Diagnostics of infertility on a hardware-software complex "IMEDIS-EXPERT"

A.A. Hovsepyan, A.S. Machanyan
(Medical Center "Shengavit", Yerevan, Armenia)

Infertility in marriage is an important medical and social problem. The data of WHO experts and many others indicate that over the past decades in countries with high living standards, along with low fertility, there has been an increase in the number of infertile marriages. Therefore, the problems of infertility have not only medical, but also important social and national importance. In health care, the problem of sterile marriage is one of the most difficult. Despite the fact that infertility and its causes have attracted the attention of doctors for a long time, there is still a lot of unexplored in this area. Treatment of infertile spouses does not always give the expected effect.

In recent years, the view on the problem of infertility has undergone significant changes, new theories and directions have appeared in its study and treatment. The variety of forms of infertility dictates the need to involve not only gynecologists and urologists in solving this problem, but also doctors of other specialties. It becomes obvious that the effectiveness of the system of medical and preventive measures will be largely determined by the coordination of the work of a wide range of specialists in the biomedical field.

The incidence of infertile marriages is 10-15%. Infertility - the inability of a mature organism to reproduce offspring. A marriage is considered sterile if spouses of childbearing age who have had a regular sex life without using contraceptives for 2 years do not become pregnant. Until recently, all cultures of the past were characterized by the belief that a woman was to blame for a sterile marriage. It has now been established that the fertility of the family depends equally on the reproductive potential of both women and men.

The causes of infertility are manifold. They can be congenital (hereditary) or acquired during pregnancy when the fetus is exposed to adverse factors (past infectious diseases, the threat of termination of pregnancy, the use of teratogenic drugs, industrial and household intoxication, etc.) and arising after childbirth.

In practice, most often in the childlessness of a married couple, inflammatory diseases of the genital organs transferred by the spouses are to blame.

It was found that 75% of cases of infertility in marriage are caused by chronic inflammatory processes in the genitals caused by protozoa (trichomoniasis), bacterial microflora (streptococci, staphylococci, E. coli), chlamydia, gardnerella, as well as poorly treated sexually transmitted diseases (gonorrhea) and other specific infections ...

Dysfunctions of the gonads in men are expressed in the fact that the testes do not produce sperm, or defective spermatozoa are formed in them, and in women, malformed eggs do not develop at all or develop in the oocytes. With some disorders in the reproductive tract, sexual intercourse (coitus) is possible, but the meeting of germ cells capable of fertilization is difficult

(for example, with inflammation of the oviducts or seminal ducts). In cases of underdevelopment of the genital tract, vagina or penis, with damage or lack of erection, not only fertilization, but also the sexual intercourse itself is impossible.

Infertility can be physiological (childhood and old age, lactation period) and pathological (with congenital diseases of the genital organs, endocrine disorders, chronic inflammatory diseases, severe non-inflammatory diseases, mental or neurological disorders, genital trauma).

The “female” factor of infertility accounts for approximately 60–70% of the causes of infertility.

Female infertility is characterized by an inability to conceive during childbearing years.

It can be primary, when there were no pregnancies at all, and secondary, in the presence and amnesis of one or more pregnancies that ended in childbirth, abortion or ectopic pregnancy, after which the pregnancy did not occur for two or more years. Infertility can be absolute if the possibility of pregnancy is completely excluded, for example, in the absence of a uterus, or relative, when the likelihood of pregnancy is not excluded, but significantly reduced.

The cause of female infertility can be congenital underdevelopment or malformations of the genital organs of a hereditary or acquired nature, diseases of the genital area, other organs and systems. Disorders of metabolic processes in a woman's body (obesity, diabetes, etc.), starvation, malnutrition and vitamin deficiency often lead to infertility. Infertility adversely affects the general condition and neuropsychiatric status of a woman; in some cases, a woman does not outwardly betray her condition, in others, more or less pronounced changes in character and behavior occur. The desire to have a child dominates all other interests. Conflicts appear in the family. A woman is seized by a feeling of inferiority, a background for development is created.

psychoneurotic diseases.

