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INTRAOPERATIVE SURGICAL CONTRACEPTION IN THE TREATMENT OF VAGINAL WALL PROLAPSE

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Genital prolapse is an important medical, social, and moral problem worldwide today. According to the World Health Organization, by 2030, approximately 63 million women will have a miscarriage, with one in nine women under the age of 80 undergoing surgery for the disease, with 30% requiring re-surgery. The tendency for the disease to grow not only among older women but also among young and middle-aged women is becoming the focus of surgeons and gynecologists. "Currently, there are more than 300 surgical treatments for small pelvic organ falls, but the effectiveness of the proposed methods is insufficient and the recurrence rate of the disease reaches 25-30%." This situation depends not only on the choice of the inadequate surgical method but also on the quality of preparation of patients before and after surgery. The greatest focus is on women of reproductive age, which requires a reduction in the recurrence of the disease and an increase in the effectiveness of treatment in addressing the issue of reproductive function. Given the severity of the disease, the age of women, and the possibility of improving the method of surgical contraception in this category of patients, it is necessary to introduce into clinical practice improved methods of surgical removal of pelvic floor falls. The monograph is intended for general practitioners, obstetricians, gynecologists, doctors of relevant specialties, masters, and students of medical institutes.

CONTENTS

LIST OF ABBREVIATIONS

DBU - is dysfunctional bleeding from the uterus
WHO - is the World Health Organization
ID - is an intrauterine device
GP - genital prolapse
PA - physical activity
PC - the physical condition
IG - in the fall of the internal genitals
VSS - is voluntary surgical sterilization
SA - social activity
VSC - is a voluntary surgical contraceptive
MOC- is a mixed oral contraceptive
IP- is the intensity of the pain
GT- is the gastrointestinal tract
RPA - the role of physical activity
MH - mental health
REA - the role of emotional activity
SI - stress incontinence
B – bladder
IHU - inability to hold urine
GSH - is a general state of health
ARVI - is an acute respiratory viral infection
QL - the quality of life
ES- is an emotional state
ED - extragenital diseases
ECG - electrocardiography
AL - is the ability to live

INTRODUCTION

The monograph provides an analysis of the reproductive and contraceptive behavior of women with genital prolapse, an optimized surgical method of simultaneous treatment of prolapse of the umbilical wall in transvaginal ICU. Indicators and criteria for the selection of patients for this operation are presented, and the effectiveness of the proposed method of surgical treatment and contraception is determined on the basis of the study of short-term and long-term results. The monograph presents the condition of the organs of the reproductive system and the dynamics of quality of life for one year after surgery. Working on this monograph, we have tried to fully and systematically reflect all modern information about surgical contraceptive methods in women suffering from complete loss of vaginal wall and, if possible, an assessment of its impact on women's quality of life.

CHAPTER I. PREVENTIVE FACTORS FOR SEXUAL DISORDERS IN REPRODUCTIVE AGE WOMEN

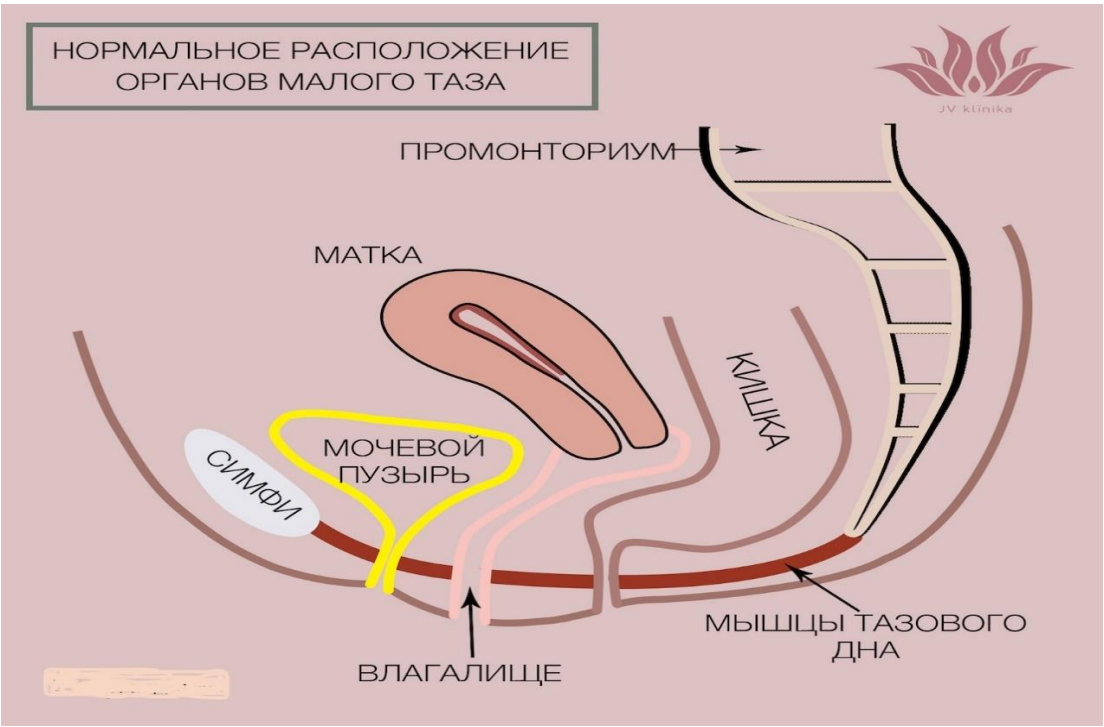
Pathogenesis and diagnosis of vaginal wall abnormalities

The etiology and pathogenesis of genital mutilation have not been fully elucidated. In recent years, a rejuvenating trend of this pathology has been observed. If 10-15 years ago it was mainly found in the elderly and elderly women, today the average age of patients does not exceed 50 years, of which 26% are women of reproductive age. The normal state of the internal genitals is facilitated by the following factors: the specific tone of the genitals, the level of sex hormones, which depends on the proper functioning of all systems of the body; the functional state of the nervous system; circulatory conditions; coordinated activity of the diaphragm and pelvic floor. The hanging, strengthening, and holding apparatus of the uterus is important. An abnormality in the location of the genitals occurs when these factors are disrupted against the background of the disease, injury, and atrophic processes.

Improper erectile dysfunction is a polyetiological disease, the basis of which is dystrophy and weakness of the uterine and pelvic floor muscles, and increased intra-abdominal pressure. Factors leading to genital pressure from the top play an important role in the origin of this pathology. In addition, physical, genetic, and psychological factors also influence the development of genital prolapse. Causes affecting the condition of the pelvic floor and uterine cervix include age, heredity, birth defects; heavy physical work; increase in abdominal pressure; inflammatory diseases and scars after surgery; psychosomatic effects on smooth muscle and vascular systems in the small pelvis; changes in products that produce sex hormones that affect the smooth muscle reaction; it can be shown that the transverse sphincter muscles cannot fully support the full position of the pelvic floor. An analysis of the scientific literature suggests that dysfunction of the pelvic floor, anterior abdominal wall, and uterine ligament apparatus leads to prolapse of the uterine and vaginal walls.

A systemic defect of connective tissue plays a leading role in the pathogenesis of genital prolapse in young, unborn women or women ID have had a single uncomplicated birth under an unchanging hormonal background and under normal social conditions. Under the influence of any of these factors,

or under the influence of any combination of them, a functional defect of the genital and pelvic floor apparatus occurs. Against this background, the limbs begin to protrude from the bottom of the pelvis. There are several pathogenetic variants of the mechanism of uterine and vaginal prolapse (Fig. 1).



1 – picture.

(Нормальное расположение органов малого таза/ Normal arrangement of the pelvic organs. Промонтроиум/ Promontroium, матка/ uterus, кишка/ intestine, мочевой пузырь/ bladder, симфи/ symphy, влагалище/ vagina, мышцы тазового дна/ pelvic floor muscles).

The first option:

• the uterus is located inside the bottom of the pelvis, which is extremely dilated and deprived of any length, through which it is squeezed;

• part of the uterus is inside and the rest is outside the inner gate of the hernia;

• one part is squeezed out and the other is in a position to stick to the base of the holder.

The second option is that the vaginal part of the uterus can sag and elongate due to the constant pressure of the inner gate of the hernia (elongation coli). The uterine body, which lies outside the internal portal of the hernia and is connected to the partially functioning m.levator, resists the complete fall of the organ. This mechanism explains the formation of an elongated and thinned uterus. Its elongation depends only or mainly on the hypertrophy of the cervix, and the uterine fundus may remain almost in the correct position. In this case, complete prolapse of the uterus occurs when the uterine axis is the same as the axis of the vagina - in retroflection. Therefore, retroflection is considered a risk factor for complete prolapse of the uterus.

Often, genital prolapse is caused by cystocele. The main causes of cystocele are weakening of the pubocervical fascia, separation of the cardinal lengths, and defect of the detrusor muscles. The formation of cystocele occurs simultaneously with the anterior wall of the vagina, deformation of the urethrovesical segment, and urinary incontinence.

In the genesis of genital prolapse, not only the total number of births but also their course characteristics are important. Even in an uncomplicated passage, a slowing of the distal conduction of the sciatic nerve is found in 20% of women (temporary in 15% of cases). This makes it possible to predict injury to the lumbar spine at birth, resulting in paralysis of the sciatic, femoral, and sciatic nerves, resulting in urinary and fecal incontinence.

One of the reasons for the development of this pathology is the increase in pressure of the abdominal cavity exogenous and endogenous type and the weakness of the pelvic floor due to the combined effect of several causes.

These include:

• Post-traumatic pelvic floor injury (most often occurs during childbirth);

• Weakness of connective tissue structures in the form of "systemic insufficiency" (the presence of localization of other lesions, manifested by the collapse of internal organs);

• Disorders of steroid hormone synthesis;

• Chronic diseases that occur simultaneously with the disruption of metabolic and microcirculatory processes.

Under normal conditions, the pressure from above on the genitals is balanced by the counter pressure of the pelvic floor and the anterior abdominal wall. Compensatory strengthening of the abdominal wall muscles temporarily

stops the fall of the genitals. At the same time, gradually the compensatory function decreases, the pressure of the internal organs on the genitals increases, the connecting apparatus of the uterus relaxes and it begins to fall down. The loose pelvic floor can no longer support the genitals and the downward shift increases. Some authors believe that this condition may be caused by adverse factors such as infantility, congenital insufficiency of the musculoskeletal system, weight loss with physical exertion, and genital atrophy in older women. First, the anterior wall of the vagina, which is attached to the urogenital diaphragm, is much weaker than the pelvic diaphragm.

Pelvic floor prolapse often develops as a result of interstitial injury and abdominal pressure constipation, constant coughing, and increased pressure under the influence of physical exertion. Often, the disease begins with retro aviation of the uterus, because in this case, the area of the area where the pressure force falls is much larger than in anteflexion.

Thus, conditions leading to loosening of the anterior abdominal wall and pelvic floor play an important role in the pathogenesis of genital prolapse. Loosening of the longitudinal apparatus of the uterus is a secondary factor and not of primary importance. Disruption of steroid hormone synthesis also plays a major role in the development of GP. The results of studies of the hormonal background in women with inconsistent ejaculation show that in prolapse of the genitals in women of childbearing age there is a violation of hormonal status, manifested by an imbalance of sex hormones, gonadotropins, and corticosteroids.

The lack of estrogens in estrogen-dependent tissues in the lower parts of the urogenital system - in the lower urinary tract, muscle layer, and mucous membrane of the vaginal wall, as well as in the pelvic floor and pelvic floor muscles - plays a leading role in the development of urogenital disorders.

Thus, under the influence of one or more of the factors listed above, functional weakness of the connecting apparatus of the internal genitals and the pelvic floor develops. As the pressure in the abdomen increases, the limbs begin to be “squeezed” out of the pelvic floor. In this case, there are several mechanisms of pathogenesis. For example, in functional insufficiency of groups of all longitudinal components that make up the hanging, attaching, and holding apparatus, the complete exit of the internal hernia of the limb is located in the center of the pelvic cavity. If part of the limb lies in the middle, and part - outside the inner gate of the hernia, the first part of it is pushed, and the rest

is pressed against the base. Thus, the part of the hernia that is outside the inner gate prevents the other part from coming out. As a result, the vaginal portion of the uterus may fall and elongate under the influence of constant pressure inside the hernia inner gate (elongation coli), however, the uterine body attached to the m.levator ani lying outside the hernia inner gate and still partially functioning resists the full fall of the organ. The uterus enters the descending stage only when its axis coincides with the axis of the vagina, i.e., in retroversion. Therefore, retroversion is an early stage of uterine prolapse and prolapse.

The study of the pathogenesis of urogenital prolapse has led to the search and development of a simple and at the same time complete classification in both CIS and Western countries. Today, there are several classifications of uterine and vaginal displacement.

According to the classification of MS Malinovsky, if the vaginal domes are close to the entrance to the vagina and uterine prolapse is observed (if the external fissure is below the plane of the spine), then there is Í-grade uterine prolapse. In grade II prolapse, the cervix protrudes from the genital fissure, with the uterine body above it. In cases of grade III prolapse (complete prolapse), the entire part of the uterus is below the genital fissure. Some authors describe Level II as an incomplete (partial) decline.

According to V.I.Krasnopolsky, I.F. Slavyansky's classification is the most successful, according to which changes in the position of the vagina and uterus are taken into account separately:

***1. Vaginal sliding down*:**

• Stage I - the fall of the anterior wall of the vagina, the posterior wall, or both; in all cases, the walls do not extend beyond the entrance to the vagina;

• Stage II - the partial collapse of the anterior wall of the vagina and part of the bladder, partial collapse of the posterior and anterior wall of the rectum, or a combination of both prolapses; the walls protrude beyond the entrance to the vagina;

• Stage III - complete prolapse of the vagina, often accompanied by uterine prolapse.

2. Uterine downward movement:

• I - stage - the uterus or cervix descends - the cervix descends to the level of the entrance to the vagina;

• Stage II - partial prolapse of the uterus or cervix - in tension the cervix protrudes beyond the boundaries of the genital fissure;

• Stage III - malignant prolapse of the uterus - outside the genital fissure is located not only the cervix, but also a part of the uterine body;

• Stage IV - complete prolapse of the uterus - the uterus is completely outside the genital fissure (between the fallen walls of the vagina).

Modern but uncommon classification M. A classification developed by Bowling called the “Small Pelvic Organ System” provides a more complete description of the condition of the apparatus that holds the internal genitals. In this classification, 6 different rating systems are used in the assessment: 1- type - urethra, 2- bottom of the bladder, 3 - cervix, 4 - Douglas cavity, 5 - rectal wall, 6 - interstitial. The first 5 rounds are evaluated the same. A score of “0” corresponds to normal anatomical interactions of small pelvic organs; "1" is a shift of less than half the distance from their normal level to the entrance to the vagina; "2" - the descent is more than half of this distance; "3" - drop to the level of the vulvar ring; "4" is the inversion of the vagina until the uterus emerges from the small pelvic cavity. The condition of the vagina is assessed on a different scale: "0" - the presence of an intact hymen membrane; "1" - thickened interval; "2" - the absence of intermediate tissue with the preservation of the rectal sphincter; "3" is the presence of a rectal sphincter disorder, "4" is the presence of a cloaca.

The standardization of the initial terminology of lower urinary tract dysfunction in European countries was proposed in 1973 by the International Continuation Society (ICS). In 1994, the ICS proposed a standard POPQ system, which allowed for detailed coverage of anatomical changes in small pelvic organs and objective dynamic monitoring. In 1996, this modification was adopted by the professional associations of Western gynecologists and

urologists as a standard system of terminology and definition of female genital prolapse and pelvic floor dysfunction.

Falling and prolapse of the internal genitals are characterized by the slow development of the process, but development can also be relatively rapid.

Numerous studies of patients with abnormal internal genital mutilation have shown that almost all of the small pelvic organs have functional disorders, which require their detection and treatment. It is noteworthy that in cases of miscarriage the internal genitals often develop a complex of symptoms, that is, urological and proctological complications come to the forefront simultaneously with the dysfunction of the genitals, which leads patients to consult appropriate specialists.

The most common complaints are: heaviness in the lower abdomen (67-70%), frequent urination, difficulty urinating (37.5-42.6%), urinary incontinence (STO) (7, 1-16.1%), constipation (24.2-31.5%), diarrhea (up to 39%), tenesmus (up to 32%), back pain (22-25%), foreign body sensation in the vagina (9 -16.4%), menstrual disorders, mainly as algodysmenorrhea (10.1-19.5%), occur in the form of secondary infertility (3.3-6.2%).

Anatomical connections, such as the proximity of pelvic organs and the connection of holding structures, lead to the development of urological complications leading to urinary tract obstruction, and trophic changes in the muscles of the bladder neck, and urethra. Of the anterior wall of the vagina an irregular fall leads to the development of a pulsating cystocele before, then a traction cystocele develops when the lateral longitudinals of the vagina rupture, in which the vaginal wall is unchanged, but there are dysuric cases. D.V. According to Kahn, urinary tract disorders in genital prolapse are detected in 74.1% of cases and are manifested by decreased urination or frequent urination, partial STO or inability to urinate during urination, dyskinesia of the upper urinary tract. A.I. According to Ishchenko (2000), stressful STOs are diagnosed in 25% of patients with internal GP. It is necessary to show a tendency to the addition of urinary tract and kidney infections, especially in patients with incomplete ejaculation. Statistics on this issue vary, the average is 60-70%. This figure increases when there is a large cystocele because there is constant residual urine in the bladder.

