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НОВЫЙ ДЕНЬ В МЕДИЦИНЕ
NEW DAY IN MEDICINE

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CLINICAL AND ANATOMICAL CRITERIA INFLUENCING THE CHOICE OF SURGICAL TACTICS IN THE COMBINED COURSE OF GENITAL PROLAPSE AND BENIGN TUMORS OF THE UTERUS AND ITS ADNEXA

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✓ ***Resume***

The article analyzes the clinical and anatomical criteria influencing the choice of surgical tactics in patients with a combined course of genital prolapse and benign tumors of the uterus and its adnexa. The study included 85 patients treated for genital prolapse. The main group consisted of 60 patients with prolapse combined with benign tumors of the uterus and/or adnexa, while the comparison group included 25 patients with prolapse without identified tumor pathology. Within the main group, according to the scope of surgical intervention, group Ia (n=35) included patients who underwent organ-preserving surgery, and group Ib (n=25) included patients who underwent radical surgical interventions. The degree of prolapse was assessed using the POP-Q system. Clinical symptoms, tumor localization, reproductive plans, menopausal status, and functional disorders were analyzed comparatively. The results showed that organ-preserving tactics were more often used in patients with preserved reproductive plans (74.3% versus 44.0%; p=0.030), whereas radical tactics were more often associated with peri-/postmenopausal status (60.0% versus 31.4%; p=0.036) and signs of compression (52.0% versus 22.9%; p=0.028). Large fibroids, multiple myomatous nodules, adnexal cysts, and recurrent bleeding were clinically important; however, when assessed separately, they did not serve as absolute grounds for radical intervention. It is substantiated that, in combined pathology, the surgical decision should be based not only on the anatomical defect but also on a comprehensive assessment of reproductive, clinical, anatomical, and functional factors.

Keywords: genital prolapse, uterine fibroid, adnexal cyst, organ-preserving surgery, radical surgery, POP-Q, surgical tactics, clinical and anatomical criteria.

GENITAL PROLAPS VA BACHADON HAMDA UNING ORTIQLARINING YAXSHI SIFATLI O'SMALARI BIRGALIKDA KECHGANDA JARROHLIK TAKTIKASINI TANLASHGA TA'SIR ETUVCHI KLINIK-ANATOMIK MEZONLAR

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✓ ***Rezyume***

Maqolada genital prolaps bachadon va uning ortiqlarining yaxshi sifatli o'smalari bilan birgalikda kechgan bemorlarda jarrohlik taktikasini tanlashga ta'sir etuvchi klinik va anatomik mezonlar tahlil qilingan. Tadqiqotga genital prolaps sababli davolangan 85 nafar bemor kiritildi. Asosiy guruhni genital prolaps bachadon va/yoki uning ortiqlarining yaxshi sifatli o'smalari bilan birgalikda kuzatilgan 60 nafar bemor, taqqoslash guruhini esa o'sma patologiyasi aniqlanmagan genital prolapsli 25 nafar bemor tashkil etdi. Asosiy guruhda jarrohlik aralashuvi hajmiga ko'ra Ia guruhga (n=35) organ saqlovchi operatsiyalar o'tkazilgan bemorlar, Ib guruhga (n=25) esa radikal jarrohlik aralashuvlari bajarilgan bemorlar kiritildi. Prolaps darajasi POP-Q tizimi yordamida baholandi. Klinik simptomlar, o'smaning joylashuvi, reproduktiv rejalar, menopauzal holat va

funksional buzilishlar qiyosiy tahlil qilindi. Natijalar organ saqlovchi taktika reproduktiv rejalari saqlangan bemorlarda ko'proq qo'llanilganini (74,3% ga nisbatan 44,0%; p=0,030), radikal taktika esa peri- va postmenopauzal holat (60,0% ga nisbatan 31,4%; p=0,036) hamda kompressiya belgilarining mavjudligi (52,0% ga nisbatan 22,9%; p=0,028) bilan ko'proq bog'liq bo'lganini ko'rsatdi. Katta o'lchamli miomalar, ko'p sonli miomatoz tugunlar, bachadon ortiqlari kistalari va takroriy qon ketishlar klinik jihatdan muhim ahamiyatga ega bo'lgan, biroq ular alohida baholanganda radikal aralashuv uchun mutlaq ko'rsatma hisoblanmagan. Birgalikdagi patologiyada jarrohlik qarori faqat anatomik nuqson darajasiga emas, balki reproduktiv, klinik, anatomik va funksional omillarni kompleks baholashga asoslanishi lozimligi asoslab berilgan.

