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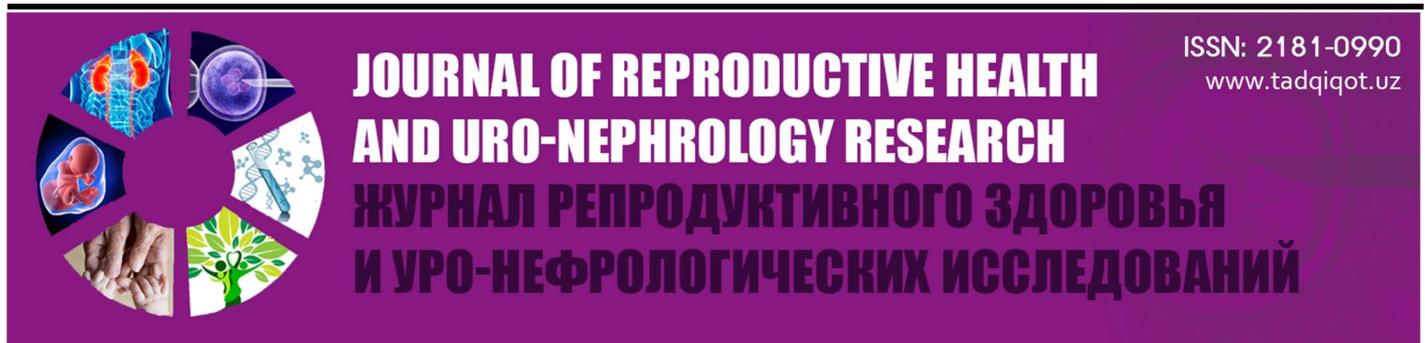
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Samarkand, Uzbekistan**CAESAREAN SECTION IN WOMEN WITH A UTERINE SCAR. MODERN METHODS OF MANAGEMENT
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Samarqand, O'zbekiston**BACHADON CHANDIG'I BO'LGAN AYOLLARDA KESARCHA KESISH OPERATSIYASI. ZAMONAVIY OLIB BORISH
USULLARI (ADABIYOTLAR TAHLILI)**

Relevance: According to WHO, the frequency of caesarean section ranges from 10-15% in economically developed countries. In some obstetric hospitals, it has reached 30-40% or more, continuing to increase. According to the world literature, every fourth woman is delivered by caesarean section, and every fifth of them has a postoperative period with complications. In Uzbekistan, this operation is performed with a frequency of about 17-20%, while the European region is characterized by a frequency of 14-24%, in the USA - 29% of all births, and in Chile and Brazil - 40%. Over the past 10 years, there has been an increase in this indicator by approximately 1.5-2 times. In

its development, this operation went through many stages, at each of which the technique of its implementation was improved. The maternal mortality rate is 0.2% and is largely dependent on the factors leading to surgery.

Objective reasons for the increase in the frequency of caesarean section in modern obstetrics:

- an increase in the number of patients with a scar on the uterus after caesarean section, the refusal of medical workers to conduct labor with a scar on the uterus through the natural birth;

- growth of patients with a scar on the uterus after conservative myomectomy, performed by laparoscopic access, with coagulation a node of myoma;

- pregnant women after IVF (often after repeated attempts);
- methods for obtaining information about the state of the fetus, which can lead to overdiagnosis of fetal distress (CTG, ultrasound).

Operation results are affected by:

- timeliness of implementation;
- methodology and scope;
- the condition of the patient;
- qualifications of the surgeon;
- anesthetic support; medical provision;
- suture material;
- the presence of blood and its components, infusion media;
- tools and technical equipment clinics, etc.

Classification according to ICD-X:

O34.2 Postoperative uterine scar, requiring the provision of medical assistance to the mother.

O75.7 Vaginal delivery after previous caesarean section.