A severe manifestation of the disease is the inability to hold gases and feces, which develops as a result of traumatic disruption of the interstitial

tissue, rectal wall, and sphincter, or as a result of deep functional disorders in the pelvic floor muscles. According to various authors, stool incontinence is observed in 21% of patients with genital prolapse and urinary incontinence and occurs in 7% of cases when prolapse without dysuric disorders.

The combination of the following factors increases the incidence of incontinence: any degree of miscarriage, urinary incontinence, menopause, illness, irritable bowel syndrome, and history of hysterectomy. In 30.9% of women with rectoceles, defecation does not occur without the help of a finger inserted into the vagina or rectum. Accumulation of fecal masses leads to enlargement of the intestines, which in turn leads to an increase in the rectocele.

The improper collapse of the vaginal and uterine walls has a negative impact on a woman's psycho-emotional state, leading to sexual dysfunction depending on the duration of the pathology.

Thus, the specificity of patients with incomplete internal genital mutilation is a relatively high incidence of aggravated premorbid background, which depends on the age of patients, on the one hand, and the etiopathogenetic mechanisms of the disease, on the choice of correction of internal genital prolapse. should be taken into account in determining.

General description of the examined patients.

The study is based on clinical and laboratory examinations of 126 patients who were routinely treated with different degrees of genital prolapse from 2012 to 2016 in the gynecology department of the maternity complex No. 3 in Samarkand.

Criteria for inclusion in the audit:

• varying degrees of miscarriage,

• with cervical elongation of the genitals,

• Surgical treatment on JANT,

• The patient's written consent to the study and ICC.

Criteria for exclusion:

• severe extragenital pathology,

• Women over 49 years of age,

• availability of contraindications to surgical treatment,

• refusal of the patient to be examined,

• mental illness,

• manifested dysfunction of the bladder (Fig. 2).

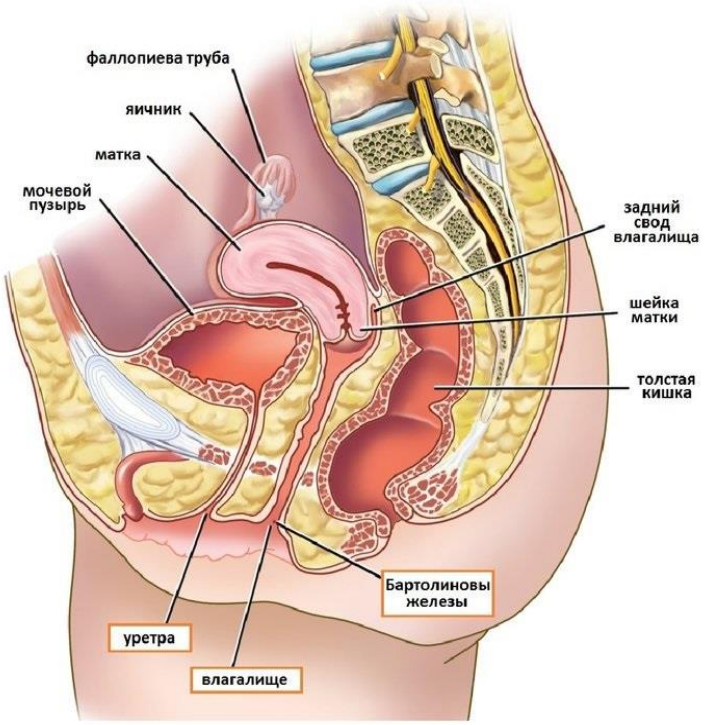


Figure 2. Normal placement of pelvic azoles.

(Фаллолиевая труба, яичник, матка, мочевой пузырь, задний свод влагалища, шейка матки, толстая кишка, бартолиновы железы, влагалище, уретра. Fallolian tube, ovary, uterus, urinary bladder, posterior vaginal fornix, cervix, colon, Bartholin glands, vagina, urethra)

All 126 patients examined were divided into 2 groups: 46 (36.5%) women underwent minilaparatomy and VSC in the first stage of surgical

correction of pelvic prolapse, and 80 (transvaginal occlusion of the fallopian tubes performed simultaneously with surgical treatment of genital prolapse). 63.5%) women were included in the main group. To adequately evaluate the results of laboratory tests, 30 healthy women were selected, who formed a control group (Figure 3):

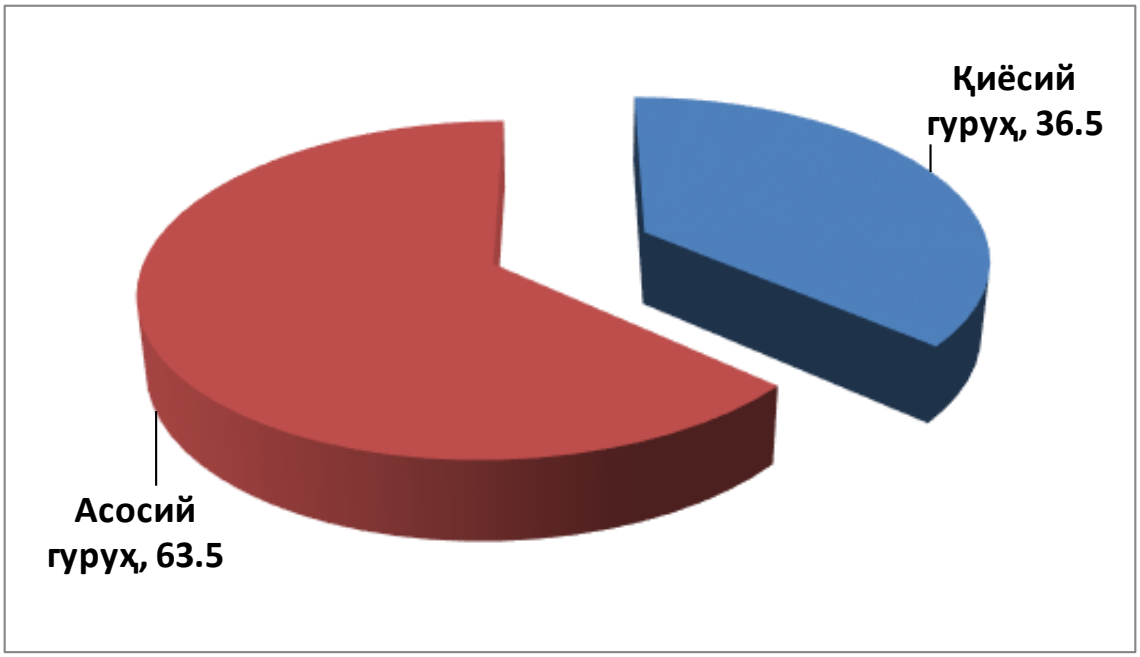


Figure 3 Division of patients into groups.
(Асосий гурух 63,5; киёсий гурух 36,5.
Main group 63.5; comparison group 36.5)

The age of the pregnant women examined ranged from 19 to 45 years. The average age in the first group was 35.9 ± 0.7 years, and in the second group - 39.8 ± 0.6 years. The majority of pregnant women were found to be between 31 and 41 years old. Women under the age of 20 accounted for 4.3% in group 1 and 8.8% in group 2 (Figure 4).

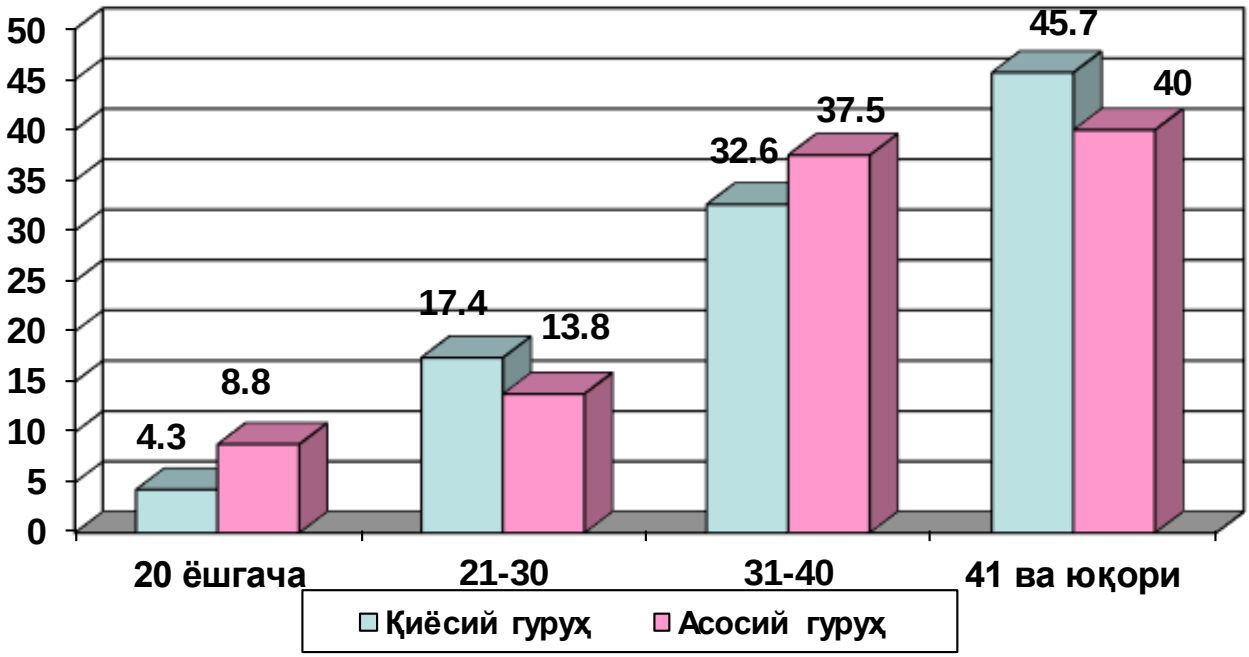


Figure 4 Distribution of examined patients by age.
(Асосий гурух, киёсий гурух. Main group, comparison group)

The presence of extragenital diseases (ECG) in the examined women was found to play an important role in the development of complications. It should be noted that the determination of the presence of ECG was carried out by us with the participation of specialized specialists (ENT doctor, nephrologist, cardiologist, infectious disease specialist). The high infection index was high in all study groups.

All women experienced childhood infections, acute respiratory viral infections (ARIs), respiratory, ENT-organ, and kidney diseases at different stages of their lives, which negatively affected the condition of various body systems needed to shape a woman's future reproductive function. Also, at least 3 of the diseases indicated in the majority of women were identified (Table 1).

1 - жадвал

The incidence of extragenital diseases in women with a history of genital prolapse is n = 126

Indicators	Comparative group (n=46)		Main group (n = 80)		χ^2	P
	patients	%	patients	%		
Infectious diseases of children	46	100,0	80	100,0	-	-
ARVI	46	100,0	80	100,0	-	-
Anemia	20	43,5	69	86,3	25,76	<0,001
Diseases of the ENT organs	2	4,3	5	6,3	0,20	>0,05
Kidney disease	3	6,5	9	11,3	0,76	>0,05
Diseases of the thyroid gland	15	32,6	39	48,8	3,11	>0,05
Cardiovascular diseases	5	10,9	10	12,5	0,07	>0,05
Lung diseases	8	17,4	12	15,0	0,13	>0,05
Diseases of the gastrointestinal tract (GIT)	2	4,3	5	6,3	0,20	>0,05
Viral hepatitis	8	17,4	11	13,8	0,30	>0,05
Obesity	7	15,2	9	11,3	0,41	>0,05

During the study of gynecological anamnesis (Table 2), it was concluded that the main pathology in the examined group of women was the presence of inflammatory diseases of the genital tract.

Among them, colpitis was observed more often (in groups, for example, 93.5% and 96.3%), uterine inflammatory diseases in group 1 - 7 (15.2%) women, in group 2 - 17 (23.1%) women, menstrual dysfunction was observed in 8 (17.4%) women in group 1 and 17 (23.1%) women in group 2. This confirms the idea that one of the leading causes of genital prolapse is a chronic intrauterine infection.

Table 2

In the anamnesis of examined women gynecological diseases n = 126

Indicators	Comparative group (n = 46)		Main group (n = 80)		χ^2	P
	patients	%	patients	%		
Colpitis	43	93,5	77	96,3	0,49	>0,05
Cervicitis	41	89,1	50	62,5	10,32	<0,001
Cervical erosion	11	23,9	14	17,5	0,76	>0,05
Inflammatory diseases of the uterus	7	15,2	17	21,3	0,69	>0,05
Inflammatory diseases of the uterine appendages	10	21,7	25	31,3	1,32	>0,05
Menstrual dysfunction	8	17,4	17	21,3	0,27	>0,05

The outcome of previous pregnancies was also significant in the examined women: in group 1, most involuntary miscarriages were observed - 42 (50.0%) women, and premature births - 4 (8.7%) and 20 (25.0%). observed in women (Table 3).

Table 3

Outcome of previous pregnancies in the examined women n = 126

Indicators	Comparative group (n = 46)		Main group (n = 80)		$\chi 2$	P
	patients	%	patients	%		
Involuntary miscarriage	17	37,0	42	50,0	2,83	>0,05
Fetal malformation	9	19,6	12	15,0	0,44	>0,05
Artificial abortion	16	34,8	8	10,0	11,63	<0,001
Premature birth	4	8,7	20	25,0	5,04	<0,05

Summing up the results, we concluded that the main background in genital prolapse is the presence of infectious-inflammatory sexually transmitted and extragenital diseases of the genitals, which aggravate the premorbid background in the anamnesis of women.

Description of women of reproductive age with improper ejaculation

All women under observation underwent an in-depth clinical examination through a thorough examination of somatic, obstetric, and gynecological anamnesis, as well as age, menarche, condition of the reproductive system, and the course of this pregnancy and childbirth. General examination, external and internal obstetric examination, clinical analysis of blood, urine, blood group, and rhesus affiliation, examination of blood for Wasserman reaction, bacterioscopic and bacteriological examination of cervical and vaginal discharge, examination of urine by Nechiporenko method.
Anamnestic data and clinical and statistical analysis of disease characteristics were conducted on the basis of specially developed maps. The map includes general clinical, special examinations, surgical treatment, contraception, and the characteristics of the postoperative period.

Observations and studies have shown that the onset of menarche is normal (12-14 years) in the majority of women (39.1% and 35.0%, respectively). (Table 4).

Table 4

Clinical and anamnestic indicators of women n = 126

Indicators	Comparative group (n = 46)		Main group (n = 80)		χ2	P
	patients	%	patients	%		
	Menstrual function					
Start:						
- early, up to 11 years	14	30,4	21	26,3	0,25	>0,05
- In moderation, 12-14 years	18	39,1	28	35,0	0,21	>0,05
- late, 15 and after	14	30,4	31	38,8	0,88	>0,05
Painfulness	8	17,4	18	22,5	0,47	>0,05
Regularity	31	67,4	35	43,8	6,54	<0,01
In small quantities	14	30,4	20	25,0	0,44	>0,05

Prolongation of tables

1	2	3	4	5	6	7
In moderation	28	60,9	33	41,3	4,50	<0,05
In large quantities	12	26,1	27	33,8	0,80	>0,05
The beginning of sexual life						
- Early	12	26,1	18	22,5	0,21	>0,05
- late	25	54,3	33	41,3	2,02	>0,05
First marriage	38	82,6	52	65,0	4,44	<0,05
Remarriage	8	17,4	28	35,0	4,44	<0,05
Regularity	32	69,6	49	61,3	0,88	>0,05
Not regular	14	30,4	31	38,8	0,88	>0,05

The regularity and frequency of menstruation were noted in women in both groups. Early onset of sexual activity was detected in 12 (26.1%) women in the comparison group and 18 (22.5%) in the main group.

18 (39.1%) women in the comparative group and 38 (47.5%) in the main group with complaints of feeling of heaviness in the lower abdomen, 3 (6.5%) in the comparison group of lumbar and lumbar pain, 6 (7 in the main group). , 5%) were observed (Table 5).

The most common complaint in the main group of women — urinary incontinence — was 60%. Complaints of "foreign body", sexual dysfunction, sexual dissatisfaction are less common in sexual intercourse.

5 - table

Complaints reported in women with genital prolapse under investigation n = 126

Complaints	Comparative group (n = 46)		Main group (n = 80)		χ2	P
	patients	%	patients	%		
Feeling of heaviness in the lower abdomen	18	39,1	38	47,5	0,83	>0,05
Pain in the buttocks and lower back	3	6,5	6	7,5	0,04	>0,05
Disorders of urinary excretion	16	34,8	48	60,0	7,43	<0,001
Sensation of "foreign body" in the genital fissure	6	13,0	18	22,5	1,69	>0,05
Sexual dysfunction	3	6,5	11	13,8	1,55	>0,05
Lack of sexual satisfaction	15	32,6	26	32,5	0,00	>0,05

Results of bacteriological, gynecological and obstetric anamnesis analysis

Prior to surgery, before and after vaginal resection, the mucosa separated from the urethra, cervical canal, and vaginal dome was examined bacterioscopically. The vaginal portion of the cervix was dried with a dry sterile swab and the urethra and cervical canal were removed with tweezers. The separation from the posterior dome of the vagina was removed using a spatula. The resulting material was rubbed on a piece of glass and stained on Gram. Bacterioscopy was performed under a simple light microscope.

