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EARLY PREGNANCY LOSSES - A NEW UNDERSTANDING OF HORMONAL DISORDERS

Abstract: In the etiological structure of habitual miscarriage, the role of endocrine factors remains relevant. However, more and more researchers are now coming to the conclusion that there is a close relationship and mutual regulation between the endocrine and immune systems, which is realized in the endometrium at the early stages of implantation [1,3,8,10].

Progesterone promotes a full-fledged secretory transformation of the endometrium, which is necessary for the introduction of blastocysts. In addition, during pregnancy, gestagens ensure the growth and development of the myometrium, its vascularization and relaxation by leveling the effect of oxytocin and reducing prostaglandin synthesis [7,8,9].

Key words: miscarriage, menstruation, dufaston, drug, goal.

According to functional diagnostic tests, luteal phase insufficiency (NLF) occurs in 85% of women with habitual early pregnancy losses.

These disorders can be a consequence of both defective steroidogenesis and insufficiency of the endometrial receptor apparatus. This pathology is

observed in women with congenital malformations of the uterus, with genital infantilism, with intrauterine synechiae, and is also often found in chronic endometritis [2,5]. In such situations, the therapeutic approach should take into account the etiology of the formation of an inferior luteal phase and neutralize unfavorable predisposing factors. So, in case of chronic inflammatory process in the uterus and ovaries, the first stage should be the appointment of individually selected antibacterial, immunomodulatory therapy (in some cases against the background of systemic enzyme therapy), which will normalize the condition of the endometrium and ensure adequate folliculogenesis. With malformations of the uterus and genital infantilism, it is possible to use acupuncture, copper electrophoresis, as well as cyclic hormone therapy, in particular, with Femostone in order to create an adequate proliferative and subsequent secretory transformation of the endometrium. In all the above cases, the final stage of preparation for pregnancy should be the appointment of gestational support, since there is evidence of an increase in the expression of progesterone receptors under the influence of an increase in its concentration in the blood. For this purpose, the administration of the drug Dufaston at a dose of 20 mg per day in the second phase of the menstrual cycle not only plays the role of substitution therapy, but also contributes to the normalization of the endometrial receptor apparatus. Dufaston (didrogesterone) is a highly selective progestogen, active when taken orally. It is especially important that the drug in therapeutic doses does not block ovulation, therefore, it can be used in the intended fertile cycle. Dufaston has no androgenic, estrogenic or corticosteroid activity.

It has no feminizing effect on the male fetus and no masculinizing effect on the female fetus. In addition, as has been shown, Dufaston does not cause drowsiness and is well tolerated.

In recent years, the immunocorrecting effect of progestogens, in particular, the drug Dufaston, has been proven. The link between the immune and endocrine systems in the early stages of gestation is progesterone-induced blocking factor (PIBF). PIBF is a protein weighing 35 kilodaltons, which is produced by CD 56 cells in the utero–embryonic space in response to the

activation of progesterone receptors. The next link is protective immunomodulation under the influence of PIBF, which consists in reducing the activity of natural killer cells and lymphokine–activated cells, inducing the synthesis of regulatory cytokines (interleukins 4, 10), suppressing the processes of embryo rejection and ensuring normal trophoblast invasion [7,8,10,11]. On the other hand, the production of cytokines that cause inflammatory and thrombophilic reactions (tumor necrosis factors, interleukin–1, etc.) is suppressed. In addition, progesterone and its derivatives stimulate the production of proteins in the endometrium, in particular, the protein Tj6, which causes apoptosis of natural killers.

In recent years, the role of inadequate development of the fetal egg, which does not adequately stimulate the maternal body to produce hormones, has been discussed [8,9]. Hypoestrogenism at the stage of selection of the dominant follicle leads to a decrease in the ovulatory peak of LH and a decrease in the level of estradiol, a slowdown in the rate of development of the preovulatory follicle, premature induction of meiosis, intrafollicular over-aging and degeneration of the oocyte. A decrease in estradiol production and, as a consequence, insufficient progesterone production lead to a lack of proper secretory transformation of the endometrium. In these conditions, without stimulation of folliculogenesis by one postovulatory appointment of progesterone, it is impossible to achieve the formation of a full-fledged fetal egg and subsequent successful implantation. The appointment of cyclic hormone therapy with Femoston with the addition of an additional 10 mg of Dufaston in the second phase of the cycle from day 16 normalizes the relationship in the hypothalamus–pituitary–ovary system and, as a result, promotes full–fledged folliculogenesis. Ovulation stimulation carried out after 2-3 menstrual cycles against this background gives a positive therapeutic effect. After pregnancy, treatment with Dufastone in a daily dose of 20 mg should be continued until 16-18 weeks of gestation, which contributes to the full formation of the placenta.

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