RECEIVING CLINICAL OBSERVATION FOR ANTICOGULIAN AND ANTITROMBOSITIC THERAPY IN THE TREATMENT OF PATIENTS WITH ISCHEMIC DISEASE AND UTERINAL MYOMA

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Annotation: *Uterine myoma (BM) is a hormone-like benign tumor-like disease that results from the smooth muscle structures of the uterine wall. According to various sources, 30-70% of women have BM during the menopause. However, the actual prevalence of this disease in the population has not been evaluated, probably due to a lack of data on the prevalence of asymptomatic tumors. Symptomatic BM can cause small pelvic pain, low back pain, dyspeptic symptoms, heavy menstrual bleeding, as well as complicated complications and infertility.*

Keywords: *Ischemic heart disease, uterine fibroids, antiplatelet therapy, anticoagulant therapy, abnormal uterine bleeding, uterine artery embolization.*

Established risk factors (XO) of BM include age, early onset of menstruation, history of infertility, late first pregnancy, and polycystic ovary syndrome. Arterial hypertension, diabetes, lifestyle (smoking, etc.) and obesity are simultaneously considered XOs for the wide spread of cardiovascular diseases and the processes associated with the development of atherosclerosis. General similarities support the assumption that the development of atherosclerotic plaques and BM share a common biological mechanism. Furthermore, the proliferation of smooth muscle cells of monoclonal origin is crucial in the development of atherosclerosis and BM. C-reactive protein (CRO) is a characteristic inflammatory predictor of atherosclerosis. An increase in the level of CRO may indicate a subclinical atherosclerotic process. Hyperhomocysteinemia is an independent risk factor for the development of atherosclerosis, which can lead to increased oxidative stress, inhibition of nitric oxide synthesis, smooth muscle proliferation, endothelial dysfunction, and thrombosis. A mild to moderate increase in homocysteine concentration is associated with the risk of atherosclerotic vascular disease. . In addition, hyperhomocysteinemia has been suggested as a frequency of estrogen-induced oncogenesis. It is known that the level of CRO is positively

associated with the risk of developing BM. In the same study, an inverse correlation was found between homocysteine levels and the development of BM, which disappeared after surgical removal of the myoma. According to foreign authors, the prevalence of BM varies between 20-40%. However, to date, there are no data on the prevalence of co-occurrence of diseases (YuIK and BM) in the general population. The appointment of antiaggregants and, in some cases, anticoagulant therapy during percutaneous coronary intervention in patients with BM should be concerned about the increased risk of bleeding.

Anomalous uterine bleeding is a widespread phenomenon and is often associated with BM. In a retrospective study, A. Sjelander et al. after the appointment of anticoagulant therapy, the frequency of complaints of uterine bleeding in the study group increased from 17.8% to 29.5%.

Anomalous bleeding from the uterus increases not only when taking vitamin K antagonists, but also under the influence of combined antiaggregants. In addition, their safety in relation to uterine bleeding has not been evaluated when prescribing new oral anticoagulants in the presence of atrial fibrillation during menopause. In addition, the long-term consequences of uterine bleeding with mono or combination antiplatelet therapy are often overlooked or underestimated. In particular, combined antiplatelet therapy prescribed after percutaneous coronary interventions can cause excessive bleeding from the uterus, which increases the risk of anemia, which is especially dangerous for patients with coronary artery disease.

The patient was born in 1975, was admitted to the cardiology department during exercise (walking, climbing 1-2 flights of stairs) in the precordial area (behind the chest, between the 3rd and 4th ribs on the left) between the shoulder blades pain that is transmitted and disappears at rest, an increase in blood pressure to 160/90 mm Hg, general weakness, periodic pain in the lower abdomen, menstruation was admitted with complaints of severe vision loss (a lot of bleeding). Anamnesis morbi et vitae The above complaints have been bothering the patient for about 2 years. Previously, a cardiologist diagnosed ischemic heart disease, angina pectoris, II functional class. In ambulatory conditions, he takes perindopril 2 mg per day, rosuvastatin 20 mg per day. The last 2 months have seen a marked decrease in exercise tolerance. He denies having had a stroke, heart attack, hypercholesterolemia was detected about 4 years ago.

Denies the existence of harmful habits.

Multispiral computed tomography (MSCT) of the coronary arteries was performed in an outpatient setting, according to which critical stenoses of the right coronary artery (RCA) were determined. Since 2005, BM has been listed as a dispensary at the women's clinic, and the rate of growth is observed. Diagnostic curettage of the uterine cavity was performed three times for hyperplastic endometrial processes (histologically confirmed); the patient refused radical surgical interventions in the gynecological department due to ischemic heart disease. An ambulatory gonadotropin-releasing hormone agonist was prescribed. He was admitted to the cardiology department as planned.

Main disease: Ischemic heart disease. Stable tension angina, functional class III. Atherosclerosis of coronary arteries (according to MSCT coronary angiography). Hypertension II stage, Arterial hypertension III stage. Risk group IV.

Complication: Chronic heart failure stage I. Comorbidity: Multiple interstitial-subserous uterine myoma, with hemorrhagic syndrome.

