МЕТОДИЧЕСКИЕ РЕКОМЕНДАЦИИ ДЛЯ СТУДЕНТОВ
По дисциплине «Основы профессионального перевода»
К теме «Акушерство и гинекология»

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Тема: Акушерство и гинекология.
Данная тема представлена для повторения грамматического материала и лексических терминов по теме. На данном этапе обучения студент может повторить ранее изученный грамматический и лексический материал, и овладеть новой информацией по теме.

Цель - совершенствование навыков перевода и помощь при переводе оригинальной медицинской литературы.

Сопутствующая задача - активизация лексического и грамматического материалов.

Формируемые компетенции: ОК-1, ОК-5, ОК-8, ОПК-1, ОПК-2

В результате изучения темы студент должен:
- знать грамматику, необходимую на данном уровне;
- уметь строить английские предложения с использованием тех или иных грамматических явлений и тематической лексики;
- владеть навыками ознакомительного чтения.

Вопросы, изученные на предшествующих дисциплинах и необходимые для освоения темы:
- временные формы глагола;
- структура английского предложения;
- виды чтения: ознакомительное, просмотровое, поисковое.
I. Give 3 forms of the following verbs.
To recognize, to determine, to examine, to place, to separate, to inspect, to define, to classify, to observe, to perform, to combine, to note, to show, to find, to see, to list, to correlate, to compare, to include, to serene, to delay, to associate, to bring, to draw, to initiate, to abuse, to require, to interpret, to injure.

II. Finish the questions using the present perfect tense passive voice.
1. Where …… the demographics of Shel by county, Tennessee, and the referral patterns to the pediatric gynecology clinic …… (to describe)?
2. By what could abnormalities of genitalia …… (to cause)?
3. Why …… the genital abnormalities ……. (to describe)
4. How many children …… (to injure)
5. How many patients …… (to abuse)

III. Finish the sentences using the word in bracket in the present indefinite tense passive voice.
1. All thought genital injures perianal injures are ……. sometimes …….. by physician (to dismiss)
2. The age distribution for the entire study group is …… in fig (to show)
3. The findings are ……. in table (to list)
4. The diagnosis of venereal disease affecting the anal canal is often (to delay) or even …… (to miss).
5. The child is often ……. (to bring) for medical care/
6. Genital infections are ……. (to associate) with vaginal discharge.

IV. Translate the sentences paying attention to the passive forms of the verb.
1. All patients in this study group were examined in an office setting by the same examiner.
2. All children in the study group were prepubertal, as confirmed by the medical examination.
3. The area was inspected under regular illumination.
4. The genital abnormalities were classified into one of three categories.
5. Normal–appearing anal and perianal regions were noted in 150 of 175 children.

V. Translate from English into Russian.
Factors affecting success; advanced techniques; enabling minimally invasive treatment; microsurgery performed through laparotomy; the first published successful treatment; early unruptured ectopic pregnancy; the affected tube; increasing serum hCG values /human choriotic gonadotropin/; in successfully treated patients; in patients desiring to preserve their fertility; continued trophoblastic development; through transcervical intratubal catheters used for in vitro fertilization; in causung resorption of the trophoblast; the highest suggested value; factors contributing to failures; undetermined reasons; in properly selected patients; a clearly visualized implantation site.

VI. Open the brackets.
1. Laparoscopic salpingotomy (to have became) the procedure of choice.
2. Since the first published successful treatment of EP /ectopic pregnancy/ with methotrexate, the interest in medical treatment (to have grown).
3. Laparotomy (to be being replaced) by laparoscopic procedures in hemodynamically stable patients.
4. Both treatments (to be deemed) successful in serum hCG returned to normal and the patient had no complications.
5. Serum hCG values (to be measured) in all patients on the day of procedure.
6. Two laparoscopic operations for terminations of early ectopic pregnancy /EP/ (to be compared).

VII. State whether the verb form is in the active or passive voice.
1) has been making; 2) has made; 3) has been made; 4) will be made; 5) is being made; 6) will have been made; 7) was not made; 8) makes; 9) are made; 10) had made.

VIII. Образуйте от прилагательных, стоящих в скобках, сравнительную и превосходную степень, в зависимости от смысла.
1. Gestations (great) than 2 cm with clearly seen implantation sites, and hCG values (high) than 2000 m1U/m1 should be treated by surgical removal of trophoblastic tissue.
2. Location of the EP in the infundibular part of the tube is considered (little) favorable for PGE2 application.
3. In one the EP was (little) than 0,5 cm and the implantation of trophoblast was not clearly seen.
4. The (low) values were 120 and 200 m1U/m1, respectively.
5. The (high) value in patients treated with PGE2 was 4500 m1U/ml.
6. The (high) suggested value for laparoscopic salpingotomy is 15.000 m1U/m1.
7. Postoperative adhesion formation is (low) when laser is used instead of diathermy, although the complication rate is (high).
8. It is (little) invasive, and hospitalization and recovery time are (short).

IX. Translate from English into Russian.
A teaching department; teaching programs; approved obstetrics and gynecology residency programs; a newly established breast disease program; a dedicated mammography unit; the newly established requirements; the required information; a basic and advanced mammography course; the widely respected mammographer; the noted excellence of these courses; mammography reading skills.

X. Find appropriate translation to the following words.
a) Primarily, exclusively, frequently, usually, newly, approximately, annually, conclusively, closely, broadly, favorably, potentially, presently, immediately, initially, clearly, correctly, widely, actively, strongly, impotently.
b) Немедленно, непосредственно; вскоре, теперь; решительно, напористо; часто, обычно; благоприятно; сильно, исключительно, единственно, только; обычно; заново, вновь, недавно; широко; ясно, очевидно, конечно, несомненно; правильно, верно, корректно; первоначально, главным образом; важно; возможно; приблизительно; активно, энергично; в начальной стадии; ежегодно; окончательно, убедительно, доказательно; близко, тесно, внимательно.

XI. Make the sentences interrogative:
1. Little doubt can exist than the female breast is a reproductive organ.
2. Routine mammography screening can reduce mortality from breast cancer.
3. Mammography can detect breast cancer of nonpalpable size.
4. One has to conclude that we have to learn mammography.
5. Since the diagnosis of breast disease has entered our residency program curricula, faculty have to teach the topic.
6. None of our faculty had the expertise to provide the required information.
7. All faculty members had to attend both a basic and advanced mammography course.
8. The best possible care was to be provided to patients.
XII. Say the following sentences in the past and future perfect passive:
1. She also has been abandoned by the primary physician responsible for her reproductive health.
2. This concept has been recognized and has been the basis for broadly based screening recommendations.
3. Over the past 2 years all house staff actively involved in the routine performance of obstetrics as well as gynecologic ultrasonography in the department.
4. The important findings have been proved.
5. A female patient has been transferred to the hospital.

