112 - PREMATURE BIRTH IN A PRIVATE MATERNITY HOSPITAL

NELSI SALETE TONINI
SIMONE PRADO
MARISTELA SALETE MARASCHIN
ELIZABETH APARECIDA DE SOUZA
ANÁLIA FIORINI OGURA
UNIOESTE – Universidade Estadual do Oeste do Paraná. Cascavel/Pr, Brasil
UNIPAR - Universidade Paranaense. Cascavel/PR, Brasil

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INTRODUCTION

According to Ribeiro; Silva; Matteucci (2010): a premature birth is the one that occurs between the 20th, to less than 37 gestational weeks, in which its product may be alive or not. According to Silva, et. al., (2009): a premature birth may be classified in spontaneous, when it results from a Preterm Labor (PTL) or from the Premature Rupture of Membranes (PROM); or elective as in a Recommended Premature Birth (RPB), when the gestation is interrupted by clinical indication, due to maternal and/or fetal conditions.

Preterm labor is diagnosed through the detection of cervical effacement and/or dilation and two or more contractions in 10 minutes before the 37th week, and it is different from the known practice contractions, because the contractions in preterm labor persist after hydration, sedation and resting for 1 hour in left lateral decubitus (PARANÁ, 2004).

Rades; Bittar; Zugaib (2004), considers elective or recommended premature birth as the one which occurs by medical recommendation, due to maternal and/or fetal complications. The causes which led to labor influence directly the neonatal results. However, the most severe complications depend directly on gestational age.

The premature rupture of membranes is the condition characterized by the spontaneous rupture of the membranes before the start of labor. When it occurs before term, it is called preterm premature rupture of membranes, and when it occurs after the 37th week, it is called premature rupture of membranes at term (BRASIL, 2012).

The Ministry of Health presents some factors that may assist in predicting premature birth, those being: maternal record of one or more abortions from the second trimester, cervical length larger than 3.0 cm, low socioeconomic status, maternal age inferior to 15 years old or superior to 40 years old, increased activity or physical effort, smoking, cocaine use, delay or absence of prenatal care, stress, twins, restricted intrauterine growth, congenital anomalies, polyhydramnios, placental abruption and the presence of Intrauterine Device (IUD) (BRASIL, 2012).

Moreover, Araújo; Pereira; Kac (2007), claim other risk factors, such as: maternal weight before and during pregnancy, ethnicity, height, age, maternal scholarship, marital status, multiple births, parity, maternal morbidity during pregnancy and risk behaviors, such as the consumption of alcoholic beverages and the ingestion of coffee.

According to Souza; Botelho (2011) a large portion of mothers in postpartum period had some preexistent chronic disease, the most commonly diagnosed were hypertension and diabetes and the least common were the autoimmune diseases, neuropathies and psychiatric disorders.

According to Silva et. al. (2009), the causes of PTL must be evaluated and studied during the prenatal care, which needs to be realized monthly until the 28th week, fortnightly from the 28th to the 36th week, and when the fetus is in full term, it must be realized weekly, especially in high-risk pregnancies.

Considering the foregoing, we have as objective to understand the occurrence of premature birth, identify which risk factors are more frequent in that maternity hospital, as well as to profile the patients who developed this condition in a private maternity hospital.

METHODS

The research was conducted in a private maternity hospital, which included room for admission and is composed of 4 apartments and 7 collective rooms, with a total of 18 beds. This private maternity hospital admits pregnant women who will be submitted to regular or cesarean delivery and pregnant women who need clinical treatment. Admission of pregnant women in preterm labor, premature rupture of membranes and elective birth also occurred, as well as admission of patients to realize post abortion curettage. The place has a mean of 100 monthly births, being regular or cesarean deliveries.

This was a descriptive, retrospective and documental research. The secondary data source was the electronic medical records of patients admitted between the months of July to December 2014. The system used to store the patient information is the Tasy system, which is a heath management system, in which all of the patient's information is available, from their admission, medical prescriptions, nursery prescriptions to their daily clinical reevaluation. The research counted with 103 medical records that fit the study's objectives.

Exclusion criteria for this study included: pregnant women who were admitted to realize post abortion curettage, pregnant women that gave birth after the 37th week of gestational age, both diagnosed via ultrasonography or other diagnostic exams, as well as pregnant women in clinical treatment, regardless of their gestational age.