Etiology and pathogenesis: A scar on the uterus occurs as a result of the following surgical interventions on the uterus:

- delivery by CS operation in history (78 -84%):
 - one CS operation (86-88%).
 - two CS operations (10-13%).
 - three or more CS operations (1%).
- history of myomectomy (10-12%);
- dissection of the septum of the uterine cavity (4-5%);
- surgical interventions associated with anomalies in the development of the uterus (up to 1%);

To date, it is not known what percentage of patients with uterine scar after CS can be selected for attempted vaginal delivery from the entire population of patients with uterine scar. According to statistics from different countries, from 13 to 30-50% of patients with a scar on the uterus can be selected for attempted vaginal delivery.

Classification of the scar on the uterus:

- according to the degree of consistency of the scar on the uterus: wealthy - scar on the uterus, insolvent - scar on the uterus.
- according to the localization of the scar on the uterus: in the lower segment of the uterus, in the body of the uterus, partly in the lower segment, partly in the body of the uterus (after an isthmic-corporeal incision on the uterus), in the fundus of the uterus.

Diagnosis of a postoperative scar:

The diagnosis of postoperative uterine scar, requiring the provision of medical assistance to the mother, is established on the basis of an indication of myomectomy (or other operations) with opening of the uterine cavity or delivery by CS surgery in history.

Wealthy scars include scars with a thickness of 2.5 mm or more, in the absence or a minimum number of echopositive inclusions (elements of connective tissue), with good vascularization.

Also, the consistency of the uterine scar and the possibility of spontaneous delivery are indicated by the absence of local pain in the pregnant woman on palpation of the uterine scar after CS, bloody

discharge from the genital tract and fetal hypoxia according to cardiotocography (CTG), which does not contradict the above document.

Preparing for a caesarean section

Preoperative preparation includes:

- 1) collection of anamnesis;
- 2) assessment of the condition of the fetus (position, presentation, heartbeat, size) and mother (Ps, blood pressure, respiratory rate, consciousness, condition of the skin, palpation of the uterus, the nature of vaginal discharge, vaginal examination);
- 3) general blood test (detailed), biochemical blood tests (general protein, albumin, glucose, urea, creatinine, bilirubin (gen., etc.), AST, ALT, etc. according to indications), coagulogram (APTT, PT, TB, 15 fibrinogen), blood type, Rh factor, Rh antibodies, testing for syphilis, HIV, hepatitis B and C;
- 4) ultrasound to determine the state of the scar on the uterus;
- 5) autodonation (preparation of autoplasm);
- 6) consultation with an anesthesiologist;
- 7) consulting related specialists, if necessary;
- 8) prevention of aspiration pneumonitis. 6-8 hours before the planned operation, it is necessary to limit the intake of food, and 2 hours before - liquids (water, sports drinks, juices without pulp, etc.). However, in patients with an increased risk of aspiration (obesity, diabetes mellitus, difficult airways), fluid intake should also be limited. Drinking fluids during labor does not increase the risk of maternal complications, but eating during labor does;
- 10) checking in the operating room - the position of the fetus, presentation and position, the presence of a heartbeat;
- 11) in all cases when a decision is made to perform a CS, an assessment of the risk of pulmonary thromboembolism should be carried out in accordance with the current regulatory documents. To prevent this complication, mechanical methods are used (elastic compression of the lower extremities, early postoperative activation of the woman) and, depending on the degree of risk;
- 12) antibiotic prophylaxis;
- 13) prevention of hypotension in the mother: the position of the woman on the operating table with an inclination to the left side by 15°. Preoperative infusion of crystalloids, use of ephedrine or phenylephedrine under regional anesthesia;
- 14) antiretroviral prophylaxis for HIV-positive women who did not receive antiretroviral therapy;
- 15) before the operation caesarean section, each woman must take informed consent for surgery and blood transfusion, in which all possible risks and complications, both from the mother and the fetus, should be indicated;

Surgical technique of caesarean section in women with a scar on the uterus.

The position of the woman on the back, may be with a lateral tilt.

The skin incision can be vertical (along the midline or paramedian) or transverse in the lower part of the abdomen (pic. 1).



Pic. 1 The main types of incision on the skin during caesarean section.

1. Perform the removal of the old postoperative scar (pic. 2) depending on the selected surgical approach.



Pic. 2 Removal of the old postoperative scar.

