MANAGEMENT OF PATIENTS WITH UTERINE FIBROIDS IN AN OUTPATIENT SETTING

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Resume. Strategic approach to treatment of patients with uterine myoma, which is one of the most frequent causes of hysterectomy. Currently, organ-preserving treatment of this widespread gynecological nosology is considered a priority. Young women with uterine myoma who have not fulfilled their reproductive function currently deserve special attention. On the other hand, in patients approaching menopause, an important task in achieving it, avoiding a surgical approach, may be rational, pathogenetically substantiated drug treatment. The implementation of the effect of progesterone receptor modulators is clinically expressed in a decrease in the size of myomatous nodes, a marked decrease in blood flow in them, amenorrhea and relief of anemia.

Key words: uterine myoma; progesterone receptor modulators; GnRH analogs; uterine artery embolization; mifepristone.

The social significance of this pathology is difficult to overestimate: myoma is one of the most common reasons for surgical removal of the uterus. The average age of detection of uterine myoma is about 35 years, the peak incidence is in the age group of 35-45 years, however, recently the disease is "getting younger": the incidence of the disease is growing in the group of young women under 30 years old who have not yet realized their reproductive function. In combination with the modern trend of late implementation of reproductive plans, the issue of organ-preserving treatment of MM is becoming especially relevant [1].

The approach to managing patients with uterine fibroids depends on many factors and should be guided by modern clinical recommendations, on the one hand, and be strictly personalized, on the other [1, 2].

Uterine fibroids are defined by:

- sizes of nodes;
- localization;
- age;
- symptoms;
- reproductive plans;
- the patient's well-being;
- the patient's preference for one or another type of treatment.

These parameters correspond to modern international principles of management of patients with uterine fibroids [2, 4]:

• due to the fact that the size, number, location and clinical signs of fibroids in women vary significantly, treatment should be individualized and, above all, aimed at the range of clinical manifestations;

• the nature of the symptoms determines the choice of treatment;

• there is no scientific evidence to support the need for surgical treatment of "asymptomatic" fibroids;

• professional expert communities speak out in support of treatment depending on the preferences of the individual patient;

• women should be informed of all available treatment options: medication, radiology and surgery;

• avoid passive tactics leading to hysterectomy.

What does "Individual approach to the treatment of uterine fibroids" mean:

1. Observe.
2. Use medications.
3. Remove the uterus.
4. Remove nodes.
5. Apply regression methods (Uterine artery embolization).

It can be observed only in avascular, clinically insignificant, small, interstitial-subperitoneal nodes of uterine myoma, mainly in perimenopause. In young patients with such nodes, much will be determined by the immediate or distant reproductive plans.

The international professional community has defined the choice of therapy strategy for small uterine fibroids. The goal of drug treatment is to alleviate or eliminate symptoms associated with uterine fibroids, and to cause regression of fibroid nodes. The drug therapy being carried out should be evaluated every 3 months, and if it is ineffective, other drugs should be prescribed. When choosing a drug therapy option, not only its effectiveness should be assessed, but also its safety and tolerability [1, 6]. Of the modern drug treatments for fibroids, the most studied (since 2020) is the use of gonadotropin-releasing hormone agonists (GnRH agonists).

The use of GnRH agonists (according to ATC – gonadotropin-releasing hormone analogues) is recommended in patients with uterine fibroids and anemia as a preoperative treatment, as well as to reduce the size of myomatous nodes and reduce intraoperative blood loss (level of evidence for recommendations A, level of reliability of evidence – 1). However, GnRH agonist therapy for uterine fibroids is not recommended for long-term use due to the profile of adverse events and risks associated with a decrease in estrogen and progesterone levels (requires combination treatment regimens: GnRH agonists + Add Back).

After their cancellation, uterine fibroids resume growing in young women. Therefore, it is more rational to use GnRH agonists in patients with uterine fibroids combined with endometrial hyperplasia. And in general: is estrogen ablation necessary specifically for uterine fibroids? Estrogens in relation to uterine fibroids only stimulate the expression of progesterone receptors and growth factors, exerting a preparatory effect. Unlike estrogens, progesterone significantly increases the expression of epidermal growth factor (EGF) in fibroids, which is its main mitogen, and inhibits apoptosis [3, 5].

When using progesterone receptor modulators (PRM), their antagonism of the effect of progesterone on uterine fibroids is exploited [7].

The effect of MPR is realized in several ways: • blocking progesterone receptors; • suppression of MM growth factors; • inhibition of angiogenesis (reduction in the level of vascular growth factors (VEGF-A).

It has long been known that three-month courses of treatment with mifepristone 50 mg every other day do not affect the level of liver enzymes [12].

Therefore, at this stage, stabilization of the size of small interstitial-subserous myomatous nodes, and their possible reduction to clinically insignificant in young patients with delayed reproductive function can be achieved with the use of mifepristone [13–15].

Given the presence of a vascularized submucosal-intramural node in combination with adenomyosis, pronounced clinical symptoms, and the fulfilled reproductive function, the patient was offered EMM (uterine fibroid embolization) or drug therapy using a course of Agest as an organ-preserving treatment. The patient preferred drug therapy. Control ultrasound examination after 3 months. The uterus has decreased in size to 5–6 weeks, a submucosal-intramural, practically avascular myomatous node measuring 17×15×13 mm remains along the anterior wall of the uterus, with a reliable decrease in the submucosal component, smoothing of the cavity deformation.

The endometrium and ovaries correspond to the MRP procedure. These clinical examples demonstrate positive dynamics in relation to vascularized myomatous nodes in women of different age groups, as well as a significant decrease in the echographic signs of adenomyosis. In our opinion, it was more appropriate to perform EMM for the patient from the second clinical example, which is fully consistent with: "it is recommended to perform endovascular embolization of uterine arteries (EMA) in patients with high surgical risk as an alternative to surgical treatment in the absence of contraindications in patients who are not planning pregnancy." Moreover, the optimization of EMM access used by us currently - through the radial artery - reduces the risk of thrombotic complications (there is no need for tight bandaging of the right inguinal-femoral region) and eliminates the risk of ascending urinary tract infection

(there is no need for a urinary catheter). However, the patient preferred drug treatment, which at her age could potentially be carried out in intermittent courses [19] up until menopause.

In conclusion, it can be noted that for uterine fibroid nodes of particularly small sizes, the drugs of choice are:

• in patients with uterine fibroids who are interested in preserving reproductive function without surgery and the potential risk of adhesions;

• in patients for whom GnRH agonists are contraindicated (high risk of thrombosis, osteoporosis, atherosclerosis) or are not appropriate due to age;

• in patients who refuse surgical treatment and who require long-term therapy to suppress the growth of myomatous nodes;

• in patients planning to undergo organ-preserving surgery to relieve anemia.

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