The data collection counted with a 24-variable form. The data was collected in August 2015, after the approval of the Research Ethics Committee (Comitê de Ética em Pesquisa), in conformity with guidelines from Resolution 466, 2012. According to report number 1.095.812 and CAAE 45354015.6.0000.0109.

Data analysis was realized quantitatively, using simple percentage.

RESULTS AND DISCUSSION

103 patient's medical records from a private maternity hospital were used in the development of this research. Three of them were ruled out from the total because they had a gestational age longer than 37 weeks, two of them were ruled out because they were clinical treatment records in which the birth had not yet occurred, and one more was also ruled out because it was actually a duplicate from another record in the system. After accounting for these exceptions, the total sample resulted in 97 medical records.

As for the area in which the patients resided, we found that 91 patients (93,8%) resided in urban areas, and 6 (6,2%) resided in rural areas, demonstrating the predominance of the urban areas over the rural ones in this study. This information differs from the ones shown by Ramos; Cuman (2009), in a study which observed that the children born in urban areas presented a smaller coefficient of child mortality when compared to the ones born in rural areas. And that the absence of basic sanitation and

environmental factors may be determinant in the child mortality rate and, therefore, in prematurity.

Referring to the marital status of the subjects, it was found that 72 (74,2%) are married, 13 (13,4%) are single, 5 (5,17%) have a stable relationship, 2 (2,06%) are divorced and 5 (5,17%), concubinage. The information presented by this study show that almost 75% of the studied subjects are married, as opposed to the results found by other study realized in Santa Catarina, which reported that a mother with no partner had a chance almost 8 times higher of developing a preterm labor (SILVA, et. al. 2009).

Regarding the age of the subjects, these varied from 15 to 44 years old. Being that, 2 (2%) of the subjects were between 15 and 19 years old, 8 (8%) between 20 and 24 years old, 27 (28%) between 25 and 29 years old, 29 (30%) between 30 and 34 years old, 27 (28%) between 35 and 39 years old, and 4 (3%) were between 40 and 44 years old.

The age prevalence between 30 and 34 years old in this study concurs with another study realized by Silva, et. al. (2009), which showed a larger number of premature births in women aged over 30. The data obtained demonstrate the change in the women's behavior in our time, since these prefer to study and to professionalize themselves, delaying the maternity, this, added to the in vitro fertilization practices, which facilitate the later age fertilization and corroborate to a higher risk of prematurity (PORTO, et. al. 2013).

Referring to the color of the patients, we found that 79 (81,5%) of the mothers were white, 2 (2%) were yellow, 1 (1%) were mulattos, and 15 (15,5%) of the evaluated medical records did not have information regarding this subject. The predominant color in the region in which the study was realized is white, the ethnical predominance contributing to the results found. Martin, et. al. (2010) relate that the susceptibility of premature birth in white mothers raised from 7.4% to 8.2%, and in black mothers, this data was stable, in 11%.

As for the profession, the study had 31 different professions in its sample, distributed in Operational Assistant, Saleswoman, Pensioner, Engineer, Farmer, Pedagogue, X-Ray Technician, Pharmacy Assistant and Artisan, 1 (1%) for each profession; Dentist, Hairdresser, Cashier, Social Assistant, Psychologist, Accountant, Pharmacist and Sales Assistant, 2 (2%) for each profession; Student, Bank Officer, Manager and Production Assistant, 3 (3%) for each profession; Nurse and Nursing Technician, 5 (5%) for each profession; Teacher and Housewife, 6 (6%) for each profession; Administrative Assistant, 9 (9%); and 13 (16%) were unemployed.

A wide variety of professions were found, but we emphasize that 9 (9%) of the patients affected by the condition work as administrative assistants, according to Martinez, Latorre (2006), in a study realized with professionals of this area, these demonstrated unsatisfactory results in the areas relative to mental health, with low mean values. We stress that 6 (6%) of the patients are housewives and that 13 (16%) were unemployed, these results represent that the absence of remuneration may be considered a risk factor for premature birth, hypothesis supported by a study realized by Ramos; Cuman (2009), which demonstrated that 71% of their sample were housewives, that is, domestic work with no remuneration.

