Possible options for reflexotherapy of post-castration and climacteric syndromes occurring with sympatho-adrenal crises

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SUMMARY

Presented by general post-castration data (PKS) and climacteric (CS) syndromes and literature data on the positive results of complex treatment with the use of reflexotherapy for the most common symptoms of ACL and CS. Attention is focused on one of the most severe symptoms of ACL and CS - sympathetic-adrenal crises, especially in women with arterial hypertension, possible ways of correcting the ongoing hypotensive pharmacotherapy and reflexotherapy, corporal and auricular points, zones and methods of exposure through reflexotherapy used in these patients are given. with a positive effect. The need for further research on this topical problem with the involvement of specialists in various medical fields is noted.

Post-castration syndrome in women (syn. PCS, PS, post-castrationdisease) - a syndrome that occurs at various times after bilateraloviectomy, radiation or chemical castration or subtotal ovarian resection and representing a complex of vegetative-vascular, neuropsychic and metabolic-endocrine disorders. According to various authors, it occurs in 60–80% [19] or almost 100% of observations [3].

Often vegetative-vascular disorders: hot flashes, increased or decreased blood pressure, palpitations, cardialgia, etc. and neuropsychiatric disorders: emotional lability, tearfulness, irritability, anxiety, depression, asthenization, general weakness, not caused by physical or mental stress, headaches and pelvic pains, etc. occur early after the operation, i.e. at the hospital stage of treatment. Early functional disorders are due to the fact that the shutdown of ovarian function is primary in comparison with the natural gradual transition of a woman to the state of menopause and is accompanied by a more rapid development of an imbalance in the woman's neuroendocrine system.

In climacteric syndrome (CS), which occurs during menopause, similar functional disorders occur in a significantly smaller percentage of women: according to some authors in 26–48% [19], according to others - in 40–50% [8] observations. Postoperative stress caused by oophorectomy, especially in women of reproductive age, leads to a sharp disruption in the functional activity of various structures of the limbic-reticular complex and hypothalamus, which provide neuroendocrine regulation. Eventually

the clinical manifestations of ACL are often more severe than with climacteric syndrome.

Symptoms of ACL can occur with varying frequency over 2–5 and more years, increasing the risk of developing dyshormonal cardiopathy, dyscirculatory encephalopathy and other disorders and reducing efficiency and work activity. At a later date after surgery and with natural menopause, metabolic and endocrine disorders develop: osteoporosis, brittle nails, weight gain, male hair growth, etc. [12].

Etiology, pathogenesis, clinic, accepted in gynecology methods complex treatment of early and late manifestations of ACL and CS are presented in manuals for physicians [3, 9, 12, 18, 19, etc.], on the use of reflexology (RT) in these syndromes with common symptoms - in monographs and manuals on RT [8, 13, 21, 26, etc.], in textbooks [1, 5], journal articles and collections of scientific papers [2, 4, 6, 9, 11, 14, 15, 16, 17, 20, 23, 24, etc.].

The goals of reflexotherapy for CS and ACL are to normalize the interaction of adrenergic and cholinergic reactions, cortical-subcortical relationships, and the hormonal function of the pituitary gland. Studies carried out at the Institute of Reflexology [5, 15, 17] indicate that after operative castration, it is advisable to start reflexotherapy in the early postoperative period - from the second day after the operation in order to treat postoperative pain syndrome and prevent early development of post-castration vegetative-vascular and nervous mental disorders. At this stage, electro-RT is used: electroacupuncture (EAP), dynamic electroneurostimulation (DENS) with the use of modern methods of reflexodiagnostics and psychological tests, at the post-hospital stage - and other RT methods with an individual selection of a program of recipes and methods.

So, according to our data, under the influence of the course of EAP, as a component of therapy, from the second day after the operation in 104 women of reproductive age with the development of early symptoms of ACD (hot flashes - 39.1%, irritability, anxiety, tearfulness - 44.4 %, insomnia - 62%, excessive sweating - 62.1%, pain in the pelvic area - 41.4%, headaches - 67.3%) there was a significant ($p < 0.05$) decrease in or relief of these symptoms, improvement of the quality of the solution of sensorimotor tests, i.e. normalization of higher cortical processes: perception, attention, sensorimotor integration.

A decrease in reactive anxiety and an improvement in well-being and mood indicated a positive effect of the RT course on the activity of the subcortical limbic-reticular structures responsible for the regulation of psychoemotional reactions. Normalization of vegetative-vascular reactions began with a decrease in the tension of the regulatory systems of autonomic homeostasis, restoration of the normal interaction of the sympathetic and parasympathetic components in the regulation of cardiac activity and other autonomic functions [17]. Thus, there was a pronounced and directed correction of the indicators of the higher cortical parts of the nervous system and the autonomic nervous system in comparison with the effect of pharmacotherapy alone.