Prior to surgery, vaginal resuscitation and cervical canal separation were bacteriologically (microbiologically) examined. If 5% blood agar was used as the nutrient medium, it is a good growing medium for most conditionally-pathogenic organisms. A 1% sugar solution was used as the “collection medium”. When sampling with a swab, a dense bar was inoculated into the ½

portion of the blood agar vial. The seedlings were incubated at 37 °. We counted the number of colonies grown after the onset of growth and added 1 ml. we determined the proportion relative to the probe, the degree of colonization of the probe to KOE / ml. we calculated in. A quantitative assessment of growth was carried out in the following scheme:

I - very low, no growth in a dense medium, grown in the liquid nutrient medium;

II - low-growing, if the number of colonies of certain species of microorganisms is up to 10 (10%);

III - in moderate amounts, if 11 - 100 colonies (10^2);

IV - in large quantities, if more than 100 colonies (10% and more).

In addition to the overall growth in the samples, we assessed the growth of all cholines detected in the first inoculated vials. We determined the sensitivity of agar to 10 antibiotics in all isolated strains by the standard paper disc diffusion method. Discs with standard concentrations of antibiotics were used in accordance with WHO recommendations. In the method of estimating half of the increase in the number of colonies grown in the Petri dish, we counted as follows: 1 to 10 colony growth was underestimated; 11 to 100 colonies - average; If more than 10 KOE / ml - massive growth. We determined in isolated ways that the isolated bacterial cultures belonged to a particular species. The bacteriological and bacterioscopic examination was carried out in the laboratory of the maternity complex No. 3 (head of the laboratory - Cherchaeva Z.V.).

We performed a bacteriological examination of all women in the group. At present, the method of choice for the assessment of vaginal biocenosis is microscopy of Gram-stained vaginal smear. The sensitivity and specificity of the method are close to 100%. The following indicators were selected as evaluation criteria: an average number of leukocytes in the field of view, type of flora, and amount of flora (Table 6).

Table 6

Vaginal smear in examined women Bacterioscopy results n = 126

Level of cleanliness	Comparative group (n = 46)		Main group (n = 80)		$\chi 2$	P
	patients	%	patients	%		

1st degree	9	19,6	10	12,5	1,14	>0,05
2nd degree	15	32,6	23	28,8	0,21	>0,05
3rd degree	21	45,7	45	56,3	1,32	>0,05
4th degree	1	2,2	2	2,5	0,01	>0,05

The first-degree purity comparison was observed in 9 (19.6%) women in the group and 10 (12.5%) in the main group. Most women in both groups were diagnosed with grades 2 and 3, indicating an important role of infection in genital prolapse.

All patients underwent preoperative bacteriological examination of the cervical canal by equalizing the secretion with the flora and determining its sensitivity to antibiotics (Table 7).

Table 7

Results of bacteriological examination n = 126

Indicators	Comparative group (n = 46)		Main group (n = 80)		χ2	P
	patients	%	patients	%		
Staphylococcus Epidermidis	7	15,2	18	22,5	0,97	>0,05
Staphylococcus aureus	6	13,0	15	18,8	0,68	>0,05
Escherichiacoli	17	37,0	28	35,0	0,05	>0,05
Sandidaalbicans	7	15,2	4	5,0	3,83	>0,05
Association	4	8,7	7	8,8	0,00	>0,05
No increase was observed	5	10,9	8	10,0	0,02	>0,05

Staphylococcus Epidermidis was obtained in 7 (15.2%) patients from the comparative group and 18 (22.5%) patients from the main group, Staphylococcus aureus - in 6 (13.0%) and 15 (18.8%) patients, Escherichiacoli - in 17 (37.5%) and 28 (35.0%) patients. Associations of microorganisms were identified in 4 (8.7%) and 7 (8.8%) patients from the comparative group: Escherichiacoli + Enterobacter, Staphylococcus aureus + Escherichiacoli, Staphylococcus aureus + Enterobacter. No growth of microorganisms was observed in 5 (10.9%) and 8 (10.0%) patients by groups.

Bacterial vaginosis was diagnosed in 6 (13.0%) patients from the comparative group and 10 (12.5%) patients from the main group based on the results of amine tests, measurement of vaginal pH, and detection of “significant cells” by vaginal microscopy. The diagnosis was made when two

of the three indicators indicated were positive. The amount of Qin Ph averaged 5.65 ± 1.5.

In most women, the disease duration was found to be more than 5 years, in the comparative group the disease duration was 87.0%, and in the main group, it was 87.5% (Fig. 5).

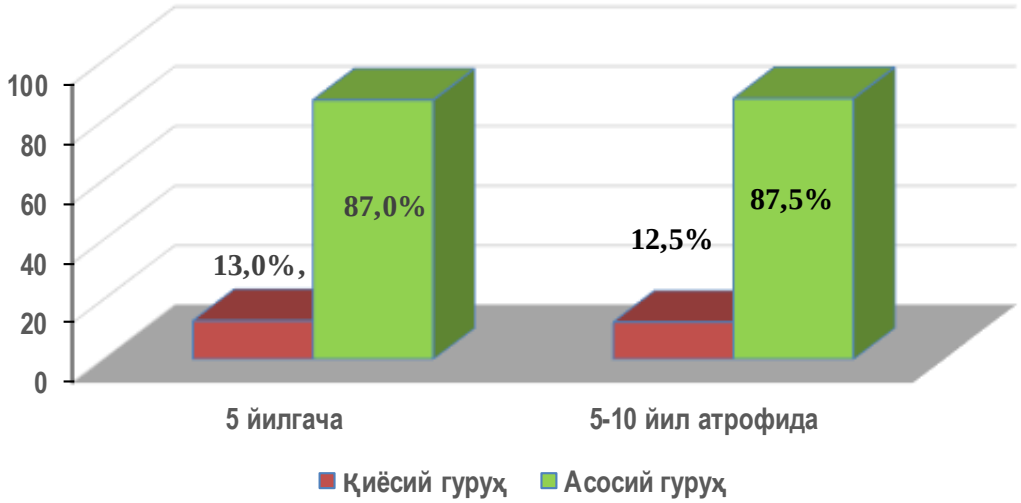


Figure 5 Duration of disease in women with genital prolapse. (Киёсий гурух, асосий гурух. 5 йилгача, 5-10 йил атрофида. Main group, Comparative group. Up to 5 years, around 5-10 years)

This is probably due to the fact that women do not feel the fall of the genitals due to the lack of symptoms at the onset of the disease.

The analysis shows that the majority of women with genital prolapse have a history of more than 4 births, and they associate the disease with multiple births. More than half of the comparative and primary groups - 35 (67.1%) and 61 (76.3%) - had a history of 1 to 4 artificial or involuntary abortions.

Hence, fixation of the cervix with clamps in abortions, instrumental removal of the fetal egg can also be risk factors for the development of genital prolapse, as in this case the cervix is damaged and the cervical apparatus loosens (Table 8).

Table 8

Obstetric anamnesis in women with genital prolapse n = 126

Indicators	Main group (n=46)		Comparative group (n=80)		$\chi 2$	P
	patients	%	patients	%		
complications						
1st birth	10	21,7	9	11,3	2,51	>0,05
2-3	4	8,7	3	3,8	1,36	>0,05
4 and more	32	69,6	68	85,0	4,25	<0,01
Abortions						
1-abortion	3	6,5	2	2,5	1,24	>0,05
2-3	8	17,4	17	21,3	0,27	>0,05
4 and more	35	76,1	61	76,3	0,00	>0,05
Involuntary miscarriage						
1 ta	0	0,0	3	3,8	1,77	>0,05
2-3	5	10,9	12	15,0	0,43	>0,05

During pregnancy, most women received a course of treatment for candidiasis, trichomoniasis, and colpitis of other etiologies. This indicates that the genital tract was infected before delivery and that it was probably the cause of the birth injury. The table shows the characteristics and incidence of soft tissue injuries of the birth canal in the examined women (according to the anamnestic data).

According to the table, episiotomy was performed in the second period of labor in 21.7% of women from the comparative group and 15.0% of women from the main group (ch2 = 0.92 I R> 0.05) according to different indicators. In the comparative group, 26.1% of women and 18.8% of women in the main group experienced birth defects with the opening of stitches that required further treatment. Thus, in 95.6% of patients, birth defects and birth injuries were the main factors in the development of cervical scarring and pelvic floor insufficiency (Table 9).

Table 9

The degree and characteristics of the incidence of cervical and interstitial injuries at birth n = 126

Indicators	Comparative group (n = 46)		Main group (n = 80)		$\chi 2$	P
	patients	%	patients	%		
Episiotomy	10	21,7	12	15,0	0,92	>0,05
Interstitial rupture	15	32,6	28	35,0	0,07	>0,05
Rupture of the cervix	9	19,6	25	31,3	2,02	>0,05
The opening of the seams	12	26,1	15	18,8	0,93	>0,05

All examined patients were found to have used different contraceptives throughout their lives (Table 10).

Table 10

Contraceptives used in the examined women n = 126

Types of contraceptives	Comparative group (n = 46)		Main group (n = 80)		$\chi 2$	P
	patients	%	patients	%		
ID	12	26,1	30	37,5	1,71	>0,05
Depo- Provera	7	15,2	8	10,0	0,76	>0,05
KOK	8	17,4	7	8,8	2,08	>0,05
Coitus interruptus	5	10,9	6	7,5	0,42	>0,05
Calendar	4	8,7	3	3,8	1,36	>0,05

More than 70 percent of women with genital prolapse have used a reliable method of contraception. According to the survey, 12 (15.0%) patients from the main group planned to become pregnant again in the future.

Held in a gynecological chair. The doctor places two fingers on the patient's vagina and raises the bladder neck to the pelvis. The patient becomes dizzy or coughs. The doctor observes the urinary excretion until and after the bladder rises (Figure 6).

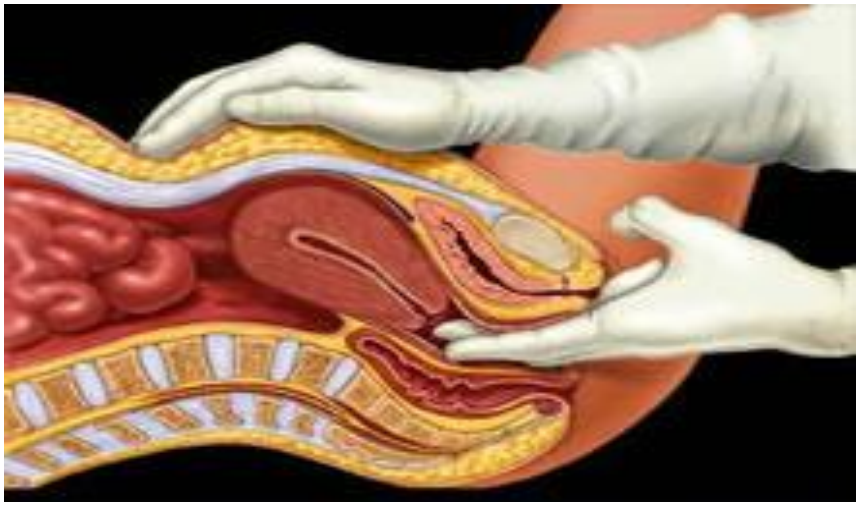


Figure 6 Bonney test technique.

Genital prolapse was assessed by a standardized POPQ (pelvic organ prolapse quantification) system developed by the International Society for Urine Retention (Figure 7).

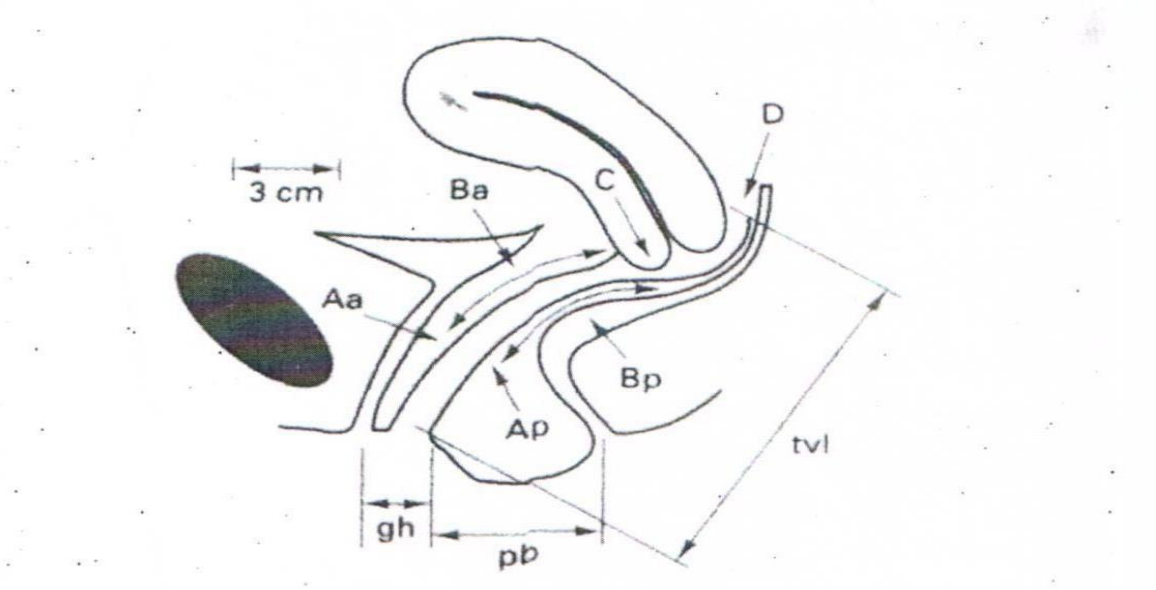


Figure 7 POPQ is a system for quantifying pelvic organ prolapse (according to O.B. Laurent, 2008).

In the POPQ system, the vagina is taken relative to the hymen, and the posterior walls, cervix, and a set of defined points in the interval are measured. There are 6 measurement points in the POPQ system - Aa, Va, S, D, Ar, and Vr. Each is measured in centimeters above the hymen (proximal) (negative number) or in centimeters below the hymen (distal) (positive number). The plane of the hymen is defined as the zero point (0). All measurements are taken when the patient is tense. The POPQ system allows for to diagnosis of prolapse,

to more accurately perform its localization and stages (Table 11), as well as to determine the tactics of treatment.

11 – table

Stages of prolapse using ICS (POPQ)

Phase 0	There is no prolapse, (points Aa, Va, Ar, Vr are located at 3 cm, and points S, D - up to (tvl - 2) cm)
Phase I	> 1 cm above the hymen; (Stage 0 criteria are not observed, but the maximum drop is less than 1 cm)
Phase II	Located proximal or distally <1 cm above the level of the hymen (maximum fall not less than 1 cm and not more than +1 cm)
Phase III	> 1 cm below the hymen, but not more than 2 cm shorter than the total length of the vagina (maximum fall more than +1 cm, but less than + (tvl -2) cm)
Phase IV	Complete overturning of the external genitalia; maximum drop at least + (tvl - 2) cm

Diagnosis under this system has advantages in the operative treatment of genital prolapse.

All examined patients were consulted by closely related specialists (therapist, cardiologist, endocrinologist, phlebologist, urologist, neuropathologist, ophthalmologist) in an outpatient or inpatient setting according to their extragenital pathology.

To diagnose and assess the symptoms of pelvic organ prolapse in women, a complex diagnosis is required, especially in cases of “hidden” incontinence; it includes a survey, an examination in a gynecological chair with a cough test, and a temporary reposition of the pelvic organs with a pad test.

We assessed the activity of the urinary system on the basis of diurnal urine (Table 12).

12 - table

Women's urination diary (PAD-test)

Date: "_____"_____ _____ й.

F.I.Sh .: _____ **Date of birth: _____**
If you have frequent urination, inability to urinate, constant urge to urinate, you should fill out this questionnaire. This will allow your doctor to make an

accurate diagnosis and recommend effective treatment. Use a different sheet if you want to provide specific information that is not shown in the diary.								
Time	What fluid did you drink? (water, coffee, juice, beer)	How much did you drink? (a cup, a mug)	How many times did you urinate in an hour?	The amount of urine? (low, average, high)	Was there a call to urinate unbearably?	Has involuntary urination occurred?	How much urine was excreted? (low,	What did you do during involuntary urination?

- This diary was used regardless of the clinical manifestations of dysuria (stress-incontinence, pollakiuria, imperative call). Although a mixed form of urinary incontinence was diagnosed in 82 (54.7%) patients during the study, SI symptoms were predominant clinically.
- The urinary diary was kept by the patients for 48 hours, after which the data were discussed in the presence of the treating physician and the patient. Each indicator was analyzed in detail: frequency, urine volume, description of the act of urination, and individual symptoms.
- Among the many questionnaires, a pad-test (pad test) is convenient for practical application. It allows a simple and objective assessment of the degree of urinary incontinence before surgery, followed by the effectiveness of treatment. The degree of urinary incontinence can be classified according to the number of pads:

  - heavy - more than 6,
  - Medium heavy - 4-6,
  - Light - 3 and less.

An hour-long pad test allows assessment of urine output during daily physical activity.