On the scholarship, variable, it was found that 3 (3%) of patients had completed only elementary school, 25 (28%) had completed high school, 1 (1%) had started but not completed high school, 56 (58%) had completed higher education, 8 (8%) had started but not completed higher education, and 2 (2%) did not inform their scholarship. Over half of the studied sample is represented by mothers which completed higher education, corroborating with the results in this same study that showed that women in the present days delay their maternity, resulting in a higher risk for premature birth. Silva, et. al. (2009), in a study showed that the scholarship was not a risk factor for prematurity, when analyzed individually, however, this must be evaluated together with their financial condition.

Other factors must be evaluated, such as socioeconomic factors, since according to Ramos; Cuman (2009), low scholarship is associated with a lower socioeconomic condition, factor which may predispose to potential risks to the mother and the newborn, in addition to narrowing the access to information and guidelines, restricting their care and assistance access and hindering the exercise of their rights and citizenship.

Referring to the gestational age, the group was divided according to the classification established by Lorena; Brito (2009), which defines moderate prematurity as babies which were born with a gestational age between 32 and 36 weeks, accentuated prematurity as babies which were born between 28 to 32 weeks of gestational age, and extreme prematurity in babies with less than 28 weeks of gestational age.

Based on the classification above, we found 5 cases (5%) of extreme prematurity (less than 28 weeks), 18 cases (19%) of accentuated prematurity (from 28 to 32 weeks), and 74 cases (76%) of moderate prematurity. Thus, we identified that more than half of the sample was characterized by moderately premature births. According to Porto, et. al. (2003), since only recently the late-preterm babies started being considered as a neonatal morbidity and mortality risk group, several professionals do not follow the practice of inhibiting the labor in this period, however, each case must be evaluated separately in order to verify the risks found for each newborn.

As for the factor which caused the admission and resulted in premature birth, we had 56 cases (58%) of elective premature birth, 34 cases (35%) of preterm labor and 7 cases (7%) of premature rupture of membranes. The study showed that over half of the premature deliveries realized in the studied period were elective premature birth, that is, the realization of the procedure defined by the obstetrician, be it due to the clinical condition of the pregnant woman, or even with no apparent reason, thus, prematurity may occur by of the removal of the fetus, leading to the inevitable occurrence of the birth before the 37th week.

Ribeiro; Silva; Matteucci (2010), commented about this variable in a study and demonstrated that the premature birth with medical recommendation is one of the main causes of the rise in the prematurity rates, as well as of the neonatal injuries.

Regarding the number of previous gestations, the study elucidated the following data: 79 (81%) of the medical records evaluated were from women in their first pregnancy, 11 (11%) had two previous gestations, 4 (4%) had three previous gestations, 2 (2%) with four previous gestations, 1 (1%) with seven previous gestations and 1 (1%) did not declare this information. We found that 81% of the sample was represented by women in their first pregnancy, this results in an agreement with the one presented by Porto, et. al. (2013), which demonstrated that 54% of the pregnant women affected by the condition were giving birth for the first time, exposing this group to the occurrence of this condition.

On the number of previous abortions, we identified that 86 (89%) of the patients did not suffer previous abortions, 8 (8%) had one previous abortion, 1 (1%) had two previous abortions, 1 (1%) had three previous abortions and 1 (1%) had five previous abortions. Almost 90% of the sample did not have a record of previous abortions, demonstrating that in the present study there is no relation between the premature birth and the record of previous abortions. This was also observed in a study realized by Araujo; et. al. (2012) which compared two groups, preterm and full term, and concluded that there were no considerable statistic differences in the obstetric records between the two groups regarding the record of previous abortions or previous stillborn, however, regarding the previous prematurity, the results showed important significance, that is, mothers with a record of previous prematurity were more susceptible to the occurrence of this condition.

Considering the current pregnancy as single or multiple, we identified that 78 (80%) of the patients had a single

pregnancy and 19 (20%) had a multiple pregnancy, with two or more fetuses. Which contradicts the study realized by Ribeiro; Silva; Matteucci (2010) in which 96,1% of the premature pregnancies were twins. Beck (2010) correlates the rise in the number of premature birth in multiple pregnancies with the frequent use of assisted reproduction techniques being used, the rise in the age of the pregnant women over 34 years old and the rise of the number of elective births, data which agrees with our study. Ramos; Cuman (2009), states that a multiple pregnancy is an important risk factor to low weight at birth, which can be considered as a risk factor to neonatal mortality.

