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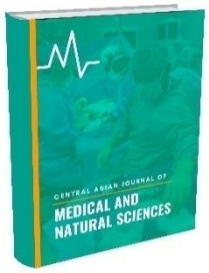

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Sexual Dysfunction in Women Suffering From Gynecological Diseases

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Abstract: The analysis of the long-term efficiency of operative treatment of pelvic prolapse for 156 women in periods ranging from 12 to 24 months was conducted through the questionnaire PISQ-12 (Pelvic Organ Prolapse and Incontinence Sexual Function Questionnaire), recommended for use in clinical practice by the International Urogynecologic Association and adapted by the authors for their work. The method of evaluating the effectiveness of surgical treatment of the pelvis and prostate has been streamlined through the introduction of a system of qualitative analysis of the results of the study of sexual function. found that operational treatments for pelvic prolapse have a positive effect on the sexual function of women. Significant differences in sexual function in the remote postoperative period depend on the type of operational benefit. The best effect with regard to the favorable dynamics of sexual function is achieved after laparoscopic operative treatment of pelvic prolapse compared with vaginal hysterectomy.

Key words: Sexual Function, postoperative period, vaginal hysterectomy, quality of life.

Introduction. The development of modern medicine is aimed at improving the quality of life for people with chronic diseases. Diseases associated with disorders in the human sexual sphere drastically reduce the quality of life [3]. Women's sexual dysfunction as a condition resulting from the combined effects of biological, psychological, and interpersonal factors and manifested by various sexual disorders does not receive due attention in Russia [2]. Meanwhile, sexual disorders that severely disrupt patients' mental balance and cause discord in interpersonal relationships may be primary specific sexological disorders or occur in a variety of organic diseases.Pelvic disorders such as prolapse of the pelvic organs and urinary and fecal incontinence occur in almost 33% of perimenopausal women and in 45% of menopausal women [1], which naturally negatively affect the social, psychological, physical, and sexual health of women.

Although there are a large number of valid and reliable questionnaires that examine sexual function, until recently their use in women with pelvic organ prolapse has been limited [3], which ensures the relevance of research on this topic.

The aim of the work was to optimize the system for evaluating the long-term results of surgical treatment of pelvic prolapse in women by performing a dynamic analysis of sexual function in patients after surgery.

Material and methods. Currently, the Pelvic Organ Prolapse and Incontinence Sexual Function Questionnaire (PISQ-31) is the only specialized questionnaire to study sexual function in women with pelvic organ prolapse and/or urinary incontinence. This questionnaire was created by Professor Rebecca Rogers in 2002 [5] and included three sections describing the behavioral and emotional sphere, the physical side of sexual relations, and relationships with a partner. PISQ-12 is a short version of PISQ that represents its full form in sufficient detail and is recommended for use in clinical practice. Each questionnaire item has five possible answers, which are scored in points.The result of the survey is expressed as the sum of points for all items. The maximum score is 48, which is an indication of the best sexual function.

Below is a sample of our customized questionnaire.

In the city of Samarkand, in the maternity complex No. 3 in the gynecological department, from 2018 to 2021, 734 operations were performed for genital prolapse. We analyzed the results of a PISQ-12 survey of 156 sexually active women aged 22 to 64 years. The average age of women was 56.52.4 years. The survey was conducted 12 months after the operation. The study included responses from 156 patients; 145 questionnaires contained incomplete answers and were excluded from the analysis.

Among women in the main clinical group, 5.4% of patients were operated on for prolapse of the posterior vaginal wall; 16.5% underwent surgery for prolapse of the anterior and posterior walls of the vagina; a vaginal hysterectomy was required in 20.7% of patients due to incomplete prolapse of the uterus; and 33.3% of patients had complete uterine prolapse. 4.1% of women were operated on for stress urinary incontinence. 20.2% of patients were after combined surgical treatment for genital prolapse and stress urinary incontinence: 3.1% had prolapse of the anterior vaginal wall and stress urinary incontinence; 2.7% had prolapse of the posterior vaginal wall and stress urinary incontinence; 14.4% had prolapse of the anterior and posterior walls of the vagina and stress urinary incontinence. As can be seen, the most common pathology in the main group was complete (33.3%) and incomplete (20.7%) prolapse of the uterus, prolapse of the anterior and posterior walls of the vagina (21.9%), and stress urinary incontinence (24.1%).

