endometrial hyperplasia and polyposis; hypertecosis, tecomatosis, tumor-like formations and benign tumors in ovaries).

Results. Various forms of mastopathy were found in 94% of clinical cases (63 patients). The diagnosis of mastopathy was established, according to the data of ultrasonographic examination, X-ray mammography, cytological and/or histological studies. Diffuse form of chronic cystic mastitis (DCCM) was found in 74,6% of cases, nodal form of chronic cystic mastitis – in 19% of cases (including 3 patients with atypical proliferation), in 4,8% of cases fibrous adenoma of mammary gland was found, and a single case of intraductal papilloma was observed. During surgical treatment of primary disorder 46 patients underwent mono- or bilateral ovariectomy. Surgical intervention on mammary gland was carried out as a second step. A total of 4 sectoral resections and one central resection was performed. 11 patients refused the suggested surgery. Patients received no pharmacotherapy of primary disorder. Five years later thorough clinical examination of the patients has revealed that only 56,7% of women who underwent surgery of uterine appendages retained mastopathy. Bilateral ovariectomy has led to 30% reduction of DCCM, unilateral ovariectomy has led to 24% reduction. No progression of mastopathy was found in patients with nodal form of chronic cystic mastitis and fibrous adenoma of mammary gland, regardless of type of surgery. No recurrence was found in patient with intraductal papilloma after bilateral ovariectomy. All women with intact ovaries (21 patient) had mastopathy after the five-year period. Nodal form of chronic cystic mastitis was found in 9 women with previously diagnosed DCCM, and two patients were diagnosed with carcinoma *in situ*. In patients who initially refused surgical intervention on mammary gland, the size of nodes has increased more than 50% during the 5 years.

Conclusions. The data above supports, that patients with CHORS should be treated as a group at a high risk of benign hyperplasias and dysplasias of mammary glands, which, in its turn, requires thorough specialized examination prior to surgical treatment of the primary disorder. When the extent of surgical operation is determined in premenopausal women, it is necessary to consider that even severe organic changes in mammary glands can resolve after surgical postmenopause. It is clear, that correct and timely surgical intervention in CHORS patients allows prevention of breast cancer.

Gabitov N.A., Gybaidullin A.R., Mavlutova Z.V.

Oncologic hospital, Kazan, Russia

VAGINAL HYSTERECTOMY OF DIFFERENT RADICALITY IN THE TREATMENT OF UTERINE DESEASES

Objective. The aim of this study was the optimization of vaginal hysterectomy (VH) using laparoscopic technology (LAVH) in order to improve the results in the treatment of benign and malignant deseases of uterine. To determine the necessarity of LAVH, to learn the possibility of adnexectomy, pelvic lymphodissection, the use of needle keeper of original construction, to investigate the relationship of postoperative period between abdominal, LAVH and vaginal hysterectomy. The next aim is to study the results of surgical treatment in patients owing abdominal, vaginal and LAVH.

Patients. 273 women undergoing abdominal hysterectomy, vaginal and LAVH (group 1 – 100 VH, main indication – prolaps of uterus), group 2 – 65 LAVH, main indication is the combination of prolaps and benign tumour, group 3 – 57 women with benign tumour (myoma – 68%, cystadenoma – 30%, hyperplasia of endometrium – 37%, chronic inflomation of adnexis – 21%), group 4 – 51 women with cancer of cervix (2 – in situ, 9 – T1a, 8 – T1b, 1 – T2a) and corporis of uterine (2 – in situ , 19 – T1a, 10 – T1b). All the women of groups 2, 3 and 4 were undergone LAVH. Group 5 – 30 women with the cancer of cervix or corporis T1abNoMo, all of them were undergone abdominal operation. Laparoscopic operations were performed by the equipment of NPF "Endomedium". We used biinstrumental bipolar coagulation and original needle keeper (patent 2223053, 2003). We used different level of laparoscopic mobilization from the cutting of lig. teres and infundibulum pelvica (LAVH-1), plica vesicouterine and Duglas with lig.sacrouterine (LAVH-2), cardinal lig. with a.a.v.v. uterine (LAVH-3), pelvic lymphodissection (LAVH-4), Celio – Shauta (LAVH-5).

Results. Indications to the LAVH have no differences in compare with the abdominal operations and have many advantages in compare with VH. In past laparotomy was a contraindication to VH. LAVH in 2, 3 and 4 groups was performed at the patients who had laparotomy in past at 25,5% (44). In the 4 group 11 cases of LAVH-4 (21,5%), 6- LAVH -5 (7,8%). Duration of operation LAVH – 4, 5 – 111 and 254 minutes , blood loss 154 and 733 ml. During lymphodissection usually 17-19 nodes were eliminated. Algoritm of LAVH indication is designed.