early termination of pregnancy in 10 cases (20%). In childbirth in 20 cases (40%) were diagnosed with anomalies of labor, of which in 17 cases - weakness of labor activity, in three cases - discoordinated labor activity.

In the control group, preeclampsia and early abortion were present in five cases (10% and 10%). Weakness of labor activity was observed in two cases (4%).

The most common complication in overweight pregnant women is found to be a violation of labor activity by 40%, which is 10-folds more often than in pregnant women with normal body weight. The course of pregnancy is complicated by gestational diabetes and placental dysfunction twice as often, preeclampsia three times more often than at normal body weight. The risk of abortion in the early stages is twice as common, which can be prevented by following a diet. Nutrition is one of the main conditions for a favorable course and completion of pregnancy and childbirth.

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MODERN APPROACHES TO THE TREATMENT OF MISCARRIAGE

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The problem of miscarriage at different terms is a medical and social problem, which indicates not only a violation of reproductive health of a particular woman, but also is an indicator of the quality of the provided care, a marker of the economic situation in the country, and reflects the physical condition of a woman and spouses who lost pregnancy. The solution of the miscarriage problem is one of the priorities of modern health care.

The role of progesterone, being well known in maintaining pregnancy, is also key in the gestational process. According to the latest scientific data, progesterone inhibits the expression of genes responsible for myometrium contractile activity, is an antagonist of prostaglandin F2α, inhibits prostaglandins activity, inhibiting their precursor - arachidonic acid. The main mechanism, contributing to maintenance of pregnancy, is related to the immunological features of pregnancy - progesterone-induced blocking factor (PIBF). It is produced in the presence of sufficient progesterone and prevents the rejection of the fertilized egg, containing foreign antigens to the mother, and is perceived as an allograft.

Utrozhestan normalizes anxiety on the 3rd day of therapy. Micronized progesterone significantly reduces the risk of miscarriage and the risk of premature birth in patients with primary miscarriage.

Studies, carried out in 2019, by the University of Biringham Coomarasy A et al A. Randomezed Trial of Progesterone in Woman with Bledeeng in Early Pregmency, have shown that vaginal progesterone therapy increases the likelihood of giving birth to alive baby at miscarriage risk.

PRISM study: the worse the situation, the better progesterone works. The more miscarriages in the anamnesis, the higher the effectiveness of micronized progesterone therapy. In the group with primary miscarriage, progesterone significantly increases the number of live borns after 34 weeks of pregnancy. Further analysis, concerning progesterone prescription,to all women without taking into account the history at the start of therapy from 6-9 tons of pregnancy, also showed an increase in the birth of alive children in this group.

In the PROMISE trial, a treatment regimen was used: progesterone from a positive pregnancy test (but not later than 6 weeks) to 12 weeks. Pre-pregnancy therapy for women with 3 or more miscarriages in the anamnesis was not performed . Most patients lost pregnancy by 6-7 weeks of gestation. The target analysis 2020 showed that the live borns in the subgroups is higher than in the placebo group in the PROMISE and PRISM study. Thus, progesterone under certain conditions can really increase live borns after 34 weeks.

The governing body of the European Association of Reproductologists and Embryologists in 2017 indicates that progesterone plays an important role in embryo implantation, and the positive

effect of progesterone can be achieved if you take progesterone from the luteal phase, and not after a positive pregnancy test.

In pregnant women in the first trimester dydrogesterone at the recommended doses has a teragetogenic effect. In the study, conducted in Israel on the basis of Maccabi Healthcare Service, which retrospectively analyzed the data for 17 years, it has been established that dydrogesterone use in the first trimester is associated with an increased risk of hypospadias, congenital CCC defects, uninhabited Bataal duct, spina bifida, as well as hydrocephaly/

Since dydrogesterone is an orally active progesterone, the structure of which differs from natural progesterone, there is danger concerning its safety for offspring.

Thus, the data of modern world investigations confirm the high efficiency of progestins use (micronized progesterone, utrozhestan) both during preconception training in women, who have had previous miscarriages, and for the purpose of treatment.

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PREREQUISITES FOR THE DEVELOPMENT OF DISORDERS OF THE MESTRUAL CYCLE AGAINST THE BACKGROUND OF ENDOCRINE SYSTEM PATHOLOGY

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In the structure of gynecological diseases in adolescents and young women, a significant place occupies functional disorders of the menstrual cycle, in particular against the background of thyroid pathology.

The purpose of the study is to establish thyroid pathology the frequency of alleles and genotypes of the GP IIIa polymorphism gene in the structure of puberty menorrhagia in girls with concomitant thyroid pathology and to identify risk factors for puberty menorrhagia based on genetic analysis.

70 teenage girls, patients with puberty menorrhagia, who were treated in the gynecological department of the city clinical maternity hospital №1 in Chernivtsi, were examined. Girls were divided into two groups: I (main) – 30 teenage girls diagnosed with puberty menorrhagia against the background of concomitant thyroid pathology, the second group (comparison) – 40 teenage girls diagnosed with puberty menorrhagia. Control group – 25 almost healthy teenage girls. GP IIIa gene polymorphism (PLA1/PLA2) was studied once, after patients were included in the study, by selecting genomic DNA.

The frequency of alleles and genotypes A1A2 of polymorphism of the GP IIIa gene was conducted in adolescents with menorrhagia, including thyroid pathology and in healthy teenage girls.It was found that the incidence of occurrence "wild" A1 allele of the GP IIIa gene in teenage girls with menorrhagia is 2.41 times greater than "mutant" A2 allele: 99 (70.7%) 41 (29.3%) cases of 140 allocated allies ($\chi2=9.64$, $p=0.002$). A similar trend was observed in the control group: A1 identified in 35 (70.0%) cases, which were 2.33 times more frequent than A2 alleles – 15 (30.0%) cases of 50 allocated alleles ($\chi2=5.63$, $p=0.018$). The resulting distribution by observation groups mirrored the total in the surveyed population, where prevailed "wild" allele over the "mutant" in 2.39 times ($\chi2=9.01$, $p=0.003$).

Genotype distribution thyroid pathology owed that A1A1-genotype is more likely to be registered in adolescents with puberty menorrhagia than 1.25 times ($\chi2=10.14$, $p=0.001$). By contrast, the relative frequency of A1A2-genotype, on the contrary, prevailed in the control group of 1.45 times ($\chi2=12.03$, $p<0.001$). Homozygote mutation A2A2 was registered only in teenage girls with menorrhagia – 8.6% (n=6 people). The relative frequency of "wild" A1 allele probably prevailed over the A2A2 genotype at 7.5 times ($\chi2=45.6$, $p<0.001$).

Epidemiological analysis of the risk of puberty menorrhagia against the background of pathology of thyroid depending on genotypes and alleed state of the GP IIIa gene thyroid pathology owed an incorrect increase in the likelihood of their appearance in carriers A2A2-, A1A2-genotypes and A2 allele in 1.33, 1.24 and 1.27 times, respectively (OR=1.37-1.46, $p\geq0.05$), for the lowest chances of menorrhagia in adolescents without the disease (OR=0.69-0.73, $p\geq0.05$). Instead, A1A1-