In emergency situations, a lower median incision is preferable, because the time of extraction of the fetus is reduced, the size of the wound is well regulated, the risk of muscle damage is reduced. In elective cesarean section operations, a Joel - Cohen transverse incision is performed.

2. Deepen the incision with a scalpel 2-3 cm in the middle of the incision in the transverse direction through the subcutaneous tissue to the aponeurosis. It is not necessary to separate the subcutaneous tissue. At the same time, blood vessels and nerves remain intact, since the subcutaneous tissue zone along the midline is the most bloodless (pic. 3).

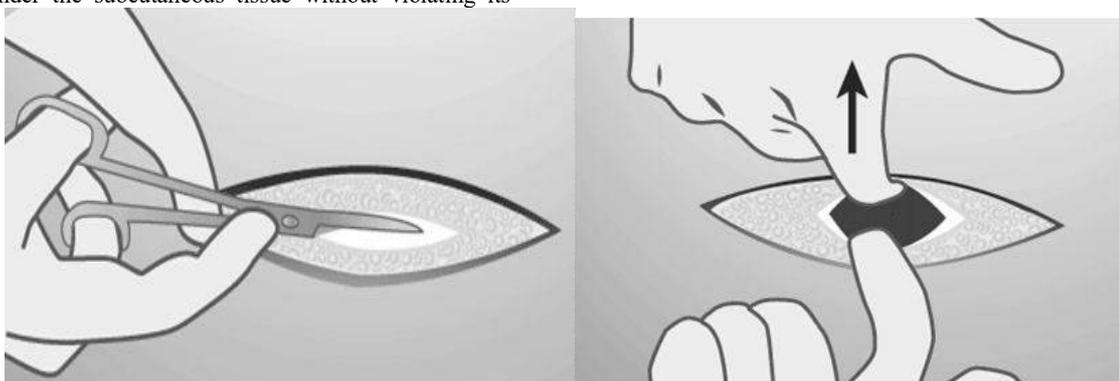


Pic. 3 Deepening of the wound after removal of the old postoperative scar.

3. Make small transverse incision of the aponeurosis with a scalpel. The use of a separate scalpel to incise the skin and deeper tissues is not required for CS because does not reduce the frequency of wound infections.

4. Continue the transverse incision of the aponeurosis (pic. 4) in both directions under the subcutaneous tissue without violating its

integrity: position the tip of the partially open scissors so that one blade is located above and the other is located below the aponeurosis. Move the scissors laterally, first away from you, and then towards you. At this level, there may be adhesions between the muscles and the aponeurosis, so care must be taken due to the high risk of muscle damage.

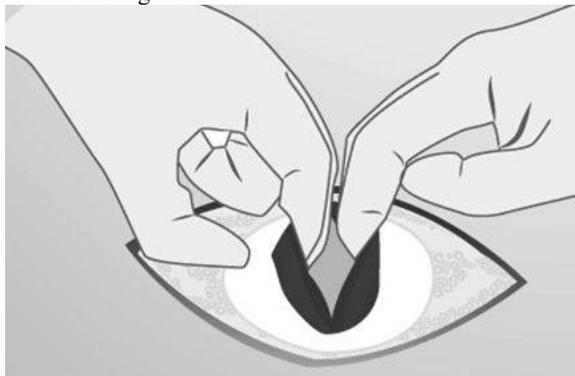


Pic. 4 Section of the aponeurosis.

5. Separate the aponeurosis from the muscles using scissors, this in turn is the prevention of rupture, tear and tear of the muscles.

6. Taking into account the repeated surgical delivery and the presence of an adhesive process, the separating of the rectus muscles is carried out together with the parietal peritoneum (pic. 5.). To do this, with your index fingers, stretch the parietal peritoneum in the transverse direction in the upper corner of the wound until a small hole is formed. Expand the hole with your index fingers in the caudal and cranial directions. If the peritoneum is stretched cranially and caudally, it is torn transversely, which prevents injury to the bladder. The use of fingers when entering the abdominal cavity prevents injury to the intestines. Next, the surgeon and assistant place the index and middle fingers of the

right hand along the middle line, grabbing the muscle and peritoneum, and then simultaneously separate them by traction with a balanced and growing force. This movement must be carried out with light external rotation, which allows you to spread the upper part of the incision more than the lower one. Often it is necessary to additionally use the index and middle fingers of the left hand of the surgeon and assistant, which are placed over the right hand to provide the necessary force to open the edges of the wound. Be careful with the application of force, as there is a high risk of damage to muscles and blood vessels during repeated operations. This maneuver allows you to move all the vessels and nerves to the side, without damaging them, to enter the abdominal cavity.