Taking into account the accompanying diagnosis, the cardiologist and gynecologist jointly decided on primary coronary angiography (CAG) and subsequent treatment tactics. CAG: type of coronary blood supply to the myocardium - right type. Angiography of the left coronary artery (LCA) revealed stenoses up to 35-40%, intersystemic collaterals in the distal parts of the coronary artery. OCA angiography revealed: orifice stenosis 80%, critical stenosis of the proximal segment, functional occlusion at the level of the medial segment. Taking into account the results of CAG, a decision was made to carry out percutaneous surgical intervention in OKA in the first stage of treatment, and embolization of the uterine arteries (BA) in the second stage. In a special department, balloon angioplasty and hole stenting were performed with satisfactory angiographic results in the proximal and medial segments of the coronary artery. In the early postoperative period, the patient noted an improvement in his general condition in the form of absence of anginal pain during exercise and at rest. At discharge, drug treatment was prescribed: antiplatelet and anticoagulant therapy (acetylsalicylic acid 100 mg/day; clopidogrel 75 mg/day), lipid-lowering therapy (rosuvastatin 20 mg/day), hypertensive therapy (perindopril 4 mg/day), hypolipidemic diet was recommended. Before the second hospitalization in the gynecological department, she was under outpatient observation by a cardiologist and a gynecologist, who noted an increased volume of blood loss during menstruation.

A month later, the patient was admitted to the second stage of

treatment. Through a radial approach, BAA was performed on the left and right uterine arteries with 500-700 μm microspheres until contrast stasis appeared in the distal segments of the vessels. According to the results of postoperative ultrasound examination, there were no signs of bleeding in myomatous nodes in color doppler examination. There were no complaints at the time of discharge from the hospital. On the 5th day, he was discharged from the hospital with the recommendation of outpatient supervision by a cardiologist and gynecologist. After 6 months, control KAG was carried out: CHKA - no dynamics, stents were installed in OKA, it passes without signs of restenosis. After re-examination by a cardiologist and a gynecologist, a positive trend was observed in both pathologies: an increase in endurance for physical exercises (according to the results of stress tests) and a regression of the size of myomatosis nodes without signs of blood flow were revealed. In patients with a cardiology profile, whose placental disease is a disease that increases the risk of developing hemorrhagic complications, the identification of concomitant diseases should be an integral part of the initial examination. As the number of women receiving anticoagulant and/or antiplatelet therapy for cardiovascular disease increases, the prevalence of abnormal uterine bleeding is increasing. Treatment of patients with CKD and BM should be carried out jointly by a cardiologist and a gynecologist.

Before starting combined antiaggregant therapy, the cardiologist should evaluate the patient's reproductive status, hematological parameters in case of abnormal bleeding from the uterus, the possibility of changing combined antiaggregant therapy during pathological bleeding, and also immediately refer to the gynecologist for further examination. The gynecologist, in turn, should evaluate the history of menstruation, perform an ultrasound examination of the pelvic organs, and also not prescribe hormonal treatment for established coronary artery disease, vascular or venous thromboembolic complications.

Thus, for the treatment of patients with a combination of UIK and BM, various specialists (x-ray endovascular and vascular surgeons, gynecologists, cardiologists) should be involved to determine the optimal treatment tactics. X-ray endovascular intervention allows not only objective confirmation, but also a complete picture of the nature and distribution of the pathology. The choice of treatment tactics in favor of X-ray endovascular embolization led to sufficient and rapid elimination of the pathology, taking into account the main disease. Currently, there are no clinical guidelines for the treatment of patients with ischemic heart

disease and BM, as well as data on the effect of combined antiplatelet therapy on the occurrence of recurrent bleeding after BAE. Conducting clinical trials allows for the development of an optimal interdisciplinary approach to the management of this category of patients.

REFERENCES:

1. ALISHEROVNA M. K., XUDOYBERDIYEVICH G. X. Treatment of Chronic Heart Diseases Insufficiency Depending On the Condition of the Kidneys. – 2021.

2. Alisherovna M. K. 24-Hour Abp Monitoring Of Blood Pressure In Patients With Chronic Heart Failure And The State Of Kidney Function //Central asian journal of medical and natural sciences. – 2021. – т. 2. – №. 1. – с. 197-204.

3. Alisherovna M. K., Tatlibayevich S. Y. Prevention of the progression of chronic kidney disease by decompensation of chronic heart failure //Euro-Asia Conferences. –2021. – Т.

4. – №. 1. – С. 54-58. 4. Tairov D. R., Yarmukhamedova S. K., Khusainova M. A. Characteristics of Metabolic Syndrome and Cardiovascular Injuries in Gout.

5. Alisherovna K. M., Tatlibayevich Y. S. RENAL HEMODYNAMICS AND GLOMERULAR FILTRATION IN PATIENTS WITH HYPERTENSION DISEASE AT THE AGE OF 40-60 YEARS //Euro-Asia Conferences. – 2021. – Т. 3. – №. 1. – С. 146-149.

6. Khusainova M., Nazarov F. Features of the circadian rhythm blood pressure in patients heart failure and impaired renal function //InterConf. – 2021.