

MODERN METHOD OF TREATMENT OF UTERINE MYOMA

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Abstract. *Uterine myoma (leiomyoma) presented in this article is one of the most common tumors of the female genital organs. It is determined that 22-28 percent of women of reproductive age have the above disease. In the following decades, cases of uterine fibroids are increasing during the period of reproductive function, because for social reasons, women postpone childbearing to a later period of reproductive age. In this regard, if they have uterine fibroids or It is logical that there are more and more questions about the possibility of pregnancy after removal, its effect on pregnancy and childbirth, many other information is presented in the article.*

Keywords: *uterine myoma, ultrasound examination, pregnancy, uterine fibroids.*

INTRODUCTION

Fibroids are the most common benign tumor of the uterus, with an estimated incidence of about 20–40% among women during their reproductive age [1, 2]. Most often fibroids uteri are detected in women over 35 years of age, age 35-55 years accounts for up to 90% of the total diseases, and uterine fibroids rarely occur in women under 20 and over 70 years of age. Over the past few decades, uterine fibroids have become increasingly common number of cases by the time of childbearing functions, since for social reasons women postponing having children until later reproductive age. Number of patients operated on for uterine fibroids in women in various gynecological hospitals varies from 41 to 74% [3].

Treatment of uterine fibroids is a subject of close attention attention of both world and domestic gynecology. On the one hand, the feasibility of radical surgical intervention in situations with an acute clinical picture or giant the size of the myomatous nodes is beyond doubt.

But at the same time, the question remains open regarding the high frequency of hysterectomies and treatment tactics asymptomatic uterine fibroids.

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Currently, “comprehensive” conservative management” of patients with uterine fibroids, proposed by V.I. Kulakov in 1997, under which implies a combination of early surgery with principles of minimizing surgical trauma, and chemical myomectomy. This approach provides restoration of reproductive function in most patients. Conservative plastic surgery is performed quite rarely: over the past 30–40 years, in no more than 10–12% of cases [4].

Meanwhile, among those operated on for uterine fibroids, every fourth woman is under the age of 40 years.

In this regard, the issue of performing gentle operations on young women is extremely relevant. However, the main method of treating uterine fibroids, which guarantees good results, is surgical. The possibilities of the surgical method have expanded significantly with the introduction and development of endoscopic technologies.

Currently, in operative gynecology everything the tendency towards the so-called functional surgery for various pathological conditions of the reproductive system, including in patients with uterine fibroids [5]. The group of conservative plastic surgeries that preserve both menstrual and reproductive function includes conservative myomectomy. With this operation Enucleation of myomatous nodes is performed while preserving the uterus with all its inherent functions, which allows young women to have children in the future [5].

Undoubtedly, the main goal of the operations performed is the possibility of successful implementation of the generative function after myomectomy. Numerous studies have shown that myomectomy can increase the frequency of pregnancy and pregnancy in patients with impaired reproductive function due to uterine fibroids [2]. However, even now there are many unresolved and controversial issues regarding surgical technique, choice of location and direction of the incision on the uterus, the suture material used and providing conditions for the formation of a full-fledged scar on the uterus.

According to various authors, restoration of generative function after myomectomy is observed in 5-69% of cases. According to the data given in the literature, after conservative myomectomy, you can expect pregnancy in every 2-3 women. The likelihood of restoring natural fertility within the next year after myomectomy is higher in patients with a single tumor node [3]. The desire of a woman of childbearing age to have pregnancy, despite the presence of fibroids requiring surgical treatment, is an indication for performing myomectomy in the vast majority of cases (with the exception of acute necrosis node with the development of a septic condition, when non-radical intervention is life-threatening, and cases fibromatosis of the uterus, when the organ is so injured during the operation that it is unlikely to can function adequately at full capacity) [5]. Currently, the indications for myomectomy have been significantly expanded and this operation can be performed in almost any location of myomatous nodes [1]. Scientific publications indicate sufficient effectiveness when performing myomectomy using all available approaches (laparotomy, laparoscopy, hysteroscopy), the choice of which depends not only on the size, number and location of nodes, the presence of concomitant gynecological and extragenital pathology, but and on the experience of the surgeon and the availability of the necessary equipment [2]. Surgical intervention in volume myomectomy is an effective method of treating uterine fibroids due to the elimination of the tumor, as well as accompanying clinical symptoms, except Moreover, it is an organ-preserving operation, allowing the patient to become pregnant in the future [4]. This is undoubtedly its advantage compared to other methods, but, unfortunately, it does not eliminate the cause of the disease and does not prevent from relapse, although its frequency does not exceed 6% [3].

Hormone therapy as an independent method There is currently no treatment for uterine fibroids. The basis of hormonal therapy for uterine fibroids is an attempt to interfere with the stimulating effects of steroid hormones (estradiol and progesterone) on tumor cells [1]. Antihormonal drugs, gonadotropin-releasing hormone (GnRH) agonists, are used mainly as stage of preparation for subsequent treatment by others methods. As a result of this therapy, persistent hypoestrogenism, comparable to that in menopause. Desensitization of the pituitary gland and

suppression of ovarian function lead to a decrease in the volume of the uterus and fibroids by about 50% and cessation of menorrhagia due to the development of amenorrhea [1]. However, long the use of GnRH agonists is limited by the development of severe side effects caused by estrogen deficiency, such as accelerated demineralization bone tissue; change in plasma lipid profile blood up to the development of coronary atherosclerosis; the development of psychovegetative disorders that significantly worsen the quality of life of patients. Except In addition, 4-6 months after cessation of therapy, the tumor size returns to its original size. As a stage of combination treatment, the use of drugs for 3-4 months allows achieving reducing the size of the uterus and fibroids, as well as reducing the level of blood supply to the uterus and correct anemia [4].

