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DORI-DARMON BILAN ABORT QILISHDAN KEYIN REABILITATSIYA (ADABIYOT SHARHI)

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РЕАБИЛИТАЦИЯ ПОСЛЕ МЕДИКАМЕНТОЗНОГО АБОРТА (ОБЗОР ЛИТЕРАТУРЫ)

Artificial termination of an unwanted pregnancy (abortion) is one of the most significant medical and social factors that have a negative impact on the reproductive health of women. The World Health Organization has recognized abortion as a serious reproductive health problem for women.

All over the world, every fourth woman during her life goes to the abortion procedure one or more times. The annual number of abortions around the world is about 56 million, 25 million of them are unsafe, as a result of which 22,000 women die, accounting for about 8% of all maternal deaths.

The problem of abortion, despite the established trend towards a decrease in their number, still requires solution due to the fact that it is one of the leading causes of maternal death, inflammatory diseases of the genital organs, infertility, and also negatively affects the course of subsequent pregnancies and childbirth, increasing the frequency miscarriage, maternal and perinatal pathology.

In March 2010, the World Abortion Congress (Lisbon) recognized that medical abortion is the most civilized technology of abortion recognized by the world community. The prevalence of abortions, including unsafe ones, is largely determined by the country's legislative policy.

The problems of preserving the reproductive health of the population, family planning and the safety of abortions are extremely urgent for the state. This is confirmed by the law "On the protection of reproductive health of citizens" adopted by the Ministry of Health of the Republic in 2019.

But, in consideration of the early resumption of sexual activity soon after an uncomplicated abortion and early restoration of fertility (already 10 days after the completion of an induced abortion in the first trimester, the probability of ovulation is 75.9% [3, 7], it is extremely important that patients are offered highly effective contraceptives methods that they can use starting immediately after the abortion [1, 8, 11].

Hormonal methods of contraception: combined (estrogen and progestogen) or purely gestagenic, can be started on the day of misoprostol (usually the third day of medical abortion). These methods include oral contraceptives, injection methods (eg, depot medroxyprogesterone acetate), implants, and a contraceptive patch. The combined estrogen-progestogen contraceptive vaginal ring can be used one day after taking misoprostol or, if bleeding is profuse, 2-3 days later. This recommendation is based on clinical experience; however, it is not known to what extent prolonged and profuse bleeding after abortion reduces the effectiveness of the vaginal ring [5, 8]. There is anecdotal evidence of the use of a vaginal ring immediately after medical abortion performed in the first trimester of pregnancy, which did not reveal any serious adverse events or association with infection during the three menstrual cycles after the abortion [4, 9].

According to some researchers, a prolonged continuous regimen of taking a combined hormonal contraceptive for three to four months is especially effective. The prolonged COC regimen has risks of side effects and complications comparable to the cyclic regimen and promotes effective suppression of proliferative processes in the endometrium and a decrease in menstrual blood loss [3,13].

Intrauterine devices can be inserted at any time after the completion of medical abortion, that is, within 48 hours after the expulsion of the ovum [1, 15]. A complete medical abortion can be confirmed by echography, a human chorionic gonadotropin test, or pelvic examination in conjunction with the patient's history of expulsion. If the IUD is scheduled for a follow-up visit (three weeks later), the woman should use barrier or hormonal contraceptives for sexual activity during this period.

Barrier methods such as condoms, diaphragms and spermicides can be used when sexual activity is resumed [6,12].

Female sterilization can be performed after the patient signs voluntary informed consent [12,15].

The working group included medical staff, researchers and external experts from WHO. To collect data, we used the methods of group and individual surveys, discussion with representatives of the public and providers, questioning women who applied for termination of pregnancy or choosing a method of contraception, monitoring abortion, pre- and post-abortion counseling. The study was devoted to studying the awareness of the population about the rights of patients, especially among socially unprotected groups; the availability of contraception and abortion; the role of a partner in reproductive health issues. In addition, this study addressed the issues of financing, management, cost and quality of services provided, namely pre-abortion counseling, organization of the abortion procedure (methods used, type of pain relief, methods of preventing complications). The results of the study revealed a pronounced lack of information about both artificial termination of pregnancy and its prevention. In addition, the study revealed an ambiguous attitude towards contraception among different strata of Russian society, which is associated with awareness of the effectiveness, benefits, side effects and availability of existing methods of contraception. Despite the fact that, in the opinion of the respondents, contraception is acceptable, and it is preferable to termination of pregnancy, it is regularly used by a very small number of respondents, mainly due to the widespread opinion about the adverse effect of contraception on health [5,9].