VOCABULARY

Gynecology (from Greek. gyne, a genitive case gynaikos - the woman and logos - a word, the doctrine) - a science about the woman, and her health.

Doctors-gynecologists will help you to decide a lot of problems. They make a checkup, diagnostics and treatment of such gynecologic diseases, as:

- The infections, which spread out by sexual intercourse;
- Inflammation of a small basin;
- Cervix of the uterus erosion;
- Polyps;
- Myoma of a uterus, endometriosis.

Now we would like to discuss some problems of gynecology. Our specialists of the Kyrgyz-German Medical Center help to solve them. Abortion - discontinuance of pregnancy in consequence of a birth of a fetus before the period of 28 weeks when the fetus is still nonviable.

There are some kinds of abortions:

- The advanced - medicamentous, abortion - on terms up to 6 weeks of pregnancy. The advantage not required surgical intervention.
- During 5 weeks of pregnancy - vacuum or mini abortion.
- Common abortion is done on term up to 12 weeks of pregnancy- surgical sometime with complications. Surgical abortion should be spent by highly skilled experts with use of adequate anesthesia. The Kyrgyz German Medical Center has such specialists.

Contraception - is not only protection against undesirable pregnancy it is also preservation of your health, a way to birth a healthy child when you want it. Nowadays there are many modern ways of contraception which can reliably warn undesirable pregnancy. In our center high-skilled doctors - gynecologists will answer all your questions about individual contraception:

Barreness - absence of pregnancy during a year by living sexual life and without taking contraceptive means

There are 2 type of barreness:

1) If the woman, living sexual life has never become pregnant
2) If the woman became pregnant in the past, nowadays she has barreness.

The most frequent reasons of man's barreness - inferiority of sperm, infringement of ejaculation, impotence. At women the reasons of barreness are anatomic and functional changes of genitals, inflammatory diseases of a uterus, uterine, ovaries, various hormonal infringements, pathology of endocrine (change of function of a thyroid gland, adrenal glands, ovaritis), myomas of a uterus,
an endometriosis, traumas of cervix of the uterus after abortions, sorts. More, than in 30 % of cases the reasons of barreness are diseases of both spouses.

**Cervical erosion** is good-quality pathological process and one of the most widespread gynecologic diseases

The reasons of occurrence of cervical erosion:

The infectious diseases spread by sexual contact- trichomoniasis, a clamidiosis, a virus of a simple herpes, etc. Infringement menstrual functions and the hormonal status.

XIII. Read, translate and discuss the texts below.

I. INTRODUCTION

Sexual reproduction is the union of the female sex cell (ovum) and the male sex cell (sperm) which results in the creation of a new individual. The ovum and sperm cell are specialized cells differing primarily from normal body cells in one important way. Each sex cell (also called a **gamete**) contains exactly half the number of chromosomes that a normal body cell contains. When the ovum and sperm cell unite, the cell produced receives half of its genetic material from its female parent, and half from its male parent; thus it contains a full, normal complement of hereditary material.

Sex cells are produced in special organs called **gonads** in the male and female. The female gonads are the **ovaries**, and the male gonads are the **testes**. The union (also called **fertilization**) of the male and female sex cells in humans takes place within the female body. **Copulation** (meaning "to couple") is the act whereby the male deposits sperm cells within the duct in the female through which an ovum (egg cell) emerges. If fertilization takes place, the new cell formed begins a nine-month period of development within the **uterus** (womb) of the female.

The female reproductive system consists of organs which produce ova and provide a place for the growth of the embryo. In addition, the female reproductive organs supply important hormones that contribute to the development of female secondary sex characteristics (body hair, breast development, structural changes in bones and fat).

Ova are produced by the ovary from the onset of **puberty** (beginning of the fertile period when secondary sex characteristics develop) to **menopause** (cessation of fertility and diminishing of hormone production). If fertilization occurs at any time during the years between puberty and menopause, the fertilized egg may grow and develop within the uterus. Various hormones are secreted from the ovary and from a blood-vessel-filled organ (**placenta**) which grows in the wall of the uterus during pregnancy. If fertilization does not occur, hormone changes result in the shedding of the uterine lining, and bleeding, or **menstruation**, occurs. The interactions of hormones in pregnancy and menstruation will be discussed in detail in a later section of this chapter.

The names of the hormones which play important roles in the processes of menstruation and pregnancy, and in the development of secondary sex characteristics, are **estrogen** and **progesterone**. Other hormones which govern the functions of the ovary, breast, and uterus are secreted by the anterior lobe of the pituitary gland, which is located behind the bridge of the nose in the anterior portion of the brain.

XIV. Give the definitions to underlined words (Ex: gamete – sex cell; sperm or egg cell)

UTERUS, OVARIRES, AND ASSOCIATED ORGANS

Figure 9—1 is a lateral view of the female reproductive organs and shows their relationship to the other organs in the pelvic cavity. The ovaries (1) (only one ovary is shown in this lateral view) are a pair of small almond-shaped organs located in the lower abdomen. The
fallopian tubes (2) (only one is shown in this view) lead from each ovary to the uterus (3), which is a muscular organ situated between the urinary bladder and the rectum and midway between the sacrum and the pubic bone. The uterus is normally in a position of anteflexion (bent forward). Midway between the uterus and the rectum is a region in the abdominal cavity known as the cul-de-sac (4). This region is often examined for the presence of cancerous growths. The vagina (5) is a muscular tube extending from the uterus to the exterior of the body. Bartholin’s glands (6) are two small, rounded glands on either side of the vaginal orifice. These glands produce a mucous secretion, which lubricates the vagina. The clitoris (7) is an organ of sensitive, erectile tissue located anterior to the vaginal orifice and in front of the urethral meatus. The clitoris is homologous with the penis in the male.

Figure 9—1 Organs of the female reproductive system, lateral view.

The region between the vaginal orifice and the anus is called the perineum (8). This region, at the floor of the pelvic cavity, may be torn in childbirth, resulting in damage to the urinary meatus and the anus. To avoid a perineal tear, the obstetrician often cuts the perineum before delivery.

Figure 9—2 is an anterior view of the female reproductive system. The ovaries (1) are held in place on either side of the uterus by the utero-ovarian ligaments (2) and are protected by a surrounding mass of fat.

Within each ovary are thousands of small sacs called graafian follicles (3). Each graafian follicle contains an ovum (4). When an ovum is mature, the graafian follicle ruptures to the surface and the ovum leaves the ovary. The release of the ovum from the ovary is called ovulation. The ruptured follicle fills first with blood, and then with a yellow fatlike material. It is then called the corpus luteum (5) (meaning "yellow body").

