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**SCREENING DIAGNOSIS DURING DIABETES AND ITS  
PREVENTION**

**G.K. Karimova,**

**F.N. Jahonqulova**

Bukhara State Medical Institute

When asked by the history taking method, whether close relatives of pregnant women with GDM had inherited diabetes mellitus, where cases of DM were diagnosed (58.2% of pregnant women with a history of GDM, 57.4% of patients with GDM).

When studying the state of somatic diseases of pregnant women in the study groups in pregnant women with GDM and GDM in history, chronic pyelonephritis occurred in 32.8% and 30.9%, thyroid disease 32.8%, 35.3%, obesity -75% and 64.2% in the two groups, respectively.

According to the analysis of blood in the case histories of patients in groups, anemia was observed in an average of 61.45% of patients.

Based on the above data, using the Microsoft Excel 2010 program, a series of variations was built to find  $M \pm m$  indicators of the degree of dependence of these features, their correlation levels were studied by the Spearman method.

**Key words:** leptin, C-peptide, pregnant with diabetes, blood glucose, 25(OH)D.

**СКРИНИНГ ДИАГНОСТИКА ВО ВРЕМЯ ДИАБЕТА И ЕЁ ПРОФИЛАКТИКА**

**Г.А. Ихтиёрова, Г.К. Каримова**

Бухарский государственный медицинский институт.

На вопрос методом сбора анамнеза, был ли сахарный диабет в наследстве у близких родственников беременных с ГСД, где были выявлены случаи диагноза СД (58,2% беременных с ГСД в анамнезе, 57,4% пациенток с ГСД).

При изучении состояния соматических заболеваний беременных в исследуемых группах у беременных с ГСД и ГСД в анамнезе хронический пиелонефрит встречался у 32,8% и 30,9%, заболевание щитовидной железы 32,8%, 35,3%, ожирение -75% и 64,2% в двух группах соответственно.

Согласно анализа крови в историях болезни больных в группах в среднем у 61,45% пациенток наблюдалась анемия.

На основании приведенных выше данных с помощью программы Microsoft Excel 2010 была построена серия вариаций для нахождения  $M \pm m$  показателей степени зависимости этих признаков, их уровни корреляции исследованы методом Спирмана.

**Ключевые слова:** лептин, С-пептид, беременные с сахарным диабетом, глюкоза в крови, 25(OH)D.

**ХОМИЛАДОРЛИК ДИАБЕТНИ СКРИНИНГИ ВА УНИНГ  
ПРОФИЛАКТИКАСИ**

**Г.А.Ихтиёрова, Г.К.Каримова**

Бухоро Давлат тиббиёт институти

Қандли диабетнинг ирсиятида мавжуд ёки мавжуд бўлмаганлиги анамнез йиғиш усули билан сўраб суруштирилганда ГҚД билан касалланган ҳомиладорларнинг яқин қариндошларида ҚД билан касалланиш ҳолати учраган (анамнезида ГҚД бўлган ҳомиладорларда 58,2%, ГҚД билан касалланганларда 57,4%).

Текширув гуруҳлардаги ҳомиладорларнинг соматик касалликлар ҳолати ўрганилганда анамнезида ГҚД ва ГҚД билан касалланган ҳомиладорларда сурункали пиелонефрит 32,8% ва 30,9% да учради, бўқоқ касаллиги 32,8%, 35,3%, семизлик ГҚД билан касалланганлар 75%, анамнезида ГҚД бўлганларда 64,2% ҳолатлар кузатилди.

Гуруҳлардаги ҳомиладорлар касаллик тарихидаги қон таҳлилига кўра анемияси бор ҳомиладорларда ўртача 61,45 %да кузатилди.

Юқорида келтирилган маълумотлардан келиб чиқиб ушбу белгиларнинг боғлиқлик даражасини Microsoft Excel 2010 дастуридан фойдаланиб  $M \pm m$  кўрсаткичлари топилган ҳолда вариацион қатор тузилди ва уларнинг Спирман усулида корреляцион боғлиқлик даражалари ўрганилди.

**Калит сўзлар:** лептин, С-пептид, қандли диабет бўлган ҳомиладорлар, қондаги глюкоза, 25(ОН)Д.

Diabetes mellitus has become a global problem among pregnant women around the world, especially during the pandemic, and is one of the pathologies that contribute to a sharp increase in obstetric and perinatal complications and the spread of the disease at a young age.