83.8% of women at the time of the survey were in menopause (159 in natural menopause and 18 in surgical menopause). In addition to pelvic disorders, most of the examined women had other gynecological pathologies: uterine fibroids (31.1%), endometriosis (13.51%), endometrial pathology (8.1%), uterine fibroids and endometriosis (2.7%), and endometriosis and endometrial pathology (5.4%).

Depending on the type of operation undergone, all patients were divided into three groups:

Group 1 (n = 56) included patients who had either anterior or posterior colporrhaphy and perineolevathoroplasty, or anterior or posterior colporrhaphy and perineolevathoroplasty.

Women in group 2 (n = 50) had vaginal hysterectomy due to total genital prolapse.

Group 3 (n = 50): women with a combination of pelvic organ prolapse and stress incontinence. He had anterior and posterior colporrhaphy, as well as perineolevathoroplasty.

The procedure for statistical processing of the obtained data was carried out using the Statistica 7.0 software package and Excel 2007 spreadsheets.

This survey is a list of questions about your and your partner's sexual lives. All information is strictly confidential. Your responses will only be used to help doctors better understand what concerns patients about their sexual lives. Please mark the answer that best suits you:

1. Have you had sexual contact in the last 6 months? Yes___ No___ If not, please answer the questions according to the last year you were sexually active.
2. If you are not currently sexually active, why not? Urinary/fecal incontinence, fear of incontinence, bladder pain, pain, burning sensation in the vagina, lack of desire, chronic diseases, stressful situations at home, partner powerlessness, partner lack of desire, partner absenceAnother reason.

At what age did you stop having sex? _____

How often do you experience sexual desire? It could be wanting to have sex, planning to have sex, feeling inferior due to a lack of sex, and so on.

Always____ 4 Usually____ 3 Sometimes___2 Occasionally____ 1 Never____

Do you achieve orgasm during intercourse with your partner?

Always____ 4 Usually____ 3 Sometimes ___ 2 Rarely ____ 1 Never ____

3. How often do you get excited during intercourse?

   Always____ 4 Usually____ 3 Sometimes ___ 2 Rarely ____ 1 Never ____
4. How satisfied are you with the variety of sexual relationships in your sex life today?

   Always____ 4 Usually____ 3 Sometimes ___ 2 Rarely ____ 1 Never ____
5. Do you experience pain during intercourse?

   Always 0 Usually 1 Occasionally 2 Rarely 3 Never 4
6. Do you have episodes of involuntary loss of urine during intercourse?

   Always____ 0 Usually: 1 Sometimes: 2 Rarely: 3 Never: 4
7. Does the fear of incontinence during intercourse limit your sexual activity?

   Always____0 Usually: 1 Sometimes: 2 Rarely: 3 Never: 4
8. Do you avoid intercourse because of the protrusion of the formations in the vagina?

   (or bladder, rectum, or prolapsing vagina?)

   Always____ 0 Usually: 1 Sometimes: 2 Rarely: 3 Never: 4
9. Do you experience feelings such as fear, disgust, shame, or guilt during sexual intercourse?

   Always____ 0 Usually: 1 Sometimes: 2 Rarely: 3 Never: 4
10. Does your partner have erection problems that negatively affect your sexual activity?

    Always____0 Usually: 1 Sometimes: 2 Rarely: 3 Never: 4
11. Does your partner have problems with premature ejaculation that negatively affect your sexual activity?

    Always____0 Usually: 1 Sometimes: 2 Rarely: 3 Never: 4
12. Compared to past orgasms, how intense have your orgasms been in the last six months?

