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CESAREAN SECTION IN UKRAINE AND THE UNITED KINGDOM: SIMILARITIES AND DIFFERENCES

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Summary

The aim of the study was to conduct a comparative analysis of cesarean sections in Ukraine and the United Kingdom in order to improve the quality of medical care and optimize outcomes for both mother and newborn.

Materials and methods. To achieve this goal, we analyzed the unified clinical protocol «Caesarean section» of the Ministry of Health of Ukraine dated January 5, 2022 and the UK NICE GUIDELINE «Caesarean birth» in the latest version dated September 6, 2023.

The work was performed in accordance with the research plan of the Department of Obstetrics and Gynecology #2 of KhNMU: «Optimization of diagnostics, treatment of diseases of the reproductive system and pregnancy complications in women with extragenital pathology» (state registration number 0121U11923).

Results. A comparative study of cesarean section protocols in Ukraine and the United Kingdom provided important insights into the current state of obstetric practice in both countries. Significant diversity in CS protocols in Ukraine and the UK was noted. This is particularly true for both clinical aspects and aspects related to organizational and sociocultural factors. A significant influence of social and cultural factors in the UK on the frequency of CR was found. The difference between the Ukrainian medical system and the NHS in the UK is mainly in the control of narcotic analgesics, the duration of the postoperative period, and the consideration of the woman's preference for the method of delivery is quite controversial.

Conclusions. Negative statistics reveal that the increase in the frequency of CS is typical not only for the UK, but also for Ukraine, although in Ukraine the explanation for this situation is the increase in the frequency of obstetric and extragenital pathology during martial law, and in the UK it is the woman's choice. Understanding the differences between countries in their approaches to CS will help improve the quality of medical care and optimize outcomes for both mother and newborn.

Understanding the differences between countries in their approaches to CS will help to improve the quality of medical care and optimize outcomes for both mother and newborn.

Key words: Pregnancy; Birth; Cesarean Section; Extragenital Pathology; Diabetes Mellitus; Obesity.

Introduction

Caesarean section (CS) is a surgical procedure in which an obstetrician-gynecologist removes a child from the uterus through an incision in the anterior abdominal wall. In modern obstetric practice, CS is recognized as one of the key surgical procedures that allows for safe delivery for both mother and fetus, especially in pregnant women with severe extragenital pathology or complicated labor. Despite existing international standards and clinical protocols, the indications for CS and its technique may vary depending on the country and its medical system [1,2,3].

Comparative statistics on the incidence of CS in Ukraine and the United Kingdom (UK) show that in the 1950s only 3 % of births in the UK were delivered by CS. In the late 1980s, this figure rose to 10 %, and in the 1990s a rapid increase began, from 12 % in 1990 to 21 % in 2001. Over the last 20 years, the incidence of CS in the UK has continued to rise, reaching 31 %, of which 15 % are emergency CS [4]. The reasons for the increase in the number of CS in the UK include medical factors: clinicians' preferences to manage complicated deliveries; a constant percentage of fetuses with breech presentation (3-4 % of the total), as this type of presentation is an indication for elective CS according to the NICE guideline [1]; an increase in the number of mothers aged 35 and over, who are more likely to undergo CS; and an increase in the use of assisted reproductive technologies (ART), which leads to multiple pregnancies, which also often end in elective CS [5]. It is also important to consider that advances in recent years have made CS safer for both

mother and fetus. Non-medical factors include maternal choice: 28 % of women aged 25-34 would choose cesarean section if given the choice; cultural influence – after several celebrities chose CS, the media promoted the idea that these women were «too important to give birth naturally», so the rise in CS rates can also be explained by women's choice. Litigation is important in the UK: the increase in CS is often linked to physicians' fear of litigation. Between 2015 and 2021, 80-90 % of the 2,821 claims in obstetrics and gynecology were related to birth injuries caused to a child at birth, including cerebral palsy (CP). Birth injuries resulting in cerebral palsy are very costly to the UK National Health Service (NHS), as judgements in these cases require lifelong education and care for these children [6,7].