Treatment for infertility in a woman depends on the underlying cause.

First of all, it is necessary to eliminate the anatomical changes in the fallopian tubes, cervix and body of the uterus, then conduct conservative therapy that corrects ovulation disorders.

The "male" factor accounts for approximately 30-40% of the causes of infertility. Male infertility is characterized by the inability of a mature male body to fertilize.

Distinguish between absolute infertility (impossibility of fertilization: occurs with testicular aplasia, azoospermia, akinospermia, aspermia, necrospermia) and relative (conception is possible after elimination of the underlying cause of the disease). Male sterility is due to the pathology of the genitals of various origins and impaired patency of the vas deferens. Male infertility can be the result of underdevelopment of the testicles, as well as their absence in the scrotum, when they are in the abdominal cavity or inguinal canal (cryptorchidism), which always leads to atrophic processes in the testicles and to impaired spermatogenesis. Underdevelopment of one testicle is not functionally

manifests itself, with bilateral underdevelopment or absence (anorchism), there is a change characteristic of eunuchoidism.

The cause of male infertility can be primary congenital or acquired hypogonadism, which is often caused by various unfavorable external factors that negatively affect spermatogenesis: infectious and inflammatory diseases, chronic intoxication (alcohol, nicotine, medicinal substances), malnutrition, especially with complete or partial starvation , ionizing radiation, work at high temperatures, inflammation and trauma of the testicles, etc. The occurrence of secondary testicular damage (secondary hypogonadism) depends on disorders in the hypothalamo-pituitary system. Insufficient formation of gonadotropic hormones during puberty causes the phenomenon of eunuchoidism, and later leads to disruption of spermatogenesis. Male infertility can be caused by aspermatism,

The most common causes of male infertility are:

1. Varicocele (15% of cases) - enlargement of the veins of the testicle and spermatic cord (a special channel for the withdrawal of sperm located in the scrotum). As a result of varicocele, the temperature in the testicles rises, their work is disrupted, and, therefore, sperm cells are damaged.

2.Injuries and defects of the genital organs of men (10-12% of cases) (undescended and twisted testicles).

3. Infectious diseases (10% of cases). First of all, those which are sexually transmitted: gonorrhea, syphilis, chlamydia, trichomoniasis, etc. But the worst of all genital infections affects men a common childhood disease - mumps ("mumps"). Inflammation of the male genitourinary organs, such as the prostate gland (prostatitis) or the urethra (urethritis).

5. Sexual dysfunctions: erectile dysfunction, premature ejaculation, etc.

6. Immunological disorders: in case of failure of immunity in the body the production of antibodies begins, which are capable of damaging their own sperm.

7. Hormonal disorders, such as a deficiency in male sex hormone - testosterone.

8. Finally, male infertility can be caused by a number of external reasons: psychoactive substances (alcohol, tobacco, drugs, some medicines), poor environment (radiation, pesticides, lack of vitamin C and zinc) and even just careless handling of your own body (too tight clothes, frequent sauna visits, excessive zeal in sports).

All causes of infertility can be reduced to the following forms:

I. Secretory form of infertility

In this form of male infertility, the testes of a man, for various reasons, do not produce healthy motile sperm in quantity,

sufficient for fertilization of the egg. The causes of such a violation can be: genetic factors, hormonal disorders, severe chronic diseases (diabetes mellitus), previous inflammatory diseases of the genital organs (orchitis, parotitis), dropsy of the testicle, varicocele, testicular torsion and others. The factors provoking the onset of the disease include: protein deficiency, vitamin deficiency, testicular injury,

occupational hazards (ionizing radiation, high temperatures, contact with various toxic substances).

With this form of female infertility in a woman, pregnancy does not occur due to a violation of ovulation (maturation of the egg). The reasons for this are the violation of hormonal regulation. These disorders can be recognized by examining the so-called hormonal profile. This includes determining the activity of both female and male sex hormones, as well as hormones produced by other organs of the endocrine system. In these situations, a biopsy of the uterine mucosa (endometrium), measurement of basal temperature also helps.

