



using specialized forms (questionnaires), must take its place in the complex diagnosis with sexual dysfunction.

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THE EFFECTIVENESS OF METHODS FOR EXPECTED FETAL WEIGHT DETERMINATION

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Introduction. The accuracy of expected fetal weight determination is of great importance in assessing the prognosis of perinatal risk for mother and fetus, as well as for choosing the method and time of delivery. Unfortunately, the large errors in these antenatal indicators have been recorded in the world literature that led us to assess the effectiveness of various methods for expected fetal weight determination and to identify the most preferable for practical use.

Materials and methods. We analyzed 48 labor records. The sampling included pregnant at the term between 37-42 weeks. There was one main criterion for selection: the period between external obstetric examination or phetometry and the birth should not be exceeded 7 days. The circumference of the abdomen at the navel (in cm) was measured with measuring tape. The fundal height of the uterus was measured from the upper edge of pubic symphysis to the uterine fundus (in cm). We estimated fetal weight according to the formula of the product of the height of the uterine fundus standing to the abdominal circumference ($HUF \times AC$). We assessed the findings of the ultrasound phetometry which was performed on the device Medison 8000 SE, following which, we calculated estimated fetal weight by standard methods based on Hadlock and Shephard formulas. Then the results were compared with actual birth weight.

Results. The maximum error, according to $HUF \times AC$ formula, comprised 1600g, 800g by Shepard formula, and 700g by Hadlock. It was found that 31 % of patients have an error of less than 200g between measured and real results, according to $HUF \times AC$ formula, according to Shepard this number accounted to 52 %, Hadlock 56 %. The discrepancy between the masses of more than 300g by $HUF \times AC$ formula was observed in 46 % of examined pregnant, whereas 35% by Shepard, 33% by Hadlock. The accuracy of more than 400g by $HUF \times AC$ formula was in 46%, 21% by Shepard and Hadlock. It was found out that there were 31% of patients with an accuracy of more than 500g by $HUF \times AC$ formula, 13% by Shepard and Hadlock. Discrepancy of more than 600g was observed in 23% of pregnant, measured by $HUF \times AC$ formula, 4% by Shepard and Hadlock. There were 17% of patients with an accuracy of more than 700g by $HUF \times AC$ formula, according to Shepard 2%, while the results by Hadlock formula were not found to have such errors. Patients with an accuracy of more than 800g accounted for 13% by $HUF \times AC$ formula, whereas the findings obtained by Shepard and Hadlock formulas did not show such errors. Errors of more than 1200 g according to $HUF \times AC$ formula were estimated in 8%, 1300g - 6 %, 1400g - 4 %, 1600g - 2 %. According to $HUF \times AC$ formula the average error value amounted to 447g, to 254g by Shepard, to 248g by Hadlow. According to the literature, the average error according to Hadlock formula is 307.4g.



Conclusions. It can be concluded that ultrasonic methods minimize measurement errors in the assessment of fetal weight. Among them, the Hadlock formula is the most preferred. Our study gives an opportunity to recommend it for practical application.

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UTERINE BLEEDING AT PUBERTY (CASE REPORT)

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Introduction. The problem of uterine bleeding at puberty currently remains a challenge because of its relatively high incidence among gynecological diseases (from 10% to 37% of cases). Pubertal uterine bleeding is a clinical condition that reflects the instability of reproductive system during its maturation (N.M.Veselova, 2007).

Results. Clinical Case. A 15-year-old patient K. was urgently admitted to gynecology department of Kharkiv City Maternity Hospital No.1 on 10/11/14 presenting with profuse bleeding from the genital tract. History of the disease: menstrual cycle disruption from August 2014 as scanty bloody discharge. Life history: according to information provided by the patient, she has not had tuberculosis, venereal diseases, infectious hepatitis. Past history includes ARVI. Allergic history is not compromised. She has not undergone any surgical operations. Gynecological history: menarche at 13, menstrual cycle is not regular, lasting for 7 days, mild, painless. Last menstrual period began on 11/03/14 and still continues. The patient is not sexually active. On examination: general state is of moderate severity. Skin, visible mucous membranes are clean and pale. The tongue is moist, with white coat. The body temperature is 36,3 ° C. Auscultation of the lungs: vesicular breathing, no wheezing. Heart: clear, rhythmic tones; pulse: 90 beats per minute; blood pressure: 110/70 mmHg. The abdomen is soft and painless. The liver and spleen are not enlarged. Pasternatsky's symptom is negative on both sides. Stool is normal. Diuresis is sufficient. Gynecologic status: external genitalia are normally developed, pubic hair distribution is of female pattern. Discharge is profuse and blood-tinged. Hymen is intact and prolapsing. Per rectum: the uterus is in retroflexio versio, slightly enlarged, painless. Blood with clots is discharged at vaginal examination. Right adnexa are not detectable, left adnexa are tender. Laboratory and instrumental studies: clinical blood essay determined a decrease in hemoglobin to 88 g/l, a decrease in red blood cells to $2.9 \times 10^{12}/l$ and a decrease in hematocrit to 0.30. Biochemical blood assay and coagulation are within norm. Pelvic ultrasound: the uterus is in retroflexio, 62×47×56mm, margins are clear with homogeneous myometrium, M-ECHO 16mm, heterogeneous structure, cervix 24×20mm, fallopian tubes are not visualized. Conclusion: Metrorrhagia. Consultation with a neurologist, diagnosis: vegetative-vascular dystonia of puberty. Treatment plan: Regulon 1 tablet 4 times a day (hereinafter according to the scheme), oxytocin 1.0+0.9% sodium chloride 200.0 +5% intravenous drip, Tranexam 1 tablet 3 times a day, Sorbifer 1 tablet 2 times a day, Ascorutin 1 tablet 3 times a day. The patient was discharged from gynecological department on 21/11/14 with the improved condition for out-patient care.

Conclusions: Thus, comprehensive, personalized therapy helps to control pubertal uterine bleeding and reduce the risk of relapses.



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