ENDOMETRIOID CYSTS: MODERN STRATEGY FOR SURGICAL TREATMENT

Sheralieva Sayyora Joraboevna
Research advisor: **Asrankulova Dilorom Bakhtiyarovna**
Head of the 1st department of obstetrics and gynecology,
doctor of medical sciences, professor

Abstract: The purpose of the study was to analyze and compare existing scientific research and clinical recommendations for the treatment of endometriosis and overcoming female infertility in order to develop the most rational approach to surgical interventions for external genital endometriosis.
Keywords: Endometriosis, method, ovarian reserve, treatment, surgical treatment.

INTRODUCTION

Endometriosis remains an unresolved problem in modern gynecology. Despite significant advances in understanding the development and course of this chronic and progressive disease, patient management algorithms in different countries have significant differences, and treatment tactics in many cases are based on the personal beliefs and experience of the doctor.

MATERIALS AND METHODS

One of the most controversial issues in the treatment of external genital endometriosis (EGE) remains the determination of indications for surgical intervention. It was noted that the operation can help restore fertility in patients with EGE and reduce the severity of pain. Also traditionally, the indication for the surgical stage of treatment of EGE is the presence of endometrioid tumors of the ovaries.

RESULTS AND DISCUSSION

Patients should be remembered and informed that currently not all endometrioid cysts are subject to mandatory surgical treatment. Both watchful waiting and surgical management of endometriomas before ART have potential benefits and risks that should be carefully assessed before making a decision. In each such case, an assessment of the ovarian reserve (AMH monitoring and CAF calculation) and consultation with a fertility specialist is required before planning the surgical stage of treatment.

However, the question of the need for a surgical stage of treatment is always decided individually, and some operations for large endometriomas cannot be postponed. Of particular importance in cases of planned surgery is the preservation of the ovarian reserve in this group of patients. In addition, the indication for surgery in the presence of endometriomas is the impossibility of stimulating ovulation, a tendency for endometrioma to grow, persistence of pain and contraindications to the use or ineffectiveness of hormonal therapy. Also, only surgical intervention allows one to obtain histological material and make morphological verification of the diagnosis.

When deciding on surgical treatment of patients with endometriomas, it should be remembered that the presence of ovarian tumors is a marker of infiltrative endometriosis and multifocal lesions [4].

Thus, since the surgical stage of treatment of endometriomas is a necessity in a number of cases, we will dwell on modern approaches to this type of operation and the nuances of their implementation, which make it possible to increase the effectiveness of treatment, reduce the risk of intraoperative predictable complications and relapses of the disease, and have minimal negative impact for ovarian reserve.

Currently, the European Society of Gynecological Endoscopy (ESGE), the European Society of Human Reproduction and Embryology (ESHRE) and the World Endometriosis Society (WES) provide recommendations on the practical aspects of various surgical techniques for the treatment of endometriosis, which discuss the main types of surgery that are used for the treatment of endometriomas in women of reproductive age, the effectiveness of a combination of different types of surgery is assessed [1].

When performing surgery on the ovary, it is necessary to remember the anatomical features associated with endometriosis. Endometriomas often adhere tightly to surrounding structures, such as the lateral wall of the pelvis, fallopian tube, posterolateral surface of the uterus and rectum, and are fixed to them by dense adhesions. It must be taken into account that in the presence of a retrocervical infiltrate, ovaries with endometriomas are usually tightly attached to the posterior wall of the uterus and the infiltrate, which may involve the ureter and vessels. The ovary receives its blood supply from two sources: the ovarian artery, which arises from the abdominal aorta below the renal artery and laterally approaches the ovary through the suspensory ligament, and the ascending branch of the uterine artery in the ligament proper of the ovary. Thus, the larger intraovarian vessels are located in the anterolateral part of the ovary. When endometrioma is localized in this area, the surgeon must be aware of the blood supply to the ovary and have sufficient technical skills to avoid possible bleeding and excessive coagulation, leading to the destruction of healthy ovarian tissue and disruption of its blood supply.

The malignant potential of simple and especially single-chamber cysts is often overestimated in practice, which leads to unnecessary surgical interventions.

Endometriomas have all the signs of a benign neoplasm and are characterized by unilocularity, ground-glass echogenicity, absence of a solid component, small echo-positive foci in the walls, which is a differential feature with a hemorrhagic cyst, and avascularity [3].

CONCLUSION

When performing the surgical stage of treatment, it is necessary to be as careful as possible with the ovarian tissue in order to preserve the ovarian reserve; hemostatic matrices and sutures should be used. Coagulation effects on ovarian tissue should be avoided. Given the recurrent nature of the disease in the postoperative period, patients are prescribed long-term drug therapy.

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