At the time of the study, no patients had an exacerbation of the extragenital disease. Among the diseases of the urinary system, chronic pyelonephritis and cystitis were observed, which are associated with changes in the anatomical and topographic location of the urinary organs. Pollakiuria, urogenital disorders in the form of urinary incontinence were observed in 16 (34.8%) women from the comparative group, and in 48 (60.0%) patients from the main group; sensation of complete emptying of the bladder in about one-third of both groups; urinary pain was observed in almost all patients. In most women, multiple symptoms have been reported to accompany. In terms of anatomical and topographic features, we found the importance of correcting urinary incontinence in the choice of surgical intervention method, taking into account the proximity of the genitals and urinary tract. The results of the PAD test (Table 13) are presented.

13 - table

According to the results of PAD-tests, the degree of stress urinary incontinence in women with genital prolapse n = 126

Number of pads	Comparative group (n = 46)		Main group (n = 80)		$\chi 2$	P
	patients	%	patients	%		
3 pads	15	32,6	10	12,5	7,43	<0,001
4 to 6 pads	9	19,6	33	41,3	6,18	<0,001
More than 6 pads	22	47,8	37	46,3	0,03	>0,05

According to the results of PAD-tests, moderate urinary incontinence was detected in 9 (19.6%) patients from the comparative group and 33 (41.3%) (ch2 = 7.43, R <0.001) patients from the main group. Severity was observed in 22 (47.8%) patients from the comparative group and 37 (46.3%) patients from the main group (ch2 = 8.25, R <0.001).

The patient's bladder stands upright with one foot resting on the stool at full time, then sneezes or coughs. Urinary incontinence is a sign of stressful urinary incontinence.

In the lithotomic state, 200 ml at room temperature through a catheter into the bladder (SP). a sterile saline solution is administered. The patient was then asked to “fill the chest with air” and then exhale without exhaling. Urinary

excretion was observed visually and compared with the intensity and timing of urination.

A positive evaluation of the probe indicates a severe level of STO. If the patient has genital prolapse, a Simpson glass back spoon is used as a barrier.

The stress test - the Valsalva test - showed the urinary loss in 22 women (47.8%) from the comparative group and 42 (52.5%) from the main group when coughing with difficulty or with a barrier (back spoon of the vagina), which was stressful in women with pelvic prolapse. confirms the degree of urinary incontinence (ch2 = 1.23, R> 0.05).

“Stop test” The “Stop test” test (m.bulbo-cavernous, m.ishio-cavernous, m.levatorani) was used to assess the ability of the pelvic floor transverse sphincter muscle involved in the formation of the sphincter system of the bladder and urethra.

The test is based on the ability of the patient to stop urinating. The patient is given 150-200 ml of saline at room temperature through a sterile catheter to the SP in the gynecological chair. The patient is then gradually moved to a vertical position and begins to urinate, after 1-2 seconds the urination stops voluntarily. The amount of urine excreted is measured. The patient then stops urinating, and the amount of urine excreted is measured again.

Discharge of less than 1/3 of the injected fluid indicates a violation of the contractile properties of the pelvic floor muscles involved in the formation of the SP and urethral sphincter system. Impairment of braking reflexes is also observed when the detrusor is unstable. Leakage of urine when the patient is transferred from a horizontal to a vertical position indicates sphincter insufficiency of the bladder-urethral structures. To evaluate the contractile properties of the pelvic floor transverse muscles involved in the formation of the sphincter system of the bladder and urethra, we used the “Stop Test” method (Table 14).

14 - table

Results of the "stop test" (150 ml of sterile warm saline solution was injected into the bladder) n = 126

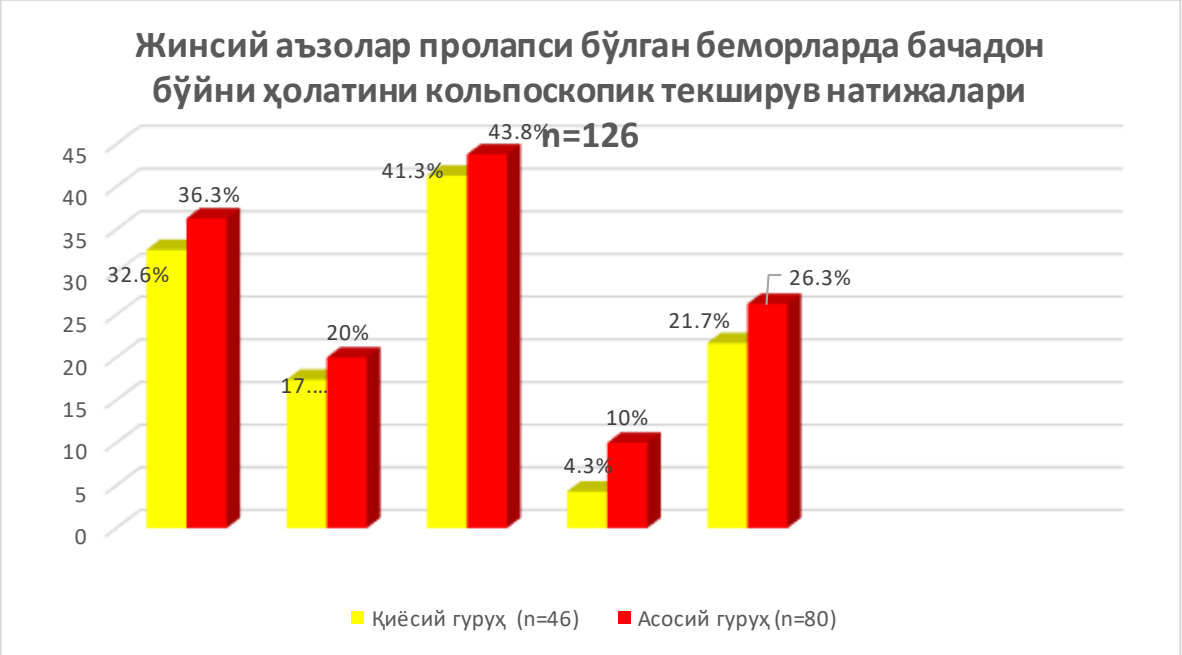
Amount of urine excreted, ml.	Comparative group (n=46)		The main group (n=80)		χ2	P
	patients	%	patients	%		
150,0	21	45,7	13	16,3	12,81	<0,001

149,0 – 100,0	8	17,4	10	12,5	0,57	>0,05
99,0 – 50,0	13	28,3	18	22,5	0,52	>0,05
< 50,0	4	8,7	39	48,8	20,84	<0,001

In our study, the "Stop test" resulted in an average urine volume of 110.5 ± 15 ml. which indicates that the contractile nature of the pelvic floor transverse muscles involved in the formation of the sphincter system of the bladder and urethra is impaired. Less than 1/3 of the administered fluid was excreted in 12.4% of patients.

The size of the surgical intervention also depended on the condition of the cervix, which we assessed visually and colposcopically. To determine the condition of the vaginal mucosa of the cervix, a colposcopy was performed before surgery using a SCANERUSB-DIGITAL colposcope with a magnification of 300 times in the usual way in all patients. Previously, a simple (explanatory) colposcopy was performed to determine the shape, size, color, and relief of the cervical mucosa, the boundary of the flat and cylindrical epithelium, and the location and shape of the subepithelial vessels. We focused on the multilayered flat and cylindrical epithelial border. For further in-depth examination and identification of all areas of pathological epithelium, we performed an extended colposcopy by treating the cervical mucosa with 3% acetic acid and 2% Lugol's aqueous solution. The presence of this or that type of epithelium as criteria for assessing the condition of the exocervicus; the color and surface of the mucous membrane, the condition of the cervical vessels and their picture; location of exo- and endocervical border, old cracks of the cervix; evaluated by the change zone feature. We defined colposcopic appearance in accordance with the international colposcopic terminology updated in 2003 in Barcelona by the International Association of Cervical Pathology and Colposcopy. All patients underwent extended colposcopy before surgery. The following pathological conditions of the cervix were identified: pseudo erosion in 15 patients from the comparative group (32.6%) and 29 patients (36.2%) from the main group (ch2 = 0.17, R> 0.05); scar deformations by groups 19 (41.3%) and 35 (43.8%) (ch2 = 0.07, R> 0.05); plant cysts 8 (17.4%) and 16 (20.0%) (ch2 = 0.13, R> 0.05) 50 (15.9%); ectropion was detected in 10 (21.7%) and 21 (26.3%) (ch2 = 0.32, R> 0.05) patients (Figure 8).

8- picture



(Жинсий аъзолар пролапси булган беморларда бачадон буйни холатини колькоскопик текширув натижалари. Results of colcoscopic examination of cervical condition in patients with genital prolapse)

All changes were cytologically and pathomorphological confirmed. Pseudoerosion and scar deformity were most commonly observed in the study. It was found that the patients examined had a history of many gynecological diseases. 70 (22, 2%) women underwent surgical interventions related to the following gynecological diseases and obstetric conditions: ovarian cysts and cysts - 12, tubal pregnancy - 7, ovarian apoplexy - 4, cesarean section - 39, use of obstetric compression - 7, conservative myomectomy - 1. (Table 15)

15- table

Gynecological diseases of patients with genital prolapse n = 126

Indicators	Comparative group (n=46)		Main group (n=80)		$\chi 2$	P
	patients	%	patients	%		
Vaginitis and vaginosis	15	32,6	28	35,0	0,07	<0,05
Salpingooophoritis and endomyometritis	9	19,6	19	23,8	0,30	<0,05
Ovarian cyst	4	8,7	8	10,0	0,06	<0,05
Uterine fibroids	2	4,3	3	3,8	0,03	<0,05
Endometriosis	2	4,3	2	2,5	0,32	<0,05
Dysfunctional uterine bleeding	0	0,0	1	1,3	0,58	<0,05
Extrauterine pregnancy	2	4,3	5	6,2	0,20	<0,05

In 289 (91.8%) patients, closely related pathology of the internal genitalia was detected. Half of them were chronic inflammatory processes of the uterus and its excesses (salpingooophoritis, endomyometritis). In the anamnesis, vaginitis and vaginosis were detected in 80.96% of patients.

Traumatic deformity of the cervix and its elongation, disturbance of the topography of the internal genitals, scarring of the interstitium, enlargement of the genital fissure are the background for the development of vaginal biocenosis, vaginitis, requiring preoperative treatment, separate preoperative preparation, and in some cases increased surgical volume.

(Нормальная анатомия женского таза. Опущение матки. Прямая кишка, матка, мочевой пузырь, мочеиспукательный канал, вагина. Normal anatomy of the female pelvis. Descent of the uterus. Rectum, uterus, bladder, urethra, vagina)

According to the International Classification of Diseases, the diagnosis was made as follows (Table 15). As can be seen from Table 15, cervical elongation and misalignment of the vaginal wall, which require surgical correction of the pathology in combination, have been frequently observed in conjunction with anterior rupture of the interstitium. According to the comparative and primary groups, vaginal wall collapse was present in 9 (19.6%) and 8 (10.0%) women, vaginal wall collapse and cervical scar deformity, cystole 14 (30.4%) and 26 (32.5%). %) were observed in women. The effect of clinical anamnestic data on the incidence of the development of genital prolapse was determined using a quantitative assessment of the relationship between pathological data (Table 16). According to the data obtained, there is an organic link between co-occurring diseases and the risk of developing genital prolapse. In this regard, the following are highly valued: the number of births <4 (OR = 2.11, EF = 61.3); seam opening (OR = 1.53, EF = 28.1); cervical rupture (OR = 3.43, EF = 59.7); the amount of urine excreted was 150.0 ml (OR = 2.94. EF = 28.1); More than 6 pads (OR = 2.08, EF = 117.6). The results obtained are confirmed by the elevation of the etiological part of the EF.

16- table

Distribution of patients according to diagnosis n = 126

Diagnosis	Comparative group (n=46)		Main group (n=80)		$\chi 2$	P
	patients	%	patients	%		
With cervical elongation and anterior rupture of the interstitium	12	26,1	32	40,0	0,65	>0,05
The improper collapse of the vaginal wall	9	19,6	8	10,0	2,29	>0,05
Fall of the vaginal wall and scarring of the cervix, cystocele	14	30,4	26	32,4	0,06	>0,05
Vaginal wall collapse and cervical elongation, cystocele	4	8,7	7	8,8	0,00	>0,05
With the collapse of the vaginal wall and the anterior rupture of the gap	7	15,2	7	8,8	0,00	>0,05
total	46	100	80	100		

Thus, the study of risk factors for the development of genital prolapse allowed to determine that the most important among these factors were: birth rate <4; opening of intermediate seams; cervical rupture; the amount of urine excreted is 150.0 ml; More than 6 pads; recurrent pneumonia; sexual dissatisfaction.

Symptoms of genital prolapse have a significant impact on a woman's lifestyle, leading to physical and social limitations as well as emotional problems.

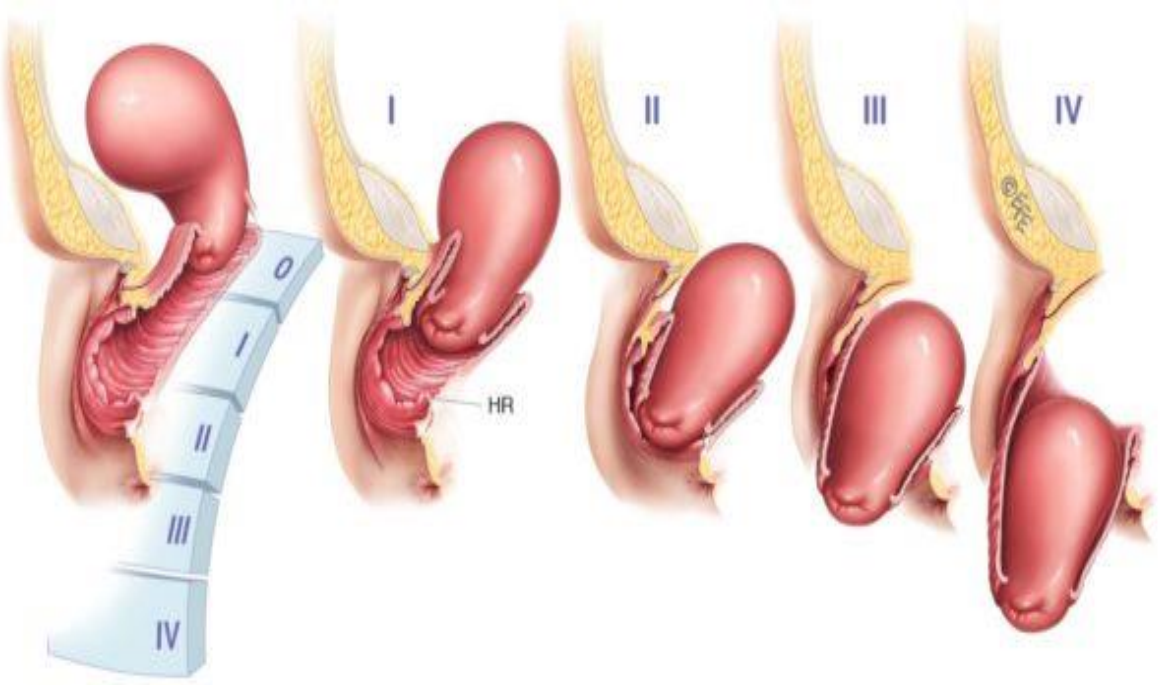


Figure-9. Uterine fall rates

17 - table

Quantitative assessment of the relationship between genital prolapse formation and clinical anamnestic factors

Risk factor	RR	АтР	OR	EF
Number of births <4	1,00	0,13	2,11	61,3
Episiotomy	1,45	-0,33	1,57	31,0
Interstitial rupture	0,93	-0,33	0,90	-7,3
The opening of the seams	1,39	-0,29	1,53	28,1
The cervix is torn	0,63	-0,54	0,54	59,7
Vaginitis and vaginosis	0,93	-0,33	0,90	-7,3
Salpingoophoritis and endomyometritis	0,82	-0,48	0,78	-21,4
Ovarian cyst	0,87	-0,58	0,86	-15,0
Uterine fibroids	1,16	-0,56	1,17	13,8
Endometriosis	1,74	-0,46	1,77	42,5

Uterine dysfunction	2,76	0,52	4,21	45,9
bleeding (DBU)	0,70	-0,67	0,68	-43,8
Extrauterine pregnancy	2,81	0,07	4,33	64,4
The amount of urine excreted is 150.0 ml.	1,39	-0,38	1,47	28,1
The amount of urine excreted is 149.0 - 100.0 ml.	2,61	-0,07	3,39	61,7
3 ta gaskade	0,47	-0,59	3,52	110,8
4 to 6 pads	1,03	-0,15	1,07	117,6

II - CHAPTER. TACTICS OF REPRODUCTIVE AGE IN WOMEN WITH DISORDERS

Modern methods of surgical correction of vaginal wall misalignment.

Surgical treatment of genital insufficiency and prolapse plays a leading role. The local and foreign scientific literature describes more than 300 methods of treating prolapse of internal genitals through vaginal, abdominal, laparoscopic, or combined access. However, the problem of a miscarriage of the internal genitals has not lost its importance, as recurrences of the disease are more common, despite the increase in the surgical treatment of miscarriages of the pelvic organs.

According to foreign scientific literature, the recurrence of the disease in the form of vaginal insufficiency and collapse reaches 30-40% after vaginal hysterectomy, according to Russian authors, the incidence of vaginal fall after surgery is 0.2-43%. About 30% of surgeries are performed on recurrent prolapse.

