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A NEW APPROACH TO THE PROBLEMS OF GENITAL PROLAPSE

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XULOSA

Ushbu maqolada 64 yoshli ayolda IV bosqichli genital prolaps va III darajadagi semizlik bilan bog‘liq klinik holat bayon etilgan. Yangi usul sifatida bachadonning aylana (yumaloq) va sakrouterin boylamlarini tikish orqali vaginal gisterektomiya taklif etilgan.

Kalit so‘zlar: *genital prolaps, bachadon.*

РЕЗЮМЕ

В данной статье представлен клинический случай 64-летней женщины с пролапсом гениталий IV степени и ожирением III степени. Предложен новый метод вагинальной гистерэктомии с прошиванием круглых и крестцово-маточных связок.

Ключевые слова: *пролапс гениталий, матка.*

Genital prolapse in women remains a pressing issue worldwide. The etiology and pathogenesis of the condition are still debated. The disease is associated with discomfort, impaired sexual and reproductive functions in women, and reduced quality of life. The condition is particularly severe in elderly women [1, 3].

Chronic conditions such as obesity, diabetes mellitus, rheumatoid diseases, digestive disorders, colon diseases, and other somatic illnesses exacerbate the severity of the condition. In many cases, surgery is the only appropriate treatment for genital prolapse in elderly patients. However, choosing the most suitable surgical technique is difficult, as it must both correct the prolapse and prevent long-term complications [2]. This requires the formation of a strong ligamentous apparatus in the pelvic cavity. Synthetic prostheses are often used in modern gynecology [5].

Clinical Case: Patient S.I., 64 years old, was admitted to the surgical gynecology department of Maternity Complex No. 6 in Tashkent. Her complaints included discomfort and pain in the perineum, a foreign body sensation in the genital area, and inability to have sexual intercourse. These symptoms had been bothering her for several years, but she had not consulted any doctor and had coped with the condition on her own.

Medical History:Satisfactory condition. Past illnesses: URTI, smallpox, and hepatitis A (in childhood). She has had hypertension for the past 8 years. No allergic or epidemiological history.

Gynecological History: Menarche at 14, married at 20. Six pregnancies, four deliveries, two abortions. All deliveries were physiological but reportedly complicated by soft tissue lacerations; two large babies were born (4600g and 4850g). She used barrier contraception for a long time. She has been menopausal for 18 years. Gynecological diseases include cervical erosion (DEC in 1997), colpitis, and bacterial vaginosis.

Gynecological Examination: External genitalia are normally developed. Stage IV complete genital prolapse was detected (Figure 1). The vagina is capacious. The hernial sac protrudes from the genital fissure (complete uterine prolapse). Both the bladder (cystocele) and rectal wall (rectocele) are bulging.

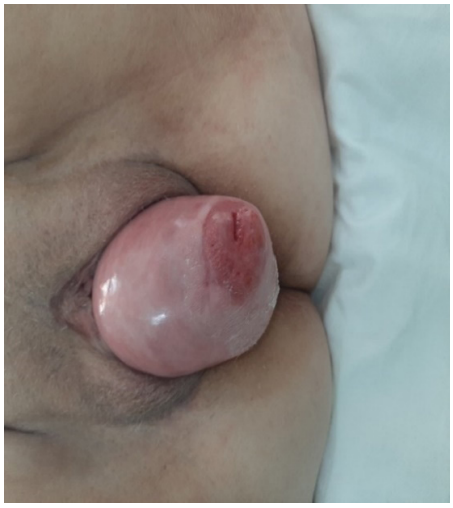

Fig. 1. Preoperative condition.

The uterus is small, corresponding to the patient’s age, mobile, non-tender on palpation, located in the thick of the hernial sac. The cervix is hypotrophic with erosive spots. The fornices are sagging. Mild discharge. The patient reports no issues with urination or pain. Bowel movements are irregular with a tendency toward constipation.

