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*Congress Program & Abstracts*



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# *Abstracts*

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preeclampsia and cases of eclampsia in 1,324 women (4.96 per 1,000 births). The early multi-disciplinary management are essential to prevent morbidity and mortality associated with preeclampsia. **Material and Methods:** The new version of the Ukrainian National Clinical Guideline (2022) "Hypertensive disorders during pregnancy, childbirth and the postpartum period" covers of the diagnosing and managing pre-eclampsia, during pregnancy, labour and birth. The current algorithm was performed at the National Pirogov Memorial Medical University, Vinnytsya, Ukraine, under budget grant No. 0121 U109141. **Results:** We presented the new algorithm of clinical management for severe pre-eclampsia "CALM DOWN" - the special mnemonic that means "step by step clinical strategy" for the medical teamwork (Table 1).

Table 1. Clinical management of severe preeclampsia Ukrainian experience

Mnemonic	Definition	Action of personnel	Optimal time
C	Calling for help	Calling on duty doctors, an anesthesiologist at the onset of symptoms of severe preeclampsia, with fixation of actual time.	1-3 min
A	Assessment	Check the airway, auscultation of the lungs, re-measure blood pressure, heart rate, assess the oxygen saturation, fetal heart beats, assess the patient's consciousness.	3-5 min
L	Low blood pressure	Antihypertensive therapy: nifedipine 10 mg p.o., urapidil 10 mg IV	5-10 min
M	Magnesium sulfate	Intravenous therapy is with a loading dose of 4 g of diluted magnesium sulphate (in 50 ml) through perfuser.	10-15 min
	Pause	Evaluate the effectiveness of prescribed medications. Target BP: sBP range of 130 to 150 mmHg; dBP range 80 to 90 mmHg.	5-10 min
D	Decision	Decide about further management. Transfer to the intensive care unit or operating theatre or delivery room, depending on gestational age and patient condition.	5-10 min
O	Oliguria	Women with severe preeclampsia immediately prior to regional anesthesia or immediate delivery: 250 mL bolus. Fluid restriction in pre-eclampsia is recommended no more than 60-80 mL/h of IV fluids.	5-10 min
W	Fetal Well being	Continuous CTG monitoring and Doppler assessment.	10-30 min
N	Parturition	All women with severe pre-eclampsia or eclampsia should be delivered within 24 hours, regardless of gestational age. Recommend vaginal birth unless a caesarean section is required for other obstetric indications. If vaginal birth is planned and the cervix is unfavorable, recommend cervical ripening to increase the chance of successful vaginal birth).	

C" is Calling for help

"A" is Assessment

"L" is Low blood pressure

"M" is Magnesium.

PAUSE is evaluated on the effectiveness of prescribed medications.

D" is Decision (decide about further management).

"O" is Oliguria (fluid restriction in preeclampsia is recommend no more than 60-80 mL/h of IV fluids - 5-10 min.

"W" is fetal Wellbeing (continuous CTG monitoring and Doppler assessment) - 10-30 min.

"N" is parturition, timing of birth is dependent on the severity and the gestational age (prolongation of pregnancy carries no benefit for the woman but may be desirable at early gestations to improve the fetal outcomes and prognosis). **Conclusion:** We have proposed the algorithm "CALM DOWN" for the optimal timing of severe PE, offers to systematize the participation of each member of the team in the provision of emergency care.

**Disclosure of Interest:** The authors declare no conflict of interest.

## THE MODERN FEATURES OF THE OPTIMAL INFUSION THERAPY OF HYPEREMESIS GRAVIDARUM

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**Problem statement:** Nausea and vomiting in early pregnancy is very common, affecting approximately 80% of pregnancies, hyperemesis gravidarum (HG) is a severe form that complicates up to 2.2% of pregnancies. In addition to the consequences of undernutrition for the mother and fetus, the severity of HG symptoms causes a serious psychosocial burden, leading to depression, anxiety and even the development of perinatal pathology. The aim of the investigation was to examine of the features of infusion therapy of HG and evaluate them based on both subjective and objective measures of efficacy, maternal and fetal safety. **Material and Methods:** A systematic data search was conducted using the databases MEDLINE, PubMed, Cochrane Database of Systematic Reviews and publications in professional publications of Ukraine for 2013–2023. The search was conducted using the terms: pregnancy, hyperemesis, infusion therapy

and the safety profile of medications prescribed during pregnancy in various combinations. The investigation was performed at the National Pirogov Memorial Medical University, Vinnytsya, Ukraine, under budget grant No. 0121 U109141. **Results:** Intravenous fluid and electrolyte replacement is an important part of symptomatic management of nausea and vomiting, as well as for correction of dehydration in women with HG. We presented the analysis of effectiveness and safety of infusion therapy in HG, according to the evidence medicine (Table 1).