Near each ovary is a duct, about BARTHOLINS-5 1/2 inches long, called a fallopian tube (6). The egg, after its release from the ovary, is caught up by the finger-like ends of the fallopian tube. These ends are called fimbriae (7). The tube itself is lined with small hairs which, through their motion, sweep the ovum along. It usually takes the ovum about five days to pass through the fallopian tube.

It is within the fallopian tube that fertilization takes place if any sperm cells are around. If copulation takes place near the time of ovulation and no contraception is used, there is a likelihood that sperm cells will be in the fallopian tube when the egg cell is passing through. If copulation has not taken place, the ovum remains unfertilized and, after a day or two of waiting, dies.

The fallopian tubes, one on side, lead into the uterus (8), a pear-shaped organ with muscular walls and a mucous membrane lining filled with a rich supply of blood vessels. The specialized epithelial mucosa of the uterus is called the endometrium (9); the middle, muscular layer is the myometrium (10); and the outer, membranous tissue layer is the perimetrium (11).
The narrow, lower portion of the uterus is called the cervix (12) (meaning "neck"). The cervical opening leads into a 3-inch-long tube called the vagina (13), which opens to the outside of the body. The external genitalia (reproductive organs) of the female are called the vulva. This includes two sets of vaginal lips (labia majora and labia minora), clitoris, perineum, and the vaginal and urethral orifices.

![Figure 9—2 Organs of the female reproductive system, anterior view.](image)

**THE BREAST (ACCESSORY ORGAN OF REPRODUCTION)**

The breasts (Figure 9—3) are two mammary (milk-producing) glands located in the upper anterior region of the chest. They are composed of glandular tissue (1) which develops in response to hormones from the ovaries during puberty. The breasts also contain fatty tissue (2), special lactiferous (milk-carrying) ducts (3), and sinuses (cavities) (4) which carry milk to the opening, or nipple. The breast nipple is called the mammary papilla (5), and the dark-pigmented area around the mammary papilla is called the areola (6).

During pregnancy, the hormones from the ovaries and the placenta stimulate glandular tissue in the breasts to their full development. After-parturition (giving birth), hormones from the pituitary gland and adrenal glands stimulate the production of milk (lactation) and its ejection from the breast.

![Figure 9—3 The breast.](image)
TERMINOLOGY OF MENSTRUATION AND PREGNANCY

MENSTRUAL CYCLE

The menstrual cycle is divided into 28 days. These days can be grouped into four time periods, which are useful in describing the events of the cycle. The time periods are:

Days 1—5 (Menstrual Period). These are the days during which bloody fluid containing disintegrated endometrial cells, glandular secretions, and blood cells is discharged through the vagina.

Days 6—13 (Postmenstrual Period). After the menstrual period is ended, the lining of the uterus begins to repair itself as the hormone estrogen is released by the maturing graafian follicle in the ovaries. This is also the period of the growth of the ovum in the graafian follicle.

Days 13—14 (Ovulatory Period). On about the 14th day of the cycle, the graafian follicle ruptures (ovulation) and the egg leaves the ovary to travel slowly down the fallopian tube.

Days 15—28 (Premenstrual Period). The empty graafian follicle fills with a yellow material and becomes known as the corpus luteum. The corpus luteum functions as an endocrine organ and secretes two hormones, estrogen and progesterone, into the bloodstream. These hormones build up the lining of the uterus in anticipation of fertilization of the egg and pregnancy. If fertilization does not occur, the corpus luteum in the ovary stops producing progesterone and estrogen and regresses. The fall in levels of progesterone and estrogen leads to the breakdown of the uterine endometrium and a new menstrual cycle begins (days 1—5).

PREGNANCY

If fertilization does occur in the fallopian tube, the fertilized egg travels to the uterus and implants in the uterine endometrium. The corpus luteum in the ovary continues to produce progesterone and estrogen which support the vascular and muscular development of the uterine lining.

The placenta, which is the organ of communication between the mother and embryo, now forms within the uterine wall. The placenta is derived from maternal endometrium and partly from the chorion, a membrane which surrounds the developing embryo.
Figure 9—4 The embryo, its placenta, and membranes surrounding it in the uterus.

The amnion is the innermost of the embryonic membranes, and it holds the fetus suspended in an amniotic cavity surrounded by a fluid called the amniotic fluid. At no time during pregnancy do the maternal blood and fetal blood mix, but important nutrients, oxygen, and waste products are exchanged as the maternal and fetal circulations pass in close proximity to each other within the placenta.

From the third month of pregnancy onward, the placenta produces its own hormone, human chorionic gonadotropin (HCG), which stimulates the ovary to continue to produce progesterone and estrogen.

Figure 9—4 shows the embryo, its placenta, and the membranes which surround it in the uterus.

**HORMONAL INTERACTIONS**

As we have seen in the previous discussion of the menstrual cycle and pregnancy, the building up and breaking down of the lining of the uterus is dependent on the level of hormones from the ovary (estrogen and progesterone). These hormones from the ovary, however, are under the influence of other hormones from the anterior lobe of the pituitary gland.

One hormone from the anterior lobe of the pituitary gland is called follicle-stimulating hormone (FSH). FSH travels from the pituitary gland, through the bloodstream, to the ovary, where it stimulates the graafian follicle to ripen and the ova to mature. In addition, FSH stimulates the graafian follicles to produce the hormone estrogen.

Estrogen, released into the bloodstream from the ovaries, travels back to the anterior lobe of the pituitary gland and causes that organ to produce another hormone called luteinizing hormone (LH). LH in the bloodstream encourages the release of the egg from the follicle (ovulation) and promotes the formation and maintenance of the corpus luteum, which begins to produce estrogen and progesterone after ovulation.

If pregnancy occurs, the corpus luteum is maintained and the level of progesterone and estrogen in the bloodstream increases under the influence of human chorionic gonadotropin (HCG), a hormone produced by the placenta. The high level of estrogen and progesterone in the bloodstream "turns off" the secretion of FSH by the anterior lobe of the pituitary. This effect (high levels of chemicals limiting the level of another chemical) is called negative feedback. Without FSH secretion, ovulation ceases and new eggs are not released during pregnancy.

Birth control pills, which contain varying levels of estrogen and progesterone, produce a condition which mimics pregnancy. These hormones thus block FSH secretion, and ovulation is suppressed. Another contraceptive mechanism, the intrauterine device (IUD), is a coil which is placed in the uterus, preventing implantation of the fertilized egg.

