

OPTIMIZATION OF THE MANAGEMENT OF PREGNANCY WITH GOOD-QUALITY TUMOR TUMORS

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✓ *Resume,*

Common cause of ovarian tumors is a number of complication during pregnancy and childbirth, and the best option is to indentify treatment before pregnancy. Morphological research of ovarian tumors in pregnant women. Showed that during pregnancy, ovarian tumors of banning predominate epithelial tumors, in particular serous custadenoma and among the tumor formation of ovarian lute in cysts.

Key words: common cause, ovarian tumors, ovarian, child birth.

ОПТИМИЗАЦИЯ ВЕДЕНИЯ БЕРЕМЕННОСТИ С ДОБРОКАЧЕСТВЕННЫМИ ОПУХОЛЯМИ ЯИЧНИКОВ

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Морфологическое исследование опухолей яичников у беременных женщин показало, что во время беременности среди доброкачественных опухолей яичников преобладают эпителиальные опухоли, в частности серозные цистаденомы, а среди опухолевидных образований яичников лютеиновые кисты.

Ключевые слова: доброкачественные опухоли, опухолевидные образования яичников, беременность.

ТУХУМДОН ЯХШИ СИФАТЛИ ЎСМАЛАРИ МАВЖУД ҲОМИЛАДОР АЁЛЛАРНИ ДАВОЛАШ МАСАЛАЛАРИ

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Ҳомиладор аёллардаги овариал шишларнинг морфологик текшируви ҳомиладорлик пайтида, тухумдонлар шишларига эпителия ўсмалари, хусусан, сероз цистаденомалар ва тухумдонларнинг лутеал кистларининг ўсимтага ўхшаш шаклланиши таъсир қилади.

Калит сўзлар: яхши сифатли ўсмалар, тухумдоннинг ўсмасимон ҳосилалари, ҳомиладорлик.

The urgency of the problem

Benign ovarian tumors (mildew) - one of the urgent problems of modern reproduction, which ranks second among all tumors of the female genital organs. The social and medical significance of this pathology is associated with an increase in the incidence of this pathology in women of reproductive age over 10 years from 6 to 25% [2,4]. The relationship of benign tumors and ovarian tumor formations with pregnancy, on the one hand, can provoke the development of severe complications due to the tumor process itself (rupture of the cyst capsule, torsion of the ovarian cyst, possibility of malignancy), on the other hand, have an adverse effect on the course of pregnancy (compression of small pelvis, mechanical obstruction in childbirth for the fetus, the presence of a permanent threat of termination of pregnancy, premature birth). In 11-15%, benign ovarian tumors form the main indications for surgical treatment, which certainly affects the reproductive potential of women. Benign ovarian tumors in pregnancy occur 3-5 times more often than malignant [1,5,7]. In the absence of clinical symptoms, a diagnosis is often first established when a pregnant woman is registered, or when an ultrasound screening is performed in the first trimester of pregnancy [3,6]. The question of the feasibility of planned treatment of MU during pregnancy remains today discussed and debatable.

Clear data on specific factors that provoke the development of benign ovarian formations during pregnancy have not been identified. Most tumors are not associated with the development of pregnancy, but can occur both during pregnancy and in the postpartum period. The incidence rate ranges from 2.2 to 5%. Often, pathological changes in the ovaries precede the onset of pregnancy. Theoretically, immunosuppressant that develops during pregnancy may contribute to the development and development of ovarian tumors. A number of studies have shown that with the onset of pregnancy, especially in the second half of it, for most women, benign lesions of a large size that can cause torsion or rupture of the ovarian capsule pose a potential danger. On the other hand, an analysis of the course of pregnancy in women showed an increase in the frequency of threatened abortion in the first and second trimester of pregnancy, compression of the pelvic organs, and the occurrence of a mechanical obstruction during birth for the fetus [5].

But it is during pregnancy that the surgical treatment of benign ovarian formations, in conjunction with other factors, can form various gestational complications, affecting prenatal outcomes. The possibility of diagnosing and correcting this pathological condition during pregnancy has not been fully studied, and the outcome of pregnancy largely depends on the development of new

and improvement of existing methods for diagnosing the disease, prevention, the effectiveness of treatment at a critical time of pregnancy and predicting the prenatal outcome.

In this regard, an in-depth study of the factors influencing the development of prenatal complications in pregnant women with benign ovarian formations, their prognosis and prevention become important medical and social importance [2].

To date, researchers have identified a number of factors that increase the risk of complications in pregnant women with benign ovarian formations. Having systematized and examined these factors, it is possible to create a model for predicting prenatal outcomes, which is of interest both for a practicing obstetrician-gynecologist and for health authorities, defining the purpose of our work.