Kalit so'zlar: genital prolaps, bachadon miomasi, bachadon ortiqlari kistasi, organ saqlovchi jarrohlik, radikal jarrohlik, POP-Q, jarrohlik taktikasi, klinik-anatomik mezonlar.

КЛИНИКО-АНАТОМИЧЕСКИЕ КРИТЕРИИ, ВЛИЯЮЩИЕ НА ВЫБОР ХИРУРГИЧЕСКОЙ ТАКТИКИ ПРИ СОЧЕТАННОМ ТЕЧЕНИИ ГЕНИТАЛЬНОГО ПРОЛАПСА И ДОБРОКАЧЕСТВЕННЫХ ОПУХОЛЕЙ МАТКИ И ЕЁ ПРИДАТКОВ

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✓ ***Резюме***

В статье проведён анализ клинических и анатомических критериев, влияющих на выбор хирургической тактики у пациенток с сочетанным течением генитального пролапса и доброкачественных опухолей матки и её придатков. В исследование были включены 85 пациенток, проходивших лечение по поводу генитального пролапса. Основную группу составили 60 пациенток с пролапсом в сочетании с доброкачественными опухолями матки и/или её придатков, группу сравнения — 25 пациенток с пролапсом без выявленной опухолевой патологии. В основной группе в зависимости от объёма хирургического вмешательства в группу Ia (n=35) вошли пациентки, которым были выполнены органосохраняющие операции, а в группу Ib (n=25) — пациентки, перенёсшие радикальные хирургические вмешательства. Степень пролапса оценивали с использованием системы POP-Q. Проведён сравнительный анализ клинических симптомов, локализации опухоли, репродуктивных планов, менопаузального статуса и функциональных нарушений. Результаты показали, что органосохраняющая тактика чаще применялась у пациенток с сохранёнными репродуктивными планами (74,3% против 44,0%; p=0,030), тогда как радикальная тактика чаще была связана с пери- и постменопаузальным статусом (60,0% против 31,4%; p=0,036) и наличием признаков компрессии (52,0% против 22,9%; p=0,028). Крупные миомы, множественные миоматозные узлы, кисты придатков матки и рецидивирующие кровотечения имели важное клиническое значение, однако при их изолированной оценке они не являлись абсолютными основаниями для выполнения радикального вмешательства. Обосновано, что при сочетанной патологии решение о хирургической тактике должно основываться не только на характере и выраженности анатомического дефекта, но и на комплексной оценке репродуктивных, клинических, анатомических и функциональных факторов.

Ключевые слова: генитальный пролапс, миома матки, киста придатков матки, органосохраняющая хирургия, радикальная хирургия, POP-Q, хирургическая тактика, клинико-анатомические критерии.

Relevance

Genital prolapse is one of the relevant gynecological problems that directly affects women's reproductive health and quality of life. Its clinical significance is not limited only to the descent of the vaginal walls or uterus. On the contrary, the disease is often accompanied by urogenital, anorectal, sexual, and psychoemotional disorders that substantially restrict daily activity and social adaptation of patients.

In clinical practice, genital prolapse is often encountered not as an isolated pathology, but in combination with benign formations such as uterine fibroids, ovarian cysts, and paraovarian formations. In such a combination, the clinical picture becomes more complex: mechanical and functional complaints typical of prolapse are accompanied by bleeding, pain syndrome, mass-related pressure, and signs of compression caused by the tumor process. As a result, when determining the scope of surgery, it is necessary to consider not only the degree of prolapse, but also the tumor type and localization, the patient's age, reproductive plans, and desire to preserve the organ.

The complexity of the problem lies in the fact that, in clinical practice, there remains a tendency to choose radical surgery for every patient in whom a large fibroid or adnexal cyst is detected. However, in combined pathology, a radical approach is not always the only correct solution. Especially in patients with preserved reproductive plans, a desire to preserve the uterus, and potentially recoverable functional status, the possibilities of organ-preserving reconstructive surgery should be assessed.

From this perspective, identifying the main clinical and anatomical criteria that influence the choice of surgical tactics in the combined course of genital prolapse and benign tumors, assessing their practical significance, and forming a simple, understandable, and clinically justified approach to decision-making are relevant tasks.