As for the use of legal drugs, we prospected for the use of alcohol and tobacco and identified that 49 (51%) of the patients used neither of them and 48 (49%) did not present this information in their medical records. We found that 51% of the analyzed medical records did not use the prospected drugs, this represents a positive factor, for according to Leopércio; Gigliotti (2004), the consumption of tobacco implies in a higher risk for pregnancy complications, which are completely linked to the effect of the tobacco and, in many cases, are treated regardless of their correlation with the smoking habit. The association of smoking and pregnancy is one of the relevant factors which contribute to the premature birth and the baby's low weight at birth.

Regarding the use of alcohol, Mattson; Schoenfeld; Riley (2001) showed that mothers addicted to psychoactive substances have a higher risk of severe perinatal diseases, such as prematurity, malformations, retardation of intrauterine and extrauterine growth, fetal distress and infections, with neurological and respiratory consequences.

On the variable regarding the presence of previous or gestational diseases, five diseases were prospected: Hypertension or High Blood Pressure (HBP), Diabetes Mellitus (DM), Human Immunodeficiency Virus (HIV), Hepatitis B and Toxoplasmosis, as shown in figure 1.

FIGURE 1: Previous or gestational diseases in women who had a premature birth in a private maternity Hospital. 2015.

Previous or Gestational Diseases	Yes (positive for the disease)		No (negative for the disease)		Ignored (Information missing from the medical records)		Total (Sample total)	
	# of pat.	%	# of pat.	%	# of pat.	%	# of pat.	%
HBP	19	19	57	59	21	22	97	100
DM	3	3	40	41	54	56	97	100
HIV	0	0	47	48	50	52	97	100
Hepatitis B	0	0	46	47	51	53	97	100
Toxoplasmosis	0	0	45	46	52	54	97	100

SOURCE: Data collection instrument/2015.

The HBP had a small incidence in the prospected patients, 19 (19%) of the patients had the condition, in accordance with Porto, et. al. (2013), who demonstrated in their study that about 25% of the cases of late prematurity are linked to hypertensive crisis. According to Souza; Amorin; Porto (2010), the only possible cure for the preeclampsia is the removal of the fetus, thus increasing the incidence of premature birth in this group, the use of antihypertensive drugs is not a well-established treatment.

In this study, the diabetes mellitus was not shown to be a risk factor for prematurity, only 3 (3%) of the patients related the presence of the disease, however, it is important to emphasize that according to Souza; Amorin; Porto (2010), the presence of diabetes during pregnancy is an important risk factor for premature birth, since it may cause other important gestational dysfunctions, considering that the presence of the disease is linked to other dysfunctions in human metabolism. Over half 54 (56%) of the prospected medical records did not have information about the presence of absence of DM, thus, it can be inferred that this pathology does not characterize an isolated risk factor for the occurrence of premature birth in this study.

This study did not identify any risk factors for diseases such as HIV, Hepatitis B and Toxoplasmosis since these end up being omitted during the interview, and sometimes may not be given full attention by the nursing professionals during the elaboration of the report. Also, a large part of the sample has a higher education degree, which allows for a better knowledge of this disease's transmission mechanisms, thus providing greater control in the occurrence of these.

According to Ferezin; Bertolini; Demarchi (2012), the serological screening for these diseases is of outmost importance during pregnancy, since it allows early treatment, thus avoiding the occurrence of congenital malformations and/or problems related to hepatitis B, toxoplasmosis and HIV, in this way, the control and screening should be started in the pregnancy's first trimester.

The use of medications during pregnancy demonstrated the following results: 17 (18%) used some kind of medication during pregnancy, 48 (49%) did not use any medication during pregnancy, and 32 (33%) did not have this information in the nursing report. Of the 17 who used some kind of drug, the distribution resulted as follows: 5 (25%) used methyldopa, 3 (18%) used vitamins, 3 (18%) inhibin, and 14 (82%) other medications.

According to Siqueira, et. al. (2011), Methyldopa is the first-line of antihypertensive drugs used in pregnancy, since the treatment with it reduces the incidence of hypertensive crisis and, at the same time, is well tolerated by the mother without showing any adverse effect on placental and fetal hemodynamics or on fetal well-being.

