ANALYSIS OF THE TREATMENT METHODS FOR ENDOMETRIOSIS

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ABSTRACT

Endometriosis has become one of the most common diseases in modern gynecology. It affects women of various ages, the etiology of which is still not fully known. On average, up to 35% of women with endometriosis suffer from infertility. The purpose of the study: to analyze various treatment methods at the modern level to identify the most effective treatment for endometriosis and infertility against its background. Conclusion: Treatment of patients at the modern level requires a careful approach to patients, it is necessary to take into account age, health status, gynecological health indicators and much more.

Keywords: endometriosis, external genital endometriosis (EGE), infertility, endometrium, anovulation, implantation, adhesions, surgical treatment, conservative treatment.

INTRODUCTION

Endometrial insufficiency plays a leading role in the development of infertility in patients with endometriosis. It is known that the receptor apparatus of the endometrium plays a decisive role in implantation. Bulun S.E. et al. in their study observed that progesterone receptors appear in the endometrium of patients with endometriosis, thereby increasing their resistance to progesterone [15, 19].

With endometriosis, tubal infertility occurs due to a violation of the anatomy of the fallopian tubes. This factor is specific for abdominal endometriosis and is directly related to the severity of the process. Prolapse of heterotopias into the fallopian tubes leads to their obliteration (anatomical form), which in turn creates a barrier that prevents the passage of germ cells and the fertilization process [2, 5, 8, 14].

PURPOSE OF THE STUDY

To analyze various treatment methods at the modern level to identify the most effective treatment for endometriosis and infertility against its background.

Recently, problems of reproductive function in patients with endometriosis have become more relevant. Today, about 176 million women aged 15 to 49 years worldwide suffer from endometriosis [1, 3, 7, 12, 16, 20]. This indicates a serious threat to the reproductive health of patients. The question of the causes of endometriosis, as well as the real mechanisms of development of infertility associated with this disease, still remains unclear [5, 9, 11, 13]. Therefore, the study of this mechanism based on the collection and analysis of available data for the treatment of endometriosis and its complications is one of the urgent tasks of modern medicine.

Existing theories of the etiopathogenesis of infertility in endometriosis cannot fully explain the true nature of infertility due to endometriosis. The main causes of infertility in endometriosis are anovulation, a decrease in ovarian reserve, deterioration in the quality of the egg, a decrease in the rate of egg fertilization, a decrease in the rate of embryo reproduction, and impaired implantation [4, 6, 10, 18].

Discoordinated contractile activity of the uterine tubes is observed as a result of prolonged exposure to prostaglandins and other biologically active substances that are intensively formed in heterotopias of external genital endometriosis, as well as due to absolute or relative hyperestrogenism in combination with progesterone deficiency of the second stage of the menstrual cycle [8, 10]. With endometrioid heterotopias, periodic menstrual bleeding and the accumulation of serous-hemorrhagic exudate lead to the accumulation of a large amount of fibrin.

Violation of microcirculation causes tissue hypoxia, enhances the formation of adhesions. In case of perinoneal infertility, local inflammation is also observed in the area of endometrioid heterotopia [10]. Chronic inflammation in external genital endometriosis occurs as a result of activation of T-cell immunity, an increase in inflammatory mediators in the abdominal cavity is detected [1, 4, 17].

In the first and second stages of endometriosis, if fertility in the first year is estimated at 20-50%, then the cumulative pregnancy rate decreases by 4% per year [1, 6]. A meta-analysis of 27 randomized controlled trials involving 8984 infertile patients showed a clinical association between infertility and endometriosis [10]. At stages I-II of endometriosis, the frequency of pregnancies significantly decreases (relative risk = 93, 95% confidence interval - 0.87-0.99, p = 0.03). In stage III-IV endometriosis, there is a decrease in the frequency of implantation (relative risk = 0.79, 95% confidence interval 0.67-0.93, 81 P = 0.006) and the frequency of clinically confirmed pregnancies (relative risk 0.79, 95% confidence interval interval). interval 0.69-0.91, p = 0.0008).

According to different authors, the frequency of infertility in women with endometriosis can reach 55-75% [4,5,8,11]. Every third patient who resorted to assisted reproductive technologies had external genital endometriosis [3,5,9,12,14]. Due to the high incidence of recurrent ovarian endometrioid formation and the negative impact of surgical treatment on the state of ovarian reserve, most authors use IVF programs as first-line therapy to overcome endometriosis-related infertility. Which relatively not every patient can afford, even though IVF is allowed in our country and there are already IVF centers both in the capital - Tashkent, and in other areas, including Samarkand.

In the studies of P. Vercellini et al. (2009) it can be seen that the pregnancy rate decreases by almost 2 times after repeated surgical interventions for recurrent endometrioid ovarian lesions, and their attempt at successful IVF also decreases [17, 18]. W. Xing (2016) did not find significant differences in the frequency of pregnancies in previously operated patients and those not operated on for IVF. However, the authors note that in patients with recurrent EGE, it is necessary to increase the initial dose of gonadotropins, and the stimulation itself is more stable than in the group of patients with stage I–II EGE [22].