As for Ukraine, the incidence of CS has also increased in recent years from 10 % to 25 %, which has led to an almost threefold decrease in perinatal mortality [8]. The increase in the incidence of CS is due to the increase in the number of pregnant women with extragenital pathology, including diabetes mellitus, uterine scarring after previous childbirth or gynecological surgery [9,10,11].

According to the Working Group on the Development of the Cesarean Section Clinical Guideline, there will be a 26.3 % increase in this indicator between 2015 and 2020. While it was 18.5 % in 2015, it reached 25.1 % in 2020 [12].

In particular, according to Moskvyyak-Lesniak D. E., in 2018 the method of delivery by cesarean section in the municipal noncommercial enterprise «Maternity Clinical Hospital No. 1 in Lviv» in 25.7 % of 4579 deliveries, which increased by

1.2 times compared to 2017-20.8 % of operations out of 4832 deliveries [13]. In the study of O. V. Hryshchenko, out of 550 women in labor who gave birth in the Kharkiv City Perinatal Center of the Kharkiv City Council in 2018-2019, 129 (23.4 %) women underwent cesarean section [14]. In the Poltava region, according to V. Vashchenko, in 2022 the frequency of cesarean delivery reached a record high of 28.7 % for all years [15].

According to Motsiuk Y. B., the current state of the problem of CS is balanced between the desire to reduce its frequency and the global trend of increasing its frequency. The urge to reduce is due to a significant number of complications, the probability of which increases with subsequent operations, and the upward trend is due to sociodemographic factors, differences in health care financing [16].

Thus, the relevance of the study lies in the need to find optimal indications and technical aspects of cesarean section, adapted to the specific conditions of each country.

The aim of the study was to conduct a comparative analysis of cesarean section in Ukraine and the UK in order to improve the quality of medical care and optimize outcomes for both mother and newborn.

Materials and methods. To accomplish these tasks, we analyzed modern scientific research, statistical data, orders and clinical protocols for cesarean section operations in Ukraine and the United Kingdom. In addition, medical records and statistical reports on this surgical procedure at

the Kharkiv Regional Clinical Hospital in recent years and their changes during martial law were studied.

The work was performed in accordance with the research plan of the Department of Obstetrics and Gynecology #2 of KhNMU: «Optimization of diagnostics, treatment of diseases of the reproductive system and pregnancy complications in women with extragenital pathology» (state registration number 0121U11923).

Results and discussion. To achieve this goal, we analyzed the uniform clinical protocol «Caesarean section» of the Ministry of Health of Ukraine dated January 5, 2022 and the British clinical protocol NICE GUIDELINE «Caesarean birth» in the latest version dated September 6, 2023 [1,2].

First, it was decided to compare the Ukrainian and English cesarean section protocols in terms of time. Depending on the time interval between the decision to deliver by cesarean section and the beginning of the operation, there is an urgent and a planned cesarean section. Urgent cesarean section is performed depending on the clinical situation, indications and the patient's consent. In Ukraine and the United Kingdom, the following categories of urgency are distinguished (Table 1). As can be seen from the table, the categories of urgency are almost identical in number and time, but have different names, and the time of planned CS in the UK is determined by the woman's or doctor's request.

Table 1.

C-section urgency category comparison

CS urgency category (by Ukrainian protocol)	CS urgency category (by UK protocol)
Category I – there is a significant threat to the life of the mother and/or fetus (e.g., fetal distress, uterine rupture, etc.) – the procedure should begin no later than 30 minutes after the indications are determined;	Category 1 (EMERGENCY) – an immediate threat to the life of the mother or fetus (suspected uterine rupture, premature abruption of a normally positioned placenta, loss of umbilical cord loops, fetal hypoxia, or persistent fetal bradycardia). Labor should be completed within 30 minutes of the decision.
Category II – the condition of the mother and/or fetus is impaired, but there is no immediate threat to the life of the mother and/or fetus (for example, abnormal labor activity in case of impaired condition of the mother or fetus) – the operation should begin no later than 75 minutes after the determination of the indications;	Category 2 (URGENT) – Maternal or fetal pathology that is not immediately life threatening. Delivery must occur within 75 minutes of the decision.
Category III – the condition of the mother and fetus is not compromised, but requires abdominal delivery (for example, prenatal rupture of membranes in case of planned CS; abnormal labor activity in the absence of compromised condition of the mother or fetus) – the operation should begin within 75 minutes, but as soon as possible;	Category 3 (PLANNED) – No maternal or fetal complications, but early delivery is required.
Category IV – according to the preliminary schedule on the scheduled day and time.	Category 4 (PLANNED) – The time of birth is chosen according to the woman's wishes or those of a health care provider.