II. Obstructive form of infertility

In this form of male infertility, the normal maturation of sperm in the testicles is preserved, but there is an obstacle in the path of the sperm from the testicles to the urethra. Such an obstacle may be a congenital absence or narrowing of the section of the vas deferens, adhesions remaining after an inflammatory or infectious process, a scar after surgery, a cyst or tumor of the genital or nearby organs.

With this form of female infertility, fertilization becomes impossible due to obstruction of the fallopian tubes, pelvic or
intrauterine adhesions, which occur, as a rule, due to inflammatory processes, after abortion. In a number of women, the cause of infertility can be congenital disorders of the shape, size of the uterus, appendages, as well as a mucosal disease such as endometriosis. To identify these reasons, a thorough instrumental examination should be carried out.

III. Immunological form of infertility

In this form of male infertility, the body begins to produce anti-testicular antibodies (antibodies to testicular tissue), which usually develop after a testicular injury. Normally, testicular tissue and the immune system do not touch. In case of injury
contact between these two systems occurs, and the body's immune system begins to perceive the testicles as a foreign formation. Antibodies can also be produced directly against sperm.

In this form, female infertility is associated with the presence of antisperm immunity, a local conflict caused by antibodies to sperm and to the egg, in particular, its transparent zone. Sperm, consisting of sperm, sperm plasma, from an immunological point of view, is a mixture of numerous antigens that can cause sensitization and induce the formation of antibodies.

Previously, it was believed that infertility, depending on immunological causes, accounts for 5% of all cases of childlessness in the family. Usually, this was associated with

the presence of antisperm immunity, local conflict caused by antibodies to sperm. At the same time, practically no attention was paid to antibodies to the egg, in particular its transparent zone. Similar antibodies can arise in the female body in response to the intake of sperm. In the last decade and a half, it was found that in rare cases, infertility is associated with an increased degree of histocompatibility of spouses for HLA antigens, that is, in this case, the immunogenetic component is important.

More recently, it has been proven that in the presence of a chronic inflammatory process in spouses, in addition to dysfunctions of the endocrine system, which often accompany chronic inflammation of the genitals, a significant role in the pathogenesis of infertility belongs to systemic and local immune responses. Their violation is due to the breakdown of endocrine-immune regulation, which as a result leads to the development of secondary immunodeficiency (SID), which aggravates infertility. A vicious circle arises: inflammation - disruption of endocrine-immune regulation - secondary immunodeficiency.

IV. Infertility of unknown origin

Probably, a number of dysfunctions of enzymes, the immune system associated with surface antigens of the egg, metabolic deficiency in sperm, abnormalities in the position of the uterus, pathology of follicle development and ovulation, pathology of the luteal phase and other phenomena can cause difficult to explain infertility. In about 10% of infertile married couples, no pathology can be detected. Thanks to the use of more advanced diagnostic methods, the number of cases of unexplained infertility has recently decreased.

Observations show that, despite the special attention that is paid to this problem, the chances of eliminating infertility of unknown origin are extremely low.

Diagnosis of patients who applied for infertility is carried out in the following sequence.

Selection and installation of the pineal gland.

1. Determination of the presence of foci and interference fields in the subject's body. We test directly pointers to sources and fields of interference (Causticum D60 + Causticum according to Hahnemann D60).

A positive test result (a decrease in the initial high values - "↓") indicates the presence of foci and interference fields in the subject's body.

2. Determination of the location of foci and interference fields by organs. We test successively pointers to foci and interference fields Causticum D60 + Causticum according to Hahnemann D60) ↓ + sequential testing of organopreparations in potency D4 ↑.

A positive test result (restoration of the initial values - "↑") indicates the presence of foci and interference fields in specific organs of the subject. The more organs in which the foci are determined, the more
common process.

If there are more than two organs, it is necessary to find out which of them is dominant.

3. Determination of the presence of a dominant focus or interference fields in the body investigated.

We test directly the pointers to the dominant source or interference fields (Causticum D400).

