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# THE ROLE OF ENDOSCOPIC SURGERY IN THE TREATMENT OF PATIENTS WITH TUBULAR PREGNANCY

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**KEYWORDS:**
*: ectopic pregnancy, diagnosis, treatment endosurgical, treatment of traditional, indications, contraindications, complications The problem of choosing a method of treating ectopic pregnancy is due to the prevalence of disease and the introduction of modern medical Technologies in surgical practice.*

**ABSTRACT:**

*The article has a comparative assessment of the informativeness of the methods for diagnosing ectopic pregnancy, the results of treatment 133 patients with progressive tubular pregnancy, pipe abortion and a rupture of the fallopian tube when using laparoscopy (88 patients) and laparotomy (45 patients). Conditions for endosurgical intervention are determined. Illuminated errors and complications, reasons for the transition from laparoscopic access to the traditional. Paths of eliminating errors and complications are shown. The advantages of surgical laparoscopy before traditional intervention are shown. The role of the use of methotrexate for the prevention of trophoblane's persistence with organ-having laparoscopic interventions was estimated. Formulated testimony and contraindications for the organ-bearing approach in the treatment of patients. The need for presence in the team of duty doctors of a qualified surgeon, which owns endoscopic surgery methods.*

**INTRODUCTION.** The growth of ectopic pregnancy (EB) is associated with the epidemic of inflammatory-abuse of the genital organs, their long-term recurrent flow [7], with an increase in the number of patients undergoing reconstructive operations on The uterine pipes, with the expansion of the use of auxiliary reproductive technologies at

infertility [1, 6]. Currently, the main method of surgical treatment of patients with tubular pregnancy is traditional-through laparotomy. In patients who have undergone laparotomy and one-sided tubectomy about pipe pregnancy, in 50-75% of cases diagnose secondary infertility [3], in 42% - neuroendocrine disorders [4]. The rationale for the use of minimally invasive surgery in the treatment of patients with EB is the desire to minimize operational injury, to preserve the organs of the sexual system, increase the reproductive potential, reduce the material costs for surgical treatment and Postoperative medication therapy [5]. However, the approaches to the endos will not systematized with copy intervention at EB. Registration of negative interventions, as laparoscopic surgery is technically more complex in comparison with the traditional, can lead to the development of serious intra- and postoperative complications, and in some cases it is not an advocacy - The impossibility of reliable hemostasis. The study of the study was to assess the possibilities of an endosurgical approach in the treatment of patients with EB in urgent gynecological practice

The methods have been a prospective and retrospective study of 133 cases of surgical treatment of patients with EB in the emergency gynecological branch of the Navoi branch of the Republican Scientific Center for emergency medical care. The age of patients amounted to 28.5 + 5.7 years. Patients were divided into two groups. Laparoscopy for the purpose of diagnosing pathology was used by all 133 patients. The group I amounted to 88 (100%) patients undergoing surgical laparoscopy, II. 45 (100%) patients operated on by laparotomy after the installation of pipe pregnancy laparoscopically. The progressive tube pregnancy was detected in 37 (42.1 + 1.69%) of patients I group I and 15 (33.3 + 3.24%) II, pipe abortion. In 49 (55.7 + 1.7%) and 23 (51.1 + 3.36%), the tip of the pipe in 2 (2.3 + 1.19%) and 7 (15.6 + 2.83%), respectively. In a satisfactory condition in the hospital, 131 (98.5%) was received in the hospital, in a state of medium severity - 1 (0.75%), in severe - 1 (0.75%). Complaints, pathognomonic for EB (pain, bleeding from sex tract, delayed Menses), 44 (33.1%) patients were presented. Symptoms of intra-abdominal bleeding took place in 34 (25.6%) patients. 62 (46.6%) The patients did not have children, 10 (7.5%) of them consisted of dispensary accounting about infertility, in 34 (25.6%) -ded EB was the first pregnancy, in 14 (10.5%). second eb. Artificial or spontaneous interruption of pregnancy was noted 90 (67.7%) women.Of these, 16 special studies have confirmed chlamydia, ureamicoplasmosis, LUES. Operational interventions on the organs of the lower bonding cavity and small pelvis had 53 (39.8%) patients. 22 (16.5%) of them were operated on eb (only two operational intervention was carried out by laparoscopy). Operational interventions on the ovaries were 8 (6.0%). At one patient, the appendages were removed in