Poly vitamin compounds are used, according to Lorena; Brito (2009), routinely in patients who underwent previous gastroplasty procedure. The use of inhibin has been studied tirelessly in order to demonstrate the real advantages of its use. According to Spallicci; Chiea; Perroni (2000), in 90% of their studied sample, preterm birth can be inhibited with the use of this medication for at least 48 hours. In the group studied, four patients had new admission for treatment of preterm labor, three of them had a preterm birth with gestational ages between 34 and 35 weeks, thus demonstrating the great advances in the use of this drug to treat the causes of premature birth.

The weight and height data of the pregnant women were evaluated as Body Mass Index (BMI), in order to better visualize the results found. The BMI is the weight/height ratio which is mathematically defined by the equation: weight (kg)/height (m^2) (RICARDO; ARAUJO 2002). For the BMI classification, the method applied by Kac; Meléndez (2005), was used and the results found were: with a BMI >19.8 and <26.0 kg/m^2, 9 (9%); with a BMI >26.0 and <29 kg/m^2 (overweight), 4 (4%); with a BMI >29.0 kg/m^2 (obese), 10 (11%); absence of data, 74 (76%).

It was found that 74 (76%) patients had no information regarding weight and height at the moment of hospitalization, representing the highest value in the sample. It is of paramount importance to evaluate the BMI of the pregnant woman, since this, when altered, constitutes a risk factor for the occurrence of preterm birth (SEABRA et. al., 2011). Although it is inferred that 11% (10) of the patients presented obesity during gestation, this result can be observed in the present society, in which humans are increasingly presenting themselves with excess weight. Seabra; et. al. (2011) argued that obese women present an increased

risk for the development of gestational complications, for example: gestational diabetes, hypertensive pregnancy syndromes, macrosomia, fetal distress, prolonged labor, surgical delivery, intrauterine growth restriction, cephalopelvic disproportion, trauma, asphyxia, perinatal death and prematurity. Bettiol; Barbieri; Silva (2010), reported that low BMI can also be considered a risk factor for prematurity, since it is one of the most apparent mediators in previous studies.

Regarding the weight of the newborn, the classification used was the one cited by Guadêncio; et. al. (2012); in a study in which they calculated and described the distributions of live births according to birth weight, such as: very low weight at birth (VLWB: <1.500g), low weight at birth (LWB: ≥1.500g and <2.500g), insufficient weight at birth (IWB: ≥2.500g and <3000g), adequate weight at birth (AWB: ≥3.000g and <4.000g), macrosomia (M: ≥4.000g), data which is presented in figure 2:

FIGURE 2: Classification of the newborn regarding the weight at birth, in women who had a premature birth in a private maternity Hospital. 2015

Weight at birth	Number of Patients	Percentage
Very low weight	23	20%
Low weight	53	45%
Insufficient weight	30	26%
Adequate Weight	8	7%
Macrosomia	2	2%
TOTAL[2]	116	100%

SOURCE: Data collection instrument/2015.

In this study, low birth weight was found in highest proportion, representing 45% of the sample. Guaudêncio, et. al. (2012), reports that low birth weight is related to morbidity and mortality, but its prevalence has a questionable significance as a neonatal health indicator; also, it relates the prevalence of low birth weight with intrauterine growth restriction and not due to prematurity. Considering the Brazilian socioeconomic condition, we can demonstrate a relationship between the findings of these authors (2012) and those obtained in our study. Carniel, et. al. (2008), shows that in developed countries, this mechanism of prematurity prevails, and in developing countries, there is mainly a relation of low birth weight with restricted intrauterine growth.

CONCLUSIONS

The main obstacle found for the realization of this study was the lack of information in the medical records prospected. The absence of information may interfere with the result of the variable researched. The most prevalent gestational age was 32 to 36 weeks (moderate prematurity), with 58% of elective premature birth, 81% of the sample were on their first pregnancy, 89% had no records of previous abortion and 80% had a single pregnancy.

Research data also revealed that preterm birth has become a public health problem because it brings with it not only physical, psychosocial, economic and cultural consequences, but also due to maternal and child health risks. Acknowledging the main causes of premature birth, as well as complications for the newborn, a health policy focused on the needs presented is required. Thus, there should be a commitment of health professionals, especially during the prenatal care in order to know the profile and needs of pregnant women, since each one of them has their own particularities.

