



International Congress on Biological, Physical And Chemical Studies

International Congress on Biological, Physical And Chemical Studies - is an international conference platform under open access policy. The conference is led by international expert members who take an objective approach to peer review, ensuring each research paper is reviewed, edited by authors and evaluated on its own scholarly merits and research integration. Publishing and joining on the proceeding of the International Congress on Biological, Physical And Chemical Studies will ensure publishing experience and indexing possibilities on various global indexing.

Common Causes of Fetal Intranatal Death

Jabborova Munisxon Abdubannon qizi

Assistant of the department of obstetrics and gynecology

ABSTRACT

Stillbirth has many causes: intrapartum complications, hypertension, diabetes, infection, congenital and genetic abnormalities, placental dysfunction, and pregnancy continuing beyond forty weeks. This is a catastrophic event with lasting consequences on all of society.

KEYWORDS

placental abnormalities, diabetes, maternal age, hypertension, infectious.

INTRODUCTION

We need to learn more about why stillbirths occur. This knowledge can help those impacted deal with grief and, more importantly, prepare to reduce stillbirth risk in subsequent pregnancies. This activity reviews the healthcare team's role in evaluating, managing, and improving care for patients diagnosed with stillbirth. There are some causes:

Placental Abnormalities:

Fetal growth restriction and placental abnormalities are the most prevalent findings in stillbirth. Most pregnancies with these findings, however, do not result in stillbirth. Placental abnormalities can also be found in stillbirths without evidence of impaired growth. Symphysis-fundal height, used to estimate serial fetal growth at the prenatal visits, has a low sensitivity and specificity for detecting a small for gestational age infant. At this time, only placental volume, velamentous insertion, and the presence of a single, umbilical artery can be detected prenatally. Diagnosing fetal growth restriction in utero is difficult. Novel methods are needed to evaluate the structure and the function of the placenta in a noninvasive way. If the birth weight is less than the 10th percentile, the risk of growth restriction is 30%, and if the birth weight is less than the 3rd percentile, the risk is 70%. The risk of stillbirth is relative to the degree of growth restriction, with the highest stillbirth risk for those delivering the most growth-restricted fetuses. The risk of stillbirth is 15/1000 for birth weights less than the 2.5th percentile and 25/1000 for birth weights less than the 5th percentile. Placental factors such as a placental abruption are found in six percent of stillbirths. A history of placental abruption increases the risk of stillbirth. This risk is greatest for preterm fetuses. Cocaine use, smoking, hypertension, and preeclampsia increase the risk for placental abruption and stillbirth. Additionally, unusual placental conditions, including choriocarcinoma or

chorioangioma, increase the risk for stillbirth.

Diabetes

Diabetes increases stillbirth risk up to five times. A meta-analysis showed that only improving glucose control prior to conception reduces the rate of stillbirth. With optimal glycemic control, the risk of stillbirth may be reduced. In type 1 diabetics, the stillbirth rate is 16.1 per 1000 births. Poor diabetic control determined by elevated glycosylated hemoglobins before pregnancy (OR 1.03) and later in pregnancy (OR 1.06) were associated with stillbirth. In type 2 diabetics, the stillbirth rate is 22.9/1000 births. A higher BMI (OR 1.07) and elevated glycosylated hemoglobin before pregnancy (OR 1.02) were associated with stillbirth. The birth weight may be affected by diabetes and is also related to the risk of stillbirth. If the birth weight is less than the 10th percentile, the risk for stillbirth is elevated six times in mothers with type 1 diabetes and three times in those with type 2 diabetes compared to fetuses weighing in the 10th to 90th percentile. With type 2 diabetes, the risk for stillbirth was twofold higher if the birth weight was over the 95th percentile. A significantly higher number of stillborns in women with type 2 diabetes are male gender. A third of the stillbirths associated with diabetes occur at term. The highest rate for stillbirth is in the 38th week for type 1 diabetes and in the 39th week for type 2 diabetes.

Age

The risk of stillbirth is augmented by advanced maternal age due to an increased risk for aneuploidy and medical complications of pregnancy. Even after controlling for these risk factors, maternal age over 35 has an increased risk for stillbirth, which is accentuated by nulliparity. At age 40, the risk is 1/116 for a nullipara and 1/304 for a multipara. Stillbirth may be caused by lethal chromosomal abnormalities, which are more prevalent when the maternal age is greater than 35. Thirteen percent of stillbirths have an abnormal karyotype. These abnormal karyotypes include Turner syndrome (XO in 23%), Down syndrome (trisomy 21 in 23%), Edwards syndrome (trisomy 18 in 21%), and Patau syndrome (trisomy 13 in 8%). A paternal age over 40 also increases the risk of stillbirth.

