International Journal of Medical Sciences And Clinical Research
(ISSN – 2771-2265)
VOLUME 04 ISSUE 05 PAGES: 62-68
SJIF IMPACT FACTOR (2022: 5. 893) (2023: 6. 184) (2024: 7.544)
OCLC – 1121105677
Crossref doi Google Scholar WorldCat MENDELEY
Publisher: Oscar Publishing Services

Journal Website: https://theusajournals.com/index.php/ijmscr



Research Article

# MODERN METHODS OF TREATMENT UTERINE FIBROIDS

**Submission Date:** May 16, 2024, **Accepted Date:** May 21, 2024,
**Published Date:** May 26, 2024
**Crossref doi:** https://doi.org/10.37547/ijmscr/Volume04Issue05-11

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## ABSTRACT

Approaches to organ-preserving treatment of uterine fibroids began to develop in parallel with the creation of radical methods of treating this disease, but this direction has always lagged somewhat behind and had few supporters. Recently, organ-preserving treatment of uterine fibroids has become one of the priority areas. In general, this is a completely natural process, due to both the development of modern treatment technologies and the growing need of women to solve reproductive problems. What is the reason for this? On the one hand, there is a persistent tendency to get pregnant at a late reproductive age, on the other hand, uterine fibroids are increasingly diagnosed in young, nulliparous women. In addition, the development of the media and the Internet is of no small importance, which, in turn, began to pay more attention to health and medical issues, covering new medical technologies.

Effective organ-preserving treatment of uterine fibroids is impossible without a full understanding of this disease. The concept of "uterine fibroids" includes a heterogeneous group of conditions that characterize pathological changes in the uterus. The doctor can call uterine fibroids a single node in the uterus 1 cm in size, which does not have any clinical manifestation, and multiple uterine fibroids, corresponding to 25 weeks of pregnancy, manifested by bleeding and compression of adjacent organs. Therefore, the approach to the treatment of this disease largely depends on the correct clinical classification. The currently existing classifications (histological and localization) are unacceptable in practical gynecology and in fact do not carry any tactical information. The currently widely used indications for hysterectomy in practice make it possible to observe patients up to the turn of 12 weeks, i.e., they allow passivity in relation to patients with smaller fibroids. Thus, a classification is needed that combines such characteristics as: size,

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number of nodes, localization, and reproductive plans of the patient, that is, a classification is needed that allows the doctor to predict treatment tactics immediately.

KEYWORDS

Uterine fibroids, mifepristone, uterine artery embolization, proliferating uterine fibroids.

## INTRODUCTION

Uterine fibroids occupy the 2nd place in the structure of gynecological morbidity. It can be detected in 77% of women in the population, and over the past 10 years there has been a trend towards "rejuvenation" of the disease: in Russia, its prevalence in women under the age of 30 has increased from 2 to 12.5%, in the United States in women aged 18 to 30 years - up to 43-57%. Uterine fibroids have a pronounced negative impact on the reproductive function and general health of women. But to date, there is no pathogenetically substantiated effect on fertility.

The management of patients with uterine fibroids is the subject of close attention of gynecologists both in our country and abroad. The risk of recurrence after organ-sparing operations occurs in 15-45% of patients, and repeated surgery is more traumatic and associated with a high intraoperative risk of bleeding and the formation of postoperative adhesions. That is why it is of great importance to search for new opportunities to reduce the likelihood of repeated surgical interventions. Also, in the postoperative period, it is necessary to carry out anti-relapse therapy, since surgical removal of fibroids does not eliminate the causes of their development, and intraoperative myometrial injury increases the risk of myoma recurrence. Therefore, at present, increasing the effectiveness of not only organ-preserving surgical treatment of uterine fibroids, but also anti-relapse drug therapy remains an urgent problem.

Controversial and debatable aspects of the use of anti-relapse therapy are specific complications associated with the development of hormonal and biochemical disorders, the shortness of the course of therapy, the recurrence of the disease after the withdrawal of drugs, and most importantly - the possibility of their use at a young age. Gonadotropinrility-releasing hormone agonists (a-GnRH) have become widespread in the treatment of uterine fibroids, but their use is limited due to the development of hypoestrogenic conditions, impaired mineral metabolism, short-term therapy and relapse of the disease after drug withdrawal. According to most researchers, the use of antigestogens, the first of which was mifepristone, is promising in the treatment of uterine fibroids.

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The aim of the research. to improve reproductive outcomes after surgical treatment of uterine fibroids and to increase the period of remission of the disease.

Materials and methods of research. The study was conducted based on the gynecological department of the multidisciplinary clinic of Samara State Medical University. The cohort prospective comparative study included 90 women who underwent organ-preserving treatment for uterine fibroids from 20121 to 2023. Inclusion criteria: age - 25-45 years, mean age - 33 ± 5.5 years; organ-preserving treatment for uterine fibroids. allergic reactions to mifepristone, patients with contraindications to the use of the drug, with a burdened somatic anamnesis, liver diseases, and hyperplastic processes of the uterus (adenomyosis, endometrial hyperplasia). Depending on the organ-preserving treatment, the patients were divided into groups.