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PREMATURE BIRTH IN A PRIVATE MATERNITY HOSPITAL

ABSTRACT: The present study had as main objective to understand the occurrence of premature birth in a private maternity hospital, and as specific objectives to identify the most frequent risk factors, as well as to identify the profile of the patients who developed this condition. The search for premature birth causes should assist the prevention of its occurrence, considering that the clinical treatment may be ineffective. It is important to emphasize that the search for a better way to inhibit the premature birth is still the most favorable treatment, provided that the chance of development and survival of the premature newborn is really small. This was a documental study, using as a secondary data source the electronic medical records of 97 patients who developed a premature birth in the period between July and December 2014. The data collection instrument was a 24-variable questionnaire. A larger occurrence of the elective premature birth was identified, corresponding to 58% of the sample, 76% were patients with a gestational age between 32 and 36 weeks, almost 90% of the sample did not have a previous abortion record and 81% were pregnant for their first time. The risk factors found by the study represent the large complexity in the evaluation of risk for premature birth and stress the importance in their identification in order to improve the development of the gestation with no complications.

Keywords: prematurity; labor; maternity hospital.

ACCOUCHEMENT PRÉMATURÉ DANS UNE MATERNITÉ PRIVÉE

RÉSUMÉ : L'objectif principal de cette étude est de connaître l'occurrence de naissances prématurées dans une maternité privée et d'identifier les facteurs de risque présentés avec une intensité accrue, ainsi que de décrire le profil des patientes ayant développé cette découverte. La recherche des causes de l'accouchement prématuré doit aider à prévenir son apparition, car le traitement clinique peut être inefficace. Il est important de souligner que la recherche d'une meilleure façon d'inhiber l'accouchement prématuré reste le traitement le plus opportun, étant donné que les chances de développement et de survie du nouveau-né prématuré sont très faibles. Il s'agit d'une étude documentaire dont les données secondaires ont été les dossiers médicaux électroniques de 97 patientes qui ont eu les accouchements prématurés de juillet à décembre 2014. L'instrument de collecte de données était un formulaire à 24 variables. Un nombre plus élevé de naissances prématurées électives correspondant à 58% de l'échantillon a été identifié, 76% étaient des patientes dont l'âge gestationnel était compris entre 32 et 36 semaines, près de 90% de l'échantillon n'avaient aucun antécédent d'avortement et 81% étaient des primigestes. Les facteurs de risque recensés dans l'étude traduisent la grande complexité de l'évaluation du risque de prématurité et relatent l'importance de la recherche de leur identification afin d'améliorer le développement de la grossesse sans changements.

Mots-clés : prématurité, travail d'accouchement, maternité.

PARTO PREMATURO EN UNA MATERNIDAD PRIVADA

RESUMO: Este estudo teve como objetivo principal conhecer a ocorrência de parto prematuro em uma maternidade privada, e como objetivos específicos identificar os fatores de risco que se apresentam com maior intensidade, bem como traçar o perfil das pacientes que desenvolveram este achado. A busca pelas causas do parto prematuro deve auxiliar no que diz respeito à prevenção da ocorrência deste, uma vez que o tratamento clínico pode ser ineficaz. É importante salientar que a busca por uma melhor forma de inibição do parto prematuro ainda é o tratamento mais oportuno, considerando que a chance de desenvolvimento e sobrevida para o recém-nato prematuro é muito pequena. Este foi um estudo documental, que teve como fonte secundária de dados os prontuários eletrônicos de 97 pacientes que tiveram parto prematuro no período de julho a dezembro de 2014. O instrumento de coleta de dados foi um formulário com 24 variáveis. Foi identificada maior ocorrência do parto prematuro eletivo correspondendo a 58% da amostra, 76% eram pacientes com idade gestacional entra 32 e 36 semanas, quase 90% da amostra não possuía histórico de aborto anterior e 81% eram primigestas. Os fatores de risco encontrados no estudo representam a grande complexidade na avaliação do risco para parto prematuro, e relacionam a importância na busca pela identificação destes a fim de melhorar o desenvolvimento da gestação sem alterações.

PALAVRAS-CHAVE: prematuridade; trabalho de parto; maternidade.

PARTO PREMATURO EM UMA MATERNIDADE PRIVADA

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Palavras-chave: prematuridade, trabalho de parto prematuro, maternidade.