Gestational diabetes mellitus (GDM) is inextricably linked with metabolic disorders and monitoring of obstetric and perinatal complications [3,18]. The International Diabetes Federation estimates that the global prevalence of GDM is up to 14%, with one in seven babies affected, including 18 million births with adverse complications such as maternal and fetal death, and will depend on the methods used and environmental factors [6,11].

The lack of treatment for GDM can pose a serious threat to the life of both the mother and the child [16,17], for example, the risk of preeclampsia or eclampsia for the mother increases by 8 times. The frequency of risk factors such as hypertension associated with pregnancy is also increasing due to adaptive anomalies, macrosomia of infants, which forces specialists to use surgical interventions: caesarean section, etc. The majority of women with GDM, almost 50%, develop type 2 diabetes at an older age, and the ancestors of mothers with GDM had an increase in blood glucose levels and changes in the lipid profile of amino acids that stimulate insulin secretion and growth factors [9,15]. As a result of these disorders, the development of type 2 diabetes in children and adolescents increases by 6 times [8,14].

In most cases, in pregnant women, the disease is accompanied by mild hyperglycemia and the absence of obvious clinical symptoms, so the peculiarity of GDM is that it is difficult to diagnose with a late manifestation. In some cases, the diagnosis of GDM in infants is detected retrospectively or is not determined at all by the phenotypic symptoms of diabetic fetopathy [1,12]. For this reason, in many countries (especially among the population where type 2 diabetes is common), mass active screening is carried out to detect this pregnancy complication [7,13].

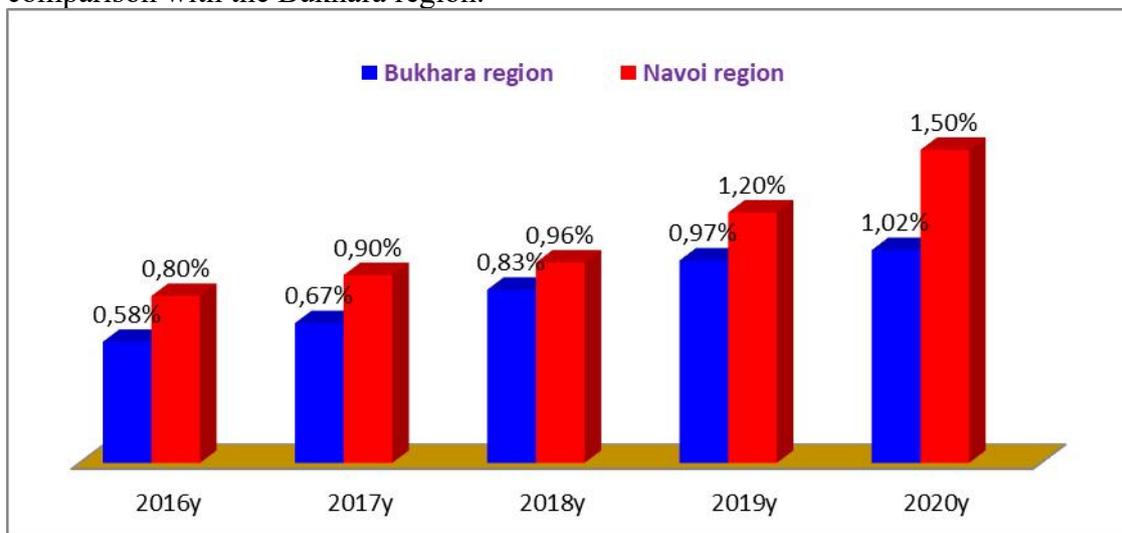
In our country, today there are no standards for early screening for GDM that could fully justify itself, and current issues such as early detection and prognosis have not been fully resolved. Currently, the mechanisms of the origin of GDM are not well understood, and therefore, scientific research is underway to identify early screening biomarkers associated with GDM [2,4]. However, the interaction of identified markers with overt and latent clinical signs of GDM has not been clearly demonstrated. For this reason, the search for predictors of GDM and complications is relevant [5,10].

It is also necessary to develop models for effective detection of women with gestational diabetes, timely screening and prevention methods, which are of particular importance in the management of gestational diabetes and help improve health outcomes. GDM is not a cure, but prevention is a priority both in terms of health and economics. In a non-diabetic woman at risk of GDM, even a small decrease in glucose levels can be an important factor for pregnancy and the health of future generations.

**The aim** of the work is introduction of screening methods based on clinical laboratory (biochemical, hormonal) and instrumental markers in the early diagnosis of gestational diabetes.