If pregnancy does not occur, the ovum dies and no placenta is formed. Hormone secretions (estrogen and progesterone) by the corpus luteum abruptly fall, stimulating increased FSH production, and a new ovulation begins.

Study Figure 9—5 to review the interactions of hormones in menstruation and pregnancy.

**XV. Read and translate Internet texts.**

**CLINICAL COURSE AND PROGNOSTIC FACTORS FOLLOWING BONE RECURRENCE FROM BREAST CANCER.**

Coleman RE. Smith P. Rubens RD.

YCRC Department of Clinical Oncology, Weston Park Hospital, Sheffield, UK.
Three hundred and sixty-seven women presenting to the Breast Unit at Guy's Hospital between 1975 and 1990 whose first distant metastasis was in the skeleton were identified and the influence of a number of patient and tumour characteristics on the development and subsequent prognosis of bone metastases was assessed. One hundred and thirty-nine women had disease that remained clinically confined to the skeleton. They were more likely to be older, with lobular carcinoma and to have presented initially with little or no axillary lymph node involvement. The 228 women who subsequently developed disease at extra-osseus sites were more likely to have poorly differentiated ductal tumours and heavy lymph node involvement at primary diagnosis. On multivariate analysis, the clinical and pathological factors of greatest prognostic importance for survival after the development of bone metastases were histological grade (P = < 0.0001), oestrogen receptor status (P = < 0.0001), bone disease at initial presentation (P = < 0.0001), disease-free interval (P = 0.002) and age (P = 0.006).

Health Care of Women in a Transition Period

The platform of the Women's Fourth International Conference in Beijing assumes that a woman's health is an aggregate of her physical, spiritual and social well-being. Achieving and maintaining the highest level of a woman's physical and psychological health are one of the strategic goals of the conference.

A woman's health depends on her emotional, social, and physical well-being and is determined by social, political and economic conditions, as well as biological factors.

In many developing countries, deterioration of the state health care system reduces the available resources for health protection and, in a number of cases, necessitates structural changes. In addition, privatization of the health system curtails state medical services without providing guarantees for a universal, accessible medical service. This situation not only has a direct impact on the health conditions of women and girls, but also imposes on them additional functions and obligations, both in the family and in the society, many of which are taken for granted; in most cases women do not receive a necessary social, psychological and economic support. The state of women's health often depends on the same conditions as that of men, but women react to the same conditions in a different way.

The existing social-economic crisis in Georgia had an impact on both, women and men; but women are most affected by the emerged problems. The economic crisis, apart from a psychological pressure, burdened women with a hard physical labor to provide for their families. In many cases, a woman is the only bread-winner; at the same time, she retains her primary role of a mother who has to be perfect in all respects to raise a healthy generation. To be perfect for a woman implies to be educated, healthy and psychologically sound and to pass through most important and responsible stages of her life: pregnancy, child-birth, breast-feeding, and motherhood. To ensure social and economic progress, today's Georgia needs a healthy woman, as a guarantor of a new healthy life-style and generator of a healthy future generation.

THE TREATMENT AND REHABILITATION OF WOMEN SUFFERING FROM INFLAMMATORY DISEASES OF SMALL PELVIS ORGANS

S.N. Zanko, A.N. Lysikov, I.M. Arestova

The purpose of the project is to develop methods for treatment and rehabilitation of the reproductive function of women suffering from inflammatory uterine adnexa.

The innovation of this study consists in 1) the character of microflora and cell content of peritoneal exudates
in patients with various forms of pelvic inflammatory disease have been studied; 2) local antiinfectious resistance and peritoneum functional condition in patients with pelvic inflammatory diseases has been estimated. The solution of these problems enabled to work out and introduce new approaches to therapy and functional rehabilitation of women suffering from pelvic inflammatory diseases. Important theoretical data concerning the development of the mechanisms of chronic inflammatory diseases of small pelvis, their treatment and prevention have been obtained.

**Field of application:** clinical medicine, gynecology.

**Proposals for co-operation:** consulting assistance in implementation, joint research.

**LOCAL TREATMENT OF CERVICAL EROSION DURING PREGNANCY BY PREPARATIONS CONTAINING GLYCOSAMINOGLYCAN**

*V.P. Kirilenko*

The treatment for cervical erosion has been carried out in 9 women for imminent abortion. The preparation was introduced onto cervix once daily. The results were assessed 8–10 days after the treatment.

The local treatment for cervical erosion with glucosaminoglycans provides rapid healing of the erosive surface and inflammation reduction of the cervical tissue.

**Methods of ABC (Artificial Birth Control)**

- **Vasectomy**: Both of a man’s vas deferens are cut to prevent passage of sperm
- **Tubal Ligation**: woman’s fallopian tubes are tied or cauterized to prevent union of sperm and egg
- **Abortion**
- **Post-coital (“Morning-after”) Contraception**: high dosage pill or IUD used within 72 hours of unprotected intercourse, to prevent fertilization or implantation
- **Barrier methods:**
  - Male Condom: Rubber sheath between the man and woman prevents union of sperm and egg. About 12 pregnancies occur over 1 year out of 100 couples using this method; effectiveness increases with spermicides used in concert.
  - Female Condom: Completely covers clitoris, greatly minimizing pleasure of intercourse for woman
  - Diaphragm: latex domes of various types and sizes which are filled with gooey spermicide and positioned over the cervix prior to intercourse; it slowly oozes the spermicide for 6 to 8 hours after intercourse before it may be removed; it must be removed within 24 hours. Diaphragms must be prescribed by a physician. About 18 pregnancies occur over one year in 100 women using this method.
  - Cervical Cap: Like diaphragm, it covers the cervix and is always used with a contraceptive cream or jelly and must be left in place for at least 8 hours after intercourse. It differs in that it is smaller and more rigid than the diaphragm, and can remain in the vagina for up to 48 hours. It can be uncomfortable and cause cervical abnormalities
  - Vaginal Sponges: Very frequently cause vaginal infections. Soft synthetic sponge, saturated with spermicide, and inserted into the vagina, over the cervix, prior to intercourse and left in place, like the diaphragm, for at least 6 to 8 hours. This
method is available without a prescription in most drug and grocery stores. About 18 to 28 pregnancies occur over one year out of 100 women using this method.