Pic. 5 Separating the muscles of the abdomen and parietal peritoneum.

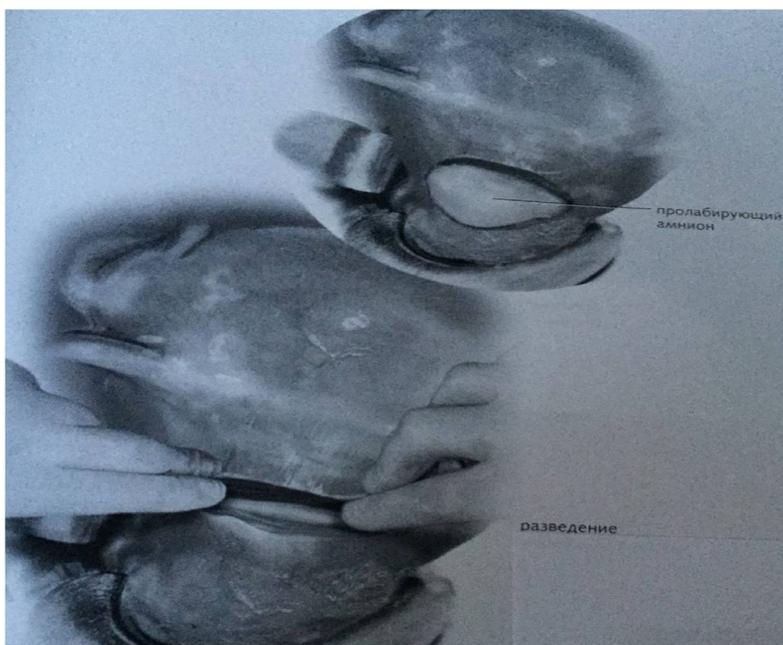
7. Next, identify lower segment in the area of the scar and urinary bladder.

8. Make an incision on the uterus 1 cm above the area of the old scar in the absence of contraindications to such an incision (placenta previa, uterine fibroids, etc.). In case of incomplete rupture along the scar, which is identified during the operation, a blunt opening of the scar in the area of the rupture is recommended.

9. With your fingers, stretch the edges of the opening on the uterus in the transverse direction. Use the thumb of the right hand mainly for

fixing in the far corner of the wound, and the index finger of the left hand for dilution in the near corner of the wound. The thumb is thicker than the index finger, which reduces the risk of injury to the vessels of the uterus. Continue the opening more to the right than to the left, as the uterus is predominantly rotated to the right at the end of pregnancy.

10. After an incision on the uterus with a whole prolapsing fetal bladder, we open it (pic. 8).



Pic. 6 An incision on the uterus with a prolapsing fetal bladder.

11. Place four fingers under the head of the fetus and remove it from the wound. The assistant presses on the fundus of the uterus to help remove the baby. Fingers take up less space, which reduces the likelihood of injury to the uterus when removing the fetus.

12. After the baby is born, the anesthesiologist injects 5 units of oxytocin intravenously. The placenta is removed by controlled traction

on the umbilical cord. To do this, the umbilical cord is kept in a state of light tension until spontaneous separation of the placenta begins. Gently pulling on the umbilical cord, the placenta is removed from the uterine cavity. Do not pull on the umbilical cord in the absence of uterine contraction and signs of separation of the placenta - this can lead to uterine eversion.

13. Also from the abdominal wound, placing the whole hand behind the uterus, massage the uterus to stimulate its contractions. In case of heavy bleeding from the placental area, squeeze the uterus between the palms. This method gives significant hemostasis. Continuing the massage of the uterus, gauze napkins remove the remnants of the fetal membranes and tissue from the uterus, stimulating its contractions. Curettage of the uterine cavity according to indications. Treatment of the uterine cavity with povidone-iodine according to indications.