The indications for *emergency* cesarean section are almost identical in Ukraine and the UK, due to the general principles of emergency care in obstetric practice. These include: 1) premature detachment of a normally located placenta before the onset of labor or during labor in the absence of conditions for rapid delivery; 2) bleeding from the genital tract of unknown etiology in late pregnancy or during labor; 3) threatened or incipient uterine rupture; 4) fetal distress (according to instrumental research methods) in the first stage of labor; 5) prolapse of pulsating umbilical

cord loops; 6) obstructed labor (posterior asynclitism, incorrect position of the fetus after amniotic fluid has been ejected, extensor presentation or insertion of the head, clinically narrow pelvis); 7) disorders of labor activity that are not corrected by medication; 8) unsuccessful attempt to induce labor; 9) critical condition, death of the pregnant woman's brain, death of a pregnant woman with a viable fetus.

A comparison of the indications for the *planned* CS is shown in Table 2.

Table 2

Planned c-section indications comparison

Planned CS indications (by Ukrainian protocol)	Planned CS indications (by UK protocol)
Placenta previa (according to ultrasound at 36+ weeks, the lower edge of the placenta is < 2 cm from the inner eye)	Partial or complete placenta previa. Growth of the placenta into a scar on the uterus (confirmed by ultrasound at 32 to 34 weeks).
Pelvic presentation of the fetus (after an unsuccessful attempt at external rotation of the fetus at 36 weeks; if there are contraindications to external rotation at the insistence of the pregnant woman)	Breech presentation of the fetus (in case of unsuccessful external obstetric rotation of the fetus after 36 weeks or refusal of this procedure by the mother) Premature birth (from 26 to 36+6 weeks) in case of breech presentation.
Lateral position of the fetus.	
Pelvic presentation or malposition of the first fetus in multiple gestation	Dichorionic diamniotic twins when the first fetus is not in breech position. Premature twin pregnancy (from 26 to 32 weeks) when the first fetus is not in breech position. Triplet pregnancy (after 35 weeks if there are no complications)
Monoamniotic twins.	Monochorionic monoamniotic twins (32 to 33+6 weeks)
Growth retardation syndrome of one of the fetuses in a multiple pregnancy.	-
Scar on the uterus with contraindications to vaginal delivery (previous cesarean section, T- or J-shaped uterine incision during previous surgery, history of uterine rupture, history of more than one cesarean section, condition after gynecological procedures involving penetration of the uterine cavity, refusal of the woman to attempt vaginal delivery).	Uterine scarring following previous SC or myomectomy.
Primary genital herpes less than 6 weeks prior to delivery.	Primary maternal infection with herpes simplex virus.
Extragenital diseases and syndromes: Circulatory system: severe pulmonary hypertension, dilatation of the ascending aorta > 45 mm, severe aortic stenosis, oral anticoagulants (vitamin K antagonists), myocardial infarction in this pregnancy, severe heart failure (NYHA functional class III or IV); respiratory system: Pulmonary disease with risk of pneumothorax, pulmonary hemorrhage occurring less than 4 weeks prior to delivery; nervous system; intracerebral tumors, hypertensive-liquor syndrome, cerebral vascular aneurysms, arterio-venous malformations, condition after hemorrhagic stroke; Sight organ: hemorrhagic form of retinopathy, perforated corneal ulcer, ocular injury with penetration, acute glaucoma attack. (NOTE! Any other ophthalmologic pathology, except for those mentioned above, is not an indication for caesarean section); Diabetes mellitus: expected fetal weight > 4500 g; Hepatitis C in combination with HIV infection;	Severe maternal extragenital pathology.
HIV infection: viral load > 50 copies/mL	Infections that can be passed from mother to child: HIV.
Tumors or bone deformities of the pelvis that prevent the birth of a child.	Deformities of the mother's pelvis and/or disproportionate size of the fetus to the mother's pelvis.
Cervical cancer.	
Grade III perineal tear in history, condition after plastic surgery on the perineum	
Condition following surgical treatment of urogenital or intestinal fistula.	
Fetal malformations to be corrected surgically in the early neonatal period: diaphragmatic hernia, spinal dysraphism, gastroschisis, teratomas (by decision of the perinatal consultation with the involvement of a specialized surgeon).	
Conjoined twins.	
Early delivery after repeated hemotransfusions in cases of immune conflicts.	
	The woman's desire. (If there are no indications, after a detailed discussion of the risks to the mother and fetus and consultation with a psychologist about tokophobia, with a record of this discussion and consent entered in the medical record).