    Significantly less intense 0 Significantly less intense 1Same intensity__2 More intense 3 Much more intense _____

Results

Depending on the total number of points that patients received when answering the questions of the PISQ-12 questionnaire, the results of the questionnaire were interpreted as follows: From 0 to 10 points, the state of sexual function worsens; from 11 to 20 points, there is no change; from 21 to 30 points, the state of sexual function improves; from 31 to 40 points, the result is good; and from 41 to 48 points, the result is excellent.

The dynamics of sexual function in patients of different clinical groups in the late period of surgical treatment of pelvic prolapse is reflected in table 1.

Table 1 shows the dynamics of sexual function in clinical groups of patients in the late stages of pelvic prolapse surgery.

Result	1 group	2 group	group	Total
Deterioration	0	3	0	3
%	0,0 %	2,5 %	0,0 %	1,4 %
No change	12	6	3	21
%	12,5 %	10,0 %	6,7 %	9,5 %
Improvement	9	5	15	29
%	18,8 %	32,5 %	33,3 %	29,7 %
Good result	28	25	21	74
%	50,0 %	37,5 %	46,7 %	41,9 %
Excellent result	7	11	6	24
%	18,8 %	17,5 %	13,3 %	17,6 %
Total	56	50	50	156

In the first group, no one scored less than 10 points; 12.5% of people turned out to be in the "no change" category; 18.8% of patients felt improvement; 50% of women scored from 31 to 40 points, the "good result" category; and "excellent result" was shown by 18.75% of people.

In the second group, the situation was different: 2.5% of patients reported a worsening of their condition after the operation, 12 (10%) reported "no change," 32.5% reported feeling better, and the majority (37.50% and 17.5%, respectively) reported good and excellent results.

In the third group, there was no deterioration in the condition of anyone, 3 patients noted 6.7% of their sexual life without changes, 15 women had 33.3% of their sexual life improved, and 46.67% and 13% felt "good" and "excellent results." 33% of patients, respectively.

The average score (Ms) in the first group was 33.57.7; in the second, 31.98.0; in the third, 33.38.6; in the fourth group, 32.36, 9 points. Comparative analysis of results between groups 1 and 2 ($p = 0.399$), groups 1 and 3 ($p = 0.867$), groups 1 and 4 ($p = 0.395$), groups 2 and 3 ($p = 0.732$), groups 2 and 4 ($p = 0.954$), and groups 3 and 4 ($p = 0.722$) did not reveal significant differences.

The study showed that the results of the assessment of the sexual function of patients according to the PISQ-12 questionnaire after surgery on the pelvic organs for genital prolapse and/or urinary incontinence were quite high and did not differ significantly between the groups. This indicated that all the studied types of surgical care did not cause a deterioration in sexual function, and, on the contrary, in the vast majority of cases, this side of the patients' lives improved significantly after surgical removal of existing defects. However, in the largest group of patients who underwent organ-preserving and the most traumatic surgery (a vaginal hysterectomy), in 10% of cases, the patients did not notice any improvements, and in 2.5% of cases, the surgery worsened the quality of sexual function. Moreover, the lowest scores were obtained when answering questions that characterized the physical

aspects of sexual life, i.e., the greatest discomfort was caused by pain (dyspareunia) in sexual relations. With regard to the nature of the surgeries, it can be concluded that the best results are obtained by minimally invasive surgical interventions, which do not cause massive surgical trauma, do not change the anatomical relationships of the pelvic organs, and during which the risk of perioperative complications is significantly lower.

Conclusion

1. Operative treatments for pelvic prolapse have a positive effect on women's sexual function. There were no significant differences in sexual function depending on the type of surgical aids used in the late postoperative period.
2. The best effect in terms of favorable dynamics of sexual function is achieved after minimally invasive surgical treatment of pelvic prolapse compared with vaginal hysterectomy.

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