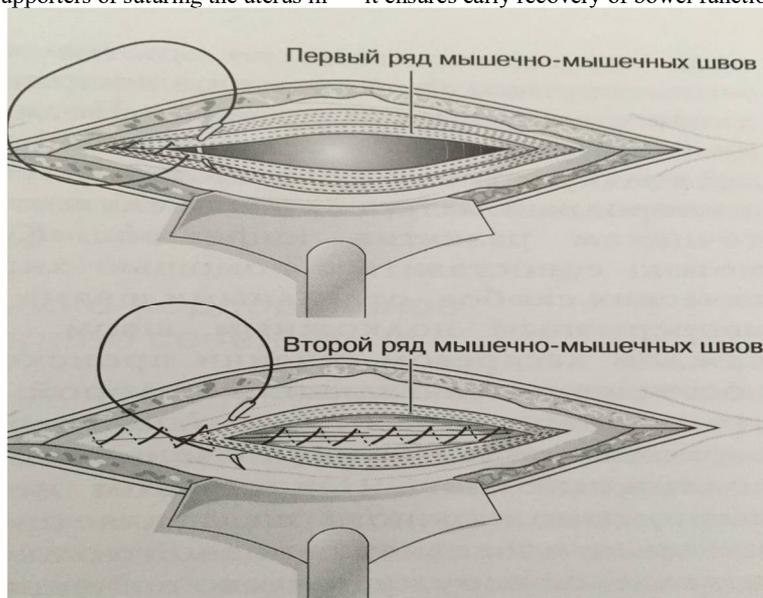
14. Grasp the center of the lower edge of the wound on the uterus with an atraumatic forceps. If necessary, dilate the cervical canal with a Hegar dilator.

15. Sew up the incised wall of the uterus with a single-row or two-row suture (pic. 9.). Start at the edge of the incision that is closest to you. Use a long ligature (use only! synthetic absorbable suture - material). Step back 1 cm from the edge of the incision above and below to ensure sufficient hemostasis. Be careful at the bottom edge of the incision to avoid injury to the bladder. In the case of pronounced thinning of the lower segment, it may be necessary to apply a second row of sutures. The uterus can be removed from the abdominal cavity or left in the cavity during suturing. Supporters of suturing the uterus in

the abdominal cavity indicate a higher incidence of nausea and vomiting during surgery, pain syndrome during removal of the uterus, while supporters of removal point to a decrease in blood loss and the duration of the operation. The obstetrics study found no difference in complication rates, except for a reduction in postoperative fever with uterine exteriorization. There is currently no evidence that evacuation or, conversely, leaving the uterus in the abdominal cavity while it is sutured is more beneficial, so some guidelines do not recommend hysterectomy, while others, on the contrary, are widely used. The experience of many obstetric institutions shows that the removal of the uterus for its suturing is a safe procedure that creates favorable conditions for restoring the integrity of the wall.

16. Control of hemostasis. Make sure hemodynamics are within normal limits. If hemostasis is insufficient, place additional sutures to ensure there is no bleeding.

17. Remove blood clots. Do not use a swab or towel to remove all liquid blood from the abdominal cavity. Liquid blood is absorbed by the peritoneum. Amniotic fluid that has entered the abdominal cavity has a bacteriostatic effect. Minimal bowel manipulation is very important as it ensures early recovery of bowel function.



Pic. 7 Suturing the uterus.

18. Drainage (including contra-aperture) of the abdominal cavity is mandatory in 100% of cases.

19. Visceral and parietal peritoneum are not sutured. Although a significant difference between sutured and unsutured peritoneum has not been proven. Cover the renewed wall of the uterus with an omentum. In a short period of time, the edges of the peritoneal wound will recover (12 hours).

20. Conduct a thorough revision and hemostasis of the muscles. With each subsequent caesarean section, the risk of muscle damage increases.