With the creation of antigestagens as modulators of progesterone receptors (MPRs), new opportunities for the treatment of uterine fibroids. The first generation MPR drug mifepristone is proposed for therapy of neoplasms in the 1990s. At the core the pharmacokinetics of MPRs lies in their ability to competitively bind to progesterone receptors of fibroid tissue, thus excluding the influence endogenous progesterone. Influencing the key factor in the pathogenesis of fibroids, antigestagens provided proven advantage of drug treatment for uterine fibroids. For the first time, fibroid therapy with the symptomatic stage has stepped into pathogenetic perspectives. However, obvious difficulties arose here too. The fact is that mifepristone also comes into contact with glucocorticosteroids receptors. Further search for pharmacological solutions was aimed at developing selective MPRs with a selective effect only on progesterone receptors [1]. For example, ulipristal acetate has a steroid structure and has selective tissue-specific effects on progesterone receptors [2].

Moreover, its molecule in tissues with different receptors can act both as an agonist and as an antagonist, which makes it possible to achieve the desired therapeutic result with minimal side effects. The action of selective MPR in the hypothalamus-pituitary-ovarian system uterus occurs at the level of the pituitary gland and suppresses ovulation without the formation of a menopausal effect due to a partial suppressive effect on the concentration of follicle-stimulating hormone (FSH). As a result, folliculogenesis does not stop, the concentration of estradiol is stabilized at the level of the middle follicular phase - this avoids the occurrence of undesirable effects hypoestrogenism.

After discontinuation of ulipristal acetate the growth of myomatous nodes does not resume, because that the molecule stimulates apoptosis in fibroid cells.

It is important that SPRM drugs exhibit antiproliferative, antifibrotic and proapoptotic properties effects only on fibroid cells, not affecting healthy myocytes. Ulipristala acetate has a direct effect on the endometrium: causes amenorrhea or reduces intensity bleeding already by the 10th day of use, as well as reduces the severity of pain that bothers most patients with symptomatic fibroids. After stopping the drug menstrual cycle usually resumes within 4 weeks. It is worth noting the absence of difficulties when performing myomectomy and enucleation of myomatous nodes. In contrast from GnRH agonists, drugs with ulipristal acetate do not cause estrogen deficiency and do not transform the fibroid pseudocapsule [2]. Proof the clinical efficacy and safety of ulipristal acetate have been presented in several large studies [2]. Thus, this antigestagen with highly selective action on target tissue receptors can be used in as an effective means of postponing surgical treatment of uterine fibroids.

In choosing a treatment method for patients with uterine fibroids a differentiated approach is required. It is determined by many factors: the age of the patient, clinical manifestations, size

and location myomatous nodes, intensity of tumor growth, the influence of fibroids on the generative function, etc.

Existing methods of conservative treatment uterine fibroids are not effective enough, therefore, despite the multifactorial nature emerging reproductive function disorders, surgical method in the complex treatment of patients reproductive age is decisive.

Up to 70% of patients with uterine fibroids undergo surgical treatment [5]. Attracts attention the fact that in the structure of surgical interventions radical operations prevail, the proportion of which is 60.9-95.3%.

Despite the radical nature of the solution to the problem and final relief of the patient from the disease that bothers her, an important negative feature of hysterectomy is the high probability occurrence of posthysterectomy syndrome.

According to various authors, this syndrome occurs in more than 50% of women who have undergone removal uterus. Considering the young age of patients with uterine fibroids, it is obvious that for most of them hysterectomy is an intervention that significantly reducing the quality of life, and subsequently leading to disability.

CONCLUSION

Despite the long history of study, the problem of treating patients with uterine fibroids who are of reproductive age continues to be the focus of attention of domestic and foreign researchers, since this disease is one of the most common benign tumors of the female genital organs. Taking into account the interest of patients in preserving the organ (uterus) and the desire of the majority of patients to preserve reproductive function, the study the effectiveness of treatment of uterine fibroids using the FUS ablation method is of great interest and requires further research.

REFERENCES

1. Кулаков В.И., Уварова Е.В., Юреньева С.В. *Гормональная реабилитация женщин при выпадении функции яичников: пособие для врачей*. Под ред. В.И. Кулакова. М. 2000;23.
2. Сметник В.П. *Медицина климактерия*. Ярославль: Изд-во Литера 2006;848.
3. Archer DF. Endometrial bleeding during hormone therapy: The effect of progestogens. *Maturitas*. 2007;57:71-76.
4. Bergeron C, Ferenczy A. Endometrial safety of continuous combined hormone replacement therapy with 17 β -oestradiol (1 or 2 mg) and dydrogesterone. *Maturitas*. 2001;37:191-199.
5. Bodner-Adler B. Expression of p16 protein in patients with uterine smooth muscle tumors: an immunohistochemical analysis. *Gynecol Oncol*. 2005;96:1:62-66.