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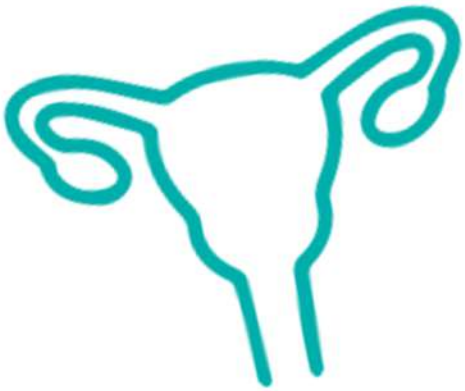

OBSTETRICS & GYNECOLOGY

surgical treatment with the possibility of performing organ-preserving intervention, as well as prolonging pregnancy.

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MANAGEMENT OF PREGNANCY IN PATIENTS WITH DYSPLASIA

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Relevance: For the last 5 years, cervical cancer (CC) has been taken 1st place among tumors of the reproductive organs detected during pregnancy. CC is preceded by cervical dysplasia. Dysplasia of the cervical epithelium is a precancerous lesion of the cervix, which is also called cervical intraepithelial neoplasia (CIN).

The cause of dysplasia (viruses, bacteria and fungi) can complicate fertilization, lead to miscarriage in the first trimester, and disrupt the proper development of the fetus at a later stage of pregnancy.

There are the following types of dysplasia: CIN 1 (or LSIL), mild dysplasia (characterized by the normal location of the surface and intermediate layers; the depth of the lesion is not more than 1/3); CIN 2, moderate (characterized by changes that cover the lower 2/3 of the thickness of the epithelial layer) and CIN 3, severe (changes cover more than 2/3 of the thickness of the epithelial layer). Detection of CIN 2 or CIN 3 (HSIL) indicates a high risk of progression to cancer.

During pregnancy as risk factors of HSIL we can highlight: trauma of the cervix due to labor ; occurrence of intense metaplastic changes in the cervix during pregnancy and after childbirth; the reduced degree of suppression of immunity that was observed during pregnancy; third trimester.

The corresponding pathological changes can be determined by using the Papanicolaou test (Pap test). A rapidly growing squamous cell metaplasia is observed, cells with a hypervacuolarized cytoplasm and an enlarged nucleus appear, which manifest

hyperplasia of the endocervical glands. The main methods of examining pregnant women with abnormal cytological smears from the cervix are colposcopy and biopsy. Treatment tactics directly depend on the degree of dysplasia. With HSIL, urgent colposcopy and surgical tactics are used only if cervical cancer is suspected. Exceptions are young patients (up to 25 years old) with CIN 2. In this case, an immunohistochemicall study of p16 protein expression can be performed. If p16+, then we rate it as HSIL (and carry out urgent surgical treatment). If p16-, then observational tactics are possible (regular PAP tests, HPV tests, colposcopy).

Conclusion: Pregnancy should not be considered a risk factor for CIN progression. Considering that the rate of progression of dysplastic lesions of the cervix during pregnancy is very low, and the risk of developing invasive cancer is insignificant, conservative tactics are preferred in the management of pregnant women with CIN. Surgical intervention is indicated only if CC is suspected, because the risk of developing obstetric complications stays high.

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SOME SIDE EFFECTS OF MODERN COMBINED ORAL CONTRACEPTIVE USE (LITERATURE REVIEW)

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Relevance: Preserving women's health and ensuring safe motherhood is the main task of modern medicine aimed at improving demographic indicators in Ukraine. One of the ways to solve it is to reduce the number of cases of unplanned pregnancy, which can be accompanied by medical abortions and cause a variety of complications. The task is accomplished by individual selection and prescription of combined oral contraceptives (COC’s) to women of reproductive age, who have a high reliability index (Pearl index <1) and a safety profile. Most women do not experience any side effects when they use them, but in some cases COC’s can have adverse effects.

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