21. Grab the edges of both sheets of aponeurosis at the corners of the wound with clamps. Place two more clamps on the upper and lower edges of the aponeurosis in the middle. Restore the integrity of the aponeurosis with a single-row interrupted or continuous suture without transfer with a slowly absorbable suture. Guide each thrust slightly diagonally across the incision. Do not use continuous double crochet stitch. Be careful around the edges of the incision so as not to damage the vessels.

22. Routine suturing of the subcutaneous tissue is not necessary unless it is more than 2 cm thick. Sew up the skin.

23. Suture the skin with a cosmetic suture or mattress sutures (if indicated). Clamp the incision edges with clamps between the sutures to ensure proper alignment of the wound edges. Leave the clamps on for 5-10 minutes. The edges of the wound are matched. This simple way of tissue repair reduces time, ensures the reliability of the suture, and prevents the development of keloid scars.

24. Begin early fluid intake (two hours after surgery), perform early lifting of the patient immediately after the effect of anesthetics. There is no need for fasting after surgery, as paresis of the intestine is very rare with this method. Early mobilization reduces the risk of thromboembolic complications and reduces the intensity and duration of postoperative pain. Reducing the feeling of pain facilitates breastfeeding, and this in turn contributes to the contraction and involution of the uterus.

25. Remove the sutures on the fifth day after the operation if there are no contraindications. It reduces the risk of infection and keloid scars

It must be remembered that the routine removal of the uterus into the wound for the purpose of suturing, compared with no withdrawal, does not have a significant difference in most cases. A single-row suture on the uterus, compared to a double-row suture, is associated with a significant reduction in the duration of the operation and the volume of blood loss, reduces postoperative pain, but is associated with a greater likelihood of uterine rupture when attempting vaginal delivery after a previous caesarean section. Refusal to suturing the peritoneum (parietal and visceral) reduces the time of surgery, the frequency of fever in the postoperative period, the length of stay in the hospital, the number of doses of analgesics in the postoperative period. Drainage of the abdominal cavity is carried out (according to indications). Routine drainage of subcutaneous tissue is not recommended, as it has no advantage over no drainage given the incidence of wound infection, fever, and endometritis. But the need for drainage may be due to the

characteristics of the operation, so the final decision remains at the discretion of the surgeon. Routine suturing of the subcutaneous tissue is optional, except when its thickness is more than 2 cm. Sewing of the subcutaneous tissue reduces the complex risk of complications from the postoperative wound (hematoma, seroma, wound infection, wound dehiscence). The risk of hematoma and seroma in the case of suturing the subcutaneous tissue is less compared to the absence of suturing. Data regarding which skin closure technique is optimal are not yet available. The choice of skin suturing technique is at the discretion of the surgeon.

Anesthesia for caesarean section

Anesthesiologist should conduct a preoperative examination of the pregnant woman, the main purpose of which is to assess the general status of the patient and determine the degree of anesthetic risk. In addition to clarifying the general condition of the woman, the anesthesiologist must determine the possibility of developing aortocaval and aspiration syndrome and assess the presence of signs of difficult intubation.

The choice of the method of anesthetic management depends on the indications for surgery; the urgency of the intervention; the wishes of the woman in labor; anesthesiologist experience; obstetrician preference.

Cesarean section can be performed under general, regional (spinal, epidural or combined spinal - epidural) or local infiltration anesthesia. In most cases, preference should be given to regional methods of anesthesia, which allow the woman to be more active and have immediate contact with the child.

When choosing an anesthesia method, it is necessary to take into account the development of certain potential complications: difficult intubation (frequency 1: 300 anesthesia), inadequate analgesia, the development of arterial hypotension (the frequency is much higher when spinal or epidural anesthesia is used), respiratory depression, nausea, vomiting, itchy skin.

There is no evidence for the benefit of regional or general anesthesia in terms of maternal and neonatal outcomes. General anesthesia, compared with regional anesthesia, reduces the time to the start of a skin incision, but reduces Apgar scores by 1 and 5 minutes. Spinal anesthesia compared with epidural reduces the time to surgery and has no difference in Apgar scores and the incidence of hypotension.