To determine the main clinical, anatomical, and reproductive criteria influencing the choice of organ-preserving and radical surgical tactics in patients with a combined course of genital prolapse and benign tumors of the uterus and its adnexa, and to assess their clinical significance.

Materials and methods

Observation and clinical analysis were performed based on the materials of 85 patients treated for genital prolapse. Depending on the combination of pathology, the patients were divided into two groups: the main group (group I, n=60) included patients with prolapse combined with benign tumors of the uterus and/or adnexa, while the comparison group (group II, n=25) included patients with prolapse without identified tumor pathology. Within the main group, according to the surgical tactics, group Ia (n=35) included patients who underwent organ-preserving surgery, and group Ib (n=25) included patients who underwent radical surgery.

Table 1. General structure of the study groups

Group	Clinical characteristics	n	%
Group I	Genital prolapse combined with benign tumors of the uterus and/or adnexa	60	70.6
Group Ia	Patients after organ-preserving surgical interventions	35	41.2
Group Ib	Patients after radical surgical interventions	25	29.4
Group II	Genital prolapse without identified tumor pathology	25	29.4
Total	All examined patients	85	100.0

The age of the patients ranged from 32 to 58 years. From a clinical point of view, the patients were divided into age groups of 32-39, 40-49, and 50-58 years. This distribution was used to assess differences related to reproductive plans, approach to menopause or menopausal status, the degree of prolapse, and the choice of surgical tactics. The degree of genital prolapse was determined according to the POP-Q classification; anterior, posterior, and apical components of prolapse and their combinations were recorded separately.

Clinical symptoms were analyzed in three directions: complaints characteristic of prolapse, complaints associated with the tumor process, and mixed symptom complexes. In tumor pathology, uterine fibroids, functional and dermoid ovarian cysts, paraovarian cysts, and combined variants of fibroids and adnexal pathology were taken into account. When choosing surgical tactics, reproductive plans, desire to preserve the uterus, peri-/postmenopausal status, POP-Q degree, clinical and anatomical features of fibroids and adnexal formations, bleeding, signs of compression, and mixed symptom complexes were evaluated.

In the statistical analysis, quantitative indicators were presented as M±SD, and qualitative indicators were presented as n and %. The χ^2 test and Fisher's exact test were used to assess differences between groups. A value of $p<0.05$ was accepted as a statistically significant difference.

Results and discussions

General Clinical Characteristics of the Patients

In the analysis of the age structure, patients aged 32-39 years in group Ia accounted for 17 cases (48.6%), those aged 40-49 years for 11 cases (31.4%), and those aged 50-58 years for 7 cases (20.0%). In group Ib, these indicators were 10 (40.0%), 7 (28.0%), and 8 (32.0%) patients, respectively. In group II, patients aged 32-39 years accounted for 6 cases (24.0%), those aged 40-49 years for 10 cases (40.0%), and those aged 50-58 years for 9 cases (36.0%). No statistically significant differences in age structure were found between the groups (χ^2=4.37; p=0.358).

The mean age was 41.66±6.90 years in group Ia, 43.92±7.84 years in group Ib, and 45.72±6.82 years in group II. The overall mean age was 43.43±7.19 years. These results indicate the demographic comparability of the groups. At the same time, the more frequent use of organ-preserving interventions in relatively younger patients with preserved reproductive plans served as an important clinical basis for further analysis.

In the analysis of the somatic background in group I, anemia was noted in 37 patients (61.7%), gastrointestinal diseases in 43 (71.7%), upper respiratory tract diseases in 36 (60.0%), kidney diseases in 29 (48.3%), cardiovascular diseases in 21 (35.0%), and obesity in 19 (31.7%). Similar indicators were observed in group II. These conditions were important when assessing surgical risk; however, within the main group they were considered not as decisive criteria for choosing organ-preserving or radical tactics, but as a general clinical background.

Degree of Prolapse According to POP-Q and Anatomical Components

According to the POP-Q classification, in group I, grade II prolapse was identified in 27 patients (45.0%), grade III in 15 (25.0%), and grade IV in 18 (30.0%). In group II, grade II prolapse was noted in 8 patients (32.0%), grade III in 11 (44.0%), and grade IV in 6 (24.0%). No statistically significant differences in the distribution of POP-Q grades were identified between the groups (χ^2=3.03; p=0.220).