Initial Tests Conducted: Complete blood count, urinalysis, biochemical blood tests, coagulation profile, triple-site smear, abdominal and pelvic ultrasound, colposcopy, and ECG–all results were within normal limits.The patient was examined by a cardiologist and a physician. Diagnosis: complete genital prolapse,

complete uterine prolapse, NMTD, cystorectocele, grade III obesity, and hypertension. Surgical treatment was planned: Vaginal hysterectomy with pelvic muscle reinforcement using a polypropylene mesh.

Surgery: Under spinal anesthesia, following antiseptic treatment of the external genitalia, the vagina was opened using a speculum. The cervix was grasped with a tenaculum, and a radial incision in the shape of a "fish mouth" was made above the cervix. The bladder walls were dissected, and the anterior and posterior walls, cardinal, sacrouterine, and vascular bundles were ligated step-by-step on both sides (Figure 2).

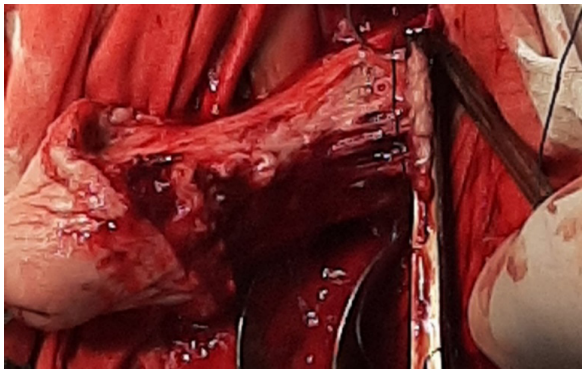

Fig. 2. Step-by-step ligation of the ligamentous apparatus.

At the cervical corners, the terminal ends of the tissues were transected and ligated. The uterus was excised from the posterior fornix. The adnexa on both sides were unremarkable. Next, the sacrouterine ligaments were sutured together using a polypropylene strip, and the proximal ends of the strip were firmly attached to the round uterine ligaments on both sides. A strong conglomerate was formed, reinforcing the pelvic cavity. Peritonization was performed using purse-string sutures.

A deep vaginal vault was created. A strong ligamentous support was formed. The likelihood of recurrent prolapse was eliminated. Following this, classic anterior and posterior colpoperineolevatoroplasty was performed. Total blood loss: 180.0 ml. Urine output via catheter: 200.0 ml, clear. Surgery duration: 75 minutes.

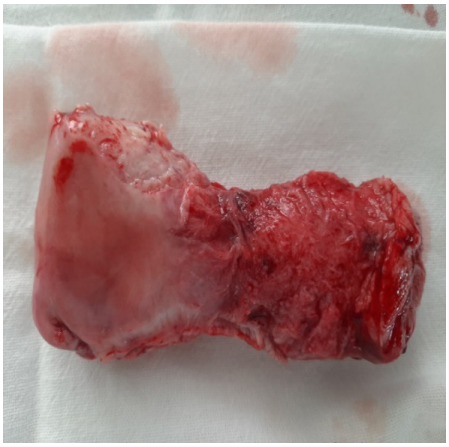

Fig. 3. Macroscopic specimen

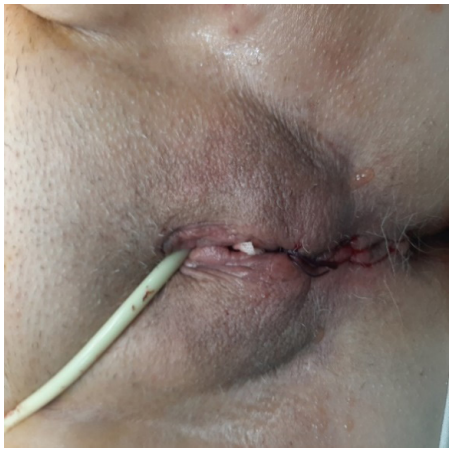

Fig. 4. Postoperative condition

Macroscopic specimen: The uterus was of normal size with an elliptical cervix. On sectioning, the endometrium appeared pale pink with no visible focal changes.

Postoperative recovery was satisfactory. The patient was discharged on day 4. After 40 days, she reported feeling excellent, and her quality of life had significantly improved.

