MINISTRY OF HEALTH OF UKRAINE

ODESSA NATIONAL MEDICAL UNIVERSITY

Faculty of international

Department of Obstetrics and Gynecology

APPROVED

Viee-rector for scientific and pedagogical work

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"29" August 2024

METHODICAL DEVELOPMENT FOR PRACTICAL LESSONS

FROM EDUCATIONAL DISCIPLINE

Faculty of international, course IV

Educational discipline "Obstetrics and gynecology"

Practical lesson № 6. Topic: « Background and precancerous diseases of female genitalia. Malignant tumors of genitalia. Trophoblastic diseases »

Approved:
Meeting of the Department of Obstetrics and Gynecology of Odesa National Medical University

Protocol №1 dated August 29, 2024.

Head of the department _____ (Ihor GLADCHUK)

Developer: associate professor of the department of Obstetrics and Gynecology _____ Kozhakov V.L.

Practical class №.6
«PRE-CANCEROUS DISEASES OF FEMALE GENITAL ORGANS.»

LEARNING OBJECTIVE Among the persistent problems are questions of practical gynecology careful selection of patients with an increased risk of cervical cancer and monitoring of their condition as cervical cancer is the second place in the structure of cancer incidence in women, it also accounts for 60% of cancer incidence among sex organs.

BASIC CONCEPTS:

1. Background and precancerous diseases of cervix: etiology, classification, clinics, diagnostics, treatment.
2. Hyperplastic processes of endometrium: etiology, pathogenesis, classification, diagnostics, treatment methods, tactics of GP.
3. Prophylaxis of background and precancerous diseases of female genitalia.

EQUIPMENT

- Multimedia equipment (computer, projector, screen), TV.
- Gynecological dummies
- Professional algorithms, structural-logical schemes, tables, videos.
- Results of laboratory and instrumental researches, situational tasks, patients, medical histories.

I. ORGANIZATIONAL STAGE

- Greetings,
- checking attendees,
- defining of educational goals,
- providing of positive motivation.

In the structure of oncologic sickness rate, tumours of the female genitals make up 20-30%. The data, published by the Committee on cancer of the International Federation of Obstetrians-Gynecologists, confirms that among the revealed patients the 1 stage was determined only in 20%, the other 80% of patients consulted the doctor with more widespread stages of the process, when radical treatment is fraught with many relapses and metastases or is in general impracticable. For the initial stages of cancer treatment results in recovery in 98-100% of the cases, in a part of the patients the generative function can be kept. Therefore, prophylactics of malignant tumours are a major actual problem of the public health services. In other words – an important contribution to solving the problem of malignant tumours of the genitals is made by active revealing and treatment of patients not only with early stages of

malignant tumours, but also with benign tumours, and also with pretumorous diseases.

II. CONTROL OF BASIC KNOWLEDGE (written work, written testing, online testing, face-to-face interview, etc.)

2.1. Requirements for the theoretical readiness of students to perform practical classes.

Knowledge requirements:

- Communication and clinical examination skills.
- Ability to determine the list of required clinical, laboratory and instrumental studies and evaluate their results.
- Ability to make a preliminary and clinical diagnosis of the disease
- Ability to perform medical manipulations
- Ability to determine the tactics of physiological pregnancy, physiological labor and the postpartum period.
- Ability to keep medical records.

List of didactic units:

- Pelvis from anatomical point of view.
- Videos from laparoscopic surgeries
- TVS-scans
- Measurement and evaluation of the pelvis.

2.2. Questions (test tasks, tasks, clinical situations) to test basic knowledge on the topic of the class.

Questions:

1. Classify and analyze clinical picture of precancerous and malignant diseases of female genital system.

2. Make plan of examination using modern methods of diagnostics, analyze data of laboratory and instrumental tests in precancerous and malignant diseases of female genitals and state preliminary diagnosis;

3. Conduct differential diagnostics of precancerous and malignant diseases of female genital system;

4. Determine tactics of patient management(principles of operative interventions and conservative treatment, rehabilitation measures) in precancerous and malignant diseases of female genital system;

5. Conduct prophylaxis of precancerous and malignant diseases of female genital system;

6. Perform necessary medical manipulations (inspection by means of mirrors)**Test tasks**

Direction: For each of the multiple-choice questions select the lettered answer that is the one best response in each case.