When anatomical components were analyzed in group I, the anterior component was registered in 49 patients (81.7%), the posterior component in 32 (53.3%), and the apical component in 39 (65.0%). In group II, the corresponding indicators were 19 (76.0%), 12 (48.0%), and 13 (52.0%) patients. In both groups, the predominance of the anterior component was maintained; however, no statistically significant differences in the frequency of components were found between the groups.

Table 2. Degree of prolapse according to POP-Q and main anatomical components

Indicator	Group I (n=60)	Group II (n=25)	p
POP-Q grade II	27 (45.0%)	8 (32.0%)	0.267
POP-Q grade III	15 (25.0%)	11 (44.0%)	0.083
POP-Q grade IV	18 (30.0%)	6 (24.0%)	0.576
Anterior component	49 (81.7%)	19 (76.0%)	0.552
Posterior component	32 (53.3%)	12 (48.0%)	0.654
Apical component	39 (65.0%)	13 (52.0%)	0.262

Regarding component combinations, in group I the most frequent variants were A+P+C in 17 cases (28.3%) and A+C in 14 cases (23.3%). In group II, an isolated anterior component was identified in 6 patients (24.0%), the A+C combination in 5 (20.0%), and A+P and A+P+C combinations in 4 cases each (16.0%).

Table 3. Type and localization of tumor pathology in the main group

Indicator	n	%
Uterine fibroid	21	35.0
Functional ovarian cyst	11	18.3
Dermoid ovarian cyst	9	15.0
Paraovarian cyst	6	10.0
Fibroid + adnexal/paraovarian pathology	13	21.7
Intramural fibroid localization	11	18.3
Subserosal fibroid localization	15	25.0
Submucosal fibroid localization	8	13.3

No significant differences were found in the overall distribution of combinations (χ^2=2.13; p=0.908). This result shows that the degree and anatomical component of prolapse are important for planning the reconstructive stage; however, when assessed alone, they do not determine the choice of organ-preserving or radical tactics.

Clinical and Anatomical Features of Tumor Pathology

In the main group, uterine fibroids were detected in 21 patients (35.0%) and represented the largest proportion among tumor pathologies. Functional ovarian cysts were noted in 11 patients (18.3%), dermoid cysts in 9 (15.0%), and paraovarian cysts in 6 (10.0%). In 13 patients (21.7%), uterine fibroids were combined with an ovarian cyst or paraovarian cyst.

In terms of localization, among myomatous nodules, subserosal localization was registered in 15 cases (25.0%), intramural localization in 11 cases (18.3%), and submucosal localization in 8 cases (13.3%). In the adnexal region, left-sided ovarian localization was noted in 18 cases (30.0%), right-sided ovarian localization in 13 cases (21.7%), and paraovarian localization in 8 cases (13.3%).

The obtained data show that, in combined pathology, the tumor process does not have a single clinical pattern. Therefore, the surgical decision cannot be based only on the general statement that "a fibroid is present" or "a cyst is present." It is necessary to evaluate the type, size, localization of the tumor, and its relationship with clinical symptoms separately.

Clinical Symptoms and Mixed Symptom Complexes

When dominant complaints characteristic of prolapse were analyzed, urinary incontinence was noted in 14 patients (23.3%) in group I, a sensation of a foreign body or protrusion in the vagina in 11 (18.3%), dyspareunia in 9 (15.0%), anorgasmia in 9 (15.0%), bowel dysfunction in 8 (13.3%), and dysuric symptoms in 9 (15.0%). Similar proportions were observed in group II; no significant differences were found in the overall structure of complaints (p=0.976).

Tumor-related clinical symptoms in group I were represented by bleeding, pain syndrome, and mass-related discomfort. Heavy and prolonged menstrual bleeding was noted in 12 patients (20.0%), lower abdominal pain in 11 (18.3%), a feeling of heaviness and pressure in the abdomen in 10 (16.7%), and discomfort associated with a mass formation in 9 (15.0%). Bloody discharge was detected in 8 patients (13.3%), pain radiating to the lumbar region in 6 (10.0%), and general weakness in 4 (6.7%).

An important feature of combined pathology is that patients more often present not with one isolated complaint, but with a combination of symptoms of prolapse and the tumor process. In group I, dyspareunia + menstrual disorders were noted in 18 cases (30.0%), sensation of a foreign body in the vagina + menorrhagia/hypermenorrhea in 14 cases (23.3%), stress incontinence + a feeling of pressure/heaviness in the lower abdomen in 12 cases (20.0%), and dysuric symptoms + discomfort associated with a mass formation in 10 cases (16.7%). This emphasizes the need to assess the totality of symptoms as a separate significant criterion when choosing surgical tactics.