connection with the twist of the cyst. 1 (0.75%) The patient suffered a laparoscopic intervention over endometriosis. Cesarean section was transferred to 4 (3.0%) patients, appendectomy. 24 (18.0%). Two or more of the operations in history had 4.5% of patients. Irregular Menses and ovarian dysfunction noted 15 (11.3%) patients. The real pipe pregnancy in 8 (6.0%) of patients has occurred on the background of the Navy, in 1 (0.75%) -posle the stimulation of ovulation by clostilbyd, in 1 (0.75%) - after eco. Detection Pathology In addition to diagnostic laparoscopy when entering the hospital, a clinical and laboratory survey was used in patients, an express test for a qualitative determination of the content of the β-subunit of choriogonic gonadotropin (xg) in Urine (55 cases), study of the level of blood levels (11 cases), ultrasound study (ultrasound) of the small pelvis organs (117), cultocentsis (81), the scraping of the uterus (43). Cheerurgical The intervention by laparoscopy was performed using the equipment and set of tools of the company KARL STORZ, (Germany). In all cases, general intubation anesthesia was used against the background of Miorolaksanta. Statistical processing of results was carried out using the Microsoft Office XP Excel program with the definition of absolute, relative frequencies and x2, the styudent criterion (at $p < 0.05$ differences considered reliable).

Results and discussion

When entering the hospital, an EB suspicion was established in 81.8% of patients I group and 71.4% II. The rest of the Patients Eb "imitated" another pathology. The diagnosis of dysfunctional uterine bleeding was exhibited in 6.8% of the patients I group and 4.4% II, the acute inflammatory process of internal genital organs. 6.8% and 8.9%, spontaneous miscarriage. 4.5% and 11.1%, respectively. When using an express test for the presence of a β-subunit of XG in the urine, a positive result was observed in 72.9% (27) of patients I group and 72.2% (13). Ii, the level of β-subunit XG in the blood ranged from 75 to 8900 m / l. With the ultrasound of the small pelvis organs, features characteristic of EB (lack of a fetal egg in the uterine cavity in combination with the presence of a free liquid in a small pelvis and / or the formation of a non-uniform echostructure in the projection of the uterine appendages), They revealed in 79.5% (62) patients with group I and 69.2% (27). Ii.

The puncture of the abdominal cavity through the rear line of the vagina was positive in 41.5% (22) and 21.4% (6) patients, respectively. According to the histological examination, the sipids of the uterus, gravidar endometrium was found in 39.3% (11) patients I group and 60.0% (9) - II. Prior to operational intervention and establishing an accurate diagnosis of EB in patients who entered the hospital with the EB clinic, it took 0.04 + 0,01 days, with an erased clinic - 2.3 + 0.9 days ($P < 0.05$), Patients enrolled in the hospital with another