1. The posterior rectus fascia (sheath) ends at the
(A) insertion of the rectus muscles
(B) insertion of the anterior rectus sheath
(C) arcuate line (semicircular line, linea semicircularis, line of Douglas)
(D) area approximately 3-4 cm below the umbilicus
(E) area approximately 2-3 cm above the pubic symphysis

2. Sacrospinous ligament
(A) a thick band of fibers filling the angle created by the pubic rami
(B) passes from the anterior superior iliac spine to the pubic tubercle
(C) triangular and extends from the lateral border of the sacrum to the ischial spine
(D) attaches to the crest of the ilium and the posterior iliac spines superiorly with an inferior attachment to the ischial tuberosity
(E) passes over the anterior surface of the sacrum

3. Sacrotuberous ligament
(A) a thick band of fibers filling the angle created by the pubic rami
(B) passes from the anterior superior iliac spine to the pubic tubercle
(C) triangular and extends from the lateral border of the sacrum to the ischial spine
(D) attaches to the crest of the ilium and the posterior iliac spines superiorly with an inferior attachment to the ischial tuberosity
(E) passes over the anterior surface of the sacrum

4. Ilioinguinal ligament
(A) a thick band of fibers filling the angle created by the pubic rami
(B) passes from the anterior superior iliac spine to the pubic tubercle
(C) triangular and extends from the lateral border of the sacrum to the ischial spine
(D) attaches to the crest of the ilium and the posterior iliac spines superiorly with an inferior attachment to the ischial tuberosity
(E) passes over the anterior surface of the sacrum

5. Arcuate ligament
(A) a thick band of fibers filling the angle created by the pubic rami

(B) passes from the anterior superior iliac spine to the pubic tubercle
(C) triangular and extends from the lateral border of the sacrum to the ischial spine
(D) attaches to the crest of the ilium and the posterior iliac spines superiorly with an inferior attachment to the ischial tuberosity
(E) passes over the anterior surface of the sacrum

6. Formed by the superior and inferior pubic rami and covered by a central membrane through which a nerve, artery, and vein pass
(A) obturator foramen
(B) greater sciatic foramen
(C) lesser sciatic foramen
(D) sacrospinous ligament
(E) sacral foramina

7. The internal pudendal vessels and pudendal nerve exit the pelvis but then reenter through this structure
(A) obturator foramen
(B) greater sciatic foramen
(C) lesser sciatic foramen
(D) sacrospinous ligament
(E) sacral foramina

8. Divides and demarcates the greater and lesser sciatic foramen
(A) obturator foramen
(B) greater sciatic foramen
(C) lesser sciatic foramen
(D) sacrospinous ligament
(E) sacral foramina

9. The piriformis muscle, gluteal vessels, and posterior femoral cutaneous nerves pass through this structure
(A) obturator foramen
(B) greater sciatic foramen
(C) lesser sciatic foramen
(D) sacrospinous ligament
(E) sacral foramina

10. Four anterior and four posterior openings through which pass small nerves
(A) obturator foramen
(B) greater sciatic foramen

(C) lesser sciatic foramen
(D) sacrospinous ligament
(E) sacral foramina

11. Which of the following statements is FALSE?
(A) The ischium has a body and two rami
(B) The internal surface of the body of the ischium provides attachments for the levator ani muscle and coccygeus muscle
(C) The superior ramus is located cephalad to the inferior ramus in the standing position
(D) The superior ramus forms the dorsolateral portion of the obturator canal
(E) The ischial tuberosity is the lowest portion of the pelvis in the erect or sitting posture and bears the weight of the human frame in the sitting position

12. Regarding the pubis, which of the following statements is FALSE?
(A) The pubis has a body and two rami
(B) The superior edge of the body of the pubis, lateral to the midline, has a raised area called the anterior iliac crest a common landmark
(C) The inferior ramus is the attachment of the adductor magnus and brevis, and obturator internus muscles
(D) The inferior rami form the lower portion of the pubic arch
(E) Inferiorly, the pubic bone is the attachment for the urogenital diaphragm

13. The sacrum
(A) is formed from 11 or 12 small fused vertebrae
(B) has an uppermost anterior portion called the obstetrical conjugate
(C) in women has a concave pelvic surface
(D) is separated from the vertebrae that make up the coccyx by the sacrococcygeal joint
(E) most often is the limiting factor in determining the size of the pelvic outlet

14. Which of the following is a muscle of the external genitalia?
(A) the gluteus
(B) the sartorius
(C) the superficial transverse perineal
(D) the deep transverse perineal
(E) the levator ani