Table 4. Clinical and anatomical criteria influencing the choice of surgical tactics in groups Ia and Ib

Indicator	Group Ia (n=35)	Group Ib (n=25)	p
Presence of reproductive plans	26 (74.3%)	11 (44.0%)	0.030
Desire to preserve the uterus	22 (62.9%)	9 (36.0%)	0.066
Peri-/postmenopause	11 (31.4%)	15 (60.0%)	0.036
POP-Q grade II	8 (22.9%)	5 (20.0%)	1.000
POP-Q grade III	17 (48.6%)	11 (44.0%)	0.796
POP-Q grade IV	10 (28.6%)	9 (36.0%)	0.583
Multiple fibroids	3 (8.6%)	7 (28.0%)	0.077
Large fibroid	5 (14.3%)	6 (24.0%)	0.500
Subserosal fibroid	3 (8.6%)	6 (24.0%)	0.145
Intramural fibroid	9 (25.7%)	7 (28.0%)	1.000
Submucosal fibroid	3 (8.6%)	5 (20.0%)	0.259
Presence of adnexal cyst	7 (20.0%)	9 (36.0%)	0.238
Large adnexal cyst	4 (11.4%)	6 (24.0%)	0.294
Recurrent bleeding	9 (25.7%)	11 (44.0%)	0.171
Signs of compression	8 (22.9%)	13 (52.0%)	0.028
Mixed symptom complexes	11 (31.4%)	13 (52.0%)	0.120

Main Criteria Influencing the Choice of Surgical Tactics

The main analysis was conducted between groups Ia and Ib. At this stage, the task was not only to describe which operations were performed more often, but also to determine the clinical and anatomical signs that had priority importance in choosing organ-preserving or radical tactics.

The data in the table showed that the presence of reproductive plans was significantly more frequent in group Ia compared with group Ib (74.3% versus 44.0%; p=0.030). This indicates that the reproductive goal is one of the main clinical criteria for choosing organ-preserving tactics. The desire to preserve the uterus was also more often noted in group Ia (62.9% versus 36.0%), but this difference did not reach statistical significance (p=0.066). Nevertheless, in clinical practice, the patient's informed consent and desire to preserve the organ remain factors that cannot be ignored when making a decision.

Peri-/postmenopausal status was registered significantly more often in group Ib (60.0% versus 31.4%; p=0.036). This result shows that radical surgical tactics were more often chosen in patients in whom reproductive function had already lost its relevance, while involutional changes and the risk of recurrence were more important. At the same time, menopausal status by itself is not an automatic indication for radical surgery; it should be evaluated together with tumor characteristics, prolapse severity, and functional disorders.

Signs of compression were significantly more frequent in group Ib compared with group Ia (52.0% versus 22.9%; p=0.028). This indicator demonstrates the high practical significance of symptom severity and mass effect when choosing radical tactics. In other words, the basis for expanding the surgical scope is not the mere presence of a tumor, but its relationship with clinical pressure, pain, urogenital, or bowel disorders.

No significant differences were found between groups Ia and Ib according to POP-Q grades II, III, and IV. This is an important result: the degree of prolapse is necessary for planning the reconstructive stage, but it does not by itself determine the choice of organ-preserving or radical tactics. Similarly, multiple fibroids, large fibroids, subserosal or submucosal localization, adnexal cysts, and recurrent bleeding were observed more often in the radical group, but no statistically significant differences were found for these indicators. Therefore, these signs are criteria that supplement the clinical decision and should not be assessed in isolation from reproductive status and symptom severity.

Practical Clinical Approach to Decision-Making

Based on the obtained results, the choice of surgical tactics in combined pathology should be based on three blocks of assessment: reproductive, anatomical-morphological, and functional-symptomatic. This approach simplifies surgical decision-making, but does not reduce it to a single indicator.

