Perimeter abdomen (OJ) measuring measuring tape that passes in front through the navel, back - through the middle of the lumbar.

Height standing uterus (VTSM) measuring tape measure from the top edge of the symphysis – him the most points serving uterus. The measurement results of AMD compared with standard hravidrhamoyu (Fig. 1) (normally up to thirty week increase GMR is 0.7 - 1.9 cm per week in the AOR - 36 weeks. - 0.6 - 1.2 ohm for weeks. , 36 and over -0.1 - 0.4 cm gap size of 2 cm or lack of growth within 2-3 weeks. during dynamic observation gives reason to suspect fetal growth retardation).

5. Palpation of the abdomen using methods outside obstetric examination of Leopold.

Methods of external obstetric examination (admission Leopold)

The first step. Purpose - to determine the height of standing uterus and part of the fetus, which is bottom of the uterus. This doctor is the right of the pregnant woman, her face, the palms of both hands put on the bottom of the uterus, determines the height of her standing above the vagina and of the fetus, located in the bottom of the uterus.

The second step. Purpose - to determine the position and type of fetal position. Both hands move with the uterus and in turn, then right, then left hand palpated part - da plane, facing the side wall of the uterus. Thus finding the back of the fetus, small parts. In the wrong position to one of the side walls of the uterus prylezhyt head.

The third step. Purpose - to determine the nature of the presenting part (presentation). One hand is certainly right that is, slightly above the pubic area, covering the pe-redlezhachu of the fetus, may carefully make moves this hand right and left. When cephalic defined dense spherical portion having sharp contours. If the fetal head is not in the plane vstavylasya entrance to the pelvis, it is easily moved between the thumb and the remaining fingers. At the breech on the volume, m'yakuvata part, it is round in shape and not able to "vote".

Fourth step. Purpose - to determine the level of standing presenting part (in particular head) on the plane of the entrance to a small basin, and the degree uu pasting. The doctor is right, facing the lower extremities pregnant, put both hands palms down on the side parts of the lower segment of the uterus and palpable accessible areas presenting part of the fetus, Nama-delay penetrate fingertips between the presenting part and lateral divisions of the entrance to a small bowl.

The method of external research technique Leopold IV are the following:

• head moving over the entrance to a small bowl - if the fingers can be brought under the head.

• Head of oppression to the door in a small bowl - the end of the fingers do not converge under the head, but the back of the head and all facial parts palpable over the entrance to a small bowl.

• The head of a small segment at the entrance of the small pelvis - occipital part of the head above the entrance to a small basin on two fingers and facial part - completely.

• The head of a large segment of the entrance to the small pelvis - occipital part of the head is palpable above the entrance to a small bowl and facial acting on two or three fingers.

• Head in the pelvic cavity - propalpovuyetsya only chin or not is determined
Since the study biomechanizmu childbirth should note the following especially in the position of the fetal head at the occipital presentation:

- The position of the head to the onset of labor slightly bent neck and small fontanel are less than great;
- Sagittal suture is in a slightly oblique of the entrance to the small pelvis, transverse size of the entrance to a small bowl out low to the sacrum and the muscles slightly smaller posterior-lateral departments pelvis.

**Biomechanism of childbirth** - a set of rotating, bending and straightening movements that performs fruit passing through the birth canal. **Biomechanism of delivery at the front form occipital presentation consists of 4 moments:**

**I moment** - bending the head and insert it into the plane login small basin. This is turning heads around its transverse axis. Because of bending head small fontanel is located at the lower pole presenting head, approaching the leading axis of the pelvis and becomes leading point. Because bending the head through the pelvis smallest circle that corresponds to the small size and is oblique 32 cm.

**II moment** - internal rotation of the head: is the transition with its broad to the narrow part of the pelvis. Head slowly back around its axis so that the neck back to symphysis and face - to the buttocks. This sagittal suture gradually changes its position, moving from the transverse size of oblique and then with oblique - in direct output size of the pelvis. In the first position of sagittal suture passes through the right, while the second - through the left obliquely. Internal cephalic is the result of adapting its smallest size to the largest size of the pelvis, as well as through progressive resistance movements head of the muscular organs.

**III moment** - head extension in the plane of the exit. Sagittal suture coincides with the right and left exit of the pelvis. Fixation point formed between the middle of the bottom edge lonnogo joints and pidpotylychnyh fossa. Around this point is unbending head, but clinically it accompanied the birth of the forehead, face and chin. During infeed head and torso moving eruption in a small bowl, and transverse size shoulder pads comes in one size skew plane entrance.

On the shoulders of pelvic floor exercise internal rotation is the same with rotation of the fetal head. Concluding twist, shoulders set up direct live of the plane out of the pelvis. This rotation is transmitted head shoulders, born that corresponds to the fourth moment biomechanism birth.

**IV moment** - internal rotation of the shoulder pads and external rotation head. Head with the back facing the hip mother at first position - right thigh, the second - to the left. Begins birth of shoulders. Front shoulder comes under lonnie arc and fixed near the bottom of the symphysis. Point of fixation - insertion deltid muscle to the humerus on the one hand and the middle lower edge of the symphysis second. Formed around the point of fixation is flexion of the trunk and the first born back shoulder, back handle. After the birth of the shoulder girdle is the expulsion of the remaining
of the fruit.

