



TOPICAL ISSUES IN THE DIAGNOSIS AND TREATMENT OF ENDOMETRIOSIS

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Article history:	Abstract:
Received: April 11 th 2023 Accepted: May 11 th 2023 Published: June 20 th 2023	The article under discussion reveals endometriosis as an actual problem in gynecological practice. The author of the article considers that endometriosis leads to functional and structural changes in the reproductive system, often adversely affecting the psychoemotional state of women, significantly reducing the quality of life. Diagnosis and treatment of endometriosis depend on the stage and localization of the disease. The choice of treatment depends on the age of the patient, the desire to restore fertility, the severity of symptoms and the extent of the disease.

Keywords: endometriosis, gynecological, fertility, localization, reproductive system, psychoemotional state, quality of life, hormonal therapy.

INTRODUCTION

Endometriosis is an outgrowth similar in structure to the uterine mucosa, outside the normal localization of the endometrium. According to modern concepts of the nature of endometriosis, this disease should be considered as a pathological process with a chronic, recurrent course. Endometriosis forms and develops against the background of disturbed immune, molecular-genetic and hormonal relationships in the female body. Endometrioid substrate has signs of autonomous growth and abnormal proliferative activity of cells. Endometriosis can be localized both in the uterine body (adenomyosis, or internal endometriosis), and outside the uterus (external endometriosis) [12]. Endometriosis leads to functional and structural changes in the reproductive system, often adversely affecting the psycho-emotional state of women, substantially reducing their quality of life. Epidemiological studies show that in 90-99% of patients endometrioid lesions are diagnosed between the ages of 20-50 years, most often in the reproductive period. In the gynecological morbidity structure endometriosis ranks the third place after inflammatory processes and hysteromyoma affecting up to 50% of women with menstrual function[1].

MATERIALS AND RESEARCH METHODS

The main theories of the development of endometriosis. The oncological aspect of endometriosis remains one of the most significant and debatable. The subject of discussions is quite contradictory information about the frequency of malignant transformation of endometriosis. Many researchers point to a high incidence of endometriosis malignization - 11-12%. According to another point of view, endometriosis

malignancy is extremely rare. No one refutes the ability of endometriosis foci to undergo malignant transformation. Thus, in patients with widespread forms of the disease, the risk of endometriosis malignization should be considered. The variety of localizations of endometriosis has led to a large number of hypotheses about its origin, there are more than 10 of them. The most widespread is the implantation theory of the origin of endometriosis, first proposed by J.F. Sampson in 1921, the author suggested that the formation of endometriosis foci occurs as a result of retrograde influx through the fallopian tubes into the abdominal cavity of viable endometrial cells, rejected during menstruation, and their further implantation in the peritoneum and surrounding organs. Although retrograde menstrual blood flow is probably a common occurrence, not all women develop endometriosis. In some observations, the prevalence of endometrioid lesions is minimal and the process may remain asymptomatic; in others, endometriosis spreads throughout the pelvic cavity and becomes the cause of various complaints. The literature suggests that the development of endometrioid structures depends on the hormonal status, the content and the ratio of steroid hormones. The activity of the hypothalamic-pituitary-ovarian system is of primary importance for the occurrence of endometriosis. Endometriosis patients have chaotic peak emissions of follicle-stimulating hormone (FSH) and luteinizing hormone (LH), there is a decrease in basal progesterone levels, many patients show hyperprolactinemia and impaired androgenic function of the adrenal cortex. There are also violations of immune homeostasis in endometriosis. Numerous studies reliably prove that endometriosis develops against the background of impaired immune balance. Thus, patients with



endometrioid lesions show common signs of immunodeficiency and autoimmunization, leading to weakened immune control, which create conditions for implantation and development of functional endometrial foci outside their normal localization[6,7}. Obviously, in addition to the common signs of immunodeficiency and autoimmunization, there are some other factors (possibly their combination) determining the perception of endometrial particles by the pelvic peritoneum, which creates conditions for implantation of these particles, instead of recognizing them as foreign and promoting their elimination. The possibility of endometriosis metastasis through blood and lymphatic vessels is of considerable interest. This type of dissemination of endometrial particles is considered one of the most important causes of the known variants of extragenital endometriosis, such as endometriosis of the lungs, skin, muscles. In recent years, sufficient data have been obtained confirming the leading role of genetic factors in the occurrence of endometriosis, as well as clarifying the significance of dysfunction of the immune and reproductive systems in the development of this pathology [3].

It affects on average 46-50% of women with this diagnosis. There are various reasons for the impossibility of becoming pregnant. This could be a disruption of ovulation (maturation and release of the egg) and/or the formation of adhesions in the pelvis as a result of endometrioid foci in the ovarian and fallopian tubes. Literature data indicate that the most frequent concomitant pathological process in endometriosis, especially in adenomyosis, is uterine myoma. The combination of adenomyosis with endometriosis of other genital organs, mainly ovaries, is also frequent and is diagnosed in 25-40% of patients. Pathological transformation of the endometrium is diagnosed in 31-35% of cases in combination with internal endometriosis. Pathological transformation of the endometrium is characterized by polyps on the background of the unchanged uterine mucosa (56%), as well as a combination of endometrial polyps and various types of hyperplasia (44%). It is important to emphasize that endometrial hyperplasia is so frequent that it may not be causally linked to endometriosis, but only combined with this pathology [3]. The disease may be asymptomatic or characterized by pelvic pain, menstrual irregularities, pain during sexual intercourse and urination, infertility, anemia, general disorders (weakness, neuropsychiatric disorders). Infertility is the most frequent and severe companion of endometriosis [4].

DIAGNOSIS AND TREATMENT.

Diagnosis and treatment depend on the stage and localization of the disease. Diagnosis consists of the collection of anamnesis, gynecological examination, ultrasound, hysteroscopy, laparoscopy, MRI, histology, X-ray methods, colonoscopy, computed tomography, and consultations with related specialists are used if differentiation is required.

CONCLUSION

In conclusion it should be noted that treatment of endometriosis can be both surgical and medicinal. The choice of treatment depends on the age of the patient, the desire to restore fertility, the severity of symptoms and the extent of the disease. But to date, the only and justified method of treating the disease to rid the patient of endometrioid heterotopias is surgery. Medicinal treatment includes monitoring for minimal manifestation of the disease. When the patient has pain syndrome, either analgesics and nonsteroidal anti-inflammatory drugs or long-term hormonal therapy are used. The goal of such treatment is to reduce the severity of the symptoms, which helps to improve the quality of life, delay the recurrence of the disease in a woman and, if necessary, achieve fertility.

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