pathology - 4.3 + 1.8 days (P <0.05). The endoscopic pattern of pipe pregnancy was identical in both groups and was characterized by its progression by local The thickening of the blue-pink color of one of the departments of the uterine pipe, the absence or scant amount of blood behind the uterus. With pipe abortion in the abdominal cavity, liquid dark blood with clots were determined, on a large seal and intestinal loops. Small bunches or blood traces, the uterine tube in one of the departments are thickened, the blue blood, from its abdominal holes, the dark blood expired or hide a bunch. With a full pipe abortion, it was not always possible to detect a blank egg, since it impregnated with blood it is like a bunch. The rupture of the uterine pipe was accompanied by minor intraperous bleeding, sometimes with the formation of peritabar hematoma. At the same time, in the wall of the pipe, in the region of its pathological thickening, the hole of the irregular shape with uneven edges was determined. According to our observations, in 6 out of 9 cases, the mutinal pipe defect was not accompanied by abundant bleeding (less than 200 ml), since the germination of the pipe wall by the trophoblast occurred in the widn averse zone, or the clearance Thrombilled with elements of a fetal egg. The indirect signs of the pipe pregnancy were expanding the vascular network of wide bundle of the uterus, the mesentery of the pipe and the ovary on the affected side. With EB, there was an increase in the size of the uterus, as well as the sinusiness of her serous cover. The localization of the fetal egg in the ampular separation of the uterine tube took place in 66 (77.6%) patients with group I and in 28 (62.2%) - II, in the intircy. In 20 (23.5%) and 11 (24.4%), in interstitial. In 2 (2.3%) and 5 (11.1%), respectively. During diagnostic laparoscopy, pipe pregnancy was not diagnosed in 2 of the 133 patients. The pronounced sleeping process did not allow carefully to inspect the abodes of the small pelvis, however, the signs of intraper bleeding were clearly revealed. With laparotomy, the diagnosis of violated EB has been confirmed. In both groups, patients with a tip of the pipe were statistically different, while with progressive pipe pregnancy and pipe abortion did not differ.Spikes in the postoperative scar area from previous operations were 9 (20.0%) patients of group I and 7 (15.6%) - II, perightpatite in 8 (9.1%) and 3 (6.7%), ovarian cyst - at 18 (20.5%) and 7 (15.5%), the uterine mioma - in 3 (3.4%) and 2 (4.4%) patients, respectively. In 1 (2.2%), the patient of the group II was revealed by the ovarian cystom, in 1 (1.1%) - in the patient I group - the steam-gate cyst, in 1 (1.1%) - in the same group - the hemangioma of the liver. The ventured peritabar hematoma took place in 1 (2.2%) of patient II of the group. Vidid laparoscopic intervention in patients of the group I consisted in 69 (78.4%) cases in the removal of the fallopian tube, In 19 (21.6%) - in the removal of a fetal egg. Of the 19 organ-powered operations in 14 cases, Salpingotomy

produced, in 5. Removal of the fruit egg by extrusion or aspiration by the irrigation tube (Table 1). The release of the lumen of pipes from blood clots was achieved by retrograde hydrotubation at the final stage of the operation. For the prevention of the Persiustenation of Chorion, 2 patients in the bed of the fetal egg after it is removed under the control of the laparoscope, 25 mg of methotrexate was introduced, 6-50 mg of methotrexate intramuscularly. For the prevention of the adhesive process and optimization of the restoration of the uterine pipe function after the surgical stage is completed, the patients created the patients with a medicine ascite with a physiological solution (0.9% NaCl) with pentoxifyillin, Ovomin or Actovegin. In 13 (14.8%) patients were drainaged by the abdominal cavity. In group II, the reason for the transition to traditional laparotomy after diagnostic laparoscopy was in 8 (17.8%) cases - a pronounced adhesion process in the abdominal cavity and Small pelvis, in 4 (8.9%) - the arrangement of the fruit egg in the interstitial separation of the uterine pipe, in 1 (2.2%) - bleeding (hemoperitoneum> 2 liters), in 1 (2.2%). Large sizes of a fruit egg (in diameter about 10 cm with peritabar hematoma). In 1 (2.2%) case against the background of a pronounced adhesive process when an attempt to divide the battle between the appales and the intestines was injured by the wall of the small intestine. In another (2.2%) case, when trying to surgical intervention about the progressive tube pregnancy in the interstitial pipe, bleeding arose, which could not be stopped with an endoscopic way. In the remaining 29 (64.4%) cases, the cause of the transition to Laparotomy was the absence of a physician in the operating brigade, which owns the technique of minimally invasive gynecological operations. In 27 (60.0%), the patients were performed by the Nursing Larother Laparotomy, in 18 (40.0%) - downturn. All patients with group II are removed of the fallopian tube (Table 1)