Addressing this problem is especially important in patients of working age, so a surgical treatment that allows the rehabilitation of the vaginal wall and women with uterine prolapse is of not only medical but also social importance. In this regard, the issues of improving operational techniques in order to increase their efficiency remain relevant.

An analysis of the scientific literature shows that the selection of the most effective method of surgical application of genital prolapse in women of reproductive age poses a particular challenge.

The degree of internal genital fall when choosing an operative guide; anatomical and functional changes in the organs of the genital system (nature of satellite gynecological pathology); the ability to maintain or restore reproductive and menstrual functions; features of impaired colon function and rectal sphincter; the age of the patient; the level of risk of surgical intervention and anesthesiological guidance associated with extragenital pathology is taken into account.

If the internal genitals do not fall to the vaginal canal, conservative treatment is possible, including exercises to strengthen the pelvic floor muscles, if the functions of neighboring organs are not impaired. Pessaries and medical bandages are prescribed when there are contraindications for surgical treatment, and wearing them for a long time can lead to the appearance of bed

sores. The main method of treating more severe levels of internal genital herpes is surgery. According to many authors, there are not as many surgical methods in any other pathological disease as in the case of internal genital prolapse. There are more than a hundred ways to do this. In each of them, there are advantages and disadvantages that are manifested in the recurrence of the disease. Particularly frequent recurrence occurs during the first three years after surgical intervention, and according to some data, it is 30-33%.

All surgical methods of correction of internal genital prolapse are grouped according to a key feature: which anatomical structures are used and strengthened to correct the location of the internal genitals.

The first group includes operations to strengthen the pelvic floor - colpoperineolevatoroplasty. Given the constant pathogenetic involvement of pelvic floor muscles in this process, colpoperineolevatoroplasty should be used as a primary or secondary guide in all surgical interventions. This group may also include plastic surgeries on the anterior wall of the vagina to strengthen the bladder-vaginal fascia by the Bum method, or simple strengthening of the musculoskeletal plate by suturing the sacrum transversely to the bladder-vaginal fascia

The most commonly used methods are the Webster-Bandi-Darting method of shortening round lengths and fixing them to the anterior wall of the uterus, the posterior surface of the uterus; Shortening of round lengths through chow canals according to Alexender Adams; Uterine ventrosuspension according to Doleri-Gilliams; Uterine trophy on Koxer. However, these surgeries are not effective enough because they are followed by the highest rate of disease recurrence. This is due to the fact that as a fixation apparatus is used tissue that is not strong enough from the beginning of the uterus - has round lengths. Operations aimed at strengthening the fixation apparatus of the

uterus (cardinal, dorsal-uterine lengths), their joint suture, and transposition are widely used. However, these surgeries do not completely solve this problem, as they lose a single joint in the pathogenesis of the disease. One of the most effective of this group is Operation Manchester. Efficacy is achieved due to the multi-component, as the operation is performed amputation of the uterus, transposition of cardinal lengths, and plasticity of the anterior wall of the vagina. However, with the recurrence of this disease, which is not without the risk of surgery, patients lose their reproductive function.

Surgery with rigid fixation of the fallen limbs to the pelvic walls (pelvis, humerus, sacrospinal length) is recommended. However, after these operations, in addition to complications such as osteomyelitis, persistent pain, operative-pathological condition of the pelvic organs, which leads to serious consequences, occurs.

In prolapse of the internal genitals, operations to strengthen and fix the longitudinal apparatus of the uterus are also performed using alloplastic materials. However, they failed to reduce disease recurrence as a result of alloplastic rejection and lead to the formation of leaks.

Surgery for partial obliteration of the vagina: Lefort-Neugebauer's moderate colporrhaphy, vaginal interstitial (Labgardt surgery) is non-physiological, loses the possibility of sexual life, does not exclude recurrence of the disease.

A radical method of surgical treatment of genital prolapse is vaginal extirpation through the vagina, in which the fallen organ is completely lost. The method has many disadvantages: recurrence of the disease in the form of

enterocele; patients lose menstrual and childbearing function; the operation is severely traumatic; the architecture of the small bowel is disturbed; an increase in the dysfunction of neighboring organs is observed, in particular, in the form of injuries to the bladder.

All of the above operations are performed with access through the vaginal or abdominal walls.

In recent years, combined surgical treatment has been used in attempts to reduce the recurrence of the disease. These surgeries include pelvic floor strengthening, vaginal wall plastics, uterine fixation, uterine rupture, or vaginal dome strengthening. However, the elimination of functional disorders of neighboring organs, especially the urinary organs, is not always achieved. It should be noted that urinary incontinence is a pathological condition in itself, its elimination is a complex issue, and surgical treatment is imperfect and therefore requires the continuation of the search for more effective methods. There is no doubt that it is necessary and expedient to conduct operations in accordance with the principles of maintaining the inviolability of the member or part of it. In organ-sparing surgery, it is possible not only to restore relations with neighboring organs but also to ensure the normal functioning of organs and systems involved in the pathological process. Thus, the specific functions of the female body and neighboring organs - the bladder and intestines are restored.

Although there are many methods of surgical treatment for women with genital herpes and prolapse, research is being conducted on new methods that take into account the reproductive goals of patients of childbearing age.

Preoperative preparation of patients with pelvic organ prolapse

The outcome of a surgical operation depends not on the surgeon's technique but on the management of the preoperative preparation and the postoperative period. The main goal of preoperative preparation is to improve the outcome of surgical intervention and reduce postoperative complications. S.V.Petrov distinguished three main types of preoperative preparation: psychological, general somatic, and special. The need for special preoperative preparation depends on the specific characteristics of the organs undergoing surgery or the specific characteristics of the changes in organ function in the background of the underlying disease. In reconstructive plastic surgery, great attention is paid to the condition of the tissue at the site of the intended surgical intervention. Vaginal access is a traditional surgical method in urogynecology and proctogynecology. In this regard, the outcome of surgery is more difficult, depending on the condition of the bladder and rectal tissue.

A woman's age is an independent and proven factor in the risk of pelvic organ prolapse. The majority of patients with this pathology are elderly and elderly women. The combination of atrophic, involute, and inflammatory changes in vaginal tissue in patients requires preoperative preparation for this category of patients. Estrogen deficiency in postmenopause is a major cause of the development of atrophic processes in estrogen-dependent organs and tissues. In menopause, estrogen deficiency leads to the cessation of proliferative processes in the vagina and urethra, a decrease in the blood supply to the vaginal wall, and the flexibility of the vaginal walls, small pelvic lengths, and fascia. It also stops glycogen synthesis in the vaginal mucosa, which

increases the pH of the vagina, the elimination of lactobacilli vaginal biocenosis, and is replaced by conditionally pathogenic and cocci flora.

According to Baden-Walker, persistent mechanical injury of the pelvic organs in III-IV degree prolapse can lead to maceration and keratinization of the walls of the cervix and vagina in the prolapsed position, and even the formation of decubital ulcers. The usual localization of such lesions in the upper third of the cervix and the posterior wall of the vagina. Performing reconstructive plastic surgery during inflammation and atrophic changes increase the likelihood of developing postoperative complications and recurrence of prolapse. An effective means of treating involutional and atrophic changes in the vagina, urethra, and vulva is local replacement hormone therapy. The specific accumulation of estradiol in vaginal tissues in the postmenopausal period was determined by E. Bergnik, which made estradiol a prone drug for local hormone replacement therapy. The affinity of estriol with estrogen receptors is 10 times lower than that of estradiol, the period in the cell nucleus does not exceed 4 hours, which prevents estradiol from causing a complete orthotropic reaction along with endometrial proliferation. In this regard, topical use of estradiol at a dose of 0.5 mg does not require the appointment of progestogens, as well as has no absolute and relative contraindications. There are three different dosage forms of estradiol: vaginal suppositories and cream, and tablet forms. According to Baden-Walker, in patients with pelvic prolapse of III-IV degree, it is convenient to use vaginal tampons with estradiol cream once a day, for 14 days at night, twice a week. In this case, the vagina is located close to the physiological state, maturation

of the vaginal walls does not occur, and a uniform application of estradiol to all walls of the vagina is provided. In patients with pelvic organ prolapse, estradiol induces vaginal epithelial proliferation, increases glycogen synthesis, restores lactobacilli populations, improves blood circulation in the vaginal wall and urethra, and increases their flexibility. To accelerate the epithelialization of decubital wounds, retail oil containing vitamins A and E, as well as dexpanthenol preparations are applied to certain areas. The preoperative preparation process takes 2-3 weeks, taking into account the genomic mechanism of estradiol exposure.

Patients with pelvic organ prolapse, especially Baden-Walker grade III-IV, often have disorders of both upper and lower urinary tract urodynamics. The prolabyrus condition causes obstruction of the uterus, fallopian tubes, urethra, and pelvic portion of the urethra, leading to the development of ureterohydronephrotic transformation and chronic obstruction of urination. According to D.V.Kan, varying degrees of ureterohydronephrotic transformations were detected in 50–85% of patients with pelvic organ prolapse and chronic or acute urinary retention in 20% of patients. Due to the secondary nature of obstructive changes in the urinary system, they usually do not require treatment and disappear spontaneously as a result of the restoration of normal anatomical relationships in the small pelvis after surgical treatment of pelvic organ prolapse. The indication for upper urinary tract drainage in the preoperative period is renal failure only against the background of bilateral ureterohydronephrotic transformations. In this case, the kidneys can be drained with internal urethral stents. In Baden-Walker grade III-IV prolapse, it is

recommended to use uterine pessary or renal drainage with antireflux internal ureteral stents to prevent reflux in the urinary tract and to prevent pyelonephritis during upper urinary drainage.

Given that surgeries performed with vaginal access are conditionally clean, patients are indicated to undergo antibacterial prophylaxis before surgery. Pre-surgical results showed that in women with genital prolapse, the uterine canal and vagina were fertilized with conditionally pathogenic and pathogenic microorganisms; this poses a high risk of postoperative complications and requires appropriate preoperative preparation. When nonspecific vaginosis and vaginitis are detected, 2% Clindatsin cream 5g (single dose) is administered intravaginally once a day for 6 days and 2.0 g of metronidazole once a day to sanitize the vagina. In the case of specific vaginitis, treatment with antibiotics was performed depending on the results of the bacteriological examination. If necessary, after treatment, the vagina was additionally cleaned with 0.02% decamethoxine solution (decasan). The course of treatment is 7–14 days.

Methods of surgical treatment of women with genital prolapse

The choice of treatment for patients with female genital mutilation, determination of the volume of treatment and access to surgery, objective assessment of its effectiveness and postoperative rehabilitation we performed on the basis of anamnesis, clinical, laboratory, ultrasound and complex urodynamic examination methods.

We have introduced pelvic floor muscle insufficiency correction and compression of the genital fissure as one of the main or components, regardless

of the size and method of operations, aimed at eliminating complications of genital prolapse, including urinary incontinence.

The types of surgical procedures in the examined women are listed in Table 18.

18 - table

Types of surgical interventions in examined women n = 126

Types of surgical interventions	абс.	%
Minilaporatomy and voluntary surgical contraception + anterior colpopharynx in the second stage, posterior colpoprenography with levatoroplasty	46	36,5
Anterior colporrhaphy, levatoroplasty with posterior colpoperineurrophy, and ligation of uterine tubes by Pomeroy	46	36,5
Nikitin N.I. cervical amputation and ligation of the fallopian tubes on Pomeroy	34	27,0
total	126	100

Minilaporatomy and VSC in comparative group women. In the comparison group, 46 patients underwent ligation of the uterine tubes along the Pomeroy by minilaparotomy prior to surgical correction of pelvic organ misalignment.

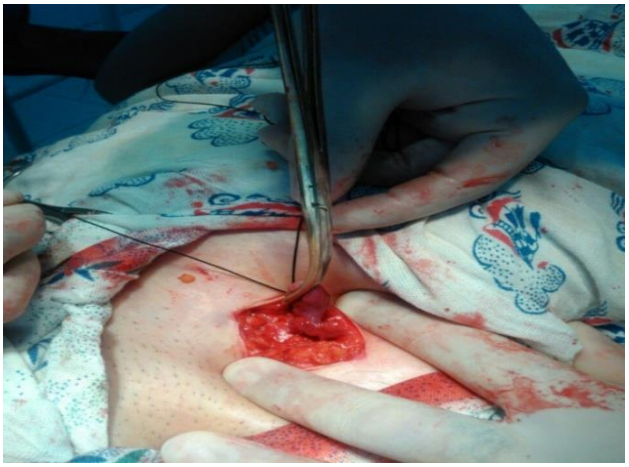
Techniques of minilaparotomy and voluntary surgical contraception

Minilaparotomy is the sterilization of the fallopian tubes at Pomeroy. The patient is given a Trendelenburg condition. The vagina is opened in the mirrors, treated 3 times with iodonate solution. The anterior lip of the cervix is fixed with axial clamps, a uterine riser is inserted into the uterine cavity, which is fixed to the inner surface of the thigh. A laparotomy is performed with a transverse 4 cm incision over the scalp. The stratum corneum is opened, and the wound is enlarged using Apelo retractors. The uterine lifter is moved and the uterine fundus and uterine portion of the fallopian tubes are removed.

Absorbent sutures (vicryl threads) in the absence of veins, 1-2 cm long tubes are connected in a loop, and the upper part of the loop is cut over the ligature (Fig. 10).

a

b



c

Figure 10 Minilaparotomy. a) opening of the anterior abdominal wall; b) holding the uterine tube on the right; c) Tie the uterine tubes along the pomeroy.

Control of hemostasis. The same process is done on the other side. The anterior wall of the abdomen is sutured in layers. A continuous (vicryl) suture is applied to the skin.

Duration of surgery 2 hours 24 minutes Blood loss - 350.0 ml.

The patient was discharged after 6 days in a satisfactory condition.

In women of childbearing age, VSC can be performed before the recovery of prolapse. VSC is an effective permanent contraceptive method.

In both groups, the management of the postoperative period was carried out according to standard techniques: a semi-liquid, easily digestible diet for 1-3 days; early activation; 800 ml. infusion therapy for 3 days. On the second day, local treatment was added with a hot solution of decane in the form of a 50 ml volume wash.

Levatoroplasty and sterilization by Pomeroy allow for the gradual strengthening of anterior colpopharynx, posterior colpoperineuria holding, supporting, fixing complexes: reduction of uterine round length, closure of the uterine-rectal cavity, strengthening of the uterine cervix, inability to urinate when necessary correction. In many postpartum women, her amputation and cardinal shortening were performed at cervical elongation and, if possible, plastic surgery was performed during the deformity. This operation was performed on 46 (65.0%) women in the main group, and in the remaining 34 (35.0%) - Nikitin N.I. cervical amputation and ligation of the fallopian tubes on Pomeroy were performed.

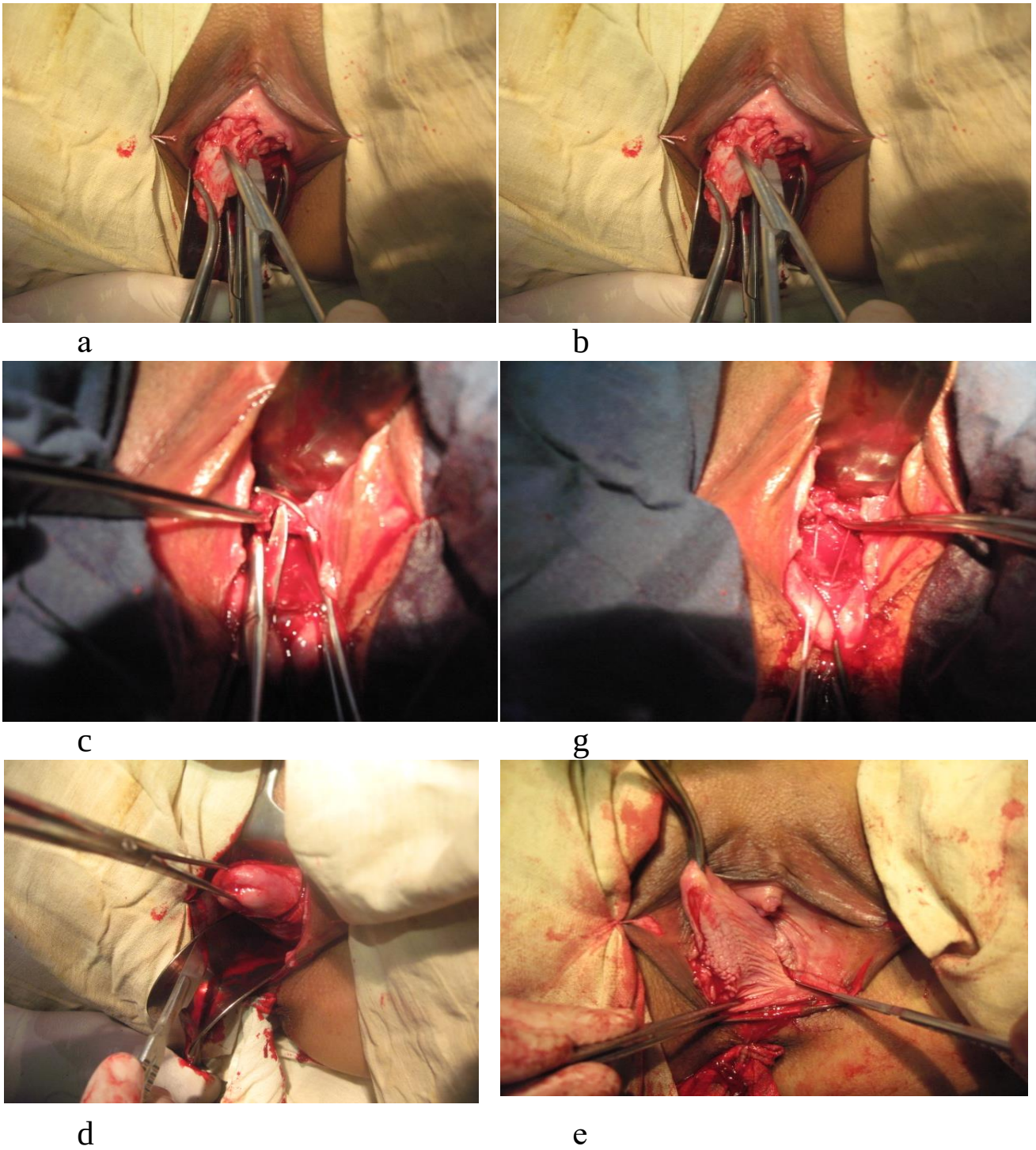
The surgery was performed under general or spinal anesthesia. Anesthesia was selected according to instructions and contraindications.

