

Some aspects of the diagnosis of genital endometriosis
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Making a correct diagnosis is one of the most important and most difficult tasks for a practitioner. Its implementation requires a comprehensive assessment of clinical, anamnestic, instrumental and additional research methods. This fully applies to diseases of the female genital area. In this paper, we would like to consider the diagnosis of genital endometriosis. The urgency of this disease is beyond doubt. Thus, at the last congress of obstetricians and gynecologists of the Republic of Belarus, the incidence of endometriosis has increased by 2.8 times over the past ten years [8]. There is also a consistent trend towards an increase in the incidence of genital endometriosis worldwide. According to the summary data of C. Wellbery, it occurs in 7–50% of women of childbearing age [18]. Based on materials by B.I. Zheleznov and A.N. Strizhakov, V.P. Baskakov et al.,

This disease remains one of the most common causes of disability and reproductive function in women. Among women suffering from infertility, endometriosis occurs in up to 40-50% of cases, with chronic pelvic pain - in 28-65% [15-17]. In the structure of gynecological diseases, it ranks third after inflammatory diseases and uterine fibroids.

The problem of endometriosis is becoming more and more urgent due to a number of reasons, one of which is the difficulty in its diagnosis, especially in the initial stages of the disease. Despite significant improvements in diagnostic methods, endometriosis is one of the most difficult diseases to diagnose. The clinical picture does not always correspond to the severity of the arising anatomical disorders [1, 11].

The complexity of the diagnosis of endometriosis and the unresolved issue of this problem is evidenced by the fact that, according to D. Barlow, in the UK the diagnosis of endometriosis is made on average 8 years after the onset of symptoms of the disease, and in the USA - on average after 11.7 years [14]. The same pattern is observed in Belarus. It is noted that the duration of the disease before the diagnosis is: up to 9 years - in 62% of patients, from 10 to 15 years - in 30%, more than 15 years - in 8% of patients [13].

Endometriosis refers to benign tumor-like formations. The essence of the disease consists in the proliferation of tissue, similar in structure and function to the endometrium, but located outside the boundaries of the normal location of the uterine mucosa.

Endometriosis is diagnosed in four main areas:

1. Detection of direct or indirect signs of the disease;
 2. Registration of ultrasound or radiological signs affected tissue, organ;
 3. Visual determination of lesions by laparoscopy;
 4. Morphological examination of biopsy material obtained during laparoscopy or laparotomy [11].
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It is easy to see that all diagnostic methods (bimanual study, hysteroscopy, hysterosalpingography, colposcopy, ultrasound, computer tomography, laparoscopy, etc.) are aimed primarily at structural establishment changes in tissues and organs caused by endometrioid process, at the macro or micro levels. These are epithelial (glandular) and stromal growths of various sizes and shapes, penetrating into surrounding tissues and organs and causing various disorders, such as: proliferative formations in the form of nodules or nodes, small cystic or cystic formations, the presence of reactive, and then chronic inflammatory processes and as a result of this degenerative changes in the form of an adhesive process, scars, and often signs complications (such as rupture of an ovarian cyst, infection, invasion into the intestine, ureter, etc.). It must be recognized that in the overwhelming majority of cases, these changes indicate a significant prescription and prevalence of the pathological process.

The main obstacle to the creation of methods for the early diagnosis of genital endometriosis is the long-term absence of specific symptoms in this disease, which initially do not differ from the signs of other pathologies of the reproductive system and small pelvis organs. As a result, improving the quality of diagnostics of endometriosis, especially the initial stages of the disease, by improving existing and developing new examination methods aimed at identifying structural changes in the affected tissues and organs, seems to us doubtful. Conducting diagnostic laparoscopy or computed tomography for all women with suspected endometriosis, as the most informative methods today, seems unrealistic due to the invasiveness of the first and the high cost of the second diagnostic tests. In addition, note that both hystero-graphy and hysteroscopy are invasive procedures [5, 9]. The disadvantages of computed tomography should also include its low throughput [4].

Assessing the current state of affairs in the diagnosis of endometriosis, leading experts make a disappointing conclusion: "The final diagnosis of endometriosis is very difficult, requires a comprehensive examination ... ie. involves the use of complex, well-established and expensive techniques and qualified specialists. All currently used markers of endometriosis are not highly specific ... "[7].