Purpose of the study

Improve prenatal outcomes by optimizing the management of pregnant women with benign ovarian tumors, in depending on the timing of the surgical treatment, based on the identification of prognostic risk factors for the development of gestation complications.

Materials and research methods

To achieve the goal and solve the research problems, we carried out a comprehensive clinical and laboratory examination of 150 pregnant women: of these, 100 patients made up the main group and 50 healthy pregnant women. In the period from January 2017 to December 2018, a prospective study was carried out in two directions to develop and substantiate an optimized approach to managing pregnancy in patients with benign ovarian tumors.

The results of the study and their discussion

According to the results of the analysis of the primary medical documentation, the age, somatic, obstetric-gynecological anamnesis, pregnancy course, fetal and fetal, birth and newborn state were assessed. All pregnant groups surveyed were comparable to the parity of pregnancy, somatic, obstetric-gynecological history.

The age of pregnant women in the main group and the comparison group ranged from 23 to 37 years and averaged 29.7 ± 1.3 years.

Analysis of gynecological morbidity indicated a low incidence of inflammatory genital pathology (chronic adnexitis, endometritis) 14% in patients of group I, 12% in patients of group II, did not occur in the control group of this pathology, which did not have statistically significant differences.

When summarizing the results of the course of the first trimester of pregnancy during the MUH, we identified a high frequency of obstetric complications. The leading complication of pregnancy I trimester in the studied groups is threatened miscarriage, which was diagnosed in 39 (78%) pregnant women of group I, in 26 (52%) in group II, ($p_1 > 2 > 0.05$), many times exceeding the group indicator control 2 (4%) ($p_u < 0.001$; $p_{2.3} < 0.001$). Permanent threat of termination of pregnancy among patients of groups I and II - 12 (24%) cases,

compared with 5 (10%) in group II, where $p, .2 < 0.05$, $p, .\} < 0.001$, in the control group This situation was not recorded. The development of the risk of miscarriage during pregnancy accompanied by MILK during it may be due to the development of deficiency of the corpus luteum, which leads to disruption of the secretory transformation of the endometrium while the ovarian reserve decreases, after surgical treatment, followed by impairment of the implantation process and embryo development. Treatment and rehabilitation in day hospital facilities for anemia, toxicosis of the first half of pregnancy were received by 17 (34%) pregnant women of group I, 19 (38%) of group II and 6 (12%) of pregnant women from the control group, $p_{1.2} < 0, 05$; $p_1, h < 0.05$, $p_2, h < 0.05$.

In the second trimester, a decrease in the frequency of threatened miscarriage was not observed compared with the indicators of the first trimester, however, a significantly more threatening miscarriage continues to be registered in pregnant women of the first group. East myco-cervical insufficiency was registered in 2 (4%) in group I, in group II in 3 (6%), ($p_{1.2} > 0.05$), in the control group did not occur. All patients needed surgical correction of the ICN. Early (10%) of group II, and only in 1 (2%) in the control group ($p, 2 > 0.05$, $p_1 > 3 < 0.001$, $p_2 3 < 0.001$). At the same time, only 5 (10%) pregnant women of group I, 2 (4%) from group II ($p!, 2 > 0.05$) were hospitalized to the department of pathology of pregnant women. The remaining pregnant women were treated for preeclampsia in day hospital conditions.

During the examination in the I and II trimester, according to the data of the echo graphic study, all patients of the main group were identified with milking. In accordance with the indications for planned operative treatment (lack of effect from conservative treatment of recurrent pain syndrome in combination with a permanent threat of miscarriage, bilateral localization of WED, growth of education in the dynamics according to ultrasound, education size more than 10 cm), laparoscopic surgical correction was performed access to the optimal gestational period - $16.3 \pm 0D$ weeks.

According to the results of the histological study of remote distant zones, respectively, mature teratoma 12 (24%), serous cystadenomas 16 (32%), yellow body cyst 10 (20%), endometrioid cyst 9 (18%), undifferentiated tumor formation 3 (6%) met.

Complications of the third trimester were preeclampsia of varying severity with prevalence of hypertension in pregnant women of group I in 9 (18%) cases, in group II 7 (14%).

The overall weight gain for pregnancy in the studied groups had statistical differences, so it was 12.1 ± 0.6 kg in group I, 13.4 ± 0.5 kg in group II, and 9.5 ± 0.8 kg in control group where p and < 0.05 , $p_{1-3} < 0.03$, $p_{2.3} < 0.001$.

When analyzing the data for risk prediction, it was noted that different risk factors have different effects on the level of perinatal morbidity. To identify and assess the risk factors for the development of antenatal and intrapartum complications in patients with DRU we used a specific analysis with the construction of a decision rule based on the learning algorithms implemented in the KVAZAR program, taking into account the informative character of the trait.