As can be seen from Table 2, the protocols of Ukraine and the United Kingdom regarding indications for planned CS have a number of differences, the most important of which is the woman's desire. In the United Kingdom, if there are no indications for CS, it can be performed at the request of the pregnant woman after a detailed discussion of the risks to the mother and fetus, consultation with a psychologist about tocophobia, and entry of informed consent in the medical record.

Much attention is paid to anesthesia during CS in both Ukraine and the UK, but the UK protocols present its features in more detail. Spinal anesthesia in the operating room is recommended for all women. Prevention of maternal hypotension includes tipping the woman to the left side up to 15° when lying on the operating table and administration of phenylephrine immediately after spinal anesthesia. Administration of antiemetics and drugs that reduce the acidity of gastric juice (antacids and proton pump inhibitors). Prevention of hypothermia: warm all intravenous fluids to 38-40°, blood products to 37°. Administration of antibiotics prior to skin incision.

According to the Ukrainian clinical protocol «Cesarean section» [2], the *peculiarities of CS in Ukraine* are represented by the following surgical technique. First, the center of the incision is located and three marks are made on the skin: one along the midline and one on each side. Slightly pull the skin in the direction of the fold, this will cause less deformation and ensure a straight incision. Make a skin incision approximately 15 cm long. It should not extend into the subcutaneous tissue. This shallow incision should be almost bloodless. Deepen the incision with the scalpel 2-3 cm from the center of the incision, across the subcutaneous tissue to the aponeurosis. Do not attempt to separate the subcutaneous tissue. The blood vessels and nerves will remain intact because the area of subcutaneous tissue in the midline is the least avascular. Make a small transverse incision in the aponeurosis with a scalpel. Extend the transverse incision of the aponeurosis in both directions under the subcutaneous tissue without breaking its integrity: position the tips of the partially opened scissors so that one blade is above and the other below the aponeurosis (support the scissors from below with the index finger of the left hand). Move the scissors laterally, first away from you and then toward you. At this level, it is not necessary to separate the rectus muscles from the aponeurosis because they are above the level of insertion of the piriformis muscles. Gently separate the aponeurosis from the muscle and use your index fingers to spread the rectus muscles cranially and caudally in preparation for the next step. Extend the rectus muscles. To do this, the surgeon and assistant place the right index and middle fingers along the midline between the rectus muscles, grasp the muscle, and then simultaneously spread them by traction with balanced and increasing force. This motion should be performed with a slight outward rotation, which allows you to spread the upper part of the incision more than the lower part. Don't be afraid to use a lot of force. This maneuver will allow you to move all vessels and nerves to the side without damaging them and to access the peritoneum by using your index fingers to stretch the parietal peritoneum transversely in the upper corner of the wound until a small opening is formed. Use your index