A positive test result (a decrease in the initial high values - "↓") indicates the presence of a dominant focus or interference fields in the subject's body.

A negative test result indicates that organ damage is not the result of damage to one organ.

In case of negative testing, point 4 is not fulfilled.

4. Determination of the location of the dominant focus or fields of interference by the organs in which the foci and fields of interference were determined.

We test the pointer to the dominant focus or interference fields:

Causticum D400 ↓ + sequential testing of organ preparations, in which the foci and interference fields were determined, in potency D4 ↑.

A positive test result (restoration of the original high values) indicates the presence of a dominant focus or interference fields in a particular organ. The organ in which the dominant focus or field of interference is determined is, as a rule, the most affected organ.

5. Determination of the presence of toxic foci in the body of the subject. We test, directly, pointers to toxic foci (Tuya D30). A positive test result (a decrease in the initial high values - "↓") indicates toxic foci in the subject's body.

A negative result indicates the absence of toxic foci in the subject's body, and in this case, points 6–9 are not fulfilled.

6. Determination of the location of toxic foci by organs. We test the pointer to the toxic focus:

Tuya D30 ↓ + sequential testing of organ preparations, in which foci and interference fields were determined, in potency D4 ↑.

A positive test result (restoration of the original high values) indicates the presence of toxic foci in specific organs of the subject.

7. Determination of the presence of dominant toxic foci in the body investigated.

We test directly the pointer to the dominant toxic focus (Tuya D200).

A positive test result (a decrease in the initial high values - "↓") indicates the presence of dominant toxic foci in the subject's body.

8. Determination of the location of the dominant toxic focus. Testing, a pointer to a dominant toxic focus:

Tuya D200 ↓ + sequential testing of organopreparations, in

of which toxic foci were determined, in potency D4 ↑.

A positive test result (restoration of the initial high values) indicates the presence of a dominant toxic focus in a particular organ of the subject.

9. Determination of the type of toxic foci.

Pointer to the dominant toxic focus:

Thuja D200 ↓ + organ preparation of the organ in which the dominant toxic focus was determined, in potency D4 ↑ + sequentially, pointers to the type of toxic burden to (Intox I, Intox II, Intox III) ↓.

A positive test result (decrease in the initial high values) indicates the presence of a specific type of toxic burden (Intox I, Intox II, Intox III) in the dominant toxic focus.

In the absence of a dominant toxic focus, testing is carried out through pointers for the presence of toxic foci (Tuya D30) in organs that belong to the reproductive system.

10. Determination of the degree of bactericidal activity in an organ with a dominant toxic load.

Pointer to the dominant toxic focus:

Thuja D200 ↓ + organ preparation of the organ in which the dominant toxic focus was determined, in potency D4 ↑ + the revealed type of toxic burden (Intox I or Intox II, or Intox III) ↓ + sequentially, until the first actuation, the degree of bactericidal activity ↑.

If the bactericidal capacity is at least 6, then a study for the presence of infectious factors in the identified focus is not performed, i.e. in this body there are no conditions for the development of infections, and research on items 11-16 is not performed.

If the level of bactericidal activity is below 6, the test is considered positive - there are conditions in the organ for the development of infections.

11. Determination of the role of bacterial loads in the emergence of a dominant toxic
focus in a specific organ.

Pointer to the dominant toxic focus:

Thuja D200 ↓ + organ preparation of the organ in which the dominant toxic focus was determined, in potency D4 ↑ + revealed type of toxic burden (Intox I or Intox II, or Intox III) ↓ + revealed degree of bactericidal activity ↑ + consecutively indicators of bacterial burden ↓.

With positive testing, it is necessary to identify the specific type of bacteria. In case of negative testing, point 12 is skipped.

12. Determining the role of specific bacteria that cause intoxication and lead to a decrease in the degree of bactericidal activity.