15. The term pudenda includes the
(A) mons pubis
(B) vulva

(C) labia
(D) external genitalia
(E) all the above

16.The term perineum describes
(A) the entire area between the thighs from the symphysis to the coccyx, bounded inferiorly by the skin and superiorly by the levator muscles of the pelvic diaphragm
(B) the anus and perianal area
(C) the superficial skin layer of the vulva
(D) the tendon joining the muscles deep to the external genitalia
(E) bulbocavernosus, ischiocavernosus, and transverse perineal muscles as a complex

17. The clitoris
(A) consists of a single crurum, a short body, and the glans clitoris, with overlying skin called the prepuce
(B) is attached to the pubic bone by a suspensory ligament
(C) contains within the shaft the corpora cavernosa, a collection of dense connective tissue that serves as support for the anterior-inferior portion of the vagina
(D) is supplied very sparsely with nerves originating primarily from the terminal branch of the ilioinguinal nerve in most women
(E) plays a secondary role in erotic stimulation in most women when compared to the role of the vagina

18. Which of the following statements regarding the muscles of the external genitalia is TRUE?
(A) The bulbocavernosus muscle surrounds the distal vagina and vestibule on each side as a single continuous strip of muscle, much like other sphincters
(B) The ischiocavernosus muscle takes origin from the ischial tuberosity and inferior ischial ramus and inserts upon the inferior pubic ramus on each side of the pelvis
(C) The superficial transverse perineal muscle arises from the ischial tuberosity and inferior ischial ramus and inserts between the posterior vagina and anterior rectum
(D) The perineal body serves as a central connection for all the superficial muscles of the external genitalia except the transverse perineal muscle which inserts directly on the external anal sphincter
(E) The muscles of the external genitalia are usually spared at the time of episiotomy when the levator ani muscle is routinely divided

19. Which of the following statements about the vagina is FALSE?
(A) The vagina is a 7-10 cm canal connecting the internal and external genitalia from the vestibule to the uterine cervix
(B) It is a hollow, distensible, fibromuscular tube with the apex (vault) having an H-shaped lumen and the external opening being flattened in the dorsal-ventral dimension
(C) The body of the vaginal tube is flattened in its normal resting state
(D) The mid-portion of the vaginal axis is nearly perpendicular to the lower sacrum in the adult human female in a standing position
(E) The posterior fornix (back wall of the vagina) is approximately 2 cm longer than the front wall and is directly connected to the peritoneal pouch (posterior cul de sac, retrouterine space, or pouch of Douglas) directly behind the uterus

20. When the infantile uterus is examined, one finds that
(A) the cervix is larger than the corpus (body of the uterus)
(B) the position is always anteflexed
(C) the cervix is the same size as the corpus
(D) the body is larger than the cervix
(E) it is as large as the adult organ in the immediate newborn period

21. The portio vaginalis of the cervix is that part which
(A) extends cephalad from the vagina
(B) protrudes into the vagina
(C) forms an internal isthmus
(D) is normally covered with endocervical epithelium
(E) all the above

22. Which of the following statements regarding the uterus is FALSE?
(A) The uterus has a body (corpus), composed mainly of smooth muscle, and a cervix, composed mainly of connective and elastic tissues, that are joined by a transitional portion (isthmus)
(B) It is an estrogen-dependent organ measuring about 7.5 cm long by 5 cm in width, and 4 cm anterior to posterior diameter in an adult female
(C) After puberty the uterus weighs about 50 grams in the nullipara and 70 grams in the multipara
(D) It lies between the bladder anteriorly and the pouch of Douglas in front of the rectum posteriorly, with the cervical portion extending into the abdomen and into the vagina
(E) The opening at the distal tip of the cervix is called the internal os

23. The uterus and adnexa are normally mobile structures, but they do have some relatively fixed anatomic characteristics. Which, if any, of the following statements about their relationship and/or positions is FALSE?
(A) Anteflexion means that the uterus is bent forward on itself
(B) The ovaries can be normally found caudad to the cervix
(C) The round ligaments are normally attached to the uterus anterior to the insertion of the fallopian tubes
(D) Adnexa refers to the tube, ovary, and their connecting structures
(E) All statements are true