Surgical treatment of genital prolapse in women of reproductive age has become the preferred method, and posterior colpoperineurography is considered. Restoration of the pelvic floor was performed in all women at the expense of their own tissue. Vaginal access was used in all patients.

Intraoperatively, the maximum dose of third-generation cephalosporins (Claforan 1.0 v / i) was administered, and a continuous catheter was inserted into the bladder within 24 hours. The mean duration of the operation was 1.5 ± 0.5 h. The mean blood loss during surgery was 180.5 ± 50.6 ml. In the postoperative period, infusion-transfusion therapy, early activation, and washing of the vagina with a warm solution of decane were performed from the second day. In the postoperative period, we did not observe any complications. In the postoperative period, bed days averaged 5.8 ± 1.3 days.

The choice of surgical treatment method depended on the following factors: the degree of misalignment of the internal genitals; the presence and nature of co-occurring genital pathology; the possibility or necessity of maintaining childbearing and menstrual function; features of rectal sphincter dysfunction.46 (65.0%) patients underwent colpoperineolevatoroplasty (opening of the bladder-vaginal fascia and then suturing with duplication) to strengthen the bladder-vaginal fascia by the Bum method.

34 patients (35.0%) underwent cervical amputation, transposition of cardinal lengths, and plastic surgery of the anterior and posterior walls of the vagina in accordance with the method of N.I. Nikitin (85), which was used by us for the first time in Uzbekistan. Indications for such extensive surgery in women of reproductive age have been associated with cervical dysplasia (3), high-grade cervical elongation and scar deformity (17), and urological disorders (stress urinary incontinence) (Fig. 11).



a b c g d e

Figure 11 a) Opening of the bladder-vaginal fascia plica vesical uterus; b) Anterior colpotomy; c) Clamping the fallopian tube; g) incision of the fallopian tube; d) Nikitin N.I. cervical amputation by the method; e) Levatorography and posterior colporaphy

The cervix is fixed with axial clamps and lowered to the maximum; a triangular incision is made in the anterior wall of the vagina at a distance of 1 cm from the outer hole of the urinary tract. The incision ends in a circle behind the cervix at the border of healthy tissue

The mucous layer is separated from the cervix by a cuff. This method improves the quality of life in women of reproductive age when they have genital prolapse and provides them with the most effective and safe method of contraception.

The technique of the developed method. We have developed a method of performing surgical intervention and received an invention patent for this development "Method of surgical sterilization in women with genital prolapse due to incontinence" (APIAP 05076, 29.08.2015) (Figure 11).

In the next stage, cervical amputation is performed.

Phase I. The vagina opens in the mirrors, the cervix is held down with clamps and lowered. 1.5-2 cm from the external urethra. an incision is made from the midline of the anterior wall of the vagina to the fascia of the bladder, then an additional transverse incision is made at the border of the vaginal mucosa and in the anterior dome. We open the abdominal cavity sharply and transparently from the anterior side of the vagina, cutting the uterine tubes along the Pomeroi method, respectively, on the right and left sides.

Phase II. The vaginal wall is widely separated from the bladder at the top and sides, the connective tissue from the cervix to the bladder is cut, and the bladder rises above the sharp and impenetrable cervical incision. By burning 2-3 stitches

with vicryl threads, a fascia-muscle plate is formed. Thus, transposition of the bladder is achieved.

*Phase III.*To completely separate the cervix from the vaginal walls, a transverse incision is made in the anterior dome along the circumference of the cervix. The vaginal dome is impermeably separated from the cervix and the cardinal lengths are palpated..

Phase IV. Lengths are taken with clips, cut and sewn with vicryl threads and set aside. We amputate the cervix with a scapel

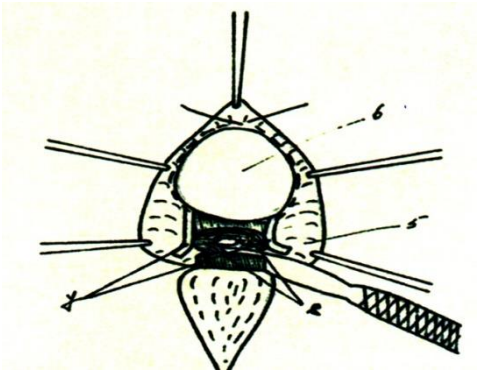
Phase V. The cut cardinal lengths are drawn to the midline and sewn together; then with additional stitches they are attached to the anterior wall of the cervix under the bottom of the bladder.

Phase VI. The excess portion of the vaginal wall is cut, and the vaginal mucosa is sutured to the cervical mucosa with continuous vicrylic sutures.

Then, colpoperineolevatoroplasty is performed.

The bladder separates from the anterior wall of the cervix, is moved behind the pelvis, and is inserted into the sac. The inner closing muscles are sutured together with vicryl. The cardinal ligaments are fixed and cut with a Koxer clamp, separated from the cervix as much as possible, sutured with vicryl, and directed to the sides. The cervix is amputated with a scalpel at the border of healthy tissue. The length of the cervical amputation depends on the degree of its elongation. The cervical tissue is cut at 3 and 9 o'clock ponasimon, the mucosal layer cuff incision is triangular in this projection. The cardinal longitudinal loops are lowered to the position formed by both sides and sewn with vicryl. The edges of the wound on the anterior wall of the vagina were

connected with continuous vicryl. A suture to the cervix with fixation of the cardinal ligaments at 3 and 9 hours allows the uterus to be raised as high as possible relative to the small pelvic plane. Plastic treatment of the remaining cervix is done with its mucous layer. The procedure involves attaching the cervical mucosa to the mucous membrane of the uterine canal so that the wound surface is covered with the cervical mucosa. The surgery ends with posterior colpoperineolevatoroplasty and interstitial suturing.



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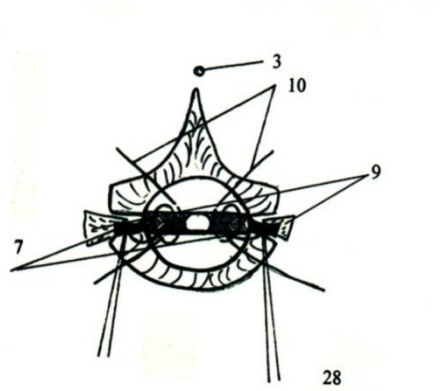

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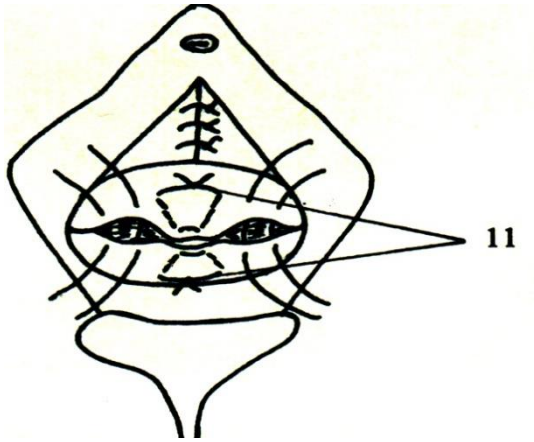

c

12 - picture. Nikitin's method: a) separation of the mucous cuff around the cervix, insertion of the bladder into the sac, cervical amputation (8); b) ponasimon resection of mucous cuff and cervical tissue in the dorsal direction from the external foramen at 3 and 9 o'clock; separation of cardiac lengths, suturing them with vicryl, suturing at 3 and 9 hours for fixation of cardial lengths (9); c) suture of the cervix.

In the method we proposed, the duration of the operation was reduced by an average of 26.8 minutes, which was 53.8% (P <0.001). The duration of hospitalization in the intensive care unit decreased by 12.1 hours (P <0.001), and the duration of anesthesia decreased by 23.9 hours (P <0.001) (Table 19).

19 - table

The main parameters of the surgical procedure in the examined patients were n = 126

Indicators	Comparative group (n=46)	Main group (n=80)	P
Duration of surgery, hours	64,3±2,3	37,5±1,1	<0,001
OSV duration, hours	2,6±0,4	1,6±0,3	<0,001
Duration of stay in the intensive care unit, hours	36,2±2,4	24,1±1,4	<0,001
Anesthesia	48,2±0,5	24,3±0,6	<0,001

Thus, the recommended method of surgical treatment of women with cervical elongation improves the regeneration and repair processes in surgical wounds by suturing the edges of the vaginal mucosa together in the postoperative period, the formation of a cosmetic cervix; prevents the formation of deforming scars. The cardinal ligaments are pulled into the formed ‘outer slit’ of the cervix, inserted into the groove at 3 and 9 o’clock in the cervix, and sutured. This allows the cervix to be raised as high as possible. The suturing of the internal sphincter muscles to each other prevents the risk of cystourethrocele and urological disorders.

CHAPTER III. EFFECTIVENESS OF TREATMENT OF SEXUAL DISORDERS AT THE SAME TIME WITH VSC

Contraceptive methods for women with abnormal genitals

Contraceptives for women who have undergone surgery for miscarriage at the reproductive age must meet the following requirements:

- no side effects;

- high efficiency and ease of use;

- not to affect sex and partner;

- not affect other members and systems.

The choice of the contraceptive method remains a difficult issue, which needs to be addressed with the individual obstetrician-gynecologist and the patient, often in conjunction with the partner, taking into account: the effectiveness, safety, contraceptive properties of contraceptives; risk of adverse reactions; the possibility of an unplanned pregnancy; restore the ability to plan future pregnancies. Genetic, reproductive factors, lifestyle characteristics, and somatic and gynecological pathology of each woman should be taken into account.

In women of late reproductive and premenopausal age, contraceptive issues often fall into the second category, which is completely wrong. A natural decline in fertility after age 40 does not mean that pregnancy is unlikely to occur, and pregnancy at this age is often unplanned and accompanied by a variety of dangerous events. In a regular periodic menstrual cycle, ovulation occurs before menopause. Although oligomenorrhea serves as indirect evidence of anovulation, it does not exclude spontaneous ovulation. However, this period is the period of the highest social activity for a woman who has accumulated professional and life experience that can be beneficial to the family and society. Ensuring a high level of quality of life in this period is one of the priorities of medicine. However, its implementation is complicated by physiological features that are accompanied by a gradual decline in ovarian function. The relative estrogen proliferation that is replaced by estrogen

deficiency leads to a variety of diseases that significantly affect a woman's health and quality of life.

The use of highly effective contraceptives in the surgical correction of genital prolapse is an important component of complex treatment, provides protection against unplanned pregnancy, childbirth, and abortion, prevents a number of gynecological diseases, and improves the quality of life. It is advisable to use two groups of contraceptives: long-acting and long-acting, which combine the 4 most effective contraceptives. One of them - intrauterine device (IV) and implants - is recommended for women (couples) who want to delay or restrict the birth of children; others - male and female sterilization - are for couples who are determined that they no longer want children. From 1994-to 1995, the World Health Organization developed a new approach to the classification of acceptance of different contraceptive methods. This has made it possible to improve the evidence-based framework for service and counseling in the field of rational use of contraceptives.

Criteria for acceptance of contraceptive methods are based on the results of many studies around the world. This allows for a qualified assessment of patients 'ability to use a specific method of contraception. It is natural that special care should be taken when prescribing contraceptives to older women of reproductive age. Unfortunately, the use of implants is not widespread in Uzbekistan, but hormonal contraceptives are widely used. The use of ethinylestradiol-containing hormonal contraceptives is limited to the risk of cardiovascular complications; obesity; arterial hypertension; risk of smoking; thrombosis and thromboembolic diseases complicated by angiopathy; diabetes mellitus; hypertriglyceridemia; diseases associated with impaired liver

function; untreated arterial hypertension cholestasis; breast cancer. Even in healthy women, with age, metabolic processes in the body change, insulin resistance increases, body weight increases, and the tendency to thrombus formation increases. Ethinylestradiol indirectly affects metabolism through the synthesis of proteins in the liver, i.e. reduces tissue insulin sensitivity, causes thrombophilic states, increases triglyceride levels, and activates the renin-angiotensin-aldosterone system. In healthy women of premenopausal age, there are no clinically adverse reactions to low-dose mixed oral contraceptives (LOCs). However, changes in metabolism with age gradually increase the risk of estrogen-related complications. From a safety point of view, the use of COCs in such patients is not advisable. In the premenopausal period, cycle management, prevention of hormone-dependent diseases, and contraceptive safety can be achieved using other contraceptives that are higher than COCs. Mixed means of contraception in premenopause have several advantages over other types of contraception, including ketogenic drugs. These include the positive effects of the estrogen component on the symptoms of estrogen deficiency. The prevalence of climacteric disorders, the association of estrogen deficiency with diseases that are the leading cause of death in older reproductive women, and the significant deterioration in the quality of life indicate the urgency of preventing menopausal disorders. This can be achieved using hormonal contraception.

The use of micro- and low-dose KOKs with generation III progestins, taking into account the age of the woman, allows to achieve maximum therapeutic and prophylactic effects, and increases the susceptibility of patients

to mixed oral contraceptives. However, it is important to remember to take the pills every day on a regular basis. KOK is often chosen by disciplined women.

Another effective general method of contraception is IVF. R.Kulier, F.M.Helmerhorst, R.A.O'Brien, M.Usher-Patel, C.D'Arcangues provided information on the effectiveness and side effects of ID in the structure of the carcass structural variety used in contraception. The study included the results of 34 examinations of 16 different HIV. MLCu375, MLCu250, TCu220, and TCu380A were more efficient than TCu200. Placing copper on the ID shoulder in the TCu380S did not increase its efficiency compared to the TCu380A. The efficacy of MLCu375 was not higher than that of TCu220 (after one year) and NovaT (after three years). No ID had a better performance than TCu380A in terms of bloody discharge, pain, or other reasons for discontinuation. Women who find it difficult to insert the TCu380A prefer the TCu380S. Multiload and NovaT carcass tools are preferred for women with a narrow uterine canal. But against the background of these means, contraceptive effectiveness is lost.

Sterilization of the fallopian tubes is a popular method of contraception in many developing countries. Peterson H.B. and others have given a systematic description of the methods of sterilization of the fallopian tubes, such as methods of access to the abdominal cavity, such as mini-laparotomy, laparoscopy, and fundoscopy. According to the authors, at least 100 million women could be sterilized in developing countries over the next 20 years. The choice of a surgical method for sterilization of the fallopian tubes is of great importance in evaluating the effectiveness of family planning programs. The

surgical method of intra-abdominal access is one of the key factors in the safety of tube sterilization. Other determinants are the anesthesia technique and the method of tying the tubes. The literature suggests that serious cases after mini-laparotomy or laparoscopy are a rare outcome, but studies included in the literature do not identify significant differences that may occur. Kuldoscopy differed in the number of serious complications compared to mini-laparotomy and the number of mild complications compared with laparoscopy. In many developing countries, mini-laparotomy is the most commonly used surgical method. The authors sought research using the Kokrainov collaboration strategy to identify regulated studies in all respects comparing minilaparotomy, laparoscopy, and colposcopy to sterilize tubes. However, only mini-laparotomy and laparoscopy were compared in the studies. Only one study was devoted to the comparison of mini-laparotomy with fundoscopy. In another study, all three methods were studied: mini-laparotomy, laparoscopy, and colposcopy. However, the low number of study subjects did not allow the assessment of a potentially significant difference between the risk of death and serious illness. The main indicators of the comparison of mini-laparotomy and laparoscopy are taken from a study conducted by the World Health Organization in the centers of seven developing countries. Further studies are needed to fully describe the surgical methods of sterilization of the fallopian tubes in the risk of death, and severe morbidity (Fig. 13).

Figure -13. Types of ID

Impact of surgical treatment of patients with vaginal wall prolapse VSC on quality of life in patients

Compared to the comparison group, the description of the quality of life in 126 patients prior to surgery, depending on the stage of development of genital prolapse, is presented in Table 21.

Studies have shown that the overall health status of all patients has deteriorated, regardless of the stage of development of genital prolapse in them. The intensity of pain reliably reduces the ability to engage in daily activities, as well as in home and out-of-home activities. However, the assessment of patients 'mental health, social activity, and the impact of emotional state on their performance were not inferior to that of women in the comparative group.