fingers to dilate the opening caudally and cranially. When the peritoneum is stretched in the cranial and caudal directions, it will tear, preventing injury to the bladder. Using your fingers to enter the abdomen will prevent injury to the bowel. Identify the lower segment of the uterus and bladder. Use a scalpel to make a 1 cm transverse superficial incision in the visceral peritoneum above the bladder. Avoiding the blood vessels, move to the right and left (10-12 cm total) so that the baby can be delivered through this opening. Use mirrors to see the movement of the instrument. Try not to lower the level of the incision as this may limit the ability to spread the edges of the uterine incision. Lower the visceral peritoneum with the bladder down using 2 fingers. Using your fingers will prevent injury to the bladder compared to using a swab. Make a small transverse incision in the lower segment of the uterus with a scalpel, or use your right index finger to make an opening in the uterus. Use your fingers to stretch the edges of the uterine opening transversely. Use your right thumb to hold the far corner of the wound and your left index finger to spread the wound in the near corner. The thumb is thicker than the index finger, which reduces the risk of injury to blood vessels on the distal side of the uterus. Continue the opening more to the right than to the left because the uterus is usually turned to the right at the end of pregnancy. Place two fingers under the fetal head and move it out of the wound. The assistant will push down on the bottom of the uterus to help push the baby out. The fingers take up less space than a full palm, reducing the likelihood of uterine injury during delivery. After the baby is born, the anesthesiologist administers 5 units of oxytocin intravenously. The afterbirth is removed by controlled traction on the umbilical cord. The umbilical cord is kept in a state of slight tension until the placenta begins to separate spontaneously. By gently pulling the umbilical cord, the afterbirth is removed from the uterine cavity. Do not pull on the umbilical cord if there are no uterine contractions and no signs of placental separation, as this may cause the uterus to prolapse! Also, if you have an abdominal wound, place your whole hand behind the uterus and massage the uterus to stimulate contractions. For heavy bleeding around the placenta, squeeze the uterus between the palms of your hands. This method provides significant hemostasis. While continuing to massage the uterus, use a gauze cloth to remove any remaining membranes and tissue from the uterus, thereby stimulating uterine contractions. Grasp the center of the lower edge of the uterine wound with an atraumatic clamp. If necessary, dilate the cervical canal with a Hegar dilator and push the dilator into the vagina for removal after surgery. This step may increase the risk of genital infection, i.e., spread from the vagina to the uterus. Restore the integrity of the uterus by placing a single or double-row continuous suture through the entire thickness of the uterine wall. Use a long (90 cm) #1 ligature (preferably a synthetic absorbable suture) and a large barbed needle. Retract 1 cm from the edge of the incision from above and below to ensure adequate hemostasis. Exercise caution in the lower part of the incision to avoid injury to the bladder. If the lower segment is thinned, a second row of sutures may be required. Check hemostasis. Ensure that blood pressure and pulse are within normal limits. If hemostasis is inadequate, apply additional sutures to ensure there is no

bleeding. Remove blood clots. Remove fluid blood from the peritoneal cavity with a suction cup. Minimize bowel manipulation to ensure early return of bowel function. Suture the visceral peritoneum: Suture the edges of the visceral and parietal peritoneum together without applying ligatures. The edges of the peritoneal wound will heal in a short period of time. Restore the integrity of the aponeurosis with a single-row continuous suture without rollover. Prefer a synthetic suture with long resorbability. Place the first suture with the knot under the aponeurosis. Place each suture slightly diagonally across the incision. Do not use a continuous suture with a rollover. Be careful at the edges of the incision to avoid damaging the vessels. Routine suturing of subcutaneous tissue is not necessary unless it is more than 2 cm thick. Suture the skin using a cosmetic intradermal suture or multiple individual Donati sutures. Clamp the edges of the incision between the sutures to ensure proper alignment of the wound edges. In the absence of intraoperative complications, offer early fluid intake to the woman in labor. Perform early mobilization of the patient immediately after the anesthetic has worn off. Postoperative fasting is not necessary. Early mobilization reduces the risk of thromboembolic complications and decreases the intensity and duration of postoperative pain. Reduced pain facilitates breastfeeding, which in turn facilitates uterine contraction and involution. Individual sutures are removed on postoperative day 7, reducing the risk of infection and keloid scarring.