Based on priority risk factors and mathematical calculations using the discriminate analysis method, we

compiled a table "Prognostic risk factors and comparative informational content of signs on the development of perinatal complications in pregnant women with benign ovarian tumors", including fourteen "leading" signs of the development of complications of gestation with benign tumors ovaries. All newborns from mothers with MUH were divided into three groups according to perinatal outcome: Group I - with a low degree of complications, Group II - a group with a high degree of complications.

Thus, a multivariate analysis of the causes of the development of pregnancy complications in patients with mildew showed that the leading factor in the development of adverse outcomes is surgical treatment in the second trimester (main group) regarding DRY during pregnancy. In the comparison group, there was a greater effect on perinatal outcomes of non-specific factors, such as the permanent threat of termination of pregnancy, severity of preeclampsia, impaired uteroplacental blood flow during dopplerometry in the period 28-36 weeks, activation of viral-bacterial infection (including ARVI), operative treatment, about the mildew before the present pregnancy.

Presents a method for predicting perinatal outcomes in pregnant women, with a history of arthritis or during this pregnancy is effective in application from the II trimester.

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We developed the prediction of prenatal status of newborns with MUK, depending on the timing of surgical treatment, allowed us to formulate a prognostic algorithm for monitoring pregnant women with MU.

In order to evaluate the effectiveness of the predictive algorithm proposed by us, the second stage of the study was conducted. The perinatal outcomes in 30 pregnant women, after surgical treatment, were analyzed for the MU during pregnancy.

The main group, 1a, was represented by 15 pregnant women who were operated on during pregnancy for benign ovarian tumors. The group conducted a full range of pregravid preparation, clinical and laboratory examinations, management and treatment according to the algorithm developed by us.

Group 2a (comparisons) - 15 pregnant women with the pathology under consideration and those who did not complete a full course of examination and treatment according to the developed algorithm.

Thus, the analysis of the data obtained by us suggests that carrying out the full range of clinical and laboratory examinations before and during gestation, the stage-by-stage pregnancy management, taking into account the presence of the patient MU and the terms of surgical treatment, reduced the incidence of miscarriage by 1.6 times, improvement of neonatal adaptation and quality of health of newborns, by reducing the severity of symptoms of maladaptation 2.2 times, reducing the hypotrophy of newborns by 2.5 times; reduce neonatal infection 2.2 times.

Conclusion

1. In the course of the study, the features of the course of pregnancy, childbirth, and the postpartum period in patients with benign ovarian tumors were revealed, depending on the timing of surgical treatment. As a result of studying the features of the course of pregnancy in patients with mortality and congenital malformations, a high percentage of gestational complications were found, among which dominate 46%, 12% miscarriage and 16%, 8% development of placental insufficiency in groups.

2. Perinatal outcomes were evaluated for benign ovarian tumors, depending on the timing of surgical treatment. Evaluation of perinatal outcomes revealed pathological conditions of newborns from mothers with mildew: 14% growth retardation according to the hypotrophic variant, 12%, 6% hypoxic-ischemic damage of the central nervous system, infections of the perinatal period in 8% in the main group

3. Based on the identification of risk factors for the development of perinatal complications during pregnancy in patients operated on for benign ovarian tumors, a rule has been drawn up for predicting perinatal well-being. Risk factors in the development of intranatal and postnatal complications for the main group were: operative treatment, regarding DRF during the second trimester of pregnancy ($pr1-0.904$); the presence of ovarian formation of large sizes (from 10 to 15 cm) ($pr2-0.811$); violation of uteroplacental blood flow with dopplerometry in the period of 16-36 weeks ($rgZ-0.570$); manifestation of thrombophilia ($rg4-0.470$); the ratio of estriol to progesterone ($rg5-0.437$).

Risk factors in the development of intranatal and postnatal complications for the comparison group were: the permanent threat of abortion (pregnancy- 0.937); severity of preeclampsia ($rg2-0.678$); violation of uteroplacental blood flow with dopplerometry in the period of 28-36 weeks ($rgZ-0.527$); activation of viral-bacterial infection (including ARVI) ($pr4-0.223$); operative treatment, for MILK to the present pregnancy ($wg5-0.178$)

4. A differentiated algorithm for monitoring pregnant women who have undergone surgical treatment for benign ovarian tumors during a real pregnancy, or in history, taking into account the variant of the prediction of perinatal outcome, has been developed and introduced into obstetric practice. Includes a differentiated approach to the tactics of pregnancy management in patients with MILF.

5. Perinatal outcomes in pregnant women with MUH operated during pregnancy and observed in accordance with the proposed algorithm did not differ in terms of perinatal outcomes from the corresponding indicators in pregnant women with a physiological course of gestation, which indicates the effectiveness of the developed algorithm for managing pregnancy with benign ovarian tumors.

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