Women suffering from improper vaginal wall collapse, unlike women in the control group, noted a decrease in the ability to engage in physical activity,

worsening of their physical condition, and its negative impact on their lifestyle, mental state, and activities.

A slight deterioration in the quality of life was observed in women of reproductive age with cervical elongation. Compared to the control group, they did not report that their physical and mental condition affected their performance.

The preservation of role function in these women can be explained by reasons such as the fact that they are mainly rural residents, have incomplete secondary education, and do not feel specific excitement and anxiety in their mental (emotional) state. In addition, 68 (53.9%) female patients of reproductive age with cervical elongation were found to have no significant difference in the quality of life compared with the control group. Therefore, the quality of life of women with genital prolapse has deteriorated.

20 table

Assess the impact of genital prolapse level on quality of life before surgery (n = 126).

№	Indicators of quality of life	Control group N = 30	Women with cervical elongation and anterior rupture of the interstitium N = 44	Fall of the vaginal wall and scarring of the cervix, cystotsele N = 40	Women with a miscarriage of the vaginal wall N = 17	Vaginal wall collapse and cervical elongation, women with cystocele, N = 11	Women suffering from vaginal wall collapse and anterior rupture of the vagina N = 14
1	General state of health	68,1±3,9	43,12±4,2***	44,1±3,7***	42,13±4,22***	40,34±5,11***	40,51±4,78***
2	Physical activity	89,9±5,9	75,2±4,3	77,1±2,4	69,5±5,2**	76,43±3,9	74,12±5,11
3	Social activity	87,5±7,2	49,2±5,1***	45,4±4,1***	44,6±4,1***	48,4±6,3***	49,7±3,7***
4	Effects on pain intensity and activity	56,0±3,4	62,2±3,2	65,1±2,6	47,1±4,8*	49,5±5,6*	
5	Ability to live	79,2±4,4	60,2±3,1*	59,4±5,8*	55.1±5,3**	54,6±3,9**	55,5±7,1**
6	Self-assessment of mental health	88,2±5,4	56,7±5,5**	59,2±7,5**	55,5±3,1**	57,3±6,3**	57,2±4,6**
7	Influence of physical condition on role activity	68,7±3,2	79,9±5,1***	60,5±4,6	59,7±5,3	57,4±6,2	57,9±3,1
8	The role of emotional state in performance	84,2±5,7	79,5±6,2	77,3±3,1	46,8±6,7***	48,6±4,3***	74,2±4,6

Note: * r <0.05, ** r <0.01, * r <0.001 The Manna-Whitney criterion is basically relative to control.**

The quality of life indicators in 126 women in the main group one year after surgical treatment are presented in Table 21.

21- table

Clinical signs of urinary incontinence in women before and after surgery 126 (n,%)

0,04	Inability to urinate during stress (SI)	Before surgery	One year after surgery
Involuntary urination as a result of physical exertion	Permanent	20 (16,2%)	-
Accelerated urination (more than 8 times a day)	Very few	30 (24,4%)	-
Cases of urinary incontinence during attempts to urinate strongly	Not registered	9 (7,3%)	-
Inability to urinate during sex	Fast	10 (8,6%)	-
Deterioration of alcohol and spicy foods (obostrenie)	Not registered	2 (1,9%)	-
Night urination	Sometimes	29 (23,5%)	2(1,6%)
Inability to urinate while lying down	When there is a clear urinary incontinence	9 (7,3%)	-
Improper feeling of emptying of the bladder	no	38 (30,5%)	1(0,95%)

Assessment of sexual function before and one year after surgical treatment.

To study the effect of genital prolapse on sexual function, a questionnaire survey was conducted on 64 women who underwent ICU and continued to have sex before and after surgery (Table 22).

The results of the survey showed that one year after surgery, there were positive changes in the field of control and retention of urine during sexual intercourse; decreased number of women abstaining from sex due to genital

prolapse; a decrease in negative moods during sex was observed. The number of women who did not restrict sexual intercourse without fear of urinary incontinence or ejaculation increased; it was noted that there were no manifestations of adverse depression during sexual intercourse.

22 table

Description of the quality of sexual life of women with IGP before and one year after VSC with surgical treatment (p,%)

Evaluation criteria	Before surgery n = 64	A year latern=64	P1-2
	1	2	
The speed of the desire to have sex			
All the time	0	47 (73,5%)	
Usually	3(4,9%)	11 (16,6%)	<0,1
Sometimes	4 (5,6%)	16 (9,9%)	<0,1
Kam	7(10,5%)	-	
Never	128(79%)	-	
The rate of orgasm			
All the time	4(2,4%)	23(14,2%)	<0,1
Usually	27(16,7%)	29(17,9%)	<0,1
Sometimes	31(19,2%)	105(64,8%)	<0,1
Kam	44(27,2%)	4(2,4%)	<0,5
Never	56(34,5%)	1(0,62%)	<0,1
Being able to feel sexual satisfaction			
All the time	2(1,3%)	13(8%)	<0,1
Usually	8(4,9%)	36(22,2%)	<0,1
Sometimes	12(7,4%)	91(56,2%)	<0,1
Kam	127 (78,4%)	14(8,6%)	<0,1
Never	13(8%)	8(4,9%)	<0,1
The rate at which pain occurs during sex			
All the time	49(30,2%)	7(4,3%)	<0,1
Usually	28(17,3%)	6(3,8%)	<0,1
Sometimes	45(27,8%)	18(11,1%)	<0,1
Kam	37(22,8%)	60(37%)	<0,1
Never	3(1,9%)	71(43,8%)	<0,1
Controlling urination during sex			
All the time	81(50%)	103(63,6%)	<0,1

Usually	37(22,9%)	48(29,6%)	<0,1
Sometimes	16(9,9%)	11(6,8%)	<0,5
Kam	21(12,9)	-	
Never	7(4,3%)	-	
Restriction of sexual life due to inability to hold urine, gas and feces			
All the time	81(50%)	3(1,9%)	<0,1
Usually	37(22,9%)	11(6,8%)	<0,1
Sometimes	16(9,9%)	8(4,9%)	<0,1
Kam	28(17,2%)	112(69,1%)	<0,1
Never	-	28(17,3%)	
Avoiding sex because IGP			
All the time	87(53,7%)	11(6,8%)	<0,1
Usually	27(16,7%)	14(8,6%)	<0,1
Sometimes	14(8,6%)	5(3%)	<0,1
Kam	22(13,6%)	106(65,4%)	<0,1
Never	12(7,4%)	26(16%)	<0,1
Avoiding sexual intimacy for fear of involuntary pregnancy			
All the time	101(62,4%)	2(1,2%)	<0,1
Usually	32(19,8%)	-	
Sometimes	21(12,9%)	5(3,1%)	<0,1
Kam	6(3,7%)	72(44,5%)	<0,1
Never	2(1,2%)	83(51,2%)	<0,1
The rate of negative emotions during sexual intercourse (shame, fear, guilt)			
All the time	82(50,6%)	2(1,2%)	<0,1
Usually	44(27,2%)	6(3,8%)	<0,1
Sometimes	18(11,1%)	115(71%)	<0,1
Kam	11(6,8%)	37(22,8%)	<0,1
Never	7(4,3%)	2(1,2%)	<0,1

Assessment of urinary system function one year after surgical treatment.

One year after surgery, improvement of the urinary system as a result of complex surgical treatment was observed in 97.5% of women.

Of the 126 patients, only 5 complained of nocturia and a feeling of incomplete emptying of the bladder. Functional tests showed a negative PAD-test (no female pads were used); No urine output was observed when coughing during the Valsalva test. As a result of complex treatment after surgery, urinary function was significantly improved in 97.5% of women. Only 3 out of 126 women complained of nocturia and no feeling of complete emptying of the bladder. During the functional tests, a negative PAD test was detected in them (none of the patients used a female pad); No urine was observed when the patient coughed during the Valsava test. It was found that the quality of sexual life affects the mental state of women. One year after the operation, the women answered the question about controlling urine output during sex with complete confidence, but said they avoided sex as a result of urinary incontinence and fear of ejaculation. The situation with such vaginal discharge in women is explained by the fear of disrupting the effectiveness of surgical treatment.

Negative moods in women during sex were also significantly reduced. The increase in the number of orgasms that women feel is exacerbated by the sensation of sexual partners; noted that she was beginning to feel sexually satisfied. All these changes are explained by increased satisfaction with sexual

life, which in turn is explained by the elimination of genital prolapse and the positive impact of IBD on women's quality of life.

Evaluation of the clinical efficacy of surgical treatment of vaginal wall prolapse simultaneously with VSC.

In operative gynecology, the structure of postoperative complications is dominated by purulent-inflammatory lesions, reaching 7-40%, increasing the duration of recovery, the patient's hospital stay and the cost of treatment. In surgery, two main sources of postoperative purulent-inflammatory complications are distinguished - exogenous and endogenous (translocation of microorganisms from the vaginal microflora and the gastrointestinal tract cavity and the surface of the mucous membrane).

In our opinion, vaginal extirpation of the uterus has great advantages over abdominal and endoscopic entrances, especially when IGP and uterine benign tumors are combined, allowing not only to remove the pathological organ with less trauma, but also to completely correct prolapse at all levels of pelvic floor.

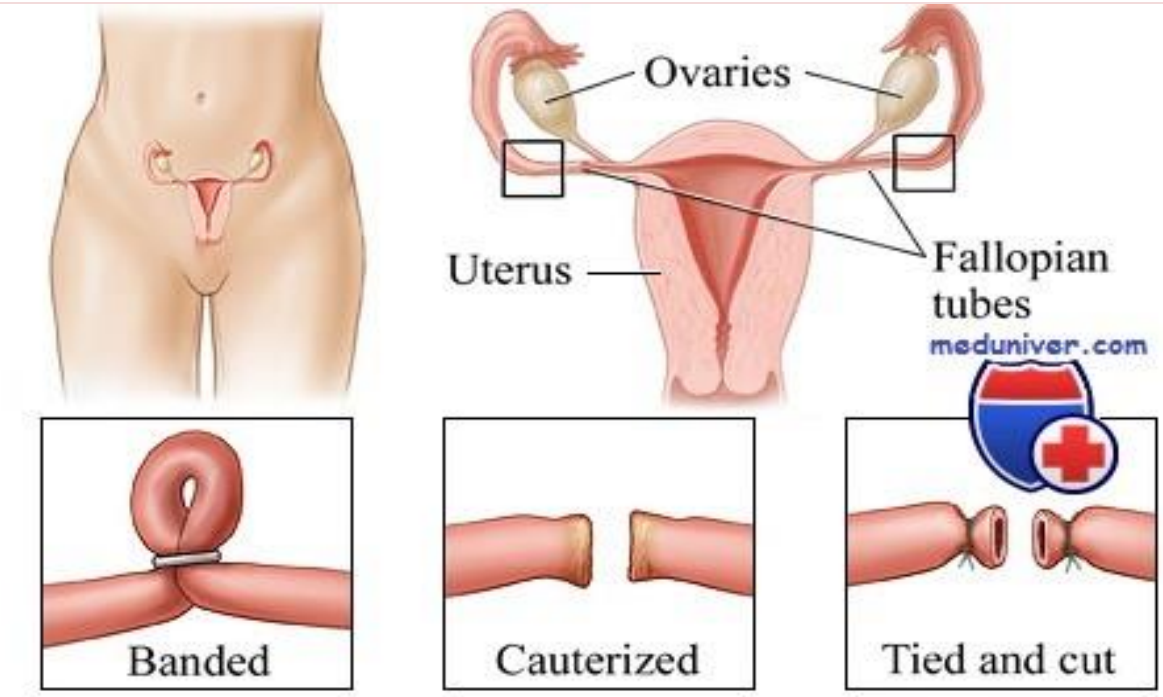

Figure -15 Tie the uterine tubes along the Pomeroy.

Urogenital disorders, pollakiuria, urinary incontinence were observed in 16 (34.8%) women from the comparative group, 48 (60.0%) patients from the main group, the feeling of incomplete bladder emptying in one third of both groups, urinary pain was all manifested in patients. Multiple symptoms have been observed in most women. In terms of anatomical and topographic features, we found the importance of correcting urinary incontinence in the choice of surgical intervention method, taking into account the proximity of the genitals and urinary tract. After 12 months, the control examination assessed the height and depth of the vagina, the condition of the scars, the tone of the vaginal muscles, the function of urinary excretion, the condition of the cervix. In the main group of patients with IGP, urine separation was monitored for comparative evaluation of long-term outcomes of surgical treatment, cervical

cervical volume was determined, and vaginal, genital fissure length, and vaginal height were measured. The results are shown in Table 23.

23 - table

Characteristics of evening outcomes of VSC and surgical treatment in the main group of patients with IGP n = 126

Indicators	Term	Comparative group (n = 46)	Main group (n = 80)
Urinary excretion rate	until treatment	> 8 марта	> 8 марта
	12 months after treatment	< 6	< 4
Total length of the vagina, cm	until treatment	4,2±0,3	3,8±0,2
	12 months after treatment	11,5±0,5***	12,2±0,5
Sex crack size (gh) - cm	until treatment	5,9±1,1	6,3±0,04
	12 months after treatment	3,8±0,8	3,9±0,01
The height of the gap (ph) -cm	until treatment	2,5±0,4	2,5±0,02
	12 months after treatment	4,3±0,5	4,5±0,04

According to the results of the study, after 12 months, moderate architecture of the vagina and vagina, cervix was found to be healthy in all patients. Colposcopic examination revealed no atypical changes in the epithelium, with only one in 80 patients with mild scarring of the cervix. Figure 14 shows the clinical efficacy criteria.

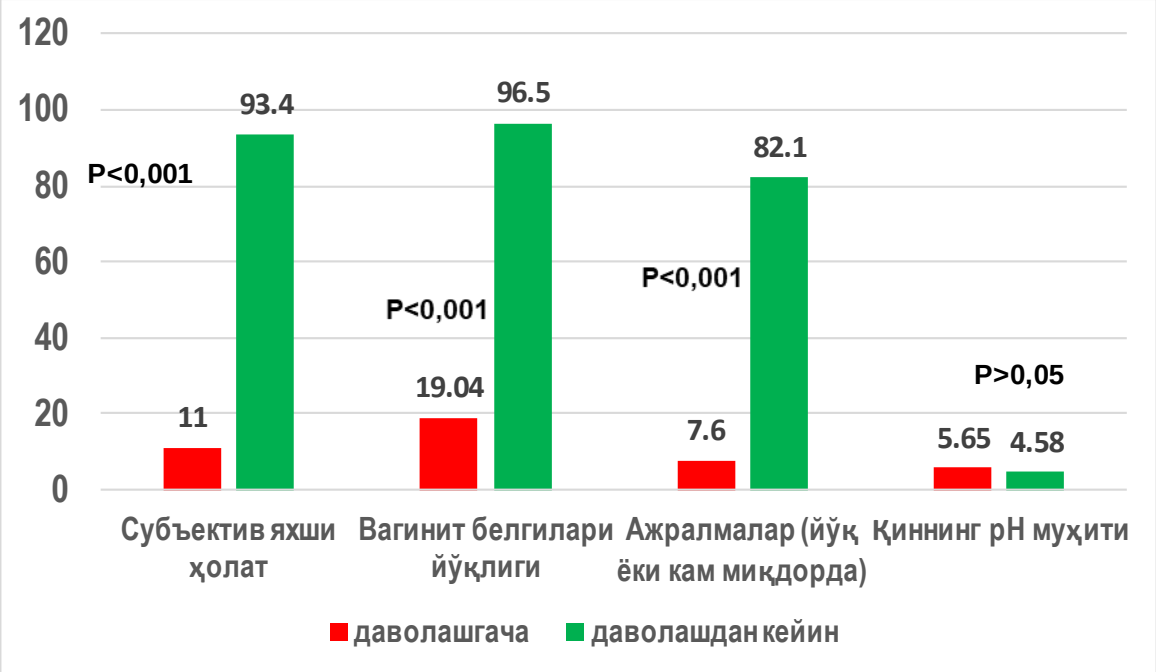

Figure 16 Dynamics of treatment effectiveness criteria.

(Субъектив яхши холат. Вагинит белгилари йуклиги. Ажралмалар йук ёки кам микдорда. Киннинг pH мухити. Даволашгача. Даволашдан кейин. Subjectively good condition. Absence of symptoms of vaginitis. Separations are load or in small quantities. Kinning rN environment. Until treatment. After treatment)

Thus, simultaneous VSC and reconstructive-plastic surgery for IG not only improves the clinical appearance, but also significantly increases the quality of life of women of reproductive age. Adverse outcomes of IG correction after one year, which resulted in recurrence of the I-grade vaginal wall that did not require surgical intervention, were observed in 2 patients.

In 3 (0.96%) women, unwanted pregnancies occurred after VSC performed with minilaparatom access. There were 7 unwanted pregnancies among women who did not have an IUD, which were terminated at the women's discretion up to 12 weeks.