Biomechanism of delivery at the posterior occipital type of presentation

I moment - bending and lowering the fetal head (no differs from the previous one in the front form occipital before lying).

II moment - internal cephalic fetus: head returns neck posteriorly to the sacral hollow, and face - doperedu to symphysis. Behind the back back back backwards fetus. So way, small fontanel is directed toward the buttocks and big - to symphysis. Sagittal suture through the same with the back bevel size goes in direct size pelvic outlet.

III moment - additional bending head. Bending the head - the head is fixed at the bottom of the front edge of the symphysis area large fontanel, formed the first point of fixation around which is additional bending, which continues until it formed the second point of fixation (suboccipital fossa and the tip of the coccyx).

IV moment - straightening head. Further cutting of head occurs due to the formation of a new, second point of fixation between occipital fossa and the tip of the coccyx. So head face comes from the heart. She erupt slightly higher circumference than the circumference of the small size of the oblique, which corresponds to the average size of the oblique.

V moment - no different from the fourth moment before kind occipital presentation.

The configuration at the back of the head form occipital presentation dolihotsefalichna.

Clinical course of sorts at the occipital presentation rear view: greater duration childbirth than at the front form occipital presentation, most maternity costs involved for the additional bending forces head; often occur perineal ruptures, secondary weak labor activity, hypoxia, and more. Labor management expectantly, but we must always be prepared to provide obstetric care, or surgery.

Childbirth is divided into three periods:

First - during opening of the cervix.
Second - the eviction of the fetus.
Third - sequence.

With the onset of labor pregnant women in call.
The first stage of labor is divided into two successive phases:

– Latent (hidden) phase - the time from the start of the regular labor activity until smoothing cervix opening to 3 cm in first delivery or up to 4 cm in all these. Usually this phase falls under, 6-8 hours (primipara) and 4-5 hours (bipara).

– The active phase - the opening of the cervix from 3.4 cm to 10 cm including minimum speed opening of the cervix into the active phase, which is the norm is 1 cm / h in the first and in subsequent births. Usually the rate of disclosure in women who give birth to a second or third more than in ¬ cal and give birth for the first time.

The active phase is divided in turn into three phases: acceleration, maximum rise and deceleration. Phases acceleration of primipara lasts up to 2 hours, bipara - up to 1 hour. Phases maximum recovery continues as many hours respectively. Phases slowdown in primipara lasts 1-2 hours in bipara - 0,5-1 hour. The slowdown
Application of these techniques causes irritation of specific afferent peripheral nerve receptors, which leads to increased levels of endorphins in cerebrospinal fluid, which are endogenous analgesic substances.

The use of pharmacologic analgesics during delivery is made only by the presence of clinical indications.

**Requirements for medical anesthesia:**

- analgesic effect;
- no negative impact on the mother and fetus;
- ease of administration and availability.

Anesthesia are using at:

- not inhaled and inhaled anesthetics;
- regional anesthesia;
- systemic analgesics (fenotiozynu derivatives, etc.);
- opioid alkaloids (at the opening of the cervix is not more than 5-6 cm).

The second period (the period of exile) of the complete opening of the cervix before birth. It is important to distinguish the early phase of the second period - from full develop-discovery to the powers and active - directly phase powers.

Note the maximum. Permissible duration of the second period in women who give birth for the first time and second time, respectively, 2 and 1:00 without epidural anesthesia, and consequently 3 and 2 hours with epidural anesthesia. Most of this time is very early phase, when the head moves slowly through birth canal to the pelvic floor without joining first attempts, and then with the gradual emergence of a strong and increasing component during contractions. The organization attempts during early phasa in the presence of normal fetus and the mother usually quickly leads to fatigue women, disrupting the internal rotation of the fetal head, injury, maternity tract and the head of the fetus, fetal cardiac abnormalities and unnecessary medical interventions.

Complete strong activity appears only when the head is tazo-ments days (active phase).

One should note that the long standing head of the fetus in a particular area of the pelvis without promotion dynamics can lead to the formation of recto- and urogenital fistulas.

Possible information about the location of the fetal head to the plane of the pelvis obtained by vaginal ported by research.

**Important concepts II period are:**

- attempts (strain) - rhythmic, consciously controlled combination of reducing uterine muscles, abdominals, diaphragm and pelvic floor;
- infeed of head - the appearance of the head of the Boulevard ring only when power;
- cutting of the head - head keeps position in Boulevard ring after cessation attempts.

**Conduct second stage of labor requires:**

- measurement of blood pressure, heart rate in women in every 10 minutes;
- Control of fetal cardiac activity every 5 minutes during the early phase, and after each power during the active phase;
• monitoring the progress of the fetal head through the birth canal, which is carried out using an internal midwifery studies every st hower.
• Due to increased risk of infection rising birth canal additional internal midwifery research in the second stage of labor allowed only if indicated:
  – Conducting amniotomy, if there is no timely outpouring of amniotic fluid.
  – When multiple pregnancy after birth of the first baby.
  – When decisions operative vaginal delivery (forceps obstetrical, vakuumekstraktsiya, extraction of the fetus for pelvic end).