The *technical characteristics of caesarean section in the United Kingdom* include the following aspects [17]. The surgical field is treated with an alcohol-based chlorhexidine antiseptic. In the absence of chlorhexidine, an iodine-containing antiseptic may be used. Treat the vagina with an iodine-containing water-based antiseptic in case of premature rupture of the membranes to prevent endometritis. The Joel-Cohen or Pfeinstiel approach is recommended in the absence of indications for other approaches [18]. The subsequent opening of the abdominal wall is recommended to be performed exclusively by the blunt method. The use of the blunt method is also recommended for widening the uterine incision to reduce blood loss, prevent postpartum hemorrhage and the need for blood product transfusion during and after surgery. Delivery is performed according to the type of fetal presentation. The placenta is removed by traction on the umbilical cord to prevent endometritis [19]. Routine uterine exteriorization is not recommended because it is associated with increased postoperative pain and nausea/vomiting during surgery. Suturing of the uterus is performed by applying a single or double row of suture to the uterus. According to recent studies, there is no direct correlation between the method of uterine suturing and postoperative complications, whether it is a single-row or double-row suture [20, 21, 22, 23, 24]. Peritonization is not recommended as it causes pain in the postoperative period. Suturing of the anterior abdominal wall is performed in layers, while suturing of subcutaneous fat is not recommended if its thickness is less than 2 cm. Skin suturing is performed with resorbable material instead of surgical staples to reduce skin defect.

Thus, after a detailed analysis of both protocols, a large number of similarities were found in the indications for CS,

surgical technique, and anesthetic support of the operation, but there were also differences.

The differences between the clinical protocols are mainly related to the indications for CS: the Ukrainian protocol describes the indications for CS in more detail, which does not allow to refer to the protocols for other pathologies. The British guideline does not give a clear answer to the questions about the presence of extragenital pathology in a pregnant woman. It is interesting that the indication «mother's wish» is present in the NICE protocol, but not in the protocol of the state publisher. There are also differences in anesthesia issues: heating solutions for infusion as prevention of hypothermia, prevention of heartburn, nausea before surgery. Differences were also found in technical aspects. From the technical point of view, the Ukrainian protocol describes the procedure of the operation in much more detail. Each stage of the surgical procedure is supplemented with schematic illustrations for better understanding. The British protocol has a rather small technical protocol of the operation without clear instructions on access to the uterus, skin suturing. It is more aimed at reducing the trauma of the operation and reducing postoperative pain. Pain relief in the postpartum period is a rather interesting issue, given that intrathecal morphine was the first-line drug in both cases. If its effect is insufficient, the addition of paracetamol is recommended to reduce the need for opioids. In the United Kingdom, the use of oral forms of morphine is also recommended. It is also possible to combine paracetamol and dihydrocodeine, which is prohibited in Ukraine. If a woman is breastfeeding, minimal doses of opioid analgesics are used, not longer than 3 days under close supervision.

Discharge of a woman in labor from the hospital varies: in Ukraine, a woman in labor after CS is discharged 3 days after surgery if the postoperative period is uncomplicated. In the UK, discharge is recommended 24 hours after the procedure if the patient is in good health, without fever and complications [25,26].

Thus, a comparative study of cesarean section protocols in Ukraine and the United Kingdom provided important insights into the current state of obstetric practice in both countries. Significant differences in cesarean section protocols in Ukraine and the United Kingdom were noted. This is especially true for clinical aspects as well as aspects related to organizational and socio-cultural factors. A significant influence of social and cultural factors in the UK on the frequency of CR was found. The difference between the Ukrainian medical system and the NHS in the UK is mainly in the control of narcotic analgesics, the duration of the postoperative period, and the consideration of the woman's preference for the method of delivery is quite controversial [27].

