MINIMALLY INVASIVE METHODS FOR TREATING PUROPENTAL-INFLAMMATORY DISEASES OF THE UTERINE APPENDIXES

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Annotation. Purulent inflammatory diseases of the uterine appendages (PIUD) in women are a complex problem associated with serious medical, social and economic losses. The progress of surgical techniques and intensive care of the postoperative period for PIUD still does not exclude a high probability of developing a threat to the lives of women.
Key words: purulent inflammatory diseases, uterine appendage, antibacterial therapy.

Introduction. Treatment for PIUD is carried out simultaneously in two main directions. Firstly, the impact on the infection, including surgical sanitation of the primary focus, systemic antibacterial therapy, correction of the altered biocenosis of the main biotopes. Secondly, the effect on the patient's body is aimed at restoring homeostasis disorders, including organ disorders: respiratory support, infusion therapy and correction of hemostasis [1, 4]. It has been established that the successful outcome of treatment of a patient with an abdominal infection depends only 15-20% on effective antibacterial therapy, and 80% on adequate surgical sanitation [2].

There are several methods of surgical treatment of PIUD: transection, laparoscopy, colpotomy and drainage of abscesses under visual control. Proponents of minimally invasive navigational surgery under ultrasound and computed tomography control perform drainage of abscesses in the pelvis using a trocar technique or special needles through the anterior abdominal wall or through the posterior vaginal fornix. In this case, purulent exudate is aspirated and antibiotics are administered [5, 6].

The use of minimally invasive endovideosurgical methods is the most promising direction in the surgery of abdominal infections, and the intensity of their

development allows us to hope for rapid and significant changes in emergency abdominal surgery [1, 6]. The development of endoscopic technology led to the introduction of laparoscopy in PIUD, first for diagnostic purposes and then for therapeutic purposes [2, 7]. Subsequently, thanks to the research of domestic and foreign scientists, the endoscopic approach gained recognition among other methods of surgical treatment of PVD as the method of choice under equal conditions and the presence of the same indications for surgical treatment [5]. Differences in the approaches of gynecologists to endoscopic treatment mainly relate to the timing and frequency of procedures. Provided that the inflammatory exudate is completely removed, a single therapeutic and diagnostic laparoscopy is sufficient. For purulent salpingitis, pyosalpinx, tubo-ovarian abscess in women of the reproductive period, the optimal option is dynamic laparoscopy and active drainage of the small pelvis [2,3]. This approach is regarded as an option for organ-preserving operations [4]. Surgical interventions for acute HFMD pose a serious problem for the reproductive health of women and are the cause of infertility in 12.5–74.0% [3]. The second most important long-term complication in 50% of women is ectopic pregnancy. One episode of purulent salpingitis increases the risk of ectopic pregnancy by 7-10 times. Relapses of inflammatory diseases of the pelvic organs occur in 11.2% and increase the likelihood of infertility in the case of a single episode by 10%, in case of three episodes - by 40-60%. In 24-30% of cases, pelvic ganglioneuritis and pain syndrome develop in patients with inflammatory processes of the uterine appendages. Chronicity of the inflammatory process in the uterine appendages occurs in 17-85% of patients with delayed treatment. In patients with this pathology, after surgery the hormonal balance changes, which is manifested by hyperpolymenorrhea (38.5-50%), algomenorrhea (16.7-18%), hypomenorrhea (6.7-7.7%), anovulation (40%) . With purulent inflammation of the uterine appendages, immune dysfunction is pronounced. Thus, there is an increase in the levels of tumor necrosis factor and interleukin 2, 6 in the blood serum and in remote organs tenfold and persists for a long time after surgery. In 82% of patients with HPVPM, there is a decrease in the production of embryotropic antibodies in the postoperative period.

As a result of purulent intoxication, in a third of patients, lipid profile indicators change: the concentration of total cholesterol, levels of low-density lipoproteins, and atherogenicity coefficient increase, hypoestrogenism occurs, which complicates rehabilitation. In some cases, morphological changes in the ovarian tissue are so pronounced that it is not possible to differentiate the organ, while the concentration of estradiol and progesterone receptors in the ovary approaches zero. However, with unilateral purulent lesions of the uterine appendages, the receptors

remain in the unaffected ovary [4]. In recent years, there has been an obvious and natural evolution of the etiological structure of severe infections in gynecology, associated with changes in the premorbid background of patients, the presence of complex hormonal disorders (including diabetes and obesity), chronic extragenital diseases, an increase in the number of immunocompromised patients and, no less important, the expansion of the scope and nature of invasive medical interventions, widely used antibiotic therapy and antibiotic prophylaxis, which constitutes a significant problem in the treatment of CVD [6].

Thus, understanding the peculiarities of the course of the purulent process of the uterine appendages and its outcome contributes to the provision of adequate surgical care in the early stages of inflammation, dictates active management tactics for patients and the implementation of new and effective programs to prevent complications and their consequences. When deciding on a surgical approach in patients with HPVPM in an urgent situation, the main point is the preservation of the reproductive organs, especially in young and nulliparous women.

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