- **Oral Contraceptive Pills:**
  - Old (pre-1975) High Dosage Pill: (Estrogen)
  - Low Dosage Pill: (Estrogen)
  - Mini-combination Pill:
    - Oral Combination Pill (estrogen and progestine): Regularizes cycle and prevents ovulation, using hormones to make body think the woman is perpetually pregnant. Must be taken consistently at the same time each day. Variety of available pills allows “matching” to individual woman. About 2 to 3 pregnancies occur over 1 year out of 100 women using this method. Effectiveness decreased by antibiotics. Causes weight gain, bad mood, and decreases sexual desire in woman; increases risk of vaginal thrush (candidiasis) and cervical erosion. Women going off the pill may experience months or even years of infertility before ovulation returns.
    - "Mini pill" (progestin only): Often prescribed to women who are sensitive to estrogen or breastfeeding. Its effectiveness is lower than the combination pill: about 3-7 pregnancies over a year out of 100 women using this method.

- **Progestin Implants (“Norplant”):** 6 matchlike-tubes are surgically inserted under the skin in the upper arm and left there for 5 years; they continually release progestin, inhibiting ovulation, changing the uterus lining, and thickening cervical mucus (to prevent sperm from entering the uterus). They cost several hundred dollars. Less than 1 pregnancy occurs over 1 year out of 100 women using Norplant.

- **Intrauterine Device (IUD):** Plastic and copper device, placed inside the woman's uterus and left there for as long as several years. About 2 to 3 pregnancies occur per year out of 100 women using this method. Presently off the market in the US due to proven cause of severe pelvic inflammatory disease and hence permanent infertility. Maintains uterus in a constant state of inflammation, causing painful periods. Especially unsafe for women with a history of pelvic infection or ectopic pregnancy.

- **Depo-Provera Injections:**

- **Suppositories:** placed in vagina prior to intercourse to kill sperm

- **Spermicidal creams and foams:** Increased risk of cervical erosion. About 21 pregnancies occur over 1 year out of 100 women using this method.

- **Post-coital douche--Douching shortly after intercourse.** Because sperm can make their way beyond the cervix within 90 seconds after ejaculation, this method is ineffective and unreliable.

- **Withdrawal**

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**Methods of Natural Birth Control**

- **Calendar (Rhythm) Method:** Unreliable method based on the false assumptions (consistent 30-day cycles for all women with ovulation always on day 14) and requiring longer periods of abstinence than modern methods. The rules were: last day of Phase I = shortest of last 10 cycles - 19; and first day of phase III = longest of last 10 cycles - 10.

- **Sympto-Thermal Method:** BBT, cervical fluid, and cervical position used to determine fertility. Most effective method of natural birth control and is able to allow the maximum period of intercourse since it relies on not one but two key fertility signs. Also, cervical
fluid may be dried up by decongestants, cough syrup, and antihistamines (which tend to dry up not only the sinuses, but cervical fluid as well), and cause a mistaken belief that post-ovulation dry-up has occurred; in such cases, the BBT sign provides a back-up. However, certain temporary or permanent conditions may make it impossible to use the BBT sign and therefore necessary to use the Billing’s Ovulation Method. Detailed rules for using the STM are below.

- **FAM** (Fertility Awareness Method): Sympto-Thermal Method used to determine fertility, supplemented with barrier contraception during fertile periods
- **NFP** (Natural Family Planning): Sympto-Thermal Method used to determine fertility, with abstinence during fertile period
- Periodic Abstinence: natural birth control involving abstinence during periods of fertility and determination of fertility using Sympto-Thermal Method, Billing’s Method, Creighton Method, BBT Method, or Calendar Method
- **Billing’s Ovulation Method** & Creighton Model- both use cervical fluid at vaginal opening as the only fertility indicator. This method requires more abstinence than NFP and is slightly less effective than NFP (due to shortness of 2nd patch in double peaks). This method is the best choice for those women whose bodies do not respond to progesterone and therefore do not observe a thermal shift around ovulation as well as for women who for various reasons (including stress) may be experiencing a long cycle with "false starts," patches of wet cervical fluid indicating a preparation for ovulation, followed by a dry period with no temperature rise. It may also be useful for women who have certain BBT conditions which add on unnecessary days of abstinence, e.g. women with a fall-back temperature pattern or women with 10 or fewer days of elevated temperatures over the coverline. Detailed rules for using the Billing’s Method are below.
- **BBT Method**- uses waking temps only as only indicator. It is very effective and simple, but may require more abstinence (especially the Phase III only version). The BBT Method is the best option for rare women who observe constant cervical fluid or encounter difficulty in interpreting the cervical fluid sign. Detailed rules for using the BBT method are below.
- Fertility Computers: Measure, store, and interpret BBT data, displaying green or red light to signal safety from pregnancy risk or need to beware of risk. Some computers analyze cervical fluid as well for several days of the cycle when fertility is unclear from BBT alone.
- **Lactational Amenorrhea Method** (LAM): (Amenorrhea = long absence of menstruation). Suckling at breast indirectly inhibits hormones responsible for ovulation, so breastfeeding women may go for up to a year with the same sticky or dry or combination cervical fluid and no BBT rise (called a BIP, or Basic Infertility Pattern). For this method, it is necessary to breastfeed frequently; otherwise ovulation can return as early as the first cycle after delivery (in about 6% of women, ovulation returns with the first cycle after delivery). Detailed rules for using the LAM are below.
- Los Angeles Study (1976) was undertaken to compare the effectiveness of Sympto- thermal and Billing’s methods; it found 100% perfect use effectiveness for Sympto- thermal and 94% perfect use effectiveness for Billing’s. Billing’s also has the disadvantage that cervical fluid must be checked diligently throughout Phase III just as in Phase I, whereas STM users have the assurance of ovulation by elevated BBT pattern and needn't check cervical fluid again during Phase III, i.e. until menstruation begins the next cycle.
Advantages of NFP and Charting

- Enables partners to enjoy intercourse with maximum pleasure and intimacy, and moreover:
  o Without risk of pregnancy if they determine that pregnancy is not desired at the time;
  o Without aesthetically unpleasant barriers like condoms;
  o Without cost (once they have learned the method);
  o Without the physical and emotional side-effects of hormone pills, Norplant surgery, IUDs, abortion, etc.
  o Without the moral dishonesty involved in use of ABCs;
  o Without compromising on related to abortion and the abortifacent mechanisms of hormone pills and the IUD