Gestational Age >38 weeks

Stillbirth risk is increased by early and late-term gestational age. Induction of labor after 40 weeks may decrease the risk of stillbirth and cesarean delivery. 145 The risk of stillbirth at 37 weeks is 0.21/1000. At 38 weeks, the risk of stillbirth in pregnancies managed expectantly is equivalent to those managed by induced delivery. At 42 weeks, the risk of stillbirth is 1.08/1000. When considering the benefit of inducing labor to reduce stillbirth, other factors, including neonatal and maternal adverse outcomes, must be considered. At 41 weeks, over 1400 deliveries would have to be induced to prevent one stillbirth. 22914394 Induction of labor is recommended after 42 weeks and might be considered after 41 weeks of gestation.

Hypertension

Chronic hypertension increases stillbirth risk three-times. Hypertension is a common condition that complicates pregnancy; incidence is 9.6% (95% CI: 6.9-12.1). The goals and outcomes for the treatment of chronic hypertension in pregnancy are poorly understood at this time. Gestational hypertension shows an increased risk for stillbirth in some studies but not in others.

Birth Defects

Congenital defects, defined as physical or biochemical abnormalities, occur in 1/33 pregnancies and are associated with a higher risk of stillbirth. The detection of congenital defects prenatally may impact antenatal surveillance policy in hopes of reducing the risk of stillbirth. Stillbirth risk is 11/1000 for bladder exstrophy and 490/1000 for the limb-body-wall complex; even for isolated congenital defects not affecting major organs, the risk of stillbirth increases. The risk for stillbirth

associated with cleft lip with cleft palate is 10/1000, transverse limb deficiencies 26/1000, longitudinal limb deficiencies 11/1000, and the amniotic band associated limb defects 110/1000. The increased stillbirth risk for sacral agenesis is 13/1000, isolated spina bifida 24/1000, and holoprosencephaly 30/1000 may be underestimated due to failure to account for elective termination of pregnancy. Dysmorphic features or skeletal issues are found in 20% of stillborns, and up to 20% have gross malformations.

Infection

Infection as a cause of stillbirth may be underrepresented because signs and symptoms of infection are often undetected, and evaluation for infection is often not conducted. Stillbirth related to infection varies from 5% to 22%. In developed countries, infection accounts for 19% of stillbirths before 28 weeks, but only 2% of stillbirths at term. When an infection is the cause of stillbirth, spontaneous preterm delivery is common. A US cohort study demonstrated infection as the probable or possible cause of stillbirth in 12.9% of cases. Predominant bacteria cultured included *Escherichia coli* 29%, group B streptococcus (GBS) 12%, enterococcus 12%, and rarely *Listeria monocytogenes*. The placental evaluation found evidence of infection in 99% of culture-positive cases. Non-bacterial organisms causing stillbirth included cytomegalovirus 8%, parvovirus 3%, syphilis 2%, and herpes simplex virus 2%. Infection is unlikely the cause of stillbirth unless it results in significant autopsy or placental findings. Serologic screening for toxoplasmosis, chlamydia, rubella, or herpes is usually not indicated when these infections are not detected on placental or autopsy examination. Malaria should be screened for in endemic areas. Human immunodeficiency virus increases the risk of stillbirth. Group B streptococcal infection is linked to the cause of stillbirth in 1% of stillbirths in developed countries and 4% in African countries. These estimates are poor given the low quality of collected data. In Mozambique, the rate of group B streptococcal associated stillbirth was 17%, which may be due to the high rate of screening performed there. GBS has to be isolated from a sterile body site such as cerebrospinal fluid and isolated detection from a surface, or placental swab would not qualify as a case related to GBS. Having a treated chlamydia infection before or during pregnancy does not increase the risk for preterm delivery, intrauterine growth restriction, or stillbirth.

We can say for conclusion, Stillbirth needs to be clearly defined. Every death must be counted, and actions to prevent these deaths must be tracked and monitored. High quality obstetric and midwifery care should be universally available. Childbirth must be provided with skilled attendants who can perform assisted vaginal deliveries and cesarean sections for fetal and maternal indications. Of all stillbirths, half occur during birth. Seventy-five percent of these are preventable with access to quality care. The ability to provide induction of labor for premature rupture of membranes and post-term pregnancy needs to be addressed.

