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**METHODS OF CERVICAL INCOMPETENCE CORRECTION IN PREGNANT**

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**Relevance**. The problem of miscarriage is one of the current challenges in obstetrics, as it not only results in disruption of women's reproductive function, but also has a negative effect on birth rate, causing a significant increase in perinatal mortality and morbidity of infants in early neonatal period. Despite the multifactorial etiology of miscarriage, cervical incompetence (CI) is one of the leading causes of spontaneous abortion in the second trimester. The incidence of this condition varies from 0.2 to 65%. Terms of abortion with CI range from 10 to 28 weeks, predominantly in 16-20 weeks.

**The purpose of the study**. To evaluate different methods of cervical incompetence correction.

**Materials and methods.** The study was performed at the Department of Obstetrics, Gynecology and Pediatric Gynecology of KhNMU at Kharkiv City Maternity Hospital No.1. The research implied a retrospective analysis of 60 case histories of CI patients.

**Results and discussion**. Patients were divided into 2 groups depending on the form of CI. The first group included 30 patients with anatomic type of CI conditioned by the development of scar tissue after intrauterine interventions, accompanied by instrumental cervical dilatation or after the rupture of the cervix during labor. The second group included 30 patients with established dishormonal disorders. CI correction for all of the patients was carried out in hospital environment. CI correction during pregnancy was performed by conservative and surgical methods. Conservative methods included bed regimen, application of rings, administration of obstetric pessary, hormonal and tocolytic therapy. Surgical correction of CI implied suturing of cervix, performed in 24 (40%) pregnant patients. Six patients underwent elective suturing of the cervix due to a history of three or more late spontaneous abortions. Thirty (50%) patients underwent application of obstetric pessary. Terms of pessary introduction and most cases of cerclage depended on the time of CI progression. Major complications after correction of cervical incompetence included colpitis, which was detected in 5 (16%) patients after administration of obstetric pessary. Suturing was complicated by their eruption in 2 (8%) patients in the period of 35-37 weeks; deformation of the cervix, which resulted in the impossibility of vaginal delivery, was detected in 1 (4%) patient. Delivery at term was observed in 25 (85%) patients who had undergone surgical correction of CI. Five (15%) patients underwent preterm delivery between 22 and 37 weeks of pregnancy. Twenty two (73.5%) patients who were administered non-surgical correction of CI underwent term delivery. Four (7.5%) patients had premature birth, two (9.5%) patients suffered from late spontaneous abortions at the term of 19-20 and 20-21 weeks. Two patients (9.5%) underwent additional suturing of the cervix due to CI progression. Noteworthy is the fact that most of the adverse outcomes of pregnancy in non-surgical correction were observed in the groups where pessary was administered in the early stages of gestation.

**Conclusion**: Differentiated approach to CI correction in patients with organic and dysfunctional form of cervical incompetence helps to avoid unnecessary surgical interventions, reduce the number of late spontaneous abortions and preterm delivery fourfold.