The scope of the examination included standard clinical, laboratory and morphological methods of research. Before the use of the drug, data were collected confirming the possibility of patients' participation in the study: inclusion/exclusion criteria; anthropometric data; the fact of smoking and drinking alcohol; lamentation; anamnesis; comorbidities; general examination; thermometry; gynecological status; Ultrasound with Doppler; general clinical laboratory tests and the type of organ-preserving surgical treatment.

The clinical and anamnestic method was used - the study of gynecological anamnesis, features of the course and duration of the disease. Somatic status was assessed using visual and physical methods.

Clinical laboratory examination included: clinical blood test; general urinalysis; biochemical blood test; coagulogram; determination of blood group, Rh factor; and bacterioscopic examination of the discharge from the cervical canal.

Instrumental examination included: transvaginal and transabdominal ultrasound of the pelvic organs with Doppler.

Material for morphological examination was taken during the use of invasive diagnostic methods (aspiration biopsy of the endometrium).

Results of the research. In the course of the study, data were obtained on the anamnesis, cand features of the course of the disease. The average age of the examined women was 33 ± 5.5 years (from 25 to 45 years). The analysis of the medical and social characteristics of the groups revealed no statistically significant differences in the time of menarche onset and age

onset of sexual activity, body mass index, duration of the disease, and concomitant gynecological and somatic diseases.

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When collecting the anamnesis, it was revealed that in 40% of women uterine fibroids had an asymptomatic course, 60% of patients were bothered by pain, 50% had menstrual irregularities such as heavy uterine bleeding, in 45% these complaints were combined. Thus, 81 patients out of 136 had pain syndrome of varying degrees of severity.

The intensity of the pain syndrome was assessed using the Verbal Rating Scale (VPS), the Digital Rating Scale (DRS) and the Wong-Baker Mimic Pain Assessment Scale. 36 patients determined the pain they experienced as mild according to the CPP, and the degree of pain was assessed as 2 points according to the CRS (can be ignored); in 27 patients - pain of moderate intensity according to the CPS, 4-5 points according to the CRS (interfered with the implementation of activities); 18 patients had severe pain according to the CPS, 7 points according to the CRS (interfered with the satisfaction of basic needs). On ultrasound, the size of the uterus corresponded to the period from 6 to 16 weeks. (on average - 10 ± 3.1), the number of myomatous nodes - from 1 to 10 (3.4 ± 1.4), and the size of myomatous nodes - from 2 to 10 cm (5.5 ± 2.4).

Depending on the clinical symptoms, size, number, type, and localization of fibroids (according to the FIGO 2011 classification), and the interest in preserving the reproductive function, the patients underwent surgical organ-preserving treatment. 48 patients with subserosal-intramural fibroids (FIGO class 5-7 2011) underwent myomectomy by laparoscopic access; 8 patients with subserosis-intramural fibroids (class 6-7) underwent vaginal myomectomy; 24 patients with intramural fibroids (class 3-4) underwent laparotomy myomectomy; 16 patients with submucous fibroids (class 0-1) underwent hysteroscopic myomectomy; 40 patients not interested in preserving reproductive function with submucosal-intramural fibroids (class 2-4) - uterine artery embolization (UAE).

No intra- and postoperative complications were noted in the operated patients. The menstrual cycle was restored within 14-21 days after surgery.

In 4 (25%) patients after myomectomy without adjuvant therapy with Gunestril, pregnancy occurred, but only in 1 patient it ended in spontaneous labor. After surgical treatment and 3-month anti-relapse therapy with Ginestril, pregnancy occurred in 37 (46%) patients, in 34 (91%) patients ended in timely delivery. After UAE and therapy with Ginestril, pregnancy occurred in 3 (10%) patients and ended in labor.

Pregnant women after surgical treatment of uterine fibroids should be classified as at high risk of obstetric and perinatal complications. The most common complication in all groups was the threat of pregnancy termination - in 19 (51%) pregnant women after myomectomy and in 4 (100%) in the control group. The threat of premature birth required inpatient treatment

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for every 4th patient in all groups. Among other complications of pregnancy, anemia was detected in 27%, preeclampsia in 16%, and fetoplacental insufficiency in 8%. The frequency of complicated pregnancy does not depend on the previous method of treatment of uterine fibroids. Of the 37 (46%) patients who became pregnant, 34 (91%) had a timely pregnancy, which indicates a beneficial effect of Ginestril on the reproductive prognosis.

## CONCLUSION

The long-term results of the study allow us to recommend Guinestril in the postoperative period to patients who have undergone organ-preserving treatment for proliferating uterine fibroids in order to prevent recurrences of the disease within 24 months after drug discontinuation. The use of Guinestril after UAE made it possible to reduce the number of recurrences of the disease in the postoperative period. Complex treatment of uterine fibroids, including myomectomy and drug therapy Ginestril made it possible to realize the reproductive function in 46% of patients. Childbirth per vias naturalis occurred in 24% of patients who received adjuvant therapy with Guinestril after myomectomy, and the incidence of complications during pregnancy does not depend on the method of surgical treatment of uterine fibroids.

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