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ECTOPIC PREGNANCY: RESTORATION OF FERTILITY

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Abstract: The development of critical conditions in patients with ectopic pregnancy is directly related to defects in the provision of medical care: errors in the formulation, and subsequently in the formulation of the final clinical diagnosis, transportation, operating room deployment time, unpreparedness for high-quality infusion therapy, and insufficient qualifications of specialists.

Keywords. Ectopic pregnancy,hysteroscopy, trophoblast implantation, fallopian tubes.

Introduction. Ectopic pregnancy was first described in the 17th century, but the diagnosis was made only after the death of the patient. A case of intravital diagnosis of ectopic pregnancy was recorded in 1812. Until 1870, only 500 cases of ectopic pregnancy were described in the world literature, and the treatment methods used did not produce a positive result [15, 27]. At the beginning of the 19th century, survival rate from ectopic pregnancy remained very low: out of 30 operated patients, only five survived. The survival rate of patients without surgery was 1:3 [15]. In the last quarter of the 19th century, serious research into this problem began, including in Russia. Zmigrodsky V.I. described 500 cases of ectopic pregnancy over ten years - from 1876 to 1886. In 1882, Fenomenov N.N. wrote a work on the indications for transection during ectopic pregnancy. Supporters of surgical treatment of this pathology were Snegirev V.F. and his students, but in those days the mortality rate was still very high [27]. In the first half of the 20th century, deaths from ectopic pregnancy remained high - 200-400 per 10,000 patients [15]. Mortality from ectopic pregnancy remains high in the 21st century, occupying second place in the structure of maternal mortality in the world, third or fourth in industrialized countries of the world and 5th in the Russian Federation [2,3,23,24]. In 2012, the maternal mortality rate from ectopic pregnancy in Russia was 0.47, in 2013 – 0.21, in 2014 – 0.26 per 100,000 live births [28]. In the USA, maternal mortality from this disease is 4-6% and is the most common cause of death in the first trimester of pregnancy [19]. occupies 2nd

place in the structure of acute gynecological diseases and first among nosological forms accompanied by intra-abdominal bleeding [2, 20]. In the structure of abdominal operations on the genitals, ectopic pregnancy occupies from 8.8% to 55% in gynecological hospitals of various profiles [21]. Among urgent gynecological operations, surgical interventions for ectopic pregnancy occupy one of the first places and account for about 50% [2,25,26,27]. Previously, numerous approaches to the diagnosis and treatment of ectopic pregnancy were proposed, various algorithms were developed and systematized aimed at optimizing the management tactics of patients with suspected ectopic trophoblast activation [1,4,8,9,10,11,21,22]. However, the emergence of new data and technologies necessitates the revision and/or improvement of a number of well-known provisions. In particular, this applies to some extratubular forms of ectopic pregnancy, especially cervical pregnancy and pregnancy in the uterine scar after cesarean section, as well as interstitial tubal pregnancy, organ-sparing treatment of which has been associated with operative hysteroscopy in recent years [2,5,12,13,14,15,16,17]. For many years, ectopic pregnancy has been one of the important problems of obstetrics and gynecology. Despite the progress made in the diagnosis of this pathology, its frequency has a steady upward trend worldwide, reaching 1.3-2.6% among all pregnancies [2,3,6,7,18,20].In the structure of acute gynecological diseases, ectopic pregnancy consistently occupies the second place. Each case of ectopic pregnancy poses not only a danger to a woman's health, but is also fraught with adverse long-term consequences. In 36-80% of women, ectopic trophoblast implantation leads to the development of secondary infertility, and the frequency of repeated ectopic pregnancy reaches 20-30%. It should be noted that the mortality rate from ectopic pregnancy is relatively high, which is 5.8-8% among the causes of maternal mortality [2,3,6,9].The fallopian tubes are the dominant area of ectopic attachment of the fetal egg, accounting for 97-98% of all cases of ectopic pregnancies [2,3,6,9]. At the same time, the most common is the location of ectopic pregnancy in the ampullary part of the fallopian tube (70%).

Purpose. To justify rehabilitation measures after tubal pregnancy on the basis of morphofunctional changes in the hypophyseal-ovarian system and adrenal glands.

