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Comparisons of the Treatments of Endometriosis

O.F. Akhtamova [1]

[1] *assistant, Department of Obstetrics and Gynecology №1, Samarkand State Medical University, st. A. Temur 18, Samarkand, 140100, Uzbekistan*

Abstract

Relevance: Today, about 176 million women aged 15 to 49 worldwide suffer from endometriosis. 20-50% of women, of which suffer from infertility. The purpose of the study: to compare various modern treatment methods to identify the most effective treatment for infertility associated with endometriosis. Materials and methods: The study included 100 women with infertility due to endometriosis, divided into two groups according to the method of treatment. Results: the use of drug treatment and stimulation of ovulation in group A was effective by 48%, and when combined with the surgical method and repeated stimulation, the effectiveness increased by another 16%. In group B, the efficiency was 52%. Conclusion: taking into account all factors and dividing patients according to the method of treatment depending on the condition, the overall effectiveness of the two methods was 58% of patients in both groups.

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

Introduction

In recent decades, the problem of maintaining reproductive function in patients with endometriosis has become increasingly important. 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

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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].

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 compare various methods of treatment at the modern level to identify the most effective overcoming of infertility against the background of endometriosis.

Materials and methods of research. The study was conducted on the basis of the gynecological department of clinic No. 1 of the Samarkand State Medical University and the Perinatal Center of the city of Samarkand for 2020-2022. The study included 100 women with endometriosis who suffered from infertility, they were divided according to the method of treatment into 2 groups: of them, 50 patients who underwent conservative treatment of endometriosis and restoration of fertility (group A), only after which, if ineffective, laparoscopic treatment was recommended, and 50 patients who underwent surgical treatment of endometriosis as the first stage, after which drug therapy was used (group B).

The clinical examination of the patients included history taking, primary examination, gynecological examination, ultrasound of the pelvic organs, hormonal examination, and the conclusion of the therapist. Examination of men included a study of spermogram 2 times with an interval of 2-3 weeks, in assessing the fertility of which the relevant WHO standards were used.

Surgical treatment of group B patients included endoscopic laparoscopy, which was

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performed using KARL STORZ equipment in accordance with generally accepted methods.

To diagnose pregnancy, the concentration of the hCG subunit was determined and ultrasound was performed.

At the first stage, patients underwent corrective therapy, and patients from group B underwent preparatory therapy for surgical intervention.

Women with obesity (BMI>30) were prescribed diet therapy in combination with dosed physical activity to reduce weight. Patients with high levels of LH and testosterone were prescribed low doses of oral contraceptives (3-6 months), with hyperprolactinemia - dostinex and hypothyroidism - L-thyroxine preparations. Treatment was started before surgery and continued in the postoperative period. Correction of hormonal disorders was carried out under the supervision of endocrinologists.

Group A patients were prescribed laparoscopy only after medical treatment (correction of hormonal disorders, elimination of cervical dysfunction factors, restoration of vaginal microcenosis) and confirmation of the ineffectiveness of attempts to restore natural fertility with the help of ovulation inducers.

When stimulated by CC, the adequacy of the ovarian response was assessed from the 9th to the 10th day of the cycle, determining the size of the growing follicles during folliculometry and determining the concentration of E2 in the blood. In the presence of a mature follicle 18 mm in size, concentration E2 = 500-2000 pmol/l, an ovulatory dose of hCG 5-10 thousand units was administered. 36-48 hours after administration, ovulation was confirmed by ultrasound.

In patients with anovulatory infertility with early detection of resistance to CC, a combination of CC + rFSH was used to stimulate ovulation.

Results and its discussion. The first series of controlled ovulation stimulation included the sequential use of folliculogenesis inducers in three cycles. After that, 10 (20%) of the women experienced uterine pregnancy during this series of ovulation stimulation.

The second series of ovulation stimulation was performed in 40 (84%) patients, which was accompanied by the onset of uterine pregnancy in 14 patients (35% of the number of patients with the second series of ovulation therapy or 28% of all patients in group A).

In 26 (52%) of 50 patients with persistent infertility after two series (6 cycles) of ovulation stimulation, laparoscopy was prescribed to detect and treat endometriosis, as well as concomitant peritoneal factors of tubal infertility.

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According to the results of laparoscopy, 24 out of 26 examined patients had one or more pathological manifestations requiring surgical correction to restore fertility. Multiple EGE heterotopias occurred with the greatest frequency (in 92.3% of the laparoscopies performed, 48% of the total number of patients in group A), adhesions of varying severity were present in 19 (38%), and functional ovarian cysts were identified in 10 (20 %). These 26 patients were re-attempted to stimulate ovulation in three consecutive cycles. Inducers of folliculogenesis during repeated stimulation of ovulation in patients of this group began immediately after surgical endoscopy, that is, in group A, unlike group B, the effect of the surgical treatment itself was not expected, which suggests a 6-month passive expectation of the onset of "spontaneous" pregnancy. As a result of repeated stimulation of ovulation, uterine pregnancy occurred in 8 (16%) patients, ectopic pregnancy - in 1 (2%) woman.

Assessing the overall effectiveness of the treatment algorithm used in patients with EGE and signs of anovulatory (endocrine) infertility, we can conclude that the consistent use of the methods of ovulation stimulation described above ensured the onset of uterine pregnancy in 32 (64%) women from group A.

For group B patients with preserved ovulatory and menstrual functions, the "first line" of treatment in all cases was the endoscopic method (laparoscopy). After endosurgical treatment of the identified pathology, a specific drug for the treatment of endometriosis, Visanne (2.0 mg dienogest) was prescribed for 6 months. At this time, spontaneous uterine pregnancy occurred in 18 (36%) patients. In cases of absence of pregnancy, they switched to the use of ovulation inducers. In general, ovulation induction with CC in this group was performed in 25 (50%) patients; As a result, uterine pregnancy occurred in 8 out of 25 patients (16%). Ovarian hyperstimulation syndrome was observed in 1 patient (2%). With 26 registered pregnancies, the proportion of ectopic pregnancy was 2% of the total number of patients in the group.

Thus, the restoration of reproductive function in patients with EGE without signs of anovulatory (endocrine) infertility ensured the onset of uterine pregnancy in 52% (26 out of 50).

Conclusions. Based on the results of the study, we made the following conclusions:

1. In patients with EGE and an anovulatory cycle, rational drug treatment and stimulation of ovulation allows natural restoration of fertility in 48% of cases. When combined with the surgical method and repeated stimulation, the effectiveness increases by another 16%, amounting to a total of 64%.
2. Laparoscopy remains the "gold standard" for diagnosing EGE and associated diseases resulting from it: 48% of patients in group A were diagnosed with EGE and adhesions, cysts during laparoscopy

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for infertility after unsuccessful conservative therapy for 6 cycles.

In patients with preserved ovulatory and menstrual functions (group B), uterine pregnancy occurs after laparoscopic treatment and 6 months of waiting in 52% of cases.

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