Birth of the fetal head should be providing manual assistance, which aims not only to preserve the integrity of the perineum women, but also the prevention of intracranial, spinal and other injuries of the fetus.

It is important to emphasize that only when necessary during the period of expulsion can be held auxiliary section perineum (perineo and episiotomy).

Testimony before the crotch section is (WHO):
  – Complicated vaginal delivery (vacuum extraction, obstetrical forceps, breech presentation).
  – The presence of scarring crotch after straightening in previous births especially after poor healing.
  – Fetal distress.

According to modern scientific evidence for the use of episiotomy indications threat perineal is not always justified. Lack of clear objective criteria "threat perineal" is the basis for wider use epizyutomiyi, which is nothing other than iatrogenic rupture of second-degree perineal In most cases, except in the presence of so-called "threat perineal" section pro-mezhyny not performed, there is a spontaneous rupture of a perineal skin and vaginal mucosa, without damage to the pelvic floor muscles (the gap of the first degree).

It should also be recognized that in some cases the perineum indeed poses challenges for the birth, and her autopsy is a necessary measure to prevent severe breaks, but the decision to perform episiotomy should be taken skilled after careful evaluation of obstetric situation.

It should be emphasized that, according to modern scientific evidence:
• The use of episiotomy should be restricted indications (Level A recommendation);
• Prerineotomiya accompanied by a higher frequency of deep ruptures with vaginal lesions straight cats and anal sphincter compared with episiotomy. (Level A recommendation);
• Routine of episiotomy does not reduce the frequency of deep ruptures with vaginal lesions straight cats and anal sphincter. (Level B recommendation);
• If the need for perineal incision is the preferred episiotomy, not lerineotomiyi. (Level B recommendation).

Thus, the decision to perform surgery should be clinically justified and granted to women to obtain permission from her. The operation should be seeing you after prelocal anesthesia.

It should be noted that the provision of a free woman during attempts facilitates more dynamic passage of the fetus through the birth canal, the most effective are the
returns within 6 weeks. Involution of the uterus occurs due to reverse development of muscles by hyaline and fatty degeneration.

Within 2-3 days after birth detsydutsalna shell remains in the uterus and is divided into two layers. The surface layer nekrotyzuyetsya stands out from Lohia (postnatal discharge). Basal layer adjacent to the endometrium, which contains endometrial cancer remains intact and becomes the basis for the regeneration of new endomyetriya.

Regeneration of the endometrium runs for three weeks, with the exception of placental site. Complete regeneration of the epithelium in the area of attachment of the placenta takes 6 weeks. Excitation regeneration in the placental site may experience postpartum hemorrhage and infection.

Cervix. After 10-12 Guolin postpartum cervical canal is funnel shape, the inner eye skips 2.3 fingers and 3 night - one finger. At 8-10 days postpartum cervix formed, the inner eye closed.

Vagina. Within 3 weeks after birth vaginal wall remain with edema, which finally disappear by the end of the postpartum period. Minor damage the lining of the vagina regenerate for 5-7 days. Gender gap closes, gradually restored the tone of the pelvic floor muscles.

Ovaries. In the postpartum period begins maturing follicles. It is characteristic of anovulatory cycles, against which is the first menstruation after childbirth Later ovulatory cycles resumed. With the release of large quantities of prolactin in women with breast-feeding, no menstruation for several months, or during the period of breast-feeding a baby.

Abdominal wall and pelvic floor. Because rupture of elastic fibers of skin and long stretching pregnant uterus, the anterior abdominal wall still soft and saggy and returns to the normal state of a few weeks. Except tuning usually abdominal wall returns to its previous state, but some muscles can remain flabby and weak. Sometimes there diastase recti. Pelvic floor muscles are gradually restoring its tone, but trauma during childbirth can lead to weakening of muscles and contribute to genital hernias (prolyapsiv).

Mammary gland. The function of breasts after childbirth reaches a climax. Estrogen and progesterone during pregnancy stimulate growth and alveolar ducts of the breast. Under the influence of prolactin is increased blood flow to the mammary glands and their engorgement, which is most pronounced on the third day postpartum period. The secretion of milk is the result of complex reflex and hormonal action. Formation of milk regulated by the nervous system and the adenohypophysis hormone - prolactin. In addition, the optimal level of insulin, and adrenal hormones play a secondary role in establishing lactation. Suckling stimulates prolactin secretion periodic and reflex, oxytocin, the latter stimulates the secretion of milk from the alveoli in the milk duct. Note that this process also enhances the reduction of postpartum uterus. In the period up to 3 days after birth breasts produce colostrum (soyiozihyhp). Colostrum has a high concentration of proteins, mainly globulins, and minerals and smaller - sugar and fat. Protein amino acid composition of colostrum by occupying a transitional state between protein fractions of human milk and serum, which obviously facilitates newborn body during the transition from placental nourishment to breast milk of the mother. Colostrum contains high levels of immunoglobulin A, O, M, O, and T-and B-lymphocytes. This is of great importance