24. Regarding the anatomy of the fallopian tube, which of the following statements is FALSE?
(A) Fallopian tubes are a conduit from the peritoneal to the uterine cavity
(B) Each fallopian tube traverses the superior portion of the broad ligament attached by a mesentery (mesosalpinx)
(C) The fallopian tube has four distinct areas in its 8-12 cm length: the portion that runs through the uterine wall (interstitial or cornual portion), the part immediately adjacent to the uterus (isthmic portion), the mid-portion of the tube (ampulla), and the distal portion containing the finger-like fimbria that expels the ovum (infundibular portion) to begin its passage toward the ovary
(D) The longest of the fimbriae (fimbria ovarica) is attached to the ovary
(E) Each tube is covered by peritoneum and consists of three layers: serosa, muscularis, and a nonciliated mucosa

25. Which of the following statements about the ovary is FALSE?
(A) The ovaries normally change in size through-out a woman’s lifetime
(B) The ovary is supported in its normal anatomic position by the infundibulopelvic ligament and the ovarian ligament
(C) The ovary produces both hormones and germ cells
(D) The ovary lies in the ovarian fossa of the true pelvis, overlying the iliac vessels
(E) The ovary produces the estrogens and androgens that regulate sexual desire in the human female

26. The pelvic peritoneum covers all of the following pelvic structures EXCEPT the
(A) fimbria of the fallopian tube
(B) uterine fundus
(C) round ligament
(D) uterorectal pouch of Douglas
(E) uterosacral ligament

III. FORMATION OF PROFESSIONAL SKILLS (mastering skills, conducting curation, determining the treatment regimen, conducting a laboratory study, etc.).

3.1. Content of tasks (tasks, clinical situations, etc.).

Interactive task:

Students of the group are divided into 3 subgroups of 3-4 people each. They work in the classroom, reception department of the gynecological hospital/department

Tasks:

– Subgroup I - to perform an encounter (anamnesis taking, etc.) with standardized patient
– Subgroup II - to perform specific gynec.exam
– Subgroup III – to assess answers of subgroups I and II and makes adjustments.

Tests:

Direction: For each of the multiple- choice questions select the lettered answer that is the one best response in each case.

1. In the absence of effect of conservative treatment of endometrial hyperplasia polypous form shown application:

A. hormone
B. Phytotherapy
C. Physiotherapy
+ D. Surgical treatment
E. antispasmodics

2. Endometrial hyperplasia was observed in:

A. polycystic ovaries
B. ovary C. Teratomas Hranulezokletochnoy ovarian tumor
D. uterine fibroids
+ E. cervical erosion

3. The clinical picture of endometrial hyperplasia:

A. oligomenorrhea
+ B. Dysfunctional uterine bleeding
C. Pain
D. leukocyte shift to the left
E. Increase ESR

4. Endometrial polyposis often occurs:

A. In menopause
B. After birth
+ C. In menopause

D. During treatment with progesterone
E. After discontinuation of oral contraceptives
5. Do adenomatous polyps belong to precancerous endometrial?
+ A. So
B. No
C. Not always
D. Only in postmenopausal women only 30 years
6. Wich factors for endometrial cancer does not apply:
+A. Obesity
B. Anovulatory menstrual cycles
C. Ovarian Tumor
D. Endogenous estrogens
E. High levels of progesterone
7. Adenomatosis - is:
+ A. Atypical endometrial hyperplasia
B. Endometrial cancer
C. Internal endometriosis
D. True cervical erosion
E. endometrial polyposis
8. Definition of cross cervical canal, uterine cavity length, presence of tumor in it, use:
A. Cervical Biopsy
B. colposcopy
C. Laparoscopy
+ D. Sounding the uterus
E. Kuldoskopiyu
9. Contraindications to diagnostic curettage:
+ A. Acute and subacute inflammatory diseases of genitals
B. Endometrial Polyps
C. Dysfunctional uterine bleeding
D. cervical polyp
E. endometrial hyperplasia
10. Dysfunctional uterine bleeding in women of childbearing age treatment should begin with:
A. Reduces B. funds hysterectomy
C. hormonal
+ D. Therapeutic and diagnostic curettage endometrial
E. antibiotic therapy

3.2. Educational materials, recommendations (instructions) for performing tasks

Background and precancerous diseases of external genitalia.

Tumors of the external genitalia - it neoplasms (growths of tissue lesions) in the vulva: vestibule, clitoris, large and small labia, large glands vestibule (Bartholin).

Background and precancerous diseases of cervix: classification.

