the risk of intrauterine growth restriction, early toxicosis, gestosis, and postpartum problems such poor labor activity throughout pregnancy. Therefore, to lessen unfavorable maternal and perinatal outcomes, careful monitoring, prompt diagnosis, and all-encompassing therapy are crucial. Both the fetal prognosis and the mother's health can be enhanced by early detection of hypotension and the use of preventative measures.

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