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Modern Views About Genital Endometriosis

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Annotation: Genital endometriosis is one of the most common diseases in women. Epidemiological studies indicate. that in 90-99% of patients, endometriotic lesions are detected between the ages of 20 and 50 years, most often during the reproductive period. The review is devoted to modern ideas about genital endometriosis.

Key words: genital endometriosis, myometrium, gynecology, diagnosis.

Relevance. Endometriosis is a benign hormone-dependent disease that develops against the background of hormonal and immune imbalance in the presence of a genetic predisposition and is characterized by the appearance of tissue identical in structure and function to the endometrium outside the normal localization of the mucous membrane of the uterine body [1].
Genital endometriosis is one of the most common diseases in women. It ranks third in the structure of gynecological diseases after inflammatory diseases and uterine fibroids [1;6]. According to various authors, for example [1], from 12 to 50% of all diseases in women of reproductive age; according to [6] up to 10% of women, according to [1] from 6 to 44% of women suffering from infertility and undergoing laparoscopy and laparotomy. In the structure of persistent pelvic pain syndrome, endometriosis occupies 80%; among patients with infertility, endometriosis occurs in 30% [4]. Epidemiological studies indicate. that in 90-99% of patients, endometriotic lesions are detected between the ages of 20 and 50 years. and most often in the reproductive period, regardless of ethnicity and socio-economic conditions [7; 14]. Risk factors for the development of endometriosis are [1;15]: disturbances in the number and function of estrogen-sensitive, progesterone-sensitive receptors of myometrial cells, disturbance of the hormone-producing function of the ovaries; inflammatory processes of the internal genital organs; violation of pelvic thermodynamics; infertility due to anovulation; hereditary factor; late onset of menarche. According to modern ideas about the nature of endometriosis, it should be considered as a benign, genetically determined, dishormonal and immune-dependent disease. Most researchers believe that endometriosis is a disease with a chronic, relapsing course; therefore, a number of concepts of its occurrence continue to be discussed in the literature, but none of them is able to explain all aspects of its pathogenesis [2;6;9;12] : 1. The metaplastic concept focuses on metaplasia of the embryonic peritoneum or coelomic epithelium under the influence of chronic inflammation, hormonal and immunological imbalance, mechanical trauma and other influences. 2. Transport theory (implantation, transplantation) which was first proposed by J.A. Sampson in 1921. The theory considers the possibility of endometriosis developing from viable endometrial cells displaced into the thickness of the uterine wall or transferred retrograde, through the fallopian tubes, into the abdominal cavity during

menstruation. 3. The dysontogenic (embryonic) concept provides for the emergence of endometriosis from abnormally located embryonic rudiments, in particular the Müllerian duct. 4. Immunological theory - suggests that congenital and acquired immunity disorders may underlie the development of endometrioid disease. It has been established that endometriosis develops T-cell immunodeficiency and suppression of the function of T-suppressors. decreased NK cell function, activation of B lymphocytes, peritoneal macrophages, and delayed-type hypersensitivity reactions [3]. 5. Genetic theory - the relationship between HLA antigen and endometriosis has been established. Quantitative and structural changes in chromosomes were found in endometrial heterotopia cells; it is possible that the presence of one or more gene defects causes a predisposition to endometriosis. Endometriosis with genital localization of foci accounts for about 95% of all cases of the disease. Extragenital endometriosis occurs many times less often than genital endometriosis in approximately 5% of cases [1]. Histological classification of internal endometriosis [15]. 1. Glandular - occurs 16 times more often than stromal; 2. Stromal: a) adenomyosis - endometriosis, accompanied by hyperplasia and hypertrophy of the muscle fibers of the uterus; c) adenomyoma - unlike adenomyosis, this form of the disease is characterized by a clearer limitation of the nodes with the surrounding tissue, with the absence of clusters of glandular inclusions of the endometrial stroma around the clusters.