The maintenance at a favorable level of the hormonal function of the pituitary gland (FSH, LH, cortisol, prolactin, insulin) was noted as a reaction of defense-compensation in conditions of “post-castration disease” [5, 6, 10, 13, 15]. Pharmaceuticals at the hospital stage were used in a smaller number of patients compared to the control group: narcotic analgesics - by 56.5%, analgin - by 27.4%, relanium - by 43.7%, sleeping pills - by 35% [17]...

With climacteric syndrome (148 women) after the first course of RT (auriculo-corporal acupuncture), recovery was noted in 89.2% and improvement - in 8.8% of observations, after the second course, recovery was noted in 96.1% and improvement - in 6.9% of observations [8, 20], with the use of corporal acupuncture in 122 women with CS, all received a positive effect [4] ...

In this article, we consider it necessary to focus on one of the uncomfortable and rather severe symptoms of ACL and CS - sympatho-adrenal crises (SAK) [19]. Their development is due to a significant decrease in the threshold of excitability due to an imbalance in the autonomic nervous system with a predominance of predominantly adrenergic reactions [8]. Sympathoadrenal crises in CS occur in 10% [19] or 13% [9] of cases, of which 59% of women with hypertension have CS with sympathoadrenal crises. The crisis form of the CS is accompanied by cyclically repeated SAH, usually in the first 4–5 years of natural and artificial menopause in 18% of cases, in other cases a protracted course is characteristic.

Sympatho-adrenal crises are usually characterized by a sudden onset of psychoemotional stress with anxiety, excitement, the appearance of spotted hyperemia of the face, neck, chest, tremors of the fingers, increasing tachycardia, increased blood pressure, sometimes to an extremely high level (240-280 mm Hg. systolic), followed by frequent and profuse urination, exhausting a woman, can last up to 1–2 or more hours, occur from 1 to several times a month for several years. The most severe SAH occurs in women with concomitant arterial hypertension, especially with a crisis course, which prompts clinicians to make differential diagnosis to exclude adrenal pathology (pheochromocytoma).

Currently, the focus of many researchers is the cardiological issues of artificial and natural menopause in connection with a significant increase in arterial hypertension, coronary heart disease, the development of cerebral stroke and heart attack, which are the leading cause of mortality during menopause. An increase in blood pressure in these women is facilitated by a change in the level of hormones in the blood with an increase in the level of androgens that increase oxidative stress, an increase in body mass index, activity of the lipid peroxidation process with an increase in vasoactive substances (endothelin 1, thromboxane A2, etc.),

For the pharmacotherapy of hypertension and arterial hypertension, which develops during artificial and natural menopause, are used

various pharmaceutical groups of antihypertensive drugs. However, with ACL and CS, due to dysfunction of neurovegetative regulation and development of SAH, the question arises of the correction of antihypertensive drugs in women with ACL and CS, namely, the exclusion of those that increase the activity of the sympatho-adrenal and renin-angiotensin-aldosterone systems. These include widely used calcium channel blockers (calcium ion antagonists), especially 1,4-dihydropyridines (nifedipine, corinfar, cordaflex, nicardipine, amlodipine, etc.), which are capable of modulating the release of mediators, incl. adrenaline from presynaptic endings and increase sympathetic activity. From this group of drugs, the same effect, but to a lesser extent, is caused by phenylalkylamines (verapamil, etc.), benzothiazepines (diltiazem, etc.). Other adreno- and sympathomimetics cause a similar effect,

Our modest experience (isolated observations) indicates that the use of calcium channel blockers for the course treatment of arterial hypertension in women with ACL and CS, despite many of their positive effects, provokes the development of sympatho-adrenal crises. When treating a hypertensive crisis with their help, tachycardia increases even more, high blood pressure does not decrease for a longer time, polyuria even more exhausts the patient (urination up to 12-15 times during a crisis), worsening the general condition. This situation also dictates to refrain from the use of adrenergic and sympathomimetics used for other indications in patients with ACL and CS, with the exception of beta-adrenergic agonists used for emergency care in asthmatic conditions.

Reflexology courses in the complex treatment of patients with ACL and CS and sympatho-adrenal crises against the background of pharmacotherapy using calcium channel blockers and other adreno- and sympathomimetics do not reduce the incidence of SAH. In the treatment of patients with climacteric and post-castration syndromes with emerging SAH, along with cyclic hormone therapy [19], it is preferable to use more extensively such "daytime" tranquilizers as diazepam, menazepam, as well as glycine, sedative homeopathic remedies (nervochel, valerianachel, Edas 111, 911, climactic acid) -hel, remens), Novo-passita and other sedative herbal preparations, vitamins B1, B6, E, C, beta-blockers and peripheral adrenolytics; psychotherapy, reflexology, physiotherapy (baths, showers, etc.), a diet excluding products containing tyramine (strong tea, coffee, chocolate, cocoa,

Antihypertensive drugs in women with CS and ACL should have a high antihypertensive activity, act on the main key mechanisms of hypertension and the variant of arterial hypertension developing against the background of CS and ACL, not have a negative effect on the symptoms of these pathological syndromes and not block the effects of reflexology and other therapeutic methods. The most effective use of agonists 11-

imidazole receptors (moxonidine) [11], beta-blockers (metoprolol, etc.) [11, 22].