Material and methods. The study included patients with the most common expected tubal localization of the ovum. To carry out the main steps During the work, 233 records of inpatients with tubal bentime by random sampling method. The criteria for the formation of of the main groups was the severity of the condition at the time of admission to the hospital; nar, as well as the outcome of the disease. Group I included 184 patients with various pathogenetic variants of tubal pregnancy, those who have undergone surgical interventions (tubectomy and tubotomy) with a volume of blood loss not exceeding 500 ml. Group II was represented by 49 “almost dead” patients -“near miss” (according to WHO criteria) with massive blood loss (more than 1500 ml), resulting from a rupture of the fallopian tube. Patients of group I were divided into clinical subgroups: 1st subgroup (n=68) - women with progressive tubal pregnancy; 2-aya (n=56) - patients with interrupted pregnancy by tubal abortion; 3rd subgroup (n=60) - patients with rupture of the fallopian tube. **Result.** Retrospective analysis of medical records of patients I groups with different pathogenetic variants of tubal pregnancy confirmed the development of classical clinical symptoms in patients of all studied subgroups. Initial contact with the antenatal clinic when a wound appears. These signs of the disease were observed with a significantly higher frequency ($p<0.05$) in patients with a progressive form of tubal pregnancy - 1st subgroup (46 out of 68 - 67.65%), compared with the 2nd (27 out of 56 -48.21%) and 3 subgroups (21 out of 60 - 35.00%). They are significantly more often were hospitalized in the hospital in the direction of the LCD. In the 2nd and 3rd subgroups of patients (respectively 29 - 51.78% and 39 women - 65.00%) prewere transported to the hospital by ambulance, or did it on their own. national health, their late appearance for help, aggravating the development pathology. From the appearance of the first symptoms of the disease to seeking treatment medical care

in all subgroups took up to 7 days (on average) it is 5.81±0.93 days). Moreover, in cases of initial contact with women's consultation, referral and hospitalization to the hospital were carried out in within 24 hours. Paradoxically, in women with a broken tubal pregnancy (2nd and 3rd subgroups), despite more pronounced cliclinical symptoms compared to the progressive form of the disease vania, delayed hospitalization prevailed compared with the 1st subgroup. The most qualified and accurate when making a diagnosis there were antenatal clinic doctors. In their directions, "ectopic pregnancy" "menacity", as the only diagnosis was made in 68.18% of cases of patients to females of the 1st subgroup, 81.48% to the 2nd and 95.24% to patients of the 3rd subgroup. When transporting by ambulance, all patients with progressive tubal pregnancy, 31.25% - with tubal-type interruption abortion and 21.05% - with a ruptured tube along with the diagnosis of "suspicion of external intrauterine pregnancy", the conclusions appeared: "spontaneous abortion", "acute adnexitis", "dysfunctional uterine bleeding". When hospitalizing patients in a gynecological hospital, The common diagnosis of "ectopic pregnancy" was met with the greatest frequency in subgroups with tubal abortion and tubal rupture: 96.43% in the 2nd subgroup and 98.33% in the 3rd. In cases of progressive tubal pregnancy. This diagnosis was made in 79.41% of patients. The time period from hospitalization to surgery required used for examining patients, clarifying the diagnosis, preoperative training was significantly lower in the 2nd and 3rd subgroups with interrupted tubal pregnancy (42.14±9.27 and 32.41±11.36), compared with progressive form (258.32±24.12) ($p<0.01$). This was facilitated by the characteristics ternary clinical picture of hemoperitoneum, confirmed additionally using research methods, deterioration of the general condition of patients, as well as complaints pathogiomonic for this disease. Determining the duration of tubal pregnancy by the date of the last menstruation struation demonstrated significant differences in the compared subgroups groin. In the 2nd and 3rd (patients with an interrupted pregnancy) - it was noted prolongation of tubal pregnancy from 4 to 7 weeks, while development without

interruption did not exceed 28 days from the beginning of the cycle. **Conclusions.** The development of critical conditions in patients with ectopic pregnancy is directly related to defects in the provision of medical care: errors in the formulation, and subsequently in the formulation of the final clinical diagnosis, transportation, operating room deployment time, unpreparedness for high-quality infusion therapy, and insufficient qualifications of specialists.

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