importance of postnatal health care provision, including home visits and midwifery services and the use of telemedicine for the facilitation of communication with the patient, and agree on the appropriate preparation for discharge and the discharge criteria. There is also agreement on the clinical aspects that should be evaluated at each postnatal visit, although discrepancies exist with regard to the contact schedule. In addition, there is consensus concerning the management of postnatal infections, perineal pain, fecal and urinary incontinence, and physical activity guidance. Clinicians should address mental health issues at each postnatal visit, according to all medical societies, but routine screening for depression is not recommended universally. As for the optimal interpregnancy interval, the American College of Obstetricians and Gynecologists recommends avoiding pregnancy for at least 6 months postpartum, whereas the National Institute for Health and Care Excellence recommends a 12-month interval. Discrepancies were identified with regards to the nutrition guidance, the recommended contraceptive methods, and the postpartum management of pregnancy complications. Of note, the World Health Organization is the only one to provide guidance regarding the prevention of specific infections during the postpartum period.

	ACOG	WHO	NICE	PHAC
Clinical evaluation at the first 24 hours	Not discussed	Vaginal bleeding, fundal height, uterine tonus, temperature, heart rate. BP measurement shortly after birth and repeat after 6h. Urine void evaluation within 6h.	Bladder function with measurement of first void after birth. Woman's health assessment.	Assess physical and psychological well-being. Vital signs, uterine tone and condition of perineum, lochia, bladder and bowel function, breasts and nipples. Promote effective feeding. Hydration and nutrition
Discharge criteria	Not discussed	24h after vaginal delivery. 1.Maternal and newborn well-being. 2. Parental and caregivers' skills and confidence for individual and newborn care. 3. Home environment and other factors affecting pp care and care-seeking behavior.	1. Woman's health and bladder function, 2. Baby's health and meconium passing. 3. Feeding plan and observation of 1 successful feed. Inform about postnatal period available support. Discuss the timing.	Review test results and possible signs of postpartum complications.
Postnatal contact schedule	Individualize. Provide postnatal care plan with contact information and instructions about the timing of postnatal contacts. First contact at first 3w, following ongoing care until the comprehensive visit <12w.	Minimum 4 postnatal contacts. First within 24h for home delivery. At least 3 additional postnatal contacts between 48-72h, between 7-14 days and during week six. Individualize.	First midwife visit at 36h after transfer of care or after home birth. First HCP at 7-14 days after midwifery care. Comprehensive evaluation by GP at 6-8 weeks.	Provide postnatal care plan with contact information and instructions for the postnatal contacts. Follow-up visit at 24-72h after discharge.

Conclusion: Although the puerperium is a critical period for the establishment of motherhood and the transition to primary care, postnatal care remains a relatively underserved aspect of maternity care. Therefore, it is crucial to develop consistent international strategies for the optimal care and support of women during this period to safely guide clinical practice and subsequently reduce maternal and neonatal morbidity.

Keywords: Postnatal care, postpartum care, puerperium, guidelines

PP-023 A comparative review of national and international guidelines on the diagnosis and management of fetal growth restriction

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DOI: 10.59215/prn.24.032supp023

Objective: Evaluation of mutual influence of antiphospholipid syndrome and TORCH infection, as well as the inclusion of plasmapheresis in preconception preparation, on the course of pregnancy, its outcome and the birth of children with fetal growth restriction.

Methods: Three hundred and eighty patients were examined at the Family Planning and Reproduction Center of the Moscow Department of Health, Maternity Hospital No. 3, and Maternity Hospital No. 4 of the City Clinical Hospital named after. V.V. Vinogradova Moscow, Russian Federation. In 270 patients, based on laboratory criteria and anamnestic data, a diagnosis of "Primary antiphospholipid syndrome" was established. There are two key classes of antiphospholipid antibodies: lupus anticoagulant and antibodies (anticardiolipin, phosphatidylserine, phosphatidylcholine, phosphatidylethanolamine, phosphatidylic acid, β2-lycoprotein-1, annexin V). 270 examined patients were divided into three groups: Group I - 132 patients without signs of activation of TORCH infection with antiphospholipid syndrome. Group II - 138 patients - verified TORCH infection with antiphospholipidsyndrome. Group III - 110 patients with confirmed TORCH infection who did not have antiphospholipidantibodies. In order to identify the infectious process, monitor the dynamics of its development, the effectiveness of treatment and verify clinical and laboratory cure, we used the determination of antibodies of the IgG and IgM classes, their avidity,

the presence/absence of antigens of infectious agents and their titer. IgG class antibodies (TORCH infections) were detected in all examined patients. Latent monoinfection was diagnosed in ¼ of cases, mixed infection was diagnosed in ¾ of cases. Markers of the activity of the infectious process were detected IgM and high-avidity IgG antibodies, as well as detection of pathogen DNA in genital smears by PCR.