Table 5. Practical interpretation of criteria when choosing surgical tactics

Group of criteria	In favor of organ-preserving tactics	In favor of radical tactics
Reproductive block	Presence of reproductive plans; desire to preserve the uterus; young patient age and informed consent	Absence of reproductive plans; peri-/postmenopause; no clinical need to preserve the organ
Anatomical block	The tumor can technically be removed; there is a possibility to preserve uterine or ovarian tissue	Tumor size, multiplicity, or localization requires a radical scope; suspicion of malignant changes is present
Functional block	Signs of compression are absent or mild; symptoms can be eliminated by reconstructive and organ-preserving intervention	Signs of compression are pronounced; mixed symptom complexes are severe; mass effect aggravates functional disorders
Prolapse block	POP-Q grade can be corrected by reconstructive repair; restoration of apical support is possible	Severity of prolapse requires extended reconstructive correction together with radical intervention

The main advantage of this approach is that it limits a simplified idea often encountered in clinical practice: “there is a fibroid, therefore the uterus must be removed.” The analysis showed that the presence of a large or multiple fibroid is not always an absolute indication for radical surgery. On the

contrary, in the presence of reproductive plans, a pronounced desire to preserve the organ, and the absence of severe compression signs, organ-preserving surgical tactics may be clinically justified.

The results of the study showed that the choice of surgical tactics in patients with a combined course of genital prolapse and benign tumors is a multifactorial clinical decision. Usually, the degree of prolapse and the presence of a tumor are considered the main reference points when determining the scope of surgery. However, in the present analysis, POP-Q degree, fibroid localization, or the presence of an adnexal cyst did not show independent statistically significant differences between groups Ia and Ib. This indicates that the surgical choice is associated not only with an anatomical finding, but to a greater extent with the patient's reproductive goal and symptom severity.

The most important criterion in favor of organ-preserving tactics was the presence of reproductive plans. This is fully clinically justified: the desire to preserve the uterus and the need to preserve reproductive function require limiting the surgical scope, as well as simultaneous planning of myomectomy, cystectomy, ovarian resection, and reconstructive-plastic interventions. At the same time, an organ-preserving approach should not be placed above safety; the nature of the tumor, its size, localization, and recurrence risk must be assessed objectively.

Peri-/postmenopausal status and signs of compression had priority importance in favor of radical tactics. This result is important for clinical practice: in older age groups, the need to preserve reproductive function decreases, while involutional changes, tissue weakness, the risk of prolapse recurrence, and tumor mass effect may provide grounds for expanding surgical tactics. Signs of compression should be considered not as a simple morphological feature, but as a clinical indicator affecting the patient's functional status.

The practical significance of the article lies in the fact that it considers organ-preserving and radical operations in combined pathology not as opposite and mutually exclusive methods, but as two tactical directions that should be individually selected for a particular patient. Indications for radical intervention should not be expanded without justification, and organ-preserving surgery should not be chosen solely according to the patient's wishes without assessing clinical safety and the expected functional outcome.

The study has certain limitations. First, the number of patients is limited; therefore, statistical significance may not have been achieved for individual clinical and anatomical signs. Second, the main analysis in this article is based on comparative assessment by separate rows; to determine independent predictors, a multivariate logistic regression analysis will be required in the future. Nevertheless, the obtained data provide sufficient grounds for identifying priority criteria for clinical decision-making and forming an algorithm applicable in practical work.

Conclusion

- In the combined course of genital prolapse and benign tumors of the uterus and its adnexa, the choice of surgical tactics should be based not only on the anatomical defect or the presence of a tumor, but also on a comprehensive assessment of clinical, anatomical, reproductive, and functional criteria.
- Organ-preserving surgical tactics were significantly more often applied in patients with preserved reproductive plans (74.3% versus 44.0%; p=0.030), confirming the priority importance of this criterion in clinical decision-making.
- Radical surgical tactics were more often associated with peri-/postmenopausal status (60.0% versus 31.4%; p=0.036) and signs of compression (52.0% versus 22.9%; p=0.028).
- The POP-Q degree, fibroid type, presence of an adnexal cyst, and recurrent bleeding are important for planning the surgical scope; however, when assessed in isolation, they do not serve as absolute criteria for choosing organ-preserving or radical tactics.
- In combined pathology, the presence of a large or multiple fibroid is not always an automatic indication for hysterectomy; the decision should be made individually, considering the patient's age, reproductive plans, symptom severity, signs of compression, and safety criteria.

Practical Recommendation

In patients with a combined course of genital prolapse and benign tumors, preoperative assessment should include a sequential comprehensive evaluation according to the scheme: “reproductive plans - menopausal status - signs of compression - clinical and anatomical features of the tumor - POP-Q components.” This approach reduces the risk of unjustified restriction of organ-preserving operations and unjustified expansion of radical interventions.

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