I. Benign background processes:

- Dishormonal processes:

1. Ectopic columnar epithelium (endocervicoses, glandular erosion, pseudo): simple, proliferate epidermiziruyuschaya.

2. polyps (benign growths polipopodobnye): simple; proliferating; epidermis-ziruyuschie.

3. Benign Area of transformation: the unfinished and finished.

4. Papillomavirus.

5. Endometriosis cervix.

- Post-traumatic processes:

1. Gaps of the cervix.

2. ectropion.

3. scarring of the cervix.

4. cervical-vaginal fistulas.

- Inflammation:

1. True erosion.

2. Cervicitis (exogenous and endocervicitis): acute and chronic.

II. Precancerous conditions:

- Dysplasia.

1. Simple leukoplakia.

2. Fields of dysplasia: multilayered squamous epithelium; metallazirovannogo prismatic epithelium.

3. Papillary area of transformation: multilayered squamous epithelium; metaplazirovannogo prismatic epithelium.

4. Precancerous transformation zone

5. Warts

6. Precancerous polyps

1.leukoplakia with atypia cells

2.erythroplakia

3. adenomatosis

III. Cervical cancer

- Pre-clinical forms:

1. proliferating leukoplakia.

2. Fields atypical epithelium.

3. Papillary transformation zone.

4. atypical transformation zone.

5. Zone atypical vascularization.

6. Cancer in situ (intraepithelial, stage 0).

7. Microcarcinomas (stage I A).

Clinical forms of cancer: exo, endophytic mixed.

Hyperplastic processes of endometrium: etiology, pathogenesis, classification, modern methods of diagnostics, management tactics, treatment principles.

Endometrial hyperplasia - a benign pathology of the endometrium, which develops in the absolute or relative hyperestrogenism.

Etiology

Risk factors for endometrial hyperplasia include:

• menstrual disorders by type of anovulation;

• a history of infertility;

• obesity;

• diabetes;

• insulin resistance;

• hereditary tendency (tumors of the ovaries, uterus, breast, colon).

Pathogenesis. The basis of the formation of endometrial hyperplasia are ovulation disorders that occur on the type of persistence or follicular atresia. The lack of ovulation is accompanied by a loss of luteal phase MC. Reduced levels of progesterone and as a result, no cyclic secretory transformation in the endometrium results in the fact that as a result of a significant increase in the level of estrogen and / or with the prolonged influence of the proliferative changes in the endometrium.

Morphologically hyperplastic processes in the endometrium aggravation and dive into the underlying layers of epithelial tissue.One morphological criteria for different forms of endometrial hyperplasia is the nature of the iron.

Simple neatipichnaya hyperplasia - an increase in the number of both glandular and stromal elements, with a slight predominance of the first - is characterized by the following features:

• Increase in the volume of the endometrium;

• structural differences from normal endometrium - active glands and stroma, glands are located unevenly, some cystic dilated;

• a balance between the glands and stroma proliferation;

• uniform distribution of blood vessels in the stroma;

• lack of atypia of the nuclei.

Integrated neatipichnaya hyperplasia - the close location of the glands distributed or focal character. She characterized by:

• more pronounced proliferation of glands;

• cancer structurally irregular shape;

• imbalance between proliferation of glands and stroma;

• more pronounced multicore epithelium;

• lack of atypia of the nuclei.

Simple atypical endometrial hyperplasia - the presence of atypia cells glands - manifested loss of polarity and location of unusual configuration of nuclei, often acquiring a rounded shape. The nuclei of cells in this type of hyperplasia - polymorphic, and they often allocated large nucleoli. The characteristic features of cell atypia:

• Cell dispolyarnost;

• wrong stratification cores;

• Anisocytosis;

• giperhromatizm cores;

• an increase of nuclei;

• Expansion of vacuoles;

• eosinophilia of the cytoplasm.

Complex atypical endometrial hyperplasia is characterized by the proliferation of epithelial component expressed as in the complex neatipichnoy hyperplasia, which is combined with the tissue and cellular atypia without invasion of the basement membrane of glandular structures. Iron loses usual for normal endometrium regularly spaced, they are very diverse in size and shape. The epithelium that lines gland, consists of large cells with polymorphic, rounded or elongated nuclei with impaired and multi-polarity of their location.

Classification

I. Simple atypical endometrial hyperplasia

II. Complex atypical endometrial hyperplasia

III. Simple atypical endometrial hyperplasia

IV. Complex atypical endometrial hyperplasia

V. Adenocarcinoma

Diagnostics

Physical methods of research

• Poll - characteristics of menstrual dysfunction; During menopause; of history - heredity (the presence of tumors in the family), infertility.