Pointer to the dominant toxic focus:

Thuja D200 ↓ + organ preparation of the organ in which the dominant toxic focus was determined, in potency D4 ↑ + revealed type of toxic burden (Intox I or Intox II, or Intox III) ↓ + revealed degree of bactericidal activity ↑ +

consecutively, nosodes of bacteria that correspond to the organ under study (from the Rufus repertory) ↓.

This is an indication of specific bacteria that cause intoxication and lead to a decrease in the degree of bactericidal activity.

The identified nosodes of bacteria are added to the list of selected ones.

13. Determination of the role of viral loads in the emergence of a dominant toxic focus in a specific organ.

Pointer to the dominant toxic focus:

Thuja D200 ↓ + organ preparation of the organ in which the dominant toxic focus was determined, in potency D4 ↑ + revealed type of toxic burden (Intox I or Intox II, or Intox III) ↓ + revealed degree of bactericidal activity ↑ + consecutively pointers to viral burden ↓.

This is an indication of the role of viral loads in the emergence of a dominant toxic focus and the degree of bactericidal activity below 6 in a specific organ.

A positive test result indicates on the Viral load "interest".

In case of negative testing, point 14 is skipped.

14. Determination of the role of specific viruses in the emergence of a dominant toxic focus and the degree of bactericidal activity below 6 in a specific organ.

Pointer to the dominant toxic focus:

Thuja D200 ↓ + organ preparation of the organ, in which the dominant toxic focus was determined, in potency D4 ↑ + revealed type of toxic burden (Intox I or Intox II, or Intox III) ↓ + revealed degree of bactericidal activity ↑ + consecutively, nosodes of viruses that correspond to the studied organ (from Rufus Repertory) ↓.

Positive result testing indicates on the "Interest" of specific viruses that cause intoxication and lead to a decrease in the degree of bactericidal activity below 6.

The detected nosodes of viruses are added to the list of selected ones.

15. Determination of the role of mycotic loads in the emergence of a dominant toxic focus in a specific organ.

Pointer to the dominant toxic focus:

Thuja D200 ↓ + organ preparation of the organ in which the dominant toxic focus was determined, in potency D4 ↑ + revealed type of toxic burden (Intox I or Intox II, or Intox III) ↓ + revealed degree of bactericidal action ↑ + sequential testing of pointers for mycotic burden.

A positive test result (a decrease in the initial high values - "↓") indicates the role of mycotic burden in the emergence of a dominant toxic focus in a particular organ. In case of negative testing, point 16 is skipped.

16. Determination of the role of specific fungi in the emergence of a dominant toxic focus in a specific organ.

Pointer to the dominant toxic focus:

Thuja D200 ↓ + organ preparation of the organ in which the dominant

toxic focus, in potency D4 ↑ + revealed type of toxic burden (Intox I or Intox II, or Intox III) ↓ + revealed degree of bactericidal activity ↑ + sequentially, fungal nosodes that correspond to the investigated organ (from Ruf's repertory) ↓.

Positive result testing indicates on the "Interest" of specific fungi, which cause intoxication and lead to a decrease in the degree of bactericidal activity below 6.

The identified fungi are added to the list of selected ones.

Thus, we have identified the presence or absence of toxic foci that are caused by infectious factors.

In the presence of infectious factors, we will be interested in infections that cause a reaction of the immune system.

17. Determination of the reactivity of the immune system in the subject. The test is indicative of the reactivity of the immune system (Spleen + Thymus). A positive test result (decrease in the initial high values - "↓") indicates the reactivity of the immune system in the subject.

A negative result indicates the absence of reactivity of the immune system in the subject, and items 18–20 are skipped.

18. Determination of the department of the immune system that reacts. We test successively indicators of the reactivity of the immune system. Spleen (neurohumoral immunity) and Thymus (cellular immunity). A positive test result (a decrease in the initial high values - "↓") indicates the reactivity of the corresponding part of the immune system in the subject.

19. Determination of the type of response of the identified immune department systems.

We test the identified division of the immune system: Spleen (neurohumoral immunity) or Thymus (cellular immunity)
↓ + sequentially, indicators of stress or depletion of the immune system ↑. A positive test result indicates character
the response of the corresponding department of the immune system in the subject.