- Enables women:
  o To better understand themselves and their bodies, important at all times but especially for adolescent and premenopausal women, both of whom suffer from certain unnecessary confusion and anxiety which charting could eliminate.
  o To become aware of and diagnose fertility and gynecological problems in a timely manner, including the following:
    - UTI-Urinary tract infection- causes discharges which may be confused with healthy cervical fluid in absence of charting Multiple ovulation occurs in up to 10% of cycles, never occurs more than 24 hours after initial ovulation, and is responsible for fraternal twins, a tendency influenced by heredity
    - If midcycle spotting (which may be a sign of cervical cancer), occurs consistently, the cancer suspicion can be lifted (this is an outflow of endometrium during lull between fall in estrogen level and rise in progesterone level) and the spotting can be used as a secondary fertility sign (confirm ovulatory period).
    - Ectopic pregnancy (implantation outside uterus, usually in fallopian tubes) linked to PID (caused by STDs) and is always fatal to baby and presents grave risk to health and life of mother.
    - Corpus Luteum Cysts: 18 days of high temperatures with no period is in all probability due to pregnancy. If home pregnancy tests or ultrasound or blood tests indicate that there is no pregnancy, these cysts may be present.
    - Hypothyroidism: indicated by higher than average temperatures throughout cycle, light menses, long cycles, and/or infertility
    - Hyperthyroidism: indicated by higher than average temperatures throughout cycle, long cycles, anovulatory "cycles," long periods of wet cervical fluid, and/or infertility.
  o To detect approach of PMS (Premenstrual Syndrome) several days in advance and take measures to minimize certain repeating pains
  o Enables women to distinguish between healthy cervical fluid and possible infections (symptoms of a true vaginal infection: itching, swelling, redness, unpleasant odor, unusual discharge), and gynecological problems.
Enables women to distinguish breakthrough and withdrawal bleeding during anovulatory "cycles" from menstruation beginning a new cycle, since the latter will follow a BBT rise and the former will not.

Enables women not seeking pregnancy to discern if ovulation was delayed in a given cycle, thus eliminating unnecessary worry about whether or not they have conceived. If ovulation was delayed, a long cycle is not cause for worry (as it would be without charting), for it does not indicate pregnancy until 18 days of heightened temperature are observed. Enables the woman to know one way or the other every cycle within 18 days of BBT rise without testing.

- **Strengthens Marriage**: Studies show that couples that use NFP have a divorce rate around 2%, compared to the divorce rate in the general population of about 50%. Similarly, the divorce rate among American Catholics remained low during the 1920s, at the time when Margaret Sanger organized the contraception movement and the divorce rate in the general American population first began to increase rapidly and did not itself begin to increase until after 1968, when Catholics began to use ABC widely in rebellion to Church teaching. The increase in ABC since the 1920s parallels the increase in the U.S. divorce rate (1910: 1 divorce to 11 new marriages; 1925: 1 to 7, 1965: 1 to 4, 1970: 1 to 3, 1977: 1 to 2). While other causes are no doubt also responsible, this clearly discredits the view that ABC strengthens marriage and proves the counter claim. The reasons why NFP may be considered so effective in strengthening marriage include:
  - Requires both partners to share responsibility and burden of birth control;
  - Offers male partner opportunity to learn more about his partner and her body and needs, including when he can expect hormone-related emotional changes;
  - As a result of the regular periodic abstinence involved in NFP, couples develop non-genital communication and expressions of affection, which can be equally meaningful and which tend to lose their meaning if they are always experienced only as a prelude to intercourse.
  - Couples using NFP are monthly reminded not to take their spouse for granted;
  - Couples using NFP do not experience sexual satiation or boredom on the one hand nor sexual addition and insatiable lust on the other;
  - Couples using NFP monthly relive the stimulating cycle of courtship, honeymoon, and marriage;
  - The periodic abstinence eliminates woman’s feeling used or loved only for sex, because she too experiences a period of desire each month and sees that her husband controls his desire. THis abstinence increases her self-esteem and her respect for him.

- **For couples trying to achieve pregnancy**:
  - Enables infertile couples seeking pregnancy to time their intercourse effectively. If a woman has long cycles, or has stress-related (including infertility-related stress) delayed ovulation, a couple that has intercourse from days 12-18 (based on the day 14 conventional wisdom), may nevertheless easily miss the fertility window. Also, a couple late in the cycle (e.g. day 23) not checking BBT and cervical fluid, may mistakenly conclude that the pregnancy window has passed, while in fact it is at its most fertile stage.
  - Enables infertile couples seeking pregnancy to find pleasure in sex as a carefree expression of love without the pressure of an effective erection and ejaculation every time throughout infertile phase, limiting the frustration of seeking
pregnancy for a large part of the cycle in which the woman is nevertheless infertile, or to take a rest from the wearisome routine of constantly trying to get pregnant during this time.

- Enables them to discern if ovulation was delayed in a given cycle, thus eliminating unnecessary worry about whether or not they have achieved pregnancy (if ovulation was delayed, they know not to get their hopes up early since a long cycle is to be expected and does not indicate pregnancy until 18 days of heightened temperature are observed). Enables the woman to know one way or the other every cycle within 18 days of BBT rise (without any tests).

- Enables them to choose the gender of their child with 75-90% accuracy.

- Enables them to know if pregnancy has occurred or not within 18 days (of consecutive high temperatures), before reliable results are possible with oral pregnancy tests (which can give false negative results since HCG levels are not yet elevated enough);

- Enables them to know the precise date of conception and hence the EDC (estimated date of childbirth) with great accuracy. The most accurate prediction of the EDC is by the Prem Rule: EDC = first day of temperature rise - 7 days + 9 months. Actual date has 99% likelihood of being within 14 days, 80% of +/- 10 days, 65% of +/- 7 days (Kippley 300). However, most doctors, because relatively few women chart, use the older by less accurate "pregnancy wheel" based on the Naegele Rule (EDC = first day of previous cycle + 7 days + 9 months), which assumes ovulation on Day 14. This is significant because doctors using an EDC obtained by the Naegele Rule may want to induce labor as much as 2 months early due to a late-cycle pregnancy which the Naegele Rule does not take into account. An accurate EDC is also helpful for eliminating erroneous timing of tests (e.g. amniosentesis)

- Enables them to identify if infertility is due to miscarriages they would be ignorant of if not charting (without charting, she would think she merely had a long cycle with a late period). Thereafter steps can be taken to correct their infertility by treating the tendency to miscarry.

- Enables them to identify if infertility is due to consistently short (less than 10 days) luteal phases (between ovulation and beginning of menstruation) and consequently inadequate time for implantation, knowledge which they could not know if they were not charting. Thereafter steps can be taken to correct their infertility by lengthening the luteal phases.

- Enables them to identify if infertility is due to a shortage of progesterone, indicated in charts by postovulatory, heightened temperatures dropping repeatedly back below coverline. Thereafter steps can be taken to correct their infertility by increasing progesterone.

- Enables them to identify if infertility is due to poor ovary activity and low estrogen levels, indicated in charts by long BIPs (Basic Infertile Patterns) (unchanging pattern of cervical fluid quality or dryness experienced instead of normal pattern of increasingly wet and fertile fluid). Thereafter steps can be taken to correct their infertility by treating these problems.