REFERENCES

1. Абдукадилова, Л. К., & Абдуллаева, Ў. Я. (2019). Тошкент шаҳри кичик ёшдаги болалар тарбияланаётган оилаларнинг ижтимоий-гигиеник ҳолатини ўрганиш натижалари. *Интернаука*, (5-2), 47-48.
2. Jasim, S. A., Mohammadi, M. J., Patra, I., Jalil, A. T., Taherian, M., Abdullaeva, U. Y., ... & Alborzi, M. (2024). The effect of microorganisms (bacteria and fungi) in dust storm on human health. *Reviews on Environmental Health*, 39(1), 65-75.
3. Каримова, М. М., Содиков, Ю. Т., Юсупова, М. М., & Мухаммадсодиков, М. М. (2022). Covid-19 о'tkazgan bemorlarda qalqonsimon bez xolatini taxlil qilish. *Журнал*

- кардиореспираторных исследований, 3(1).
4. Алимова, Н. У., & Мухамадсадиқов, М. М. (2022). Оценка Современных Методов Диагностики И Лечения Врождённого Гипотиреоза. AMALIY VA TIBBIYOT FANLARI ILMIY JURNALI, 1(6), 62-75.
 5. Каримова, М. М., Содиков, Ю. Т., Юсупова, М. М., & Мухаммадсодиқов, М. М. (2022). АНАЛИЗ СОСТОЯНИЯ ЩИТОВИДНОЙ ЖЕЛЕЗЫ У ПАЦИЕНТОВ, ПЕРЕНЕСШИХ COVID-19. Journal of cardiorespiratory research, 1(1), 44-46.
 6. Shukhratjonovich, S. E. (2023). TREATMENT OF PATIENTS WITH CHRONIC RECURRENT CYSTITIS WITH A DRUG BASED ON BACTERIOPHAGES. Best Journal of Innovation in Science, Research and Development, 2(10), 541-544.
 7. Shukhratjon, S. E. (2023). UROLITHIASIS DISEASE. World Bulletin of Public Health, 27, 35-36.
 8. Rapikov, I. (2023). Formation of savings and entrepreneurship on the basis of labor education according to age characteristics in primary school students. Procedia of Engineering and Medical Sciences, 8(12), 80-83.
 9. Алимова, И. А. (2023). МЕТОДИКА ИССЛЕДОВАНИЯ И РЕАБИЛИТАЦИЯ ДЕТСКОГО АУТИЗМА У ДЕТЕЙ В ФЕРГАНСКОМ РЕГИОНАЛЬНОМ ФИЛИАЛЕ РЕСПУБЛИКАНСКОГО ЦЕНТРА СОЦИАЛЬНОЙ АДАПТАЦИИ ДЕТЕЙ.
 10. Алимова, И. А. КОМПЛЕКСНЫЕ РЕАБИЛИТАЦИОННЫЕ ТЕХНОЛОГИИ У ДЕТЕЙ С ОСОБЫМИ ПОТРЕБНОСТЯМИ ПОСЛЕ COVID-19.
 11. G'aniyevich, R. I. (2023). Formation of National Crafts in the family of Primary School students. Best Journal of Innovation in Science, Research and Development, 283-286.
 12. Рапиқов, И. Г. (2019). Женское семейное членство в обучении учителя. Научные горизонты, (4), 85-89.
 13. Sattievna, D. G. (2024). FARG'ONA VILOYATIDA REPRODUKTIV YOSHDAGI AYOLLARNI KONTRASEPTIV VOSITALARNI QO'LLASH USULLARI HAQIDAGI XABARDORLIK DARAJASINI O'RGANISH. Лучшие интеллектуальные исследования, 14(2), 239-243.
 14. Mukhtarzhanovna, I. G. (2023). DIAGNOSTIC METHODS OF VAGINAL DYSBIOSIS DURING PREGNANCY. EUROPEAN JOURNAL OF MODERN MEDICINE AND PRACTICE, 3(11), 136-137.
 15. Isroilova, G. (2023). DEVELOPING THE PRINCIPLES OF STUDYING AND TREATMENT OF VAGINAL DYSBIOSIS DURING PREGNANCY. Modern Science and Research, 2(4), 52-53.
 16. Mukhtarjanovna, I. G. (2023). Developing the Principles of Studying and Treatment of Vaginal Dysbiosis During Pregnancy. Texas Journal of Medical Science, 16, 67-68.
 17. Jabborova, M. A., & Shokirova, S. M. (2022). PLASENTA YETISHMOVCHILIGI KASALLIGI. Новости образования: исследование в XXI веке, 1(3), 291-294.
 18. Soliyevich, I. M. (2024, May). FOREIGN BODIES IN THE ANORECTAL AREA. In Proceedings of International Conference on Modern Science and Scientific Studies (Vol. 3, No. 5, pp. 72-76).
 19. Soliyevich, Isroilov Maxamadsodiq. "COMPLICATIONS AFTER OPERAS PERFORMED IN GRISHPRUNG'S DISEASE." Proceedings of International Educators Conference. Vol. 3. No. 5. 2024.
 20. Soliyevich, Isroilov Maxamadsodiq. "CHANGES IN THE MICROFLORA OF THE COLON IN GRISHPRUNG DISEASE." Miasto Przyszłości 48 (2024): 170-173.