Antihypertensive drugs of other pharmaceutical groups can also be used that do not have sympatho-adrenal and renin-angiotensin-aldosterone activity (angiotensin-converting enzyme inhibitors, angiotensin II receptor blockers, thiazide diuretics), which prevent the stimulation of catecholamines, vasopressin II, endotensin II, aldiotensin II. Thus, a stable hypotensive effect of the ACE inhibitor lisinopril (diroton) was obtained in 56 women with arterial hypertension in peri- and postmenopausal women and an improvement in cerebral hemodynamics at the extra- and intracranial level [22].

Our research results indicate a highly effective positive effect of RT on many links in the pathogenesis of CS and ACL suggest that it may be an important component of the complex treatment of these syndromes occurring with sympatho-adrenal crises with the correction of antihypertensive therapy described in this article. Of the reflexology methods, we use corporal and auricular acupuncture, magneto-RT, electro-RT, cranio-RT, tsubo- and microneedle-RT, acupressure and linear massages, applications of silver plates. It is important to use techniques, RT methods, acupuncture points (TA) and impact zones that do not cause an increase in sympatho-adrenal and renin-angiotensin-aldosterone activity.

When using corporal acupuncture, acupressure, electro-RT, the methods of choice are mainly sedative TA, accessory points and segmental TA of YIN channels (methods of harmonizing influence). Dynamic electroneurostimulation, in addition to auricular and corporal TA, is used in local, segmental, trigger zones, as well as in metameric-segmental viscerotonic and universal (general and multi-organ) zones and a specific (suprapubic) zone [7]. The second, comfortable energy range of stimulation is mainly used. The RT course is carried out under the control of reflexodiagnostics, electrophysiological and psychological tests.

The most commonly used corporal TA - LU5, SP3, 4, 5, 6; HT5,7; PC5,7; KI3 (5), 6; KI12,13; LR2, 3; CV7, 14, 15, 17), in the cervical-collar region - LI15, TE10, GB21, CV21, EX-HN3 yin-tan, EX-HN9 tai-yang, zones of the lumbosacral region - BL31-34), auricular - AT22, 23, 34, 38, 40, 55, 59, 83, 98, 104, 105, 113, extraordinary canal Yin LV (PC6-SP4), cranio-RT zones - MS1, MS5, MS7, MS10, MS12.

For cardialgia, AT55.98 (left), 104, SP15, HT7, PC4.6 are more widely used; KI3 (5), LR8, CV14; with hypertension - AT34, 59; SP4, 5, 6, 9; HT5,7; PC6,7,9; KI5, LR2, 3, 14; CV15. With common symptoms of CS and ACL in women with sympatho-adrenal crises, we apply a similar correction of TA and zones prescriptions. So, for headaches of any localization - AT55, LU7, frontal - AT33, EX-HN3-yin-tan, temporal - AT34, 35; SP4, CV5, EX-HN9 tai-yang; occipital - AT29, SP6, diffuse - AT55, LU7, SP6, EX-H3in-tan; with "tides" of heat - AT22, 34, 55, 113; LU7, SP6, HT7, PC6.7; KI 6.27; LR2, 3, 5; at

dizziness - AT55, LU7, PC6, LR8; with cardialgia - AT55, 98 (left), SP15, HT5.7; KI6, LR2, 3, 8, 13; with insomnia - AT34, 55; LU7, HT4, 5, 6; KI6, LR2, 3, 8, 10; for joint pain - AT 26a, 34, 55 and auricular points taking into account somatotopia, corporal - sedative, analgesic, source points, local and segmental TA of YIN channels; with weight gain - AT18, 28, 34, 51, 84, 87; SP8, KI2, 7; LR2, 3; CV12; for pain in the lumbosacral region - AT38, 40, 55, 56, 104, BL31-34, 60.

After the RT procedure, according to indications, auricular and corporal tsubo- or microneedle-RT (silver microneedles) are used, applications of silver plates, if electro-RT was not used - magnets-applicators. RT course - 10-15 procedures, daily; during the year - at least 4–6 courses of RT. In our observations after the abolition of calcium channel blockers and the appointment of other antihypertensive drugs for course treatment (angiotensin II receptor blocker valsartan, highly selective beta-blocker bisoprolol) in women with ACL and concomitant arterial hypertension against the background of the correction of antihypertensive therapy and reflexology of sympathetic adrenal crises occurred much less frequently (once every 1–2 months for 5–6 months in a mild form, then they stopped.

Our experience (single observations with a positive effect in remission for 3-4 years) does not allow today to present a convincing conclusion about the effectiveness of the proposed approaches to the treatment of ACL and CS accompanied by sympatho-adrenal crises, especially with concomitant hypertension and symptomatic arterial hypertension, but we consider it necessary to focus the attention of therapists, reflex therapists, clinical pharmacologists, gynecologists-endocrinologists, psychotherapists and social psychologists on this topical problem.

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