CONCLUSION

This surgical technique of suturing the sacrouterine and round ligaments allows for the formation of a strong pelvic support, eliminating the risk of future prolapse recurrence. More research is required in this area of surgical gynecology.

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PREDICTING FETAL MACROSOMIA USING ANTENATAL DIAGNOSIS

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XULOSA

Ushbu maqolada homila makrosomiyasining antenatal tashhisini takomillashtirish masalalari ko‘rib chiqilgan. Homila vaznining yetarli aniqlikda baholanishi ona va bola salomatligini ta’minlash, shuningdek, tug‘ruqning optimal taktikasini belgilashda muhim omil hisoblanadi. Tadqiqotda klinik-antropometrik formulalar va ultratovush asosidagi fetometrik usullar taqqoslab tahlil qilingan, ularning aniqlik darajasi va qo‘llanish imkoniyatlari baholangan. Shuningdek, zamonaviy regressiya tenglamalari asosida tuzilgan prognozlash modellari muhokama qilinib, ularning amaliyotdagi samaradorligi ochib berilgan. Xulosa sifatida, homila massasini oldindan aniq baholash perinatal asoratlarning oldini olishda, tug‘ruqni individual yondashuv asosida tashkil etishda va sezaryen amaliyotining asosli qo‘llanishida muhim rol o‘ynashi ta’kidlanadi.

Kalit so`zlar: *homila makrosomiyasi, antenatal tashhis, homila massasini baholash, klinik-antropometrik formulalar, ultrasonografik fetometriya, tug‘ruq asoratlari, regressiya tenglamalari, Sezaryen ko‘rsatkichlari, ona va bola xavfsizligi, tug‘ruqni rejalashtirish.*

РЕЗЮМЕ

В данной статье рассматриваются вопросы совершенствования антенатальной диагностики фетальной макросомии. Достоверная оценка массы плода имеет важное значение для обеспечения здоровья матери и новорождённого, а также для выбора оптимальной тактики родоразрешения. Проведён сравнительный анализ клинико-антропометрических формул и ультразвуковых фетометрических методов с оценкой их точности и применимости в практике. Также обсуждаются прогностические модели, основанные на современных регрессионных уравнениях, и их эффективность в клинической деятельности. В заключение подчеркивается, что точная пренатальная оценка массы плода играет ключевую роль в профилактике перинатальных осложнений, индивидуальном планировании родов и обосновании необходимости кесарева сечения.

Ключевые слова: *макросомия плода, антенатальная диагностика, оценка массы плода, клинико-антропометрические формулы, ультразвуковая фетометрия, осложнения родов, регрессионные уравнения, показания к кесареву сечению, безопасность матери и плода, планирование родов.*

Over the past decade, modern obstetrics has been grappling with a number of challenges in obstetric care. Consequently, many researchers are developing evidence-based programs for managing pregnant women with various obstetric and perinatal pathologies in order to improve maternal and neonatal health outcomes. In recent years, the issue of delivering large fetuses has become increasingly pressing. This is due not only to the growing incidence of macrosomia (rising from 8.2 % to 16.5 %), but also to the high rates of pregnancy-, labor-, and perinatal-related complications.

Adverse outcomes associated with macrocosmic births occur 3.6 times more often, and the perinatal mortality rate is three times higher than in deliveries of average-weight fetuses. Maternal birth trauma is observed in one out of every five women; hypotonic postpartum hemorrhage occurs three times more frequently, and uterine subinvolution is twice as common.

Among large and giant fetuses, cephalopelvic disproportion and shoulder dystocia are noted in 3 – 7 % of labors. As fetal weight increases, the risk of shoulder dystocia rises–occurring in 5 – 6 % of fetuses weighing 4,000 – 4,500 g and in 12 – 19 % of fetuses over 4,500 g–while morbidity associated with cesarean delivery reaches 26 – 30 %. According to A. N. Strijakova (2000), performing cesarean section in cases of large fetuses halves the incidence of birth asphyxia, reduces the detection of neurological disorders in the early neonatal period by