In the presence of severe bradycardia in the fetus, the development of hemorrhagic shock (uterine rupture, significant placental abruption), seizures, allergies to local anesthetics, hypocoagulation, significant anatomical anomalies of the spine, generalized infection and lack of equipment for continuous monitoring, general anesthesia should be performed.

Postoperative analgesia

The woman should be informed about the different types of postoperative analgesia.

Adequate pain relief after surgery is especially important because women in labor have an increased risk of developing thromboembolic complications, and effective analgesia makes it possible to mobilize early and provide care for a newborn child.

Pain relief after surgery, which was performed using general or spinal anesthesia, consists in the combination of the administration of opioids with non-steroidal anti-inflammatory drugs. The use of self-controlled analgesia is more effective.

If intrathecal opioids are used, hourly monitoring of respiratory rate, sedation, and pain during the first 24 hours (morphine) is necessary.

Women receiving opioids in the epidural space should have their respiratory rate, sedation, and pain monitored every ½ hour and at least 2 hours after the end of administration.

The woman is given morphine (0.15–0.25 mg intrathecally) for intraoperative and postoperative analgesia, as this reduces the need for additional analgesia after CS. Morphine 2.5–5.0 mg can be used alternatively in the epidural space.

In the absence of contraindications to the use of NSAIDs, they can be prescribed in the postoperative period, as they reduce the need for opioids.

Postoperative wound care: the dressing is removed 24 hours after the CS, the condition of the wound (pain, redness, discharge from the

wound) is monitored daily, it is treated, the body temperature is controlled.

Replenishment of blood loss

Infusion-transfusion therapy for caesarean section should be timely and adequate. Replenishment of blood loss during caesarean section must be carried out taking into account the peculiarities of hemodynamics and the hemostasis system during pregnancy. Considering that BCC during pregnancy increases by almost 25–40%, and the maximum values are achieved during childbirth due to the acceleration of blood flow, periodic ejection of blood from the uteroplacental circle, and also as a result of mobilization of blood from the liver and spleen. It should also be remembered that immediately after the extraction of the fetus and afterbirth, the uterine - placental blood flow is turned off, as a result of which 500–600 ml of deposited blood enters the general blood flow. We should also not forget about the already mentioned activation of the hemostasis system. It must be remembered that in general, the blood flow during caesarean section gets elements of the fetal egg, rich in thromboplastic substances. The amount of blood loss during caesarean section varies from 500 to 1000 ml, averaging 800 ml.

In a set of measures to replenish blood loss after caesarean section, in particular, blood components are used (erythrocyte mass, suspension of washed erythrocytes, plasma). Indications for blood transfusion are severe anemia (hemoglobin less than 80 g/l, hematocrit less than 25%) and hypoproteinemia (general protein below 50 g/l). Even with normal blood loss, blood transfusion is recommended for severe pre-eclampsia due to severe hypovolemia. It is advisable to carry out blood transfusion in the amount of 50% of the lost blood with blood loss up to 1% of body weight or 50–70% with higher blood loss. With blood loss of more than 1% of body weight, as well as in adverse situations, such as preeclampsia, anemia, placenta previa or abruption, etc., it is mandatory to transfuse single-group fresh frozen plasma.

Prevention of purulent-inflammatory diseases.

After caesarean section, the involution of the uterus, in comparison with childbirth through the natural birth canal, changes in a certain way. This is manifested by a slow reduction in the transverse and longitudinal dimensions, thickening of the anterior wall, lagging behind the increase in the thickness of its posterior wall. There is no expansion of the uterine cavity in the lower third, which is characteristic of the normal course of the process of uterine involution after normal childbirth.

The main measures for the prevention of purulent-inflammatory diseases after caesarean section include:

- performing a caesarean section according to strict indications, taking into account the necessary conditions for this and contraindications after adequate examination and preparation;
- preliminary study of the nature of the microflora of the genitourinary tract;
- timely execution of the operation and an increase in the share of planned operations; the use of rational surgical techniques and appropriate synthetic suture materials;
- adequate anesthesia and rational infusion-transfusion therapy;
- the use of modern methods of instrumental control over the nature of the involution of the uterus and the healing of the postoperative wound.