21. Абдуллаев, С. (2024). АКТУАЛЬНОСТЬ ПРОБЛЕМ РАЗВИТИЯ ОСТРЫХ ПНЕВМОНИЙ У ДЕТЕЙ. THEORY AND ANALYTICAL ASPECTS OF RECENT RESEARCH, 2(22), 29-33.
22. Solijon o'g'li, A. S. (2024). BACTERIAL, VIRAL AND MUCOPLASMA PNEUMONIA IN CHILDREN. American Journal of Pediatric Medicine and Health Sciences (2993-2149), 2(1), 273-280.
23. Абдуллаев, С. (2024). ПСИХОЛОГИЧЕСКИЕ ОСОБЕННОСТИ УЧЕБНЫХ ИГР В ПОДГОТОВКЕ СТУДЕНТОВ МЕДИЦИНСКИХ ИНСТИТУТОВ. FORMATION OF PSYCHOLOGY AND PEDAGOGY AS INTERDISCIPLINARY SCIENCES, 2(25), 222-224.
24. Abdullaev, S. S. (2023). TO THE QUESTION OF COMMUNITY-ACCOMPANIED PNEUMONIA IN YOUNG CHILDREN. Journal of Social Sciences and Humanities Research Fundamentals, 3(05), 51-53.
25. Kamoldinovich, X. D. (2024, May). ULTRASOUND LEVELING AND ITS ADVANTAGES. In Proceedings of International Conference on Modern Science and Scientific Studies (Vol. 3, No. 5, pp. 59-64).
26. Kamoldinovich, X. D. (2024, May). MODERN CONTRAST AGENTS IN MEDICINE. In Proceedings of Scientific Conference on Multidisciplinary Studies (Vol. 3, No. 5, pp. 132-144).
27. Kamoldinovich, X. D. (2024). INTRAVENOUS ADMINISTRATION OF CONTRAST AGENTS AND ITS CHARACTERISTICS. Miasto Przyszłości, 48, 119-131.
28. Хожирaxmatov, D. K. (2023). THE IMPORTANCE OF COMPUTED TOMOGRAPHY IN THE DIAGNOSIS OF URETEROLITHIASIS AND ITS COMPLICATIONS. Procedia of Engineering and Medical Sciences, 7(12), 31-34.
29. Анварова, З. (2024). СПИД/ВИЧ ИНФИЦИРОВАНИЕ И ДЕТИ. THEORY AND ANALYTICAL ASPECTS OF RECENT RESEARCH, 2(22), 41-45.
30. Анварова, З. (2024). ЗАДЕРЖКА ВНУТРИУТРОБНОГО РАЗВИТИЯ ПЛОДА КАК ФАКТОР НАРУШЕНИЯ ГАРМОНИЧНОГО РАЗВИТИЯ ДЕТЕЙ. THEORY AND ANALYTICAL ASPECTS OF RECENT RESEARCH, 2(21), 234-237.
31. Zakhridinovich, I. B. (2024). SOME NEUROLOGICAL DISEASES IN CHILDREN. Miasto Przyszłości, 48, 162-169.
32. Vadimovich, F. R., Satvaldiyevna, P. M., & Zakhridinovich, I. B. (2021). Relationship between the expression of pain syndrome and the size of the inter vertebral hernia of the lumbar spine. ACADEMICIA: An International Multidisciplinary Research Journal, 11(4), 1481-1488.
33. Qosimovna, A. Z. (2023). Factors that lead to asphyxia in babies. American Journal of Pediatric Medicine and Health Sciences (2993-2149), 1(10), 740-743.
34. Madaminjonovna, Q. Z. (2024, January). THE PROCESS OF DEVELOPING HYPERTENSION. In Proceedings of International Conference on Educational Discoveries and Humanities (Vol. 3, No. 2, pp. 177-182).
35. Madaminjonovna, K. Z. (2024). ETIOLOGICAL FACTORS CAUSING HYPERTENSION DISEASE AND MEASURES TO CONTROL IT. American Journal of Pediatric Medicine and Health Sciences (2993-2149), 2(1), 326-332.
36. Madaminjanovna, Q. Z. (2023). Hypertensive Disease: History of Nosology Development. American Journal of Pediatric Medicine and Health Sciences (2993-2149), 1(10), 97-103.