However, less than half of patients of reproductive age (45%) consult a doctor to obtain information on methods of preventing unwanted pregnancies. The rest prefer to focus on their knowledge and experience of their close environment [10].

The likelihood of developing complications after an abortion is progressively increasing with an increase in the number of procedures performed. So, according to I.S. Savelyeva, a history of up to two abortions leads to complications in 3-4% of cases; three to four abortions in history are complicated in 20% of cases; and patients who have undergone more than six abortions in 100% of cases are at risk of complications. The use of hormonal contraception in the post-abortion period serves as a pathogenetic agent in the treatment of complications (menstrual dysfunction, PID), as well as prevention of the development of gynecological pathology (uterine myoma, endometrial hyperplastic processes, endometriosis) [11,17].

As a result of the excitation of the hypothalamic-pituitary system against the background of a stressful state after an abortion, the body produces steroid hormones - follicle-stimulating, adrenocorticotropic, estrogens and glucorticoids, in connection with which it becomes necessary to reduce the excitability of the hypothalamus and, accordingly, to prevent the development of changes in the ovaries and hyperplastic processes in the endometrium. With repeated abortions, menstrual dysfunction is recorded in 25-30% of women. Complications associated with these disorders develop gradually and are often not associated with previous abortions due to their late clinical signs [6, 15]. The use of estrogen-progestogenic oral contraceptives, according to the researchers, promotes adequate rehabilitation of the function of the hypothalamic-pituitary system and the restoration of reproductive function in the post-abortion period. Immediately after an abortion, the use of COCs provides: a decrease in the severity (elimination) of bleeding; oppression of proliferative processes; anti-inflammatory and regenerative effect at the endometrial level; a decrease in the excitability of the hypothalamic-pituitary system and a decrease in gonadotropic activity; elimination of estrogen and progestin deficiency; protection from pregnancy [7,12]. This is important for young and young women, because the termination of the first pregnancy, which occurred with an incompletely formed reproductive system, often leads to infertility [8, 16].

Prevention of infectious complications remains controversial in the issue of rehabilitation after pharmacological abortion. Currently, it has been proven that antibiotic prophylaxis during surgical abortion can prevent infectious complications (evidence class A).

One should not forget about the side effects and complications caused by the use of hormonal contraceptives. The most formidable of them are thrombosis and thromboembolism [12, 13]. Moreover, their risk increases 2-7 times as the duration of use increases [11,15]. According to different authors, the use of combined oral contraceptives is accompanied by hemostatic changes in the woman's body, which are considered as a tendency to hypercoagulemia and are manifested by hyperfibrinogenemia, activation of factor VII, increased resistance to protein C [7, 13]. Fibrinolysis is often activated - a response to increased fibrin formation, which is realized by lowering the level of plasminogen activation inhibitor, which determines the rate of plasminogen conversion to plasmin (or fibrinolysin) [6, 8]. The influence of oral contraceptives on the anticoagulant potential is not excluded, although all the possibilities are mentioned in the literature: some have found a decrease in the amount, others have insensitivity, and still others have inhibition of antithrombin III when exposed to sex steroids [1]. The intensity of hemostatic changes increases with an increase in the dose of the estrogenic component and the duration of the contraceptive use; shifts in the platelet and coagulation links of hemostasis are coupled and unidirectional. More pronounced changes in the platelet link occur in the first cycle of hormonal contraceptive use, preceding in time the appearance of changes in the coagulation (biochemical) component of hemostasis, which indicates the initiating role of platelets in the activation of coagulation [2, 7].

An alternative to the use of combined oral contraceptives are purely gestagenic drugs, the effect on hemostasis of which is less pronounced, according to some authors [10], but increases the degree of hyperhomocysteinemia (HHC) and the intensity of changes in the platelet and coagulation links of hemostasis, according to others [5,6] ... Currently, HHC is considered one of the main risk factors for the development of thrombotic and atherosclerotic complications [13]. Hyperhomocysteinemia is the result of the combined effect of many hereditary and acquired factors, potentiates hemostatic shifts in both platelet and coagulation links of the hemostasis system, and at the same time suppresses the activity of natural anticoagulants and the fibrinolysis system [12].

Thus, the tactics of managing patients after artificial termination of pregnancy should not only include standard therapy, treatment of perioperative complications, but also provide for the prophylactic administration of COCs to prevent new complications and long-term negative consequences for women's health, since this is pharmacoeconomically justified. Only in this case will the number of complications decrease, and, consequently, long-term morbidity and mortality, which will provide a significant economic effect and will have a positive effect on the somatic and reproductive health of women.

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