**Materials and methods:** The study included general clinical, biochemical (C-reactive protein, ferritin, D-dimer, APTT, ketone, homocysteine, glucose, creatinine, LDH, LII, PGTT, glycated hemoglobin), hormonal (leptin, C-peptide, 25 (ON)D , HOMA-IRCP, HOMA-Islet, methods of correlation and statistical research.

**Results and discussion:** analyzed clinical and anamnestic data and indicators of reproductive health of women with hyperglycemia in the blood. It became known that out of the analyzed data of 68 pregnant women with GDM complications, all of them were diagnosed on the basis of clinical and anamnestic (obesity, large fetus, antenatal fetal death, polyhydramnios, fetal malformation), instrumental and diagnostic data (ultrasound). In pregnant women in Bukhara and Navoi regions in 2016, it was observed in 0.58/0.8% of cases of GDM, in 2017 - in 0.67/0.9% of cases of GDM, in 2018 - in 0.83 /0.96% of GSD cases, in 2019 - in 0.97/1.2% of GDM cases and in 2020 - in 1.02/1.5% of GDM cases (Fig. 1). As can be seen from the figure, the frequency of detection of GDM is more often diagnosed and occurs in the Navoi region in comparison with the Bukhara region.



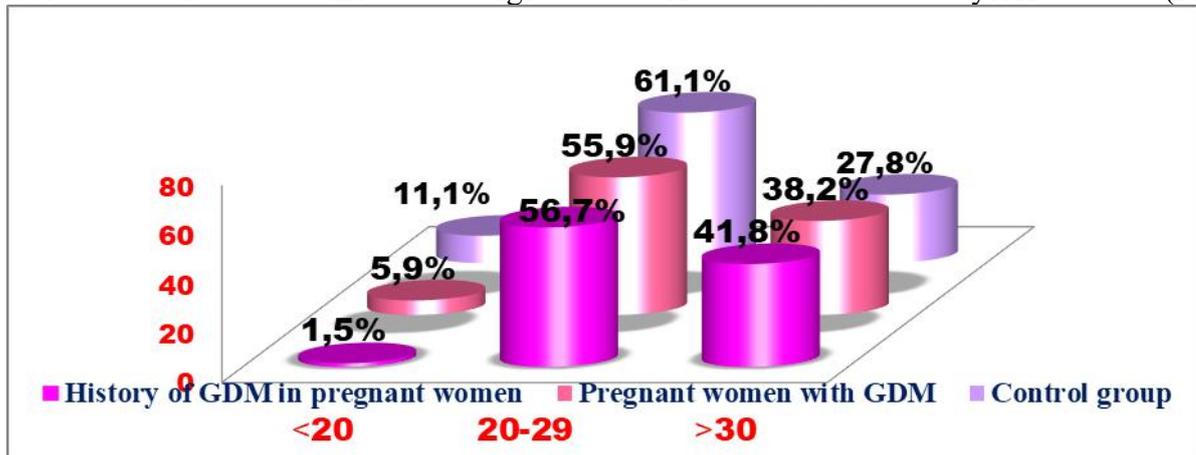
**Figure 1.** Incidence rate of GDM in Bukhara and Navoi regions (%).

The selection criterion for patients was pregnant women with a high risk of GDM with a gestational age of 22–38 weeks, with various obstetric and somatic complicated anamnesis.

When collecting anamnesis, the place of residence of patients was taken into account, since the annual increase in metabolic diseases directly correlates with a decrease in physical activity. It was revealed that 20 (30.2%) pregnant women with GDM live in the village, and in the control group 28 (77.8%). Pregnant women with GDM living in the city amounted to 48 (69.8%), in the control group -8 (22.2%).

It can be seen that GDM is relatively high in areas with stress factors such as metabolic diseases and conditions associated with low mobility and modern development.