According to the experts of the American Society for Reproductive Medicine (ASRM), endometriosis with infertility should be considered as a disease in which the patient needs to develop a long-term plan with the use of drug treatment (if indicated) to exclude reoperation [2, 6, 8, 11, 14, 20].

Patients with external genital endometriosis require an individualized approach in the choice of management tactics to achieve the desired pregnancy.

Until now, the role and features of assisted reproductive technologies (ART) programs in choosing the most effective treatment method, its targeted implementation in patients with recurrent EGE, as well as ways to improve their effectiveness are widely discussed. The state of the ovarian reserve, the woman's age, the duration of infertility, the presence of pain syndrome and the stage of the disease must be taken into account when developing tactics for the treatment of patients with infertility associated with endometriosis [2, 3, 7, 11, 12, 15, 21].

According to the authors, if endometriosis is suspected in patients with infertility, diagnostic laparoscopy should be used to determine the stage of spread of the endometrioid process in the pelvic area and the subsequent removal or elimination of endometriotic lesions using various types of energy.

If stage I-II endometriosis is detected, expectant management is possible, probably 6-12 months after surgery, in accordance with the ESHRE-2019 clinical guidelines for the treatment of patients with infertility,

spontaneous pregnancy will occur [1, 4, 6, 8]. The effectiveness of surgical treatment as the only way to restore pregnancy with the predominance of EGE stages I-II, according to foreign authors, is 20-40% [13, 16, 17, 22].

However, the rejection of waiting tactics and intrauterine insemination with the husband's or donor's sperm, especially the use of gonadotropins to stimulate ovulation, significantly increase the frequency of pregnancy and childbirth. In the absence of pregnancy within 6 months, intrauterine insemination (IUI) is recommended against the background of ovulation induction with gonadotropins with a low ovarian reserve and taking into account the patient's age.

According to the literature, against the background of ovulation induction with clostilbegit, the pregnancy rate is lower compared with stimulation with gonadotropins [16,17,22]. In the absence of pregnancy within 1 year, IVF was recommended [2, 5, 9, 11, 13]. At the same time, IVF should be considered as the first line of treatment in patients with low ovarian reserve, older than 30 years and infertility for more than 2 years [2, 10, 11, 14, 17].

In patients with HE in preparation for IVF, GnRH administration for 2-3 months and with diffuse infiltrative endometriosis for 3-6 months, positive ART results with a high degree of evidence are shown, and the clinical gestational age is more than 4 times [1, 2, 5].

In infiltrative diffuse endometriosis, the “Superlong” protocol with GnRH may have a number of advantages [3, 5]. The "super-long" protocol is primarily hormonal suppressive therapy (HST), in which a long and deep hypoestrogenic state is formed; At the end of HST, gonadotropins are prescribed to induce superovulation.

However, it should be noted that prolonged suppression of ovarian function leads to a decrease in ovarian reserve or non-reactivity at the time of ovarian stimulation, and this may be especially pronounced in patients with reduced ovarian reserve and older reproductive age.

It should be noted that combined oral contraceptives and gestagens, especially dienogest, serve as first-line drugs for depletion of the ovarian reserve and are recommended for patients of older reproductive age.

According to some scientists, in patients with moderate and severe forms of EGE and infertility, surgical treatment is not prescribed to achieve spontaneous pregnancy, but serves only as a preparatory process to increase therapeutic efficacy and reduce pain symptoms in patients [6, 14, 17, 22].

According to existing international recommendations, in patients with stage III-IV EGE after surgery, the condition of the fallopian tubes, the state of the ovarian reserve improves and serves as an alternative way to overcome infertility. This indicates that the chances of resuming natural fertility in the postoperative period increase.

According to scientists, in patients with moderate to severe forms of EGE, especially in the presence of a recurrent period of EGE, the most effective way to overcome infertility associated with endometriosis is laparoscopy and IVF.

To date, the role of surgical methods, medical and IVF in the treatment of patients with EGE, especially in the case of relapse, is the subject of a lively discussion. The high prevalence of endometriosis, its negative impact on the reproductive function of young women requires a detailed study of this disease and the development of innovative treatment tactics.

CONCLUSIONS.

По результатам исследования мы сделали следующие выводы:

1. У больных с НГЭ и ановуляторным циклом рациональное медикаметозное лечение и стимуляция овуляции позволяет естественным образом восстановить фертильность в 48% случаев. При комбинировании его с хирургическим методом и повторной стимуляцией эффективность возрастает еще на 16%, составляя в общей сумме 64%.

2. Лапароскопия остается «золотым стандартом» диагностики НГЭ и сопутствующих заболеваний истекающих из него: у 48% пациенток группы А диагностирована НГЭ и спайки, кисты при лапароскопии по поводу бесплодия после безуспешной консервативной терапии в течении 6 циклов.

У пациенток с сохраненной овуляторной и менструальной функциями (группа Б) маточная беременность наступает после лапароскопического лечения и 6 месячного ожидания в 52% случаев.

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