Results: The mutual reinforcing effect of antiphospholipidantibodies of the IgG class and TORCH infection on the likelihood of pregnancy complications and the developmental features of newborns in the early neonatal period was clearly demonstrated. Plasmapheresis, included in comprehensive preconception preparation, had a positive effect on both the course of antiphospholipid syndrome and TORCH infections. When comparing the frequency of detection of antiphospholipid antibodies in the examined patients before and after preconception preparation with the inclusion of plasmapheresis, the maximum decrease in antibodies to β2-glycoprotein-1 after efferent therapy in the main group using plasmapheresis was revealed: by 65.2% in group I and by 68 % in group II. At the same time, in patients who underwent standard therapy, no statistically significant changes were noted in the frequency of occurrence of antibodies to β2-glycoprotein-1: in group I - by 17.8%, in group IIc - by 7.3%. The frequency of detection of lupus anticoagulant in group I decreased by 52.8%, in group II - by 61.8%, in group II - by 31.4%. The use of plasmapheresis in women of group I made it possible to reduce the level of antiphospholipid antibodies by more than 3 times compared to the initial (before therapy) level. At the same time, most of the immunoglobulin indicators approached the physiological norm at the end of the course of therapy.

However, it should be noted that the prevention of thrombotic complications in combination with complex antiviral therapy contributed to a more pronounced decrease in the titer of antiphospholipid antibodies in TORCH-infected women than standard therapy in women with no markers of TORCH infection activity. Moreover, in a number of cases, against the background of standard therapy, a weak tendency to an increase in a number of indicators of the level of antiphospholipidantibodies in the blood was observed. Thus, in patients of group II after therapy, a tendency towards an increase in the concentration of antiphospholipid antibodies was revealed. This logic of changes in the content of antiphospholipid antibodies against the background of the use of plasmapheresis and the standard protocol for the prevention of thrombus formation with antiviral therapy allows us to assert the presence of immunological mechanisms of pregnancy complications in history, induced by viruses and coagulopathy, as an independent pathogenic unit. The use of a complex of therapeutic agents (antiplatelet agents, anticoagulants, plasmapheresis), dynamic observation, monitoring of laboratory parameters and timely detection and correction of complications made it possible to bring the pregnancy to a successful completion in 97% of cases, to normalize blood clotting indicators, which made it possible to reduce the dose of glucocarticoids to the minimum. One of the key points revealed in our study is the fact that plasma exchange reduces the titer of antiphospholipid antibodies, regardless of the presence or absence of TORCH infection (as evidenced by comparable levels of antiphospholipid antibodies after therapy in both subgroups of the main group).

Conclusion: Thus, in the course of a long-term study, we comprehensively studied the mutual influence of antiphospholipid syndrome and TORCH infection, and also that plasmapheresis at the stage of preconception preparation as part of complex therapy can reduce the incidence of pregnancy complications such as fetal growth restriction and the development of placental dysfunction. In our study, among 57 newborns from women who managed to carry their previous pregnancy to term beyond 34 weeks, 42.1% were diagnosed with fetal growth restriction. After preconception preparation and active management of pregnancy, intrauterine growth restriction syndrome was diagnosed in 11.4% of cases, i.e. 3.7 times less often. Thus, the incidence of intrauterine growth retardation syndrome during the use of plasmapheresis procedures in the preconception period is lower about 62.9%.

Keywords: Antiphospholipid syndrome , fetal growth retardation, TORCH infection, plasmapheresis

PP-024 Evaluation of the effectiveness of plasmapheresis in patients with habitual miscarriage and antiphospholipid syndrom

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DOI: 10.59215/prn.24.032supp024

Objective: To evaluate the effect of plasmapheresis on the level of antiphospholipid antibodies in women with habitual miscarriage against the background of antiphospholipid syndrome.

Methods: The study was carried out on the Center