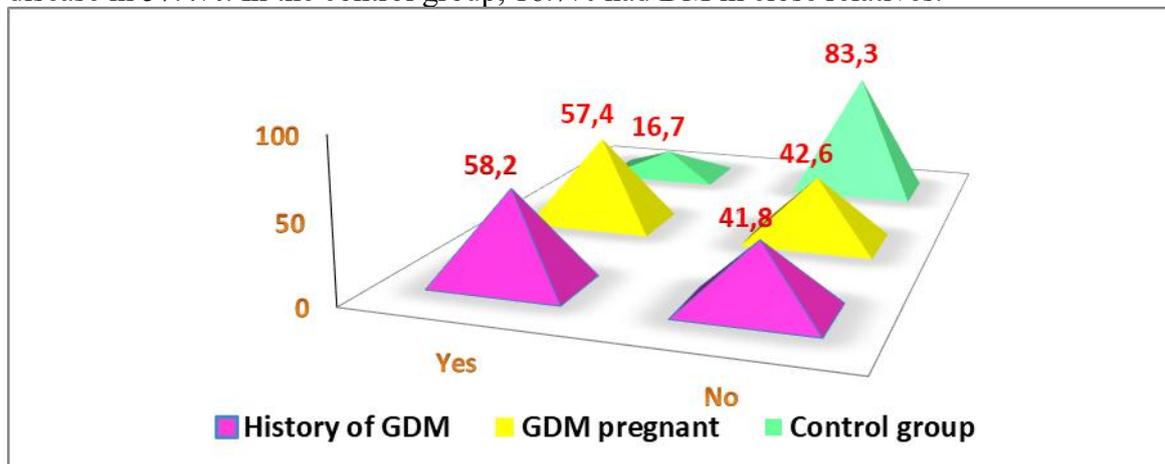
We also paid special attention to the age status of the patients. As can be seen from Figure 3, the incidence of GDM was higher in pregnant women aged 20–29 years due to gestational age and a higher proportion of pregnant women with a history of GDM (56.7% and 55.9%, respectively). Pregnant women aged 30 years and older accounted for 38.2% of pregnant women with GDM and 41.8% of pregnant women with a history of GDM. For comparison, healthy pregnant women in the control group were 11.1% at the age of 20 years, 61.1% at the age of 20-29 years and 27.8% at the age of 30 years (Fig.



2).  
**Fig 2** Age indicators of pregnant women (%).

In the control group there were 13 firstborns and 23 second children, respectively 36.1% and 63.9%.

Also, by taking an anamnesis, it was determined whether the pregnant woman had a hereditary DM disease or not. The results of the survey showed that close relatives of pregnant women with a history of GDM accounted for 58.2%, and pregnant women with DM had hereditary GDM disease in 57.4%. In the control group, 16.7% had DM in close relatives.



**Fig 3.** Patients with hereditary diabetes.

However, in pregnant women with a history of GDM and in women with GDM in this pregnancy in the control group without DM, the rates were 41.8%, 42.6 and 83.3%, respectively (Fig. 3).

Thus, based on the data obtained, the role of the above risk factors (obesity BMI  $\geq 30$ , overweight index BMI 25-30, heredity, polyhydramnios, complicated obstetric anamnesis, large fetus) in early development in pregnant women with GDM should be noted.

We performed basic routine laboratory tests for pregnant women with GDM and then analyzed them: blood, urinalysis, fasting and loading oral glucose tolerance test (OGTT),

glycated hemoglobin index, PTI and coagulogram containing thrombotest, urinalysis for glucose, urea, creatinine.

Particular attention was paid to the study of biochemical analysis of glycated hemoglobin and blood sugar in women who had a history of GDM in previous years (67 pregnant women), 68 pregnant women with GDM (identified during our study) and 36 pregnant women in our control groups.

The purpose of conducting biochemical studies of all fractions of bilirubin, ALT and AST enzymes, total protein, urea and creatinine was to determine the degree of liver and kidney dysfunction, was to determine the characteristic features for GDM in pregnant women.

To identify placental and fetal circulatory disorders associated with the development of complications, we also studied specific analyzes in dynamics, such as homocysteine, leptin, C-peptide, D-dimer and 25 (OH)D. When septic complications occurred, the following indicators were included in the studies as C-reactive protein and procalcitonin.

Of the 68 pregnant women, only 26 received 6 to 10 units of insulin per day on the recommendation of an endocrinologist.

Pregnancy is accompanied by an increase in hematopoiesis, an increase in plasma volume by 2.5-3 times, respectively, with a change in the composition of formed elements and hemoglobin.

The obtained results show that the peripheral blood parameters of pregnant women with a physiological shift (n=36) significantly differ from those of pregnant women with GDM (n=68). In both groups, both healthy and pregnant women with GDM showed a decrease in the levels of erythrocytes and hemoglobin compared to the reference values.