24-table

The quality of life after surgery in women with genital malformations in the main group (M ± м)

Test indicators SF-36	Before surgery	1 year after surgery	P1-2
General state of health	43,7 ± 1,41	56,03 ± 1,78	<0,001
Physical activity	74,16±3,13	62,92± 2,89	0,002
Social activity	48,21±1,1	43,97±1,2	0,002
Effects on pain intensity and activity	64,01±2,59	79,03±2,3	<0,001
Ability to live	52,66±2,02	62,93±2,02	<0,001
Self-assessment of mental health	55,16±1,67	67,53±1,75	<0,001
The effect of physical condition on role performance	66,69±5,02	46,38±5,97	<0,001
The role of emotional state in performance	73,15±4,30	66,84±4,38	<0,001

Thus, surgical interventions combined with voluntary surgical contraception at the same time that we propose are the optimal method of treating women of reproductive age with genital prolapse and malignant prolapse, including cervical elongation. They help to maintain the specific functions of the female body and improve the quality of life of women.

DISCUSSION OF THE RESULTS

Prolapse of the internal genitals is a common gynecological pathology. Few studies have been conducted in Uzbekistan to study this pathology. According to DF Karimova, cervical elongation is the initial stage of prolapse of the internal genitals. This not only worsens a woman's quality of life but also creates conditions for the development of more severe forms of sexual prolapse.

According to the researchers, the disease occurs in 63.1% of cases among women of reproductive age. Of these, 10.1 percent are women under the age of 30; From 30 to 45 years - 40.2% (V.I. Krasnopolsky,). The “rejuvenation” of the disease is explained by an increase in the detection of patients in the early stages of prolapse development. Therefore, the importance of studying the prolapse of internal genitals, including elongation of the cervix, and early subclinical forms is growing.

Under our supervision, there were 126 women of reproductive age, mostly women aged 31-40 years (53.3%). Two patients (0.15%) were younger than 20 years of age. This is consistent with the literature data. Cervical elongation was detected in 54% of women, and incomplete reduction of the internal genitals was observed in 8.3%. The study showed that 58.5% of women had self-diagnosed genital prolapse. This may be due to patients coming to the doctor late. In only 41.5% of cases, prolapse of the internal genitals was detected at an early stage, 1-2 years after birth, before the appearance of clinical signs.

There are controversial issues that have not been adequately addressed in the multifaceted challenges of treating women with internal genital prolapse. These include contraceptive methods, which complicate the prevention of unwanted pregnancies in women with pelvic floor pathology. The hereditary factor is important in this regard. In our study, 55.9% of women who reported first- and second-line relatives found that heredity was a factor that aggravated all levels of internal genital fall, including the development of cervical elongation.

Many researchers recognize the negative role of strenuous physical activity in the formation of internal genital prolapse. However, according to our data, the first cause is another factor, not the cause of physical labor, but it only exacerbates the pathology. This is due to the fact that 22.9% of women who are not involved in physical activity have a miscarriage during labor. However, studies of the negative impact of constant strenuous physical labor on the development of genital prolapse have confirmed that the higher the physical load, the more pronounced the degree of internal genital prolapse.

In scientific sources, we did not find any data on whether the prolapse of the internal genitals depends on the place of residence of women (urban, rural), the volume of work they do in production, and daily activities. We found that working in the garden or backyard had a significant impact on the development of prolapse in rural women engaged in animal husbandry. In urban women who had a garden or yard and cared for pets, this type of activity also had a clear effect on the formation of internal genital prolapse. In our study, 67% of women participated in urban areas and 33% in rural areas.

Many authors believe that one of the main causes of sexual prolapse is childbirth and interstitial injury. L.R. Toktar points out that the development of pelvic floor defect and pelvic organ prolapse is associated with interstitial injury during childbirth. Patients examined by us were born through natural childbirth. 17.1 percent of women had three or more births. Nearly 27 percent of women had an anamnesis episiotomy, and 6.7 percent had a birth injury with a suture opening. The weight of the newborn is also important in the pathogenesis of sexual prolapse. In our study, 29.2 percent of infants weighed

more than 4,000 grams. Of the 126 women examined (63.5%) had a history of 1 to 4 medical and involuntary abortions, and 16.1 percent had more than three abortions. Our data on the important role of childbirth and abortion in the development of internal genital prolapse are consistent with the views of other authors. Cervical erosion, a separate diagnostic abrasion (CFT) in disorders of the menstrual cycle, and uterine revision after miscarriage significantly affect the development of pathology. These treatments are performed by pulling and lowering the cervix, which does not exclude the expansion and injury of weak structures such as the urogenital diaphragm, the cervix, and the rectal-vaginal fascia. In such cases, injury is practically inevitable, resulting in the subsequent development of internal genital prolapse and prolapse.

The scientific literature notes that women with various extragenital pathologies have a significantly higher risk of developing internal genital prolapse. We found that 95.6% of women with internal genital prolapse had somatic, mostly, chronic pathology. On average, one patient examined accounted for 2.8 percent of chronic illnesses. Anemia (53%), urinary tract diseases, respiratory and gastrointestinal diseases, and obesity predominated.

In our study, the incidence of respiratory diseases (2.9%) did not increase in patients with internal genital prolapse. These data differ from the conclusions of a number of authors who emphasize the frequency of these diseases. Referring to a study by M.V. Kairaluoma, M. Broens-Oostveen noted that the prevalence of genital azo prolapse in the regions of central Finland is 2.5 cases per 100,000 population, with a high incidence of cardiovascular (48%) and psychoneurological (15%) diseases.

It is recognized that the secretory degranulation of phagocytes may be due to a mechanism of formation of cervical elongation, a violation of the structure of collagen fibers. Such a mechanism of elongation formation is confirmed by the results of histological examination. In patients with cervical elongation, inflammatory changes in the vaginal mucosa, and pseudo erosion, are often observed, which, according to a number of authors, can be considered an inflammatory process.

Various gynecological pathologies were detected in 94.9% of patients. Chronic inflammation of the uterus and uterine lining 45.7%; vaginitis and vaginosis disease 80.96%; uterine fibroids - 2.2%, endometriosis - 1.9%, ovarian cysts - 2.9%. On average, 1 woman had 1.1 cases of gynecological disease.

According to scientific sources, the hereditary structural defect of connective tissue leads to a decrease in cross-linking in the collagen molecule and an increase in its sensitivity to the negative effects of the external environment due to a violation of its stability. Many extragenital and gynecological pathologies caused by hormonal and humoral shifts in women are a favorable factor in the development of prolapse and prolapse of the internal genitals.

Surgery is currently the leading treatment for internal genital prolapse. The number of surgeries proposed for the correction of this pathology is currently several hundred. This is due to the insufficient level of effectiveness of existing surgeries: the recurrence rate of the disease after them ranges from 16.0% to 33.3%. New methods using various prostheses are being developed

and implemented to improve surgical treatment. But more often, as always, vaginal extirpation of the uterus, colporrhaphy, levatoroplasty, and Lefor-Neiggebauer surgeries are performed.

In our study, anterior, and posterior colporrhaphy (62.9%), along with levatoroplasty, was dominated by cervical amputation (21.3%) according to N.I. Nikitin. Frequent recurrences after various amounts of surgical intervention were observed only in the first year after surgery. In our study, we did not observe a recurrence of the disease during this period.

One of the priorities of modern health care is to improve the quality of life (HS) of people as a result of this treatment. The severity of the disease and its impact on quality of life determines its physical, social, and psychological well-being. Among the diseases that significantly worsen the quality of life of women, prolapse of the internal genitals occupies one of the first places. Given the "rejuvenation" trend, sexual prolapse is a personal, familial, and social problem that affects not only the medical but also the sexual and professional aspects of a patient's life.

Data on the quality of life of patients with internal genital prolapse in the scientific literature are inaccurate, as such studies are few and the use of special questionnaires is limited. The negative significance of the surveys lies in the fact that a number of patients have some questions about the sexual side of their lives, which is unacceptable, especially for the older age group.

Some scientific sources have shown that patients 'dissatisfaction with the quality of life may be manifested by psychosomatic, somatic, and neurological pathology. Although there are various methods for surgical correction of

genital prolapse and other disorders of pelvic organ function, the patient still suffers from a decrease in quality of life after prompt treatment.

To study the quality of life, we used the SF-36 survey, which covers all areas of it, and the PISQ survey, which allows us to assess the state of sexual life.

In all patients with internal genital hernias, regardless of severity, a low self-assessment of women's overall health prior to surgical treatment was found. Women's own the level of quality of life assessment depended on the severity of the pathology. The quality of life of patients with complete propagation of the internal genitals is characterized by a decrease in most indicators associated with age control; assessing one's mental health, excluding the impact of social activity and emotional state on role-playing activities.

Patients with cervical elongation had the best quality of life indicators. Perhaps this is because patients are generally younger. In women with a miscarriage under the age of 45, the indicators of general health, emotional state impact on life activities, social activity, and viability index differed from the control group.

Other quality of life indicators of elongated patients did not differ significantly from those of the control group. Compared with the control group, the quality of life characteristics of patients with incomplete and complete prolapse of the internal genitalia decreased significantly more than that of the elongated patients.

In our study, only women of reproductive age were examined. But researchers such as Mant, Nguen, and Pasculin have pointed out that one of the main factors that reduce the quality of life of patients is human age.

The feeling of psychological discomfort plays a major role in the decline in quality of life with age.

A comparative analysis of quality of life indicators of patients with genital prolapse before and 1 year after surgical treatment showed that women's levels of psychological comfort and viability increased 1 year after surgery; the manifestation of pain perception and its impact on daily activities decreased; the assessment of his general health increases. The decline in quality of life indicators that characterize the physical condition of some women is probably related to the limitations associated with maintaining the outcome of surgical procedures. When comparing different methods of contraception used by women after surgery, the quality of life in the group undergoing voluntary surgical contraception compared to the control group is characterized by an increase in physical activity, and a decrease in the dependence of role activity on physical and emotional state.

Evaluation of preoperative and postoperative quality of life indicators in women with genital prolapse, depending on the type of surgical treatment, showed that colpoperineolevatoroplasty has a positive effect on overall and mental health. In addition to surgical treatment of uterine prolapse, transplantation of uterine tubes with transvaginal ligation significantly increased almost all indicators of quality of life and had a positive effect on the emotional state in life activities.

Kulakov V.I. et al. (2000), and Makarov O.V. (2001) have shown that sexually transmitted diseases, depression, often occur after internal genital prolapse and prolapse, as well as after vaginal hysterectomy. In some studies by foreign authors, it has been reported that women who underwent uterine extirpation experienced anger; their emotional state and overall health are lower than those of healthy women. Only women of childbearing age with no clinical signs of complete uterine prolapse participated in our study, and we did not perform a hysterectomy.

No significant changes in SUH were observed in women who underwent cervical amputation and uterine domes, but a slight decrease in physical activity was observed. Presumably, this is due to self-limitation in the recommended physical functions upon discharge from the hospital. However, their emotional state has improved, and their mental health assessment indicators have increased. We learned after 1 year that changes in quality of life indicators depend on the volume of surgery performed. Significant improvements in quality of life were observed in almost all indicators after colpoperineolevatoroplasty and cervical amputation and dome transplantation. Thus, the reduction of internal genitals increases the self-assessment of emotional position and ability to live after any method of surgical treatment.

It has not been established that women's quality of life depends on where they live before and after surgery. In our study, many patients with internal genital warts did not have sex, did not pay attention to it, and were ashamed to discuss this topic due to their upbringing characteristics. During the study, the majority of patients were married (69.2%) and 30.8% did not have sex due to

widowhood or husband's illness. It could not but affect the quality of life indicators and emotional state.

Sexual preference should be recognized in 73.5% of women as a positive outcome of surgical treatment of genital prolapse. Women who use the method of regular contraception have noted satisfaction with sexual life, an increase in the frequency of orgasms, and an increase in arousal with a sexual partner.

After surgery, most women responded that they had reliable control of urination during sex. But some have tried to limit sex for fear of "disrupting the effectiveness of surgical procedures".

Our studies have shown that the elimination of prolapse is not convincingly important for the resumption of sexual life in women who have not had sexual intercourse even before surgical treatment. Women of reproductive age reported that although the fear of "disrupting the effectiveness of surgical procedures" lasted for several months, the cause of discomfort during sex was lost. There is a tendency to improve quality of life as a result of sexual satisfaction, which has a positive effect on overall health indicators after surgical treatment of prolapse in combination with voluntary surgical contraception.

Our study demonstrated for the first time the importance of studying the quality of life in women with genital warts, the method of continuous contraception without additional surgical intervention, and the effects of the associated physical and emotional injuries. The use of questionnaires to study the quality of life of women before and after surgical treatment is an important tool of evidence-based medicine, allowing the evaluation of different methods

of surgery in modern gynecology. Our study, based on the quality of life surveys, provided a scientific basis for the positive impact of surgical treatment of pelvic organ prolapse in combination with voluntary surgical contraception on all aspects of patients 'lives.

The most important factor in maintaining the health of women who have undergone surgery for genital prolapse is to address the problem of unwanted pregnancy. In this regard, the use of contraceptives is one of the most important areas of rehabilitation of women with sexual prolapse. Despite the serious attention of clinicians to the problem of contraception, the use of modern contraceptives after surgical correction of genital prolapse is rarely studied or debated. Recent studies have shown the possibility of successful use of various contraceptive methods, but their effectiveness and acceptability for women with sexual prolapse have not been sufficiently studied.

For women of reproductive age with genital miscarriage, the proposed voluntary surgical contraceptive method involves transvaginal access to the uterine tubes during surgery for pelvic organ prolapse. To reduce abdominal infection, we suggested lowering the fallopian tubes using the Ramatibodi tubular loop. For comparison, the effects of voluntary surgical contraception with mini-laparotomy were studied in 30 women in the first phase of surgical intervention. The comparable key features of the selected groups are similar and identical ($r > 0.05$). Clinical signs were assessed before and one year after surgical treatment and voluntary surgical contraception. In voluntary surgical contraception, we studied the duration of surgery, the postoperative period, complications, blood loss, and unwanted pregnancies in the late stages to

determine the best access route to the uterine tubes. During the postoperative period, the patient's condition was assessed according to the following criteria: pain syndrome, temperature reaction, condition of the stitches, leukocyte reaction in the general blood test; the presence of vaginal discharge, and restoration of urinary ability. In the comparison group, the intensity of pain syndrome in the postoperative period was maintained for 3 days and was significantly higher than in the main group. This was due to bilateral surgical injuries to the lower abdomen (mini-laparotomy entry) and genital area. Subfebrile in the main group between 37.3 ° C and 37.1 ° C on the first day; in the comparison group, subfebrile temperature persisted for up to 5 days in the postoperative period ($r < 0.05$). The interstitial suture line was not significantly different in the 5–7 days postoperatively in both groups of women: sutures in 94% and 86.6% of patients ($r < 0.05$) dense, relatively painful on palpation, with a pinkish glossy surface and signs of epimerization. It is noteworthy that during the first 5 days after surgery, there was a significant difference in the interval suture in both groups, which was probably due to an increase in the duration of the operation. The average duration of the operation performed at two different inputs was 2.1 hours ± 0.5 hours; mean blood loss 195.8 ± 50.0 ml; In the correction of vaginal entry and subsequent prolapse, the duration of surgery was 1.5 ± 0.5 hours, and the mean blood loss was 180.5 ± 50.6 ml ($r < 0.01$).

Thus, surgical interventions combined with voluntary surgical contraception at the same time that we propose are the optimal method of treating women of reproductive age with genital prolapse and malignant

prolapse, including cervical elongation. They help to maintain the specific functions of the female body and improve the quality of life of women.

CONCLUSION

1. In women of reproductive age, factors that cause genital miscarriage are directly related to the outcome of neuroendocrine disorders, the period of perimenopause, high-frequency gynecological (64.22%), and additional diseases (94.5%). Risk factors for this disease include multiple pregnancies (82.57%), 2-3 or more births (91.74%), interstitial rupture during childbirth, episiotomy (55.96%), and hereditary predisposition (42.2%).
2. Simultaneous surgical restoration of urinary incontinence with genital misdiagnosis was used in 52.0% of patients, which allowed to effectively eliminate the underlying disease and dysuria syndrome.
3. The proposed surgical method for the treatment of women with cervical elongation allows to bring together the vaginal mucosa to improve the process of regeneration and repair, cosmetic cervical shaping prevents the formation of deforming scars ("Genital miscarriage Surgical sterilization method in women with ", the patent for the invention №IAP 05076, 29.08.2015.).
4. Surgical recovery of genital misdiagnosis after surgery and long-term results confirm the high effectiveness of the proposed method, reduce the risk of postoperative wound infiltration and suture separation by 1.5 times, reduce the length of hospital stay by 1.45 days, long allowed to reduce the risk of recurrence of the disease by 1.6-2.8 times over a period of time.
5. Simultaneous surgical treatment of VSC with improper internal genital mutilation not only improves the clinical symptoms but also significantly improves the quality of life of women of reproductive age. Adverse effects of correction of internal genital miscarriage were observed in only 0.64% of patients after 1 year, and unwanted pregnancies did not occur in any of the women.

PRACTICAL RECOMMENDATIONS

1. Given the rapid development of the disease with the occurrence of severe forms, surgical correction of the pelvic floor should be performed in the early stages of disease development.
2. Treatment of women with abnormal genital warts, selection of the scope and surgical approach to surgical treatment, as well as an objective assessment of its effectiveness and postoperative rehabilitation based on anamnesis, clinical, laboratory, ultrasound and complex urodynamic examination methods need
3. Correction of pelvic floor muscle defects and forced narrowing of the genital fissure should be performed as the main or specific component, regardless of the scope of the operation and the route of entry, aimed at eliminating genital prolapse, including the complication of urinary incontinence.

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