- Change in BBT indicates that ovulation is occurring and no treatment is needed to stimulate ovulation (including the drug Clomis, almost always prescribed immediately to couples reporting infertility, regardless of whether the woman is actually ovulating)
Moral Significance of Birth Control Methods

- ABC involves a serious moral offense, a dishonest expression of total self-giving, i.e. saying with body language that one gives oneself unreservedly, totally to the partner, and receives the same in return, while both in fact hold back their fertility.

- The moral offense can also be seen in that marital contraception and contraceptive premarital sex, contraceptive adultery, sodomy, anal and oral sex, all have the same logical basis: the goal of making sex sterile, regardless of means. Permitting one and not permitting another are inconsistent once one grants that the nature of sex is an expression of love, without reference to childbirth.

- The misuse of the sexual act implicit in ABC is easier for some to see in view of its social consequences: increased adultery, fornication, pornography, homosexuality, births out-of-wedlock, STD's, abortions, teenage pregnancy, and government regulation of childbearing, which all skyrocketed in the wake of the availability and widespread use of the Pill starting in 1960. These effects were specifically predicted by numerous individuals, include Gandhi and Pope Paul VI:

  - Ghandi (1925): “I urge the advocates of artificial methods to consider the consequences. Any large use of the methods is likely to result in the dissolution of the marriage bond and in free love.”

  - Anglican Bishop Charles Gore (1930), dissenting to the Anglican decision at Lambeth to allow ABC, said it would open Pandora's Box of social ills.

  - Pope Paul VI (Humanae Vitae 17): "Upright men can even better convince themselves of the solid grounds on which the teaching of the Church in this field is based, if they care to reflect upon the consequences of methods of artificial birth control. Let them consider, first of all, how wide and easy a road would thus be opened up towards conjugal infidelity and the general lowering of morality. Not much experience is needed in order to know human weakness, and to understand that men - especially the young, who are so vulnerable on this point -- have need of encouragement to be faithful to the moral law. so that they must not be offered some easy means of eluding its observance. It is also to be feared that the man, growing used to the employment of anti-conceptive practices, may finally lose respect for the woman and, no longer caring for her physical and psychological equilibrium, may come to the point of considering her as a mere instrument of selfish enjoyment, and no longer his respected and beloved companion. Let it be considered also that a dangerous weapon would thus be placed in the hands of those public authorities who take no heed of moral exigencies. Who could blame a government for applying to the solution of the problems of the community those means acknowledged to be licit for married couples in the solution of a family problem? Who will stop rulers from favoring, from even imposing upon their peoples, if they were to consider it necessary, the method of contraception which they judge to be more efficacious? In such a way men, wishing to avoid individual, family, or social difficulties encountered in the observance of the divine law, would reach the point of placing at the mercy of the intervention of public authorities the most personal and most reserved sector of conjugal intimacy."
- The counter-measures proposed to combat these social evils (e.g. pro-contraceptive sexual education, free distribution of contraceptive devices) have failed to stem the tide to any noticeable degree and apparently have actually increased it: more sexual activity, more contraceptive use, more contraceptive failure, more pregnancy, more abortions, more births out-of-wedlock.

- Christian teaching, including Protestant, was always against ABC until 1930.
  - Charles Provan (contemporary Evangelical Protestant theologian): "We have found not one orthodox theologian to defend Birth Control before the 1900s. NOT ONE! On the other hand, we have found that many highly regarded Protestant theologians were enthusiastically opposed to it, all the way back to the very beginning of the Reformation" (Kippley 267).
  - Luther: "Ths is a most disgraceful sin. It is far more atrocious than incest or adultery. We can it unchastity, yes, a Sodomic sin" (Kippley 267).
  - Calvin: described Onanism as a kind of homicide (Kippley 267).
  - J. Wesley: such sins are very displeasing to God, he will destroy the souls of those who practice them (Kippley 267).
  - 1870's: American Congress (expressing Protestant ethos and reacting against Neo-Malthusian promotion of condoms in wake of discovery of rubber in 1839) enacted the Comstock Laws proposed by the Protestant Anthony Comstock, against the sale and distribution of contraceptives, especially condoms.
  - 1908: Anglican Church expressly condemned ABC
  - 1920: Anglican Church again expressly condemned ABC: "We utter an emphatic warning against the use of unnatural means for the avoidance of conception" (Kippley 272).
  - 1930: Anglican Church, in an abrupt change of course, at the Lambeth Conference, allowed careful and restrained use of ABC, becoming the first organized Christian body to permit ABC in history.
  - 1931: American Federal Council of Churches followed the Anglican bishops' decision to authorize ABC, suggesting that contraceptive use among married couples would be "careful and restrained."
  - 1931: Walter Maier (Lutheran theologian) responding to these decisions: "Birth control . . . involving the use of contraceptives, is one of the most repugnant of modern aberrations, representing a 20th century renewal of pagan bankruptcy" (Kippley 273).
  - 1931: Warren Chandler (Methodist bishop) responded: "The whole disgusting movement rests on the assumption of man's sameness with the brutes" (Kippley 273).
  - mid-1930s: U.S. Supreme Court began limiting application of Comstock Laws (Kippley 491).
  - 1961: American National Council of Churches accepted unreservedly all ABC that operated by preventing conception (Kippley 288).
  - 1965: US Supreme Court struck down the last of the Comstock Laws still in force (Kippley 491).
Infertility and Treatment

- **Some women have unusually high fertility** due to characteristic short cycles (hence more fertile days per year) or long periods of fertile cervical fluid each cycle
- **85% of women** using no protection will become pregnant after one year.

**Infertility is usually defined as a year of unsuccessful pregnancy attempts without protection;** in fact a fertile, non-charting couple simply by missing the proper window could go a year without achieving pregnancy. Conversely, a charting couple can determine accurately if they have infertility within 4-6 cycles of unsuccessful pregnancy attempts despite timing intercourse properly.

- **The infertility rate in the 1950s was about one couple in ten.** In the 1990s, it was one couple in five. This is due to the chemical effects of contraceptives, delayed childbearing, poor health habits, environmental factors, and increased promiscuity which spreads sterilizing STDs like gonorrhea and clamydia (Kippley 305).