It should be emphasized that thymic immunity (cellular immunity) is never in tension, its sharp decrease indicates gross dystrophic disorders up to oncology.

20. Determination of infections that cause immune shifts in
the organism of the investigated.

We test the identified division of the immune system: Spleen (neurohumoral immunity) or Thymus (cellular immunity)
↓ + detected level of stress or exhaustion ↑ + infections that
were determined in organs with foci and interference fields ↓.

Testing through the identified indicators of tension or depletion of the corresponding part of the immune system of the identified infections allows one to judge the degree of toxicity (depletion of neurohumoral immunity) and virulence (tension of neurohumoral immunity) of these infections.

In acute processes, as a rule, there is tension, and in chronic processes - depletion of neurohumoral immunity.

If the identified infections lead to a decrease in thymic immunity, they are most dangerous and can cause autoimmune reactions. As a rule, they refer to oncogenic infections (viruses).

In patients with immunological forms of infertility, a decrease in thymic immunity can lead to the formation of antibodies to their own sperm in men or to eggs in women.

Treatment of these infections in immunological forms of infertility is of paramount importance.

Identified in this way, infections are active and require treatment in the first place. All other infections identified through the corresponding pointers are not active, and the patient is only a carrier in terms of these infections, i.e. treatment of these infections is a minor task. As you know, when prescribing inversion nosodes of infections and the decay of the corresponding infections, or when they are activated for direct prescription, many toxic products are formed, the presence of which makes the body more energy expenditures for detoxification and drainage, mobilizes the compensatory mechanisms of the body. With reduced body reserves and a depleted immune system, such a situation is undesirable, since it can lead to a breakdown of compensatory mechanisms and a deterioration in the patient's condition. Therefore,

For the above reasons, the appointment of inactive nosodes of infections to which the immune system does not respond is impractical.

21. Determination of the presence of vegetative burden in the body investigated. We test sequentially the maximum degrees of vegetative burdening until the first failure (pointers according to A.A. Hovsepyan's version).

A positive test result (a decrease in the initial high values - "↓") indicates the presence of a vegetative burden in the subject's body. A negative result indicates its absence, and paragraph 22 is omitted.

22. Determination of the organs in which the maximum degree is determined vegetative burden.

Indicative is the maximum degree of vegetative burden (indexes according to A.A. Hovsepyan's version) ↓ + sequentially, organopreparations in potency D4 ↑.

A positive test result indicates the presence of
vegetative burden in specific organs. Authority having
the maximum degree of vegetative burden is one of the main sources of patient complaints.

The presence of vegetative burden at the level of the fallopian tubes indicates a violation of peristalsis and the impossibility of penetration of the egg into the uterine cavity. The presence of vegetative burden at the level of the spermatic cord indicates a violation of peristalsis and the impossibility of moving spermatozoa into the overlying sections.

The presence of vegetative burden at the level of the prostate indicates a violation of erectile and ejaculatory function.

23. Determination of the presence of metabolic hypoxia in the body investigated. We test the indicator for the presence of metabolic hypoxia (Cytochrome-A D60 N).

A positive test result (a decrease in the initial high values - "↓") indicates the presence of metabolic hypoxia in the subject's body. A negative result indicates its absence in the subject's body, and paragraph 24 is skipped.

24. Determination of organs in which metabolic hypoxia.

Pointer to the presence of metabolic hypoxia (Cytochrome-A D60 N) ↓ + sequential testing of organ products of organs related to the reproductive system, in potency D4 ↑.

A positive test result (restoration of the original high values) indicates the presence of metabolic hypoxia in specific organs. An indication of the presence of metabolic hypoxia in the testicular area is usually the result of varicocele or wearing tight underwear.

An indication of the presence of metabolic hypoxia in the ovarian region is, as a rule, the result of degenerative changes in both the ovary itself and the tissues surrounding it.

The organs in which metabolic hypoxia is determined are the organs in which there are metabolic disorders.