According to the data of the Kharkiv Regional Hospital and the Kharkiv Regional Perinatal Center, we analyzed the indications for CS, especially during the period of martial law. It was found that in the pre-war period the frequency of CS was 37.5 %, and the ratio of planned CS/urgent CS was 74.7 %/25.3 %. During martial law, the frequency of CS increased to 43.8 %, and the corresponding ratio was 66 %/34 %. The data obtained indicate an increase in the frequency and urgency of CS, which may be due both to an increase in extragenital pathology (from 70.7 % to 80.6 %) and to stress factors. It is noteworthy that among

the endocrine pathologies, the incidence of obesity increased from 19.9 % in 2020 to 30.1 % in 2023 (1.5 times) and gestational diabetes mellitus (from 16.6 % to 27.5 %) by 1.7 times, respectively, the incidence of CS increased significantly due to these reasons.

Thus, the need to find optimal indications and improve the technical aspects of cesarean section adapted to the specific conditions of each country, use the best practices of foreign colleagues in the issues of indications for CS in pregnant women with extragenital pathology, psychological support, consideration of the mother's interests and postpartum pain relief are quite interesting and promising issues for Ukrainian obstetric practice [28,29,30,31,32].

Conclusions. Negative statistics reveal that the increase in the frequency of CS is typical not only for the UK, but also for Ukraine, although in Ukraine the explanation for this situation is the increase in the frequency

of obstetric and extragenital pathology during martial law, and in the UK it is the woman's choice. Understanding the differences between countries in their approaches to CS will help improve the quality of medical care and optimize outcomes for both mother and newborn.

Prospects for further research: Our results indicate the need for further research to better understand the problems of indications for CR and improve obstetrical tactics in Ukraine, based on the rich domestic and foreign experience, especially in women with extragenital pathology.

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КЕСАРІВ РОЗТИН В УКРАЇНІ ТА ВЕЛИКОЇ БРИТАНІЇ: ЗБІГИ ТА ВІДМІННОСТІ

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Резюме.

Метою дослідження було проведення порівняльного аналізу операції кесаревого розтину в Україні та Великій Британії для покращення якості медичної допомоги та оптимізації результатів як для матері, так і для новонародженого.

Матеріали та методи дослідження. Для досягнення мети нами було проаналізовано уніфікований клінічний протокол «Кесарів розтин» МОЗ України від 5 січня 2022 року та клінічний протокол Великої Британії NICE GUIDELINE «Caesarean birth» в останній редакції від 6 вересня 2023 року.

Робота виконана згідно плану НДР кафедри акушерства та гінекології № 2 ХНМУ: «Оптимізація діагностики, лікування захворювань репродуктивної системи та ускладнень вагітності у жінок з екстрагенітальною патологією» (№ державної реєстрації 0121U11923).

Результати. Порівняльне дослідження протоколів проведення кесарівого розрізу в Україні та Великій Британії надало важливі уявлення про сучасний стан акушерської практики в обох країнах. Зафіксована значуща різноманітність у протоколах КР в Україні та Великобританії. Особливо це стосується як клінічних аспектів, так і аспектів, пов'язаних з організаційними та соціокультурними чинниками. Був виявлений значущий вплив соціальних та культурних факторів в Британії на частоту КР. Відмінність української медичної системи та NHS Британії заключається переважно в питаннях контролю прийому нарко-

тичних анальгетиків, тривалості післяопераційного періоду та врахування бажання жінки щодо методу розродження є досить дискусійними

Висновки. Негативна статистика демонструє, що зростання частоти КР є характерним не тільки для Великої Британії, але і для України, хоча в Україні причиною цієї ситуації є підвищення частоти акушерської та екстрагенітальної патології під час вийськового стану, а в Британії – бажання жінки. Розуміння відмінностей між країнами щодо підходів до КР сприятиме покращенню якості медичної допомоги та оптимізації результатів як для матері так і для новонародженого.

Ключові слова: вагітність, пологи, кесарів розтин, екстрагенітальна патологія, цукровий діабет, ожиріння.

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