The most common surgical complications are:

- bleeding from aa. epigastricae inferiores et vv. epigastricae inferiores, a.a. circumflexa ilium profundus;
- injury to the bladder
- wound of the ureter;
- ligation of the ureter;
- injury of ligaments;
- injury of the retrovesical plexus of venous;
- uterine rupture during caesarean section;
- rupture of the uterus along the old scar;
- hypotonic uterine bleeding;
- intestinal injury;
- dissection of an uninfected urachus;
- false restoration of the integrity of the wound of the anterior wall of the uterus.

Clinical and laboratory studies after caesarean section.

After operative delivery, the following studies are necessary:

- 1) Clinical general blood test (deployed) on the 1st, 3rd day (according to indications on the 0th day);
- 2) Hemostasiogram on the 1st, 3rd day only in the group of medium and high risk for thromboembolic complications (according to indications on the 0th day);
- 3) Ultrasound examination on the 3rd-4th day after the operation;
- 4) Consultation of related specialists: therapists, surgeons, neurologists, etc. only by indications.
- 5) Vaginal examination is carried out according to indications;
- 6) If complications arise, the examination plan may change.

Ultrasound is effective, safe and non-invasive assessment of the state of the uterus in the postpartum period, however, it is necessary to focus on clinical and laboratory indicators.

Criteria for normal ultrasound after caesarean section:

1. The study should be carried out on the 3-4th day with a moderate filled bladder;
2. When measuring the width of the uterine cavity, the maximum allowable expansion in the upper and middle thirds is 1.5 cm, in the lower thirds - 1.8 cm.;
3. At any width in the uterine cavity, the remains of placental tissue, which is defined as the formation of increased echogenicity, should not be visualized rounded forms of spongy structures with the presence of vascularization zones.
4. Remains of the rejection decidual tissues can be visualized normally, the interpretation of the results depends on the number of tissue fragments.
5. The presence of gas (hyperechoic inclusions) in the uterine cavity is acceptable, but the interpretation of the results depends on clinical and laboratory data.
6. When assessing the suture area on the uterus and anterior abdominal wall:
 - 1) infiltrates should not be visualized
 - 2) in the presence of pathological formations, it is necessary to clearly describe size and localization, with large sizes (more than 5 cm), the interpretation of the results depends on clinical and laboratory data and dynamic ultrasound data.
 - 3) in the presence of hyperechoic formations in the suture area, it is necessary to check with surgeons for the presence of hemostatic sponges.

7. When assessing the area of parametrium, it is necessary to assess the presence or absence of space-occupying formations (including retroperitoneal localization) and hematomas.

8. The amount of free fluid in the pelvis and in the abdominal cavity is also estimated.

Breastfeeding: early breastfeeding, mother and child being together are recommended.

Discharge from the hospital.

Early discharge is preferable in the absence of hyperthermia and uncomplicated postoperative period (4-5 days):

- 1) the size of the uterus corresponding to the normal terms of involution according to the data of a gynecological examination and ultrasound;
- 2) the absence of cracks in the nipples with signs of suppuration and lactostasis;
- 3) the area of the sutures without signs of inflammation, discharge is possible with non-absorbable suture material, followed by removal of the suture thread at the place of residence;
- 4) absence of hyperthermia (above 37.2°C);
- 5) an increased number of leukocytes in the blood has a low prognostic value for confirming the presence of an infection. In this case, the blood formula must be within the limits.

At discharge, all women receive postpartum counseling.

Rehabilitation.

Providing information about the regime of a woman in the postoperative postpartum period, the beginning of sexual life, recommendations for contraception.

For women with severe extragenital pathology, observation by a specialized specialist with the implementation of his recommendations.

Prevention.

Examination by an obstetrician-gynecologist in the postoperative period.

For women with severe extragenital pathology, if necessary, the prevention of complications of the underlying disease is carried out, agreed with the specialist.

Compliance with the principles of individual hygiene in the postoperative period.

Compliance with effective contraception for 1 year after surgery, including the method of lactational amenorrhea (MLA).

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