25. Determination of the presence of cicatricial interference fields. The indication of cicatricial interference fields is tested.

A positive test result (a decrease in the initial high values - "↓") indicates the presence of cicatricial interference fields in the subject.

A negative result indicates the absence of cicatricial interference fields in the subject's body, and paragraph 26 is skipped.

26. Determination of the organs in which the cicatricial interference fields are determined. Indications for cicatricial interference fields ↓ + sequential testing of organ products of organs related to the reproductive system in potency D4 ↑.

A positive test result (restoration of the original high values) indicates the presence of cicatricial interference fields in organs that belong to the reproductive system.

The indication of the presence of cicatricial fields of interference in the testicular area is, as a rule, the result of fibrotic changes in the testicles themselves.

An indication of the presence of cicatricial fields of interference in the ovarian region is, as a rule, the result of dystrophic, cystic, changes in both the ovary itself and the tissues surrounding it.

An indication of the presence of cicatricial fields of interference in the uterus is, as a rule, the result of dystrophic, fibrous, changes in both the uterus itself,

endometrium and surrounding tissues.

An indication of the presence of cicatricial interference fields in the area of the fallopian tubes is, as a rule, the result of dystrophic, fibrous, adhesive changes in both the fallopian tubes themselves and the tissues surrounding it.

Patients in whom cicatricial fields are tested interference on the above organs, as a rule, require surgical correction and are poorly promising in terms of conservative treatment.

27. Determination of the "interest" of the endocrine system. Testing of the endocrine system in women should be carried out on the days of expected ovulation, i.e. on the 9-12th day of the menstrual cycle.

We test directly, before the first failure: Endocrine index ↓.

This is an indication of the level of pituitary disorders.

A positive test result (a decrease in the initial high values) indicates the "interest" of the pituitary gland in the disorders of the endocrine system. If the test is negative, point 28 is skipped.

28. Determination of endocrine glands with disorders as a result dysfunctions of the pituitary gland.

We test the maximum revealed endocrine index ↓ + organopreparations of the endocrine glands in potency D4 ↑.

Thus, we can identify endocrine glands with impaired functions, which is of fundamental importance in secretory forms of infertility. If pituitary dysfunction is not tested, then further research is carried out as follows.

29. Determination of the nature of the "interest" of the endocrine system in investigated.

Are tested maximum degree stresses and exhaustion endocrine system, until the first failure.

A positive test result (a decrease in the initial high values - "↓") indicates the "interest" of the endocrine system in the form of stress or exhaustion in the subject.

Both conditions are tested more often.

This means that for some hormones there is tension, and for some - depletion.

This may mean a violation of different glands of the endocrine system or one, but producing different hormones.

With negative testing, there is no stress or depletion, i.e. there are no endocrine disorders, - point 30 is skipped.

30. Determination of "interested" hormones, with the identified degrees stress or exhaustion of the endocrine system.

The revealed degrees of tension and depletion of the endocrine system are tested ↓ + hormones ↑.

This is an indication of specific hormones. Revealed hormones put the list of selected ones.

Knowing which glands produce specific hormones, you can understand which glands are affected.

31. Determination of the presence of genetic defects.

An indication of genetic defects (Argentum nitricum C12) is being tested. A positive test result (a decrease in the initial high values - "↓") indicates the presence of genetic defects in the subject.

In case of negative testing, point 32 is skipped.

32. Identification of organs with genetic defects.

An indication of genetic defects (Argentum nitricum C12) is tested ↓ + organ products of organs that belong to the reproductive system, potency D4 ↑.

Positive result testing indicates on the Availability genetic flaws in the studied organs, which refer to reproductive system.

Such patients are unpromising in terms of conservative treatment.

Treatment for infertility depends on the underlying cause.

Further research and treatment depends on the identified disorders and is carried out according to the organ that plays a major role in the pathogenesis of infertility.

A.A. Hovsepyan, A.S. Machanyan Diagnostics of infertility on the hardware and software complex "IMEDIS-EXPERT" // XI "IMEDIS", 2005, v.1 - P.185-204