Type of fluid	Quantity/rate	Comments
Hartmann's	1-2 L. Initial rate 1L/ 2 hours, and then 5L/4 hours.	May be used for slow hydration (over 6-8 hours).
0.9% sodium chloride	1-2 L. Initial rate 1L/ 4 hours, and then 500 ml every 4-6 hours.	Avoid rapid administration (can lead to the development of central pontine myelinolysis). In case of hyponatremia ( $K^+ < 3.5$ mmol/L) - 1000 ml of 0.9% sodium chloride with 20 mmol of potassium is administered over 4 hours.
4% dextrose and 0.18% sodium chloride or 5% dextrose	1 L. Initial rate 1L/ 2 hours.	Consider as an option if minimal oral intake, starvation or uncontrolled nausea and only after correction of thiamine deficiency (thiamine 200-300 mg should be added to the infusion) and exclusion of hyponatremia. Avoid usage for fluid replacement as can precipitate Wernicke's encephalopathy.
Potassium chloride	30-40 mmol/L. Maximum infusion rate 10mmol over 1 hour	Administer with caution as per local protocol. Preferred product is premixed 30mmol potassium chloride in 1 L bags of 0.9% sodium chloride. Use large peripheral vein or central venous access only.
Magnesium sulphate	10-20 mmol/day over 20-40 minutes	Oral with 1000ml 0.9% sodium chloride. Use large peripheral vein or central venous access only.
Xylitol	4-8 ml/kg of weight	Duration of therapy is 3-5 days. Does not affect the level of blood glucose and does not contribute to the secretion of endogenous insulin.

**Conclusion:** Emergency management of HG should focus on correction of dehydration and/or electrolyte disturbances, control of nausea and vomiting, to ensure optimal enteral nutrition. Women presenting to the emergency department require infusion therapy based on the severity of HG. The optimal addition to the generally accepted treatment regimens for HG, especially relapses, is the inclusion of the polyatomic alcohol xylitol in the treatment regimen. Xylitol reduces ketogenic intoxication and reduces the synthesis of ketone bodies by accelerating the oxidation of acetyl-CoA in the Krebs cycle, accelerates the removal of ketone bodies from the body and corrects metabolic acidosis, and the balanced composition of electrolytes restores their balance.

**Disclosure of Interest:** The authors declare no conflict of interest.

## ACUTE MASTITIS AS A TRIGGER FOR THE DIAGNOSIS OF ACUTE MYELOID LEUKEMIA.

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Acute myeloid leukemia (AML) refers to a diverse group of aggressive hematologic malignancies involving the proliferation of myeloid blasts committed to granulocytic, monocytic, erythroid, or megakaryocytic lineages. AML is the most common acute leukemia in adults, accounting for approximately 80% of cases in this age group. Patients with AML usually present with symptoms associated with complications of pancytopenia (eg, anemia, neutropenia, and thrombocytopenia), including weakness and easy fatigability, infections of variable severity, and/or bleeding findings such as gingival bleeding, ecchymosis, epistaxis, or menorrhagia. Combinations of these symptoms are common. **Clinical case:** 34-year-old woman with no relevant history, who came to the emergency room due to right mastalgia together with a breast lump of about 3 days of evolution. In emergency analysis, the following is observed: significant elevation of CRP 35.89 mg/dL and procalcitonin 0.65 ng/dL, anemia with hemoglobin of 9.2g/dL, leukocytosis of 16,750 u/mL, with 5% atypical cells, 74% of segmented (hypogranulated) neutrophils, 9% lymphocytes and 12% monocytes and they recommend a consultation with hematology. A bone marrow study was started confirming the presence of 6% lymphocytes, 4% of the erythroid series, 13% neutrophils, 1% mature monocytes and 62% blasts. It is oriented with the diagnosis of acute myelomonocytic leukemia (M4). **Discussion:** The clinical case makes us think about the importance of performing an analysis when the patient went to the emergency room for the first time, the diagnosis of an infectious process was made and the analysis was rejected. Evidently, the evolutionary symptoms of leukemia, with feverish spikes led her to consult a second time, where she performed the analysis with which I suspect the diagnosis of hematological disease. The discrepancy between the symptoms and local examination of the right breast with the fever spikes, which in our opinion were not justified, was also striking. The rapid diagnostic suspicion on the part of the laboratory and the services involved in monitoring and treatment led to the fact that 24 hours after admission to the hospital due to mastitis, it was oriented as possible acute leukemia and transferred to the hematology service where it was confirmed. The diagnosis of AML.