The postoperative period in 87 (98.8%) of the patients I group I and 43 (95.6%) II passed without features. In 1 (1.1%) patient from the I group after endoscopic tubotomy and removal of the fetal egg for the 2nd day after the operation, the pelvioperitonite clinic was developed. Due to the suspicion of injury of internal organs, laparotomy was produced. In the audit of the abdominal organs, the serous effusion in the amount of 400 ml, the extended vessels of the pelvic peritoneum, hyperemia and the edema of the operated uterine pipe with the fibrin charter. The pipe was removed, lavage and drainage of the abdominal cavity. Antibacterial therapy is appointed taking into account the exacerbation of a hidden urogenital infection (combination of chlamydia and ureaplasmosis). One patient from the I group, which was performed by organo-grinding intervention without drug prevention of the Persistence of Trofoblast, was re-in the hospital after 3 weeks with the symptoms of intra-

abdominal bleeding and the presence volume formation in a small pelvis according to ultrasound data. Due to the presence of intra-painted bleeding, a laparotomy was made. With the audit of the abdominal organs, about 200 ml of dark blood and bunches in the straight-turn-and-darley pocket, in the area of the operated pipe - loose spikes, peritabar hematoma, pipe Thickened in the ottymatic section of up to 3.0-3.5 cm, the blue-blast color, with the presence of a defect of the wall of an irregular shape with a length of 2.0 cm and protruding in the lumen of chorion vials. Removal of pipe, lavage and drainage of the abdominal cavity. In group II, complications were observed in 2 cases in the form of a partial discrepancy between the postoperative seam and the impudent of the hematoma of a small pelvis. The material costs for patients in the postoperative period after laparoscopy amounted to 84.9 + 5.1 cu, after laparotomy - 128.9 + 6.8 cu ($p < 0,05$).

This fact led to significant difficulties in the differential diagnosis of EB with other pathological conditions and was the cause of a number of diagnostic errors (at a pre-hospital stage - 26.3% of cases, in the hospital - 21.8%). Doubtful cases of EB demanded additional diagnostic methods. Thus, the informativeness of the ultrasound was 76.1%, the determination of the XG in the urine. 72.7%, cute fees. 34.6%, histological examination of the scraping of the uterus. 46,5%. Laparoscopy turned out to be the most informative (98.5%) in the diagnosis of EB, made it possible to simultaneously carry out surgical treatment and correction of the concomitant pathology of the small pelvis (51.1% of cases). In the overwhelming majority of patients during a laparoscopic operation (78.4%), as well as at laparotomy (100%), radical intervention was performed. Removal of the uterine tube, while the objective situation allowed to perform organ-bearing operations at least in half cases. Only in each 5th case, with endosurgical treatment, organ-bearing intervention was performed (the removal of the fetal egg) using the local or systemic administration of methotrexate (42.1%) for the prevention of persistence Chorione. The reasons for the removal of the pipe with laparoscopy were: 1) pronounced anatomical changes in the fallopian tube (large defect, peritabar hematoma); 2) signs of concomitant inflammation in a small pelvis: muddy effusion, extended peritoneum vessels of a small pelvis, the suppuration of the affected pipe or peritabar hematoma; 3) a pronounced adhesion process; 4) bleeding with the inability to carry out adequate hemostasis; 5) the perfection of the patient in the preservation of the reproductive function; 6) the absence of the doctors of the experience of organ-bearing endoscopic operations during tubular pregnancy, as well as uncertainty in a favorable outcome. Errors made in the course of laparoscopy and led to waste, are associated with the underestimation of the situation and self-confidence of the

surgeon. Complications with endosurgical treatment were observed 2 times less frequently than with traditional. The use of methotrexate for the prevention of the Persistence of Chorione when removing the fetal egg allows to expand the indications to the preservation of the reproductive system

CONCLUSIONS

1. Evta clinical current EB, a significant percentage of diagnostic errors, high informativeness of laparoscopy in the diagnosis of EB, the possibility of simultaneous endosurgical intervention and the correction of the concomitant pathology of the small organs The pelvis causes the need to wider use of laparoscopy in the treatment of patients with EB.

2. The conditions for carrying out laparoscopic operations with EB is the stable state of the patient, the presence of endoscopic equipment, the presence of a qualified surgeon in the team, which owns the laparoscopy method. 3. Indications for laparoscopic organ-bearing operations for pipe pregnancy are: the interest of the patient in preserving the reproductive function, infertility, pregnancy in the only pipe, the inferiority of the second Pipes. Continations are: pronounced destructive changes in the fallopian tube, pregnancy in a previously operated pipe, continuing bleeding after salpingotomy, the localization of the fruit egg in the interstitial uterine Pipes, large sizes of a fruit egg (more than 6-8 sm with diameter), a pronounced adhesion process.

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