The methods of EPD (electropunctural diagnostics) according to R. Voll and ART (autonomic resonance test) are fundamentally different from the above diagnostic methods. The methods are based on the theoretical provisions of quantum, or information-wave medicine. Within the framework of the views of quantum medicine, there is an idea of the presence of an information (wave) frame of an organism, which is formed as a result of coherent interaction of radiation of cellular structures. All vibrations or vibrations of cells of internal organs in a state of health are coherent, i.e. the most consistent. Interacting with the substance of certain organs, coherent vibrations regulate the course of biochemical reactions, ensuring their normal functioning. In case of decline, by

For one reason or another, the coherence of signals generated by the organism itself, the normal course of biochemical reactions is disrupted, leading in turn to structural disorders, a pathological state of the organism arises, which is interpreted as a disease. From the above it follows that, and changes in the body at the information (wave) level occur earlier than at other levels of functioning of the living. These changes can be recorded by wave resonance methods, in particular, EPD. The resonance effect in the body of the investigated person upon presentation of a certain spectrum of frequencies from the outside, by means of diagnostic nosodes, occurs only if there is a similar spectrum of frequencies in the human body, which is manifested by a change in the ECS (electrocutaneous resistance) recorded by the device for EPD. This allows for the diagnosis and differential diagnosis of latent, erased, atypical forms of the disease, especially at the stage of pre-pathology, when there are no clinical signs of the disease. It is extremely important that the disease is detected regardless of the localization of the pathological focus,

Over the past year and a half, we examined 259 women of reproductive age. 120 (46.33%) of them had complaints: for uterine bleeding - 8 people (6.67%), spotting in the pre- and postmenstrual periods - "smearing" - in 35 (29.17%), abundant and prolonged periods - in 56 (46.67%), infertility - in 27 (22.5%), pain in the lower abdomen and lumbar region - in 77 (64.17%), pain with intimacy - in 14 patients (11, 67%).

According to generally accepted clinical examinations, he was diagnosed with uterine fibroids - in 56 women (46.66%), ovarian cysts - in 31 (25.83%), cervical cysts - in 13 (10.83%), endometriosis - in 14 (11.66%), adnexitis (acute and chronic forms) - in 77 (64.17%). (A number of patients had several diagnoses, therefore the total number of nosological forms exceeds the number of patients).

When diagnosed by the EPD method, the following pathology was determined: uterine fibroids - in 11 women (9.17%), ovarian cysts - in 51 (42.5%), cervical cysts uterus - in 15 (12.5%), endometriosis - in 59 (49.16%), adnexitis (acute and chronic forms) - in 39 (32.5%).

Noteworthy change quantity some nosological forms as a result of testing by the EPD method. So, the number women diagnosed with uterine fibroids decreased by 5.09 times, with adnexitis - by 1.97 times. At the same time, there is an increase in the number of diseases such as ovarian cysts - by 1.65 times, endometriosis - by 4.21 times.

This contradiction can be resolved if we consider the clinical manifestations of various forms of genital endometriosis. With adenomyosis, the main symptoms are an increase in the size of the uterus, determined by ultrasound and bimanual examinations, and abundant, long, painful periods, since internal endometriosis is often combined with glandular hyperplasia of the endometrium. With diagnostic curettage of the uterine cavity, such patients are often given a histological conclusion: glandular or glandular cystic hyperplasia of the endometrium. The main symptoms of uterine fibroids are an increase in the size of the uterus, bleeding (menorrhagia - cyclic bleeding, less often metrorrhagia -

acyclic bleeding). Heavy and prolonged menstruation is caused by an increase in the surface of the endometrium, i.e. its hyperplasia. Most often (80% of cases) there are multiple uterine fibroids with various sizes (from microscopic to the size of an adult's head and more) and the number (from 2-3 to 20 or more) nodes [12]. The similarity of clinical symptoms and data of objective examination methods for uterine myoma and adenomyosis has been noted by many authors. It is noted that as a result of this, the nodal form of endometriosis is difficult to distinguish from uterine fibroids, especially when it is localized in the submucosal layer [10]. Based on the foregoing and the data of our research, we assume that in most cases with proliferative lesions of the uterine body, such patients are diagnosed with "uterine fibroids".

