the endometriosis nodi, 2 – pharmocotheraphy) is pathognomonically substantiated. First stage envisages destruction of all or most of endometriosis nidi which cause number of condition leading to depressed generative function, while the second stage inactivates eutopic endometrium which is the constant source of endometriosis.

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SUBSTANTIATION OF ADJUVANT INTRAPERITONEAL CHEMOTHERAPY IN COMPLEX TREATMENT OF WIDESPREAD ENDOMETRIOSIS (III–IV STAGES)

Preface. Hormonal therapy is the integral component of complex treatment of all forms of endometriosis. The saved up 20-years world experience shows, that the best results are achieved with GnRH-agonists using, and the basic mechanism of their action is amenorrhea achievement. The mentioned mono- or adjuvant therapy is always coexisting with development of by-effects: the developed picture of climacteric infringements, mental and vegetative frustration. It does impossible and inexpedient carrying out of hormonal therapy during more, than 6-8 months. Frequency of relapse of clinical signs reaches 48% after GnRH canceling within first two years of supervision. Works by Thipgen J.T. et al. (2004) have proved expediency of carrying out of intraperitoneal chemotherapy with doxorubicin and cisplatin in disseminated endometrial cancer management, and also have confirmed efficiency of application intraperitoneal chemotherapy (ICT) with these drugs with the purpose of suppression of growth and resorbtion activation of endometrial deposits.

Objective. To show expediency of carrying out of ICT with cytostatics in treatment of the widespread endometriosis.

Material and methods. Carrying out of hyperthermal intraoperational intraperitoneal (ICT) and normothermal postoperative chemotherapy with doxorubicin 60 mg/m2 and cisplatin 50 mg/m2 at 23 patients with endometriosis III-IV (ASRM staging). Control group – 10 women – adjuvant therapy with GnRH agonists for 3 months

Results. Adjuvant ICT was effective at treatment of the widespread endometriosis and has led to proof positive clinical effect at 93,4% of women within the first year of supervision. Single-staged adjuvant ICT at the widespread endometriosis is not accompanied by development after operation of any by-effects; and performance of second-look laparoscopy at 14 (60,9%) women has shown, that efficiency of ICT is higher, than adjuvant 3-4 month courses of GnRH agonists (Zoladex, Buserelin) and leads to full resorbtion of endometriosis heterotopies and surrounding infiltration. The use of "soft" modes of CT (30 minutes perfusion of 42 C solutions) was not accompanied by development of adhesive process after operation in any case, and, hence, had no negative mechanical action on fertility patients. The specified variant of therapy did not result in ovulatory function disturbances.

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OPTIMAL PROTOCOL OF NORMO- AND HYPERTHERMAL INTRAPERITONEAL CHEMOTHERAPY (ICT) IN COMPLEX MANAGEMENT OF THE WIDESPREAD ENDOMETRIOSIS (III–IV STAGES)

At a hyperthermal variant it is better to begin the intraperitoneal chemotherapy (ICT) right after performance of a surgical stage. Perfusion is better to carry out by introduction through troacar ports of 2 laparoscopic irrigation tips connected to perfusion system. It's need to provide a horizontal position of the patient, so that the pelvis would be covered with perfusing fluid. An irrigation tip leaves in Douglas pouch, aspirational – collects perfusate from utero-vesical pouch. Perfusion speed is not less than 500 ml/mines, perfusing temperature on input – 42C, duration of perfusion – 30 minutes. The total perfusate amount is 2000-3000 ml in which the demanded doze of cytostatics is contained. There could be a fractional injection of 1000 ml of warm (42C) perfusate intraabdominally and its replacement each 3-4 minutes with new portion of warm solution – duration has to be increased up to 40 minutes, we leave drainage for removal of the rests of perfusate.

At normothermal variant – after performance of a surgical stage we place in an abdominal cavity 1000 ml of the saline containing cytostatics dose. In douglas pouch we leave a drainage not less than 7 mm in diameter which was opened later with 20-24 hours after the primary surgery for removal of the rests of perfusing fluid. Calculation of cy-

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