

PREVENTION OF ADHESIVE DISEASE OF THE PELVIC ORGANS

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Abstract: The publication describes the pathogenesis, diagnosis and prevention of adhesions of the pelvic organs in women. Adhesive disease ranks 2nd in the list of common gynecological diseases around the world after inflammatory diseases of the pelvic organs.

Key words: adhesions of the pelvic organs, endometriosis, fibrosis.

INTRODUCTION

Pelvic adhesions refer to strong bands of tissue sticking organs together in an unnatural way. They are a common source of pain in many women.

There are four broad categories of adhesion formation:

1. **Post-surgical:** where there has been continued leakage of blood from the surgical margins
2. **Residual pathology:** where the excision of particular endometriosis has been incomplete, leaving tissue to continue to grow, bleed and eventually form further deep fibrous bands
3. **Infective adhesions:** where there has been a rupture of an organ (a burst appendix is a good example) or a transmitted infection (PID, chlamydia/gonorrhoea); treatment with appropriate antibiotics is the first-line measure in dealing with any STD
4. **Radiation adhesions:** rare in general gynaecology, and seen in patients who may have undergone pelvic lymph node radiotherapy (eg cervical cancer); these patients generally remain under the care of an oncology team rather than a general gynaecologist.

Adhesions seen in the pelvis can be caused by the following:

- an ongoing inflammatory disease process (endometriosis is the classic example). Patients with incompletely excised endometriosis may have short term relief of chronic pelvic pain, then a return of familiar symptoms. Patients with a longer history of feeling well, then years later having a return of that pain are most likely to have recurrent endometriosis, especially if that diagnosis was previously confirmed at laparoscopy[1,2,3].
- infection (chlamydia, gonorrhoea most commonly), Tuberculosis
- Iatrogenic Organ injury – most commonly damaged bowel during a surgical procedure
- Iatrogenic Haemorrhage – bleeding at the time of surgery creating a mass of fibrous adhesions

MATERIALS AND METHODS

Statistical data of the reporting documentation of the Fergana Medical Regional Health Department for the period 2024

Materials were taken on the incidence of adhesive disease in 70 women. 15% TORCH infection, 15% surgical interventions in the abdominal cavity Adhesive disease is a common gynecological complication [4,5,6]. Factors influencing the formation of adhesions process, include infectious and inflammatory diseases of the pelvic organs, endometriosis [7,8,9], chlamydial, gonococcal and mycoplasma infections [10], surgical interventions [11]

The leading factor in the pathogenesis of the adhesive process is damage to the peritoneum, resulting from any impact that results in an increase in permeability vessels, ischemia, impaired fibrinolysis and increased fibroblast activity occur. Fibroblasts, in turn, enhance collagenogenesis [12].

There are several phases of adhesion formation: reactive, lasting several hours; exudative – accompanied by increased vascular permeability, penetration of inflammatory agents into the abdominal cavity (this phase lasts from 1 to 3 days);

Phase adhesion is characterized by the deposition of fibrin on the surface of the abdominal organs and the active differentiation of fibroblasts producing collagen fibers; in the next phase[13,14], lasting up to 2 weeks, loose adhesions are formed and angiogenesis begins, after which the phase of mature adhesions begins with the formation of dense adhesions.

In the clinical picture of this complication, the leading place is occupied by pelvic pain syndrome [15,16,17]. Women also experience dyspareunia and secondary dysmenorrhea. In severe cases, adhesive disease can lead to intestinal obstruction. The consequence of the adhesive process in women of reproductive age is very often tubo-peritoneal infertility. The adhesive process is observed in 15–20% of women with infertility.

To diagnose pelvic adhesive disease, the ultrasound method is used [18,19,20]. When conducting an ultrasound examination of the pelvic organs, the relative position of the organs and their mobility are assessed.

The slip amplitude is studied, as well as the continuity of the echo-dense track. The amplitude of the slip is assessed during the patient's respiratory movements or during manual compression of the abdominal wall. A decrease in this ultrasound sign by less than 1 cm is evidence of adhesions. Additional criteria include “blurring” of the contours of the ovary; fixation of the ovary with the uterus, which is preserved during palpation; an increase in the distance from the sensor to the ovary by more than 11 mm. An indirect sign may be “fluid formations” in the pelvic organs. An indirect sign may be “fluid formations” in the pelvic organs. Recent developments in non-invasive diagnostics[21,22].

Magnetic resonance imaging is used, the information content of which reaches 87.2–92.5%

In the diagnosis of adhesions, the “gold standard” is the method of control (dynamic) laparoscopy - second-look, which allows you to visually assess the prevalence and nature of adhesions with a high degree of information [23].

Prevention of the adhesive process should include: reducing the surface area of peritoneal trauma, reducing the activity of the inflammatory process, the intensity of

fibrin deposition on the surface of the abdominal organs, and creating a barrier between the serous surfaces [24,25].

Glucocorticoid, antihistamine, non-steroidal anti-inflammatory therapy does not have a significant effect in preventing the formation of adhesions. Among medications, gonadotropin-releasing hormone agonists have been used to reduce the likelihood of adhesion formation.

The use of this method turned out to be especially effective groups of drugs in the surgical treatment of patients with uterine fibroids and endometriosis. The action of gonadotropin-releasing hormone agonists is associated with the suppression of estrogen-dependent modulators and growth factors, inhibitor of plasminogen activation, the level of fibrin degradation products, decreased production of inflammatory factors, which reduces the risk of formation of adhesions.

In recent decades, to prevent the development of adhesions, it has been proposed to use agents to block active enzymes of collagen synthesis, which affect the process of fibrosis. These are drugs based on perfluoroorganic compounds Pentoxifylline, Perftoran, which suppress the synthesis of collagen and glycosaminoglycans, Isonides[26,27].

CONCLUSION

The most effective treatment and prevention for adhesions in the first instance is excellent and meticulous surgical technique. In patients with very advanced endometriosis, the challenge is to excise all of the inflammatory scar tissue as safely as possible; in certain circumstances, it may not be safe to proceed at this surgery, and it is better in this situation to discuss options for management in the post-op period, rather than create an inadvertent injury

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