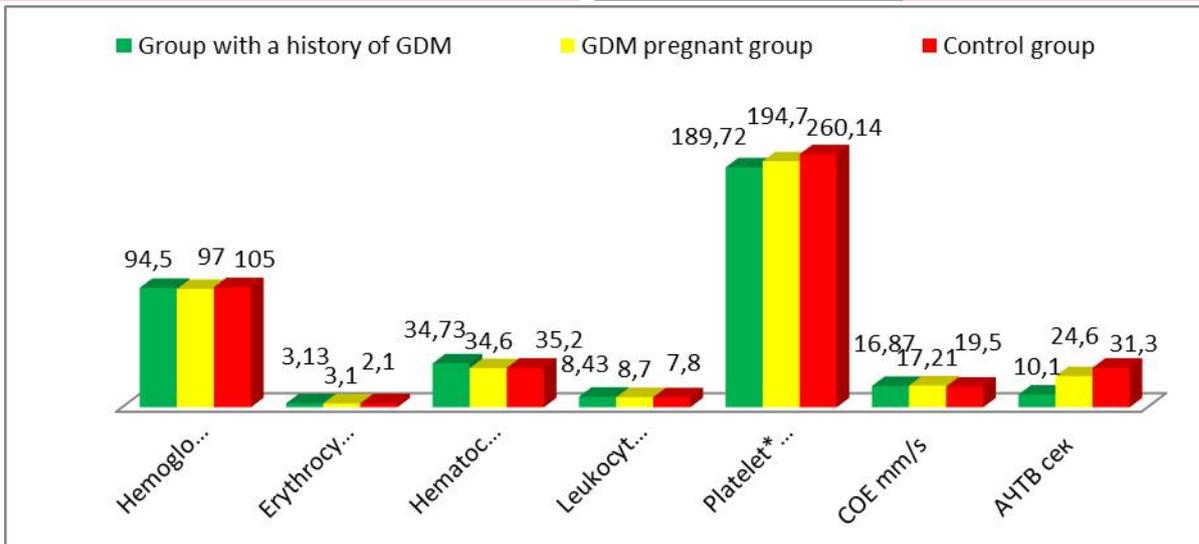
Compared to the generally accepted norms, erythrocytes decreased by 0.7 and 0.4 (2.8 and 3.1), and hemoglobin in both groups decreased by 15.2 and 7.2 (98 and 113.2 g/l), respectively.

The color index, which reflects the average concentration of hemoglobin (Hb) protein in one erythrocyte, ranged from 0.8 to 1.0 without anemia. A decrease in this indicator was observed in different conditions: with various forms of anemia, for example, iron deficiency, anemia after hemorrhoids, often with chronic diseases of internal organs (Fig. 4).

In the study of the white part of the blood (leukocytes) in the group of pregnant women with GDM, this indicator was slightly higher than in healthy people ( $8.7 \pm 0.3$ ;  $7.8 \pm 0.24$   $\times 10^9$  /l).

The number of platelets responsible for important blood coagulation processes during and after childbirth was also 65.7 thousand less than in the group of healthy pregnant women ( $194.72 \pm 2.22$  and  $260.14 \pm 2.19$ , respectively), and in women with a history of GDM  $189.72 \pm 2.15$  ( $P < 0.01$ ), as a result, in the early postpartum period, despite the preventive measures to combat bleeding, there were still cases of obstetric bleeding.

These changes suggest that fluctuations in CBC in pregnant women with GDM further confirmed that this group is at risk for frequent inflammatory processes due to changes in both immune depression and microcirculatory disturbances.



**Figure 4.** Results of laboratory blood tests.

**Conclusions:** In our studies, the risk factors for the development of gestational diabetes were: obesity of the 1st degree (43%), 2nd degree (21.5%) and the growth of overweight (12%), women with hereditary diabetes mellitus (57.4%), the presence a large fetus in history (80.9%), preeclampsia (66.2%), polyhydramnios (35.3%), with a condition after COVID-19, complicated by transient diabetes (14.7%).

The negative impact of gestational diabetes on both the mother's body and the fetus, with the subsequent development of DF and insulin resistance of the fetus.

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Ikhtiyarova Gulchekhira Akmalevna – Zav.kafedroy akusherstva i gynecologii №1 BukhMI.

Phone: +99890 7181917

ikhtiyarova7272@mail.ru

<https://orcid.org/0000-0002-2398-3711>

Kudratova Dilnoza Sharifovna - PhD, associate professor TGSI

Phone: 998905106555

dilnoza.kudratova@mail

[https://orcid.org/\\_0009-0007-9961-5695](https://orcid.org/_0009-0007-9961-5695)

Goykhman Yaron Borisovich is the head of clinical IMTs.

Phone: +998900080034

dr.yaron@ivf.uz

[https://orcid.org/\\_0009-0006-79966351](https://orcid.org/_0009-0006-79966351)