With ovarian endometriosis, cystic cavities of various sizes are formed. Small endometriotic cavities may be located on the surface of the ovaries. Ovarian endometriosis is asymptomatic until a certain time, especially in I, and often II degree of lesion. Repeated hemorrhages in the cyst wall and microperforation cause the spread of the pathological process in the ovaries and beyond, and the peritoneum is involved in the process. This is accompanied by severe pain, reactive inflammation and the formation of extensive adhesions with surrounding organs and tissues. With a long course of endometriosis of the uterus and peritoneum is always accompanied by chronic

inflammatory process. Objective research data for ovarian endometriosis, as well as the clinic, resemble inflammatory processes. On one or both sides, dense, enlarged, painful ovaries or conglomerates of the uterine appendages are palpable, characterized by their immobility and soreness before menstruation. In this case, anti-inflammatory therapy is prescribed, which is symptomatic and does not give an effect; against this background, exacerbations associated with spontaneous perforation of the cyst are often observed. Such patients have been unsuccessfully observed in antenatal clinics for years. Particular difficulties in diagnosis arise with an isolated lesion of the ovaries. Therefore, it is noted that ovarian endometriosis must be differentiated from inflammatory formations of the uterine appendages, and the diagnosis is facilitated in the presence of endometriosis of another localization [10]. In our opinion, at endometrioid lesion of the ovaries is most often diagnosed as an inflammatory process of the uterine appendages or ovarian cyst (when it reaches its size, determined by ultrasound), which corresponds to the pathogenesis of the process, but does not reflect the causality of the pathology. It also leads to underdiagnosis of genital endometriosis.

In common forms of endometriosis, two (uterus and ovaries), three (uterus, ovaries and retrocervical region), four (uterus, cervix, ovaries and retrocervical region) and more adjacent anatomical structures are affected.

Combined damage to the organs of the female reproductive system

is well known in gynecological practice. Numerous patients of antenatal clinics and gynecological departments often have several diagnoses (according to the localization of the pathological process): uterine myoma and chronic endocervicitis, glandular (glandular-cystic) endometrial hyperplasia and chronic recurrent salpingitis, chronic endometritis and limited adhesions in the small pelvis, cervical cysts and chronic adnexitis and various other combinations.

I would like to emphasize that we do not question the competence of fellow doctors, since gynecological pathology is interpreted by them within the framework of modern theoretical views of the etiopathogenesis of diseases and is detected using methods aimed primarily at determining morphological changes in tissues and organs (see above.).

It seems that the trends that we identified in the diagnosis of endometriosis by the EPD method are widespread and natural. Based on this, we believe that in many cases in the above examples, as in many others, we are talking about one pathology - genital endometriosis, which, as indicated, can occur in various forms, causing a clinical picture of combined lesions of the organs of the reproductive system and small pelvis. This always speaks of the prevalence of the endometrioid process and indicates the difficulties in diagnosis, not only at the initial stages of the disease, but often, with a detailed clinical picture of the disease. As a result, this can (and often does) lead to an inadequate therapeutic effect. It seems to us that genital endometriosis should be considered as more

common pathology than it is interpreted today. According to our preliminary data, genital endometriosis occupies 43–45% in the structure of the entire gynecological pathology of women.

Thus, using EPD methods, it is possible to carry out the diagnosis and differential diagnosis of various diseases of female reproductive sphere. This, in turn, allows us to assess the extent of the spread of genital endometriosis, uterine fibroids, ovarian cysts and other diseases. It is also important that EPD methods make it possible to determine the pathology of the initial forms of the disease. In the process of working in the quantum medicine office, we note other patterns in the diagnosis of genital endometriosis, in particular, this concerns diagnostic markers and the construction of an examination algorithm. Today, genital endometriosis cannot be determined before the onset of the menstrual cycle, although it is obvious that the tendency to this pathology exists long before that. The search for methods to determine the predisposition to this disease before the onset of menarche remains relevant. We hope to provide generalized data in subsequent works.

It seems to us that genital endometriosis is a complex, not fully understood pathology of the female reproductive sphere, which determines the need for further research.

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