**Possible causes of infertility:**

  o Possible causes of female infertility: Fallopian tubes closed or scarred, no ovulation, cervical fluid unsuitable for sperm penetration, Egg production low, Luteinized Unruptured Follicle Syndrome (LUFS) (Ovum remains inside luteinized follicle, unable to leave ovaries and break into the fallopian tubes), Endometriosis (growth of endometrial tissue outside the uterus), over-exercising, over-dieting, anorexia, obesity.

  o Possible causes of male infertility: sperm count (# of sperm per ejaculate) low, i.e. less than 50,000,000; sperm motility (% of sperm that swim well in a forward direction) low, i.e. less than 60%; sperm morphology (% of sperm with normal size and shape) low, i.e. less than 60%; and sperm concentration low (less than 20,000,000 sperm per milliliter of ejaculate). Since the 1930s, the average male sperm count has dropped by 50%. Varicoceles veins may be a cause of low sperm count. Other causes include scarred sperm ducts, hormonal deficiency, testicular failure (due to sport injury, severe childhood sickness), antibodies to own sperm

  o Possible causes of fertility incompatibility: antibodies to man’s sperm in woman’s cervical fluid

**Infertility Testing**

  o Problems in female fertility analyzed by charting, hormone blood tests, cervical fluid ferning tests (analyzes receptivity to sperm movement), postcoital test (analyzes compatibility of sperm and cervical fluid, within 2 hours of intercourse), ultrasound (identifies LUFS), endometrial biopsy (tests ability of endometrium to sustain implanted zygote), HSG (Hysterosalpinogram) (tests openness of fallopian tubes), laparoscopy (tests for endometriosis)

  o Problems in male fertility analyzed by sperm analysis (easily done, Results: Normal, Low, or Infertile). Also, the “hamster egg penetration test” is used to evaluate sperms’ ability to fertilize an egg. A sperm culture may be taken to identify possible sperm clumping. Sperm can be obtained for analysis without the morally-objectionable practice of masturbating by using a perforated silicone condom (untreated with spermicides) or the Huhner test, which removes sperm from the vagina within several hours of intercourse and has the added advantage of simultaneously checking for compatibility of the man's sperm with the woman's cervical fluid.

**A Basic Survey of Infertility Treatment**
Short fertility window due to low quantity of fertile cervical fluid: treated by timing intercourse effectively by charting

Short luteal phase, early miscarriages: treated with Progesterone, which delays menstruation and gives zygote adequate time to implant

Endomtriosis: treated with hormones or surgery

No ovulation: treated by woman’s weight normalization, if obese or anorexic; Clomid or Pergonal stimulate ovulation (Pergonal, the stronger drug, often stimulates release of multiple ova at once, increasing likelihood of fraternal twins if desired)

Low sperm count: treated by dietary changes, loose clothing, removal of varicocele vein in scrotum, which keeps testicular temperature higher than optimal

Low sperm motility and sperm antibodies: treated with sperm washing (motility increased by separating best swimmers by mixing ejaculate with culture and centrifuging) + IUI (or IVF or GIFT if IUI is unsuccessful)

Egg production low: treated with Clomid, which shortens luteal phase (Since Clomid also dries up cervical fluid, Clomid may actually not help but even prevent pregnancy if the problem is not related to egg production. For this reason, it is sometimes prescribed together with Estrogen, which compensates for the drying effect.)

Antibodies to man’s sperm in woman’s cervical fluid: hormonal treatment or condom therapy (intercourse for 6 months is regulated to prevent contact of sperm with cervical fluid, so that woman’s immune system will not attack them and her antibody level to the sperm falls; then strategically timed intercourse before antibodies have time to rise)

Non-fertilization due to low sperm count, incompatible or infertile cervical fluid, unexplained infertility: treated with Artificial Insemination (AI), a.k.a. Intra-Uterine Insemination (IUI): Insertion of sperm (either partner’s—"homologous"—or donor’s—"heterologous") through catheter either just outside the cervix or through the cervix and directly into the uterus. Least invasive of intercourse-bypass techniques. Usually performed in concert with sperm washing and Pergonal-stimulated ovulation. Morally objectionable due to masturbation and depersonalization of conception.

Non-fertilization: treated with In-vitro fertilization (IVF): several of a woman’s eggs are placed in petri dish and fertilized, then placed into uterus 2 days later. Morally objectionable due to masturbation and depersonalization of conception.

Non-fertilization: treated with Gamete Intra-fallopian transfer (GIFT): woman’s eggs are removed from her ovaries and placed in her fallopian tubes together with partner’s (homologous GIFT) or a donor’s (heterologous GIFT) sperm. Morally status is in question since it may be done by obtaining egg and sperm after an act of intercourse, without masturbation or as clear a depersonalization of conception.
ЛЕЧЕНИЕ И ПРОФИЛАКТИКА НЕОНАТАЛЬНОЙ ГЕРПЕТИЧЕСКОЙ ИНФЕКЦИИ

Среди вирусных заболеваний герпетическая инфекция (ГИ) является одним из главных повреждающих факторов плода и новорожденного, вызывая увеличение самопроизвольных абортов, преждевременных родов, рождения детей с патологией ЦНС и внутренних органов.

Согласно данным исследователей только 20% инфицированных ВПГ имеют диагностированный герпес, 60% - атипичную форму и 20% - бессимптомный герпес. Бессимптомная форма представляет наибольшую эпидемиологическую опасность, т.к. больные с данной формой чаще всего становятся источниками инфицирования, а беременные женщины – источником инфицирования ребенка. Более часто встречается вирус простого герпеса (ВПГ). ВПГ условно подразделяют на 2 типа – ВПГ1, ВПГ2.

По данным литературы, число случаев инфекции ВПГ у новорожденного составляет от 1 на 3000 до 1 на 20000 рожденных живыми. Частота неонатального герпеса при первичной инфекции матери составляет 20-25%, при рецидивирующей до 8%.

Механизмы передачи ВПГ от матери к плоду: трансплацентарный, трансцервикальный, инфицирование в родах при прохождении через родовые пути и через маточные трубы из брюшной полости. Клинические проявления ГИ зависят от сроков гестации. Раннее заражение может привести к выкидышу или нарушению органогенеза. При ГИ развивается иммунодефицитное состояние с поражением внутренних органов: почек, легких, ЦНС.

Все новорожденные с клиническими проявлениями ГИ, а также, рожденные от матерей с клиникой ГИ подлежат изоляции. При всех видах неонатальной ГИ показано применение противовирусных терапии в сочетании с иммунотерапией. «Золотым стандартом» противогерпетической химиотерапии является ацикловир.

Иммунотерапия ГИ включает применение иммуноглобулина человеческого нормального, сандоглобулина, интерферонов и индукторов интерферона, препаратов стимулирующих Т- и В-звенья иммунитета и фагоцитоз.

The article is about…
The article deals with…
The article is devoted to…
The article touches upon…
At the beginning of the text the author describes (mentions, analyses, characterizes)…
Then the author passes on to…
Further on the author gives detailed analyses of…
Attention is devoted to…
The article ends with…
The author comes to the conclusion that…
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