An important role in timely diagnosis and making a correct diagnosis has a purposefully collected anamnesis, knowledge of the main symptoms, the ability to identify their relationship with the menstrual cycle, generative function, correct interpretation of pain syndrome, identification and assessment of provoking factors in... Vaginal and rectovaginal examination are quite informative, examination of the cervix and vaginal walls in the speculum. Of the additional diagnostic research methods, the most commonly used are: ultrasound, colposcopy; hysteroscopy, laparoscopy, cervical biopsy, less often NMR and x-ray methods are used. General objective examination: body features, height, obesity, nature of hair growth, degree of anemia. The examination begins with examination of the external genitalia and vulva. Rarely, but still sometimes it is possible to detect a focus of endometriosis in the form of a bluish compaction in the area of the scar after perineotomy. It is clearly visible during menstruation. When examined in speculums on the vaginal part of the cervix, you can see endometrioid lesions ranging in size from 1-2 to 5-7 mm of red or dark purple color. During menstruation, the lesions enlarge and sometimes empty. In the posterior fornix, at the border with the cervix, you can see brown or dark blue foci of retrocervical endometriosis in the form of small tuberous formations. Bimanual examination - with adenomyosis, an enlarged uterus is palpated (70% of patients), especially in the anteroposterior size, often fixed in the posterior fornix, its shape can be spherical (diffuse version of adenomyosis) or tuberous (nodular version). At the same time, the size of the uterus changes cyclically: during menstruation it increases, and during the intermenstrual period it decreases, sometimes to its original size. A fine nodular roughness of the surface of the uterus and the pain of these nodules on palpation can be determined. An attempt to displace the uterus anteriorly causes sharp pain. Hormonal studies can reveal the dysfunction of the hypothalamic-pituitary-ovarian system inherent in endometriosis with the development of an imbalance of sex hormones. The concentrations of FSH, LH, estradiol, and progesterone are determined over time. Characteristics of endometriosis are: the absence of a peak in the levels of FSH and LH in the blood in the middle of the menstrual cycle; an increase in the concentration of estradiol in the blood in the second phase of the menstrual cycle. Ultrasonography. For a detailed assessment of structural changes in the endometrium and myometrium, ultrasound using transvaginal sensors is

used; The accuracy of diagnosing endometriosis exceeds 90-95%. The most informative ultrasound is in the second phase of the menstrual cycle (on the 23-25th day of the menstrual cycle). Signs of adenomyosis: Hysteroscopy - diagnostic value ranges from 30 to 92%. carried out if internal endometriosis of the uterine body is suspected no later than 5-7 days of the cycle. Endometrioid ducts are found in the form of dark red pinholes against the background of a pale pink tint of the cervical mucosa, from which blood flows (the "honeycomb" symptom). Diffuse form of adenomyosis: expansion of the uterine cavity and the appearance of folding and uneven contour of the surface of the basal layer of the endometrium. Nodular form of adenomyosis: enlargement and deformation of the uterine cavity due to local bulging, its affected walls, and the appearance of endometriotic "eyes" on them [13]. Hysterosalpingography. This method has not lost its importance in the diagnosis of adenomyis. Information content reaches up to 85% of cases. The study is carried out on the 5-7th day of the menstrual cycle with water-soluble contrast, so that the racing mucous membrane of the beginning of the proliferation stage does not interfere with the penetration of the contrast agent into the endometrioid lesions. Laparoscopy followed by biopsy. It is the most accurate instrumental method for diagnosing peritoneal endometriosis. The endoscopic picture is determined by the degree of spread of the pathological process, the duration of its existence and the characteristics of the macroscopic structure of the implants. The high resolution of optical technology makes it possible to examine foci of endometriosis in the early stages of development and carry out differentiated treatment with different types of energies depending on the form of the disease [6]. There are "typical" (classical) and mild (atypical) laparoscopic signs of the disease [2]: Typical signs: black, bluish-purple, dark red spots on the surface of the peritoneum; scar tissue surrounding endometrioid implants; white, opaque plaques surrounded by scar tissue; ovarian formations with a dense dark blue capsule with blue-purple fragments; adhesive process in the pelvis (between the posterior layers of the broad uterine uterus and the ovaries, the immobile part of the sigmoid colon and the posterior wall of the vagina). Atypical signs: areas of white opaque peritoneum; red "flame-like" spots; subovarian adhesions; yellow-brown spots on the surface of the peritoneum; circular defects of the peritoneum; petechial peritoneum; glandular neoplasms on the surface of the peritoneum; hypervascular zones. Signs of adenomyosis: "marbled" and pale serous lining of the uterus; uniform increase in the size of the uterus; sharp thickening of the anterior or posterior wall of the uterus (with focal and nodular forms); wall deformation due to adenomyosis; myometrial hyperplasia.

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