• General inspection - the presence of anemia, signs of obesity.

• Deep palpation of the abdomen - pain.

• Examination of the external genitalia.

• Inspection of the mirrors.

• bimanual gynecological examination - mobility, pain, size, texture of the uterus.

Laboratory methods

• determination of blood group and Rh factor;

• CBC - signs of anemia;

• general urine analysis;

• determine the level of sugar in the blood - the presence of diabetes;

• biochemical blood;

• bacterioscopic analysis of discharge;

• hormone kolpotsitologiya;

• cytology aspirates and swabs from the uterine cavity (can be used to monitor the ongoing conservative therapy).

Instrumental methods

1. US (transabdominal, transvaginal preferable, doppler)

2. Fractional diagnostic curettage.

In the presence of indications:

• Hysteroscopy (visualization of pathological changes of the endometrium, their localization, the ability to perform intrauterine surgery using electricity, cryo or laser surgery);

• endometrial biopsy;

• X-ray examination (hysterosalpingography and bikontrastnaya gynecography - now rarely used).

Treatment

Pharmacotherapy

Treatment begins with a separate treatment and diagnostic curettage walls of the uterus and cervix.

The mainstay of treatment of endometrial hyperplasia is a hormone therapy.

Hormone therapy is conducted in conjunction with other methods of pathogenetic therapy

Surgery

Indications for surgical treatment of patients with endometrial hyperplasia

In reproductive age:

• complex atypical hyperplasia in the absence of effect of conservative treatment after 3 months;

• simple and complex atypical hyperplasia neatipichnaya in the absence of effect of conservative treatment at 6 months.

When neatipichnyh forms of endometrial hyperplasia, especially in women of reproductive age, it is advisable to use hysteroscopic resection or ablation of the endometrium, while atypical - preference is given to a hysterectomy.

At menopause:

• complex atypical hyperplasia - at diagnosis;

• simple and complex atypical hyperplasia neatipichnaya - in the absence of effect of conservative treatment after 3 months.

Prevention

To prevent the development of cervical pathology are necessary:

- Prevention, timely diagnosis and treatment of inflammatory processes of genitals;

- The timely correction of hormonal and immune homeostasis;

- Promotion of a culture of sexual relations;

- Prevention of abortions (rational contraception);

- To give up smoking.

Women need to know that the symptoms of cervical disease are scarce and inexpressive. They can be found in a timely manner to resolve the issue of the necessary treatment only for the regular observation of the gynecologist!

LIST OF PRACTICAL SKILLS

1. Collect special gynecological history, assess the results of laboratory studies (general and biochemical analyzes of blood, urine, blood coagulation system, etc.).

2. Perform gynecological research (mirror, bimanual, rectal).

3. Taking material from the vagina, cervix and urethra for research.

4. Evaluate: urogenital smear microscopy results, onkotsytolohichnoho research colposcopy; Bacteriological results and other methods of detecting pathogens inflammatory diseases of female genital mutilation; the results of ultrasound; results of functional tests.

5. Prepare a plan of inspection sick with various kinds of gynecological diseases.

6. Develop an algorithm for diagnosis and first aid uterine bleeding

7. Make a plan with preoperative preparation routine and urgent gynecological operations. Driving postoperative period.

Some practical skill

Inspection by means of mirrors.

Use mirrors Cusco or spoon-shaped mirror with a lift. Before the introduction of the mirror in the vagina dilute labia I and II of the fingers of his left hand. Wing mirror cloistered administered to the vaginal vault, and then open it to expose the cervix.

Spoon-shaped mirror is introduced on the back wall of the vagina, pushing the crotch. Introduced hoist lift the front wall of the vagina, examine the cervix and vagina vaults. At the same time pay attention to the color of the mucous membrane of the vagina, on the size, shape, position and state of the cervix, the shape and condition of the external os, on discharge from the cervical canal.

When viewed with the help of mirrors estimate:

- The capacity of the vagina;

- The state of the vaginal mucosa, the severity of folding, color, inflammatory changes, the nature of discharge, the presence of warts, partitions;

- Cervical shape (conical - nulliparous, cylindrical - in nulliparous women);

- Scar cervical strain;

- The state of the external os (round shape - nulliparous, slit - have given birth);

- The nature of discharge from the cervical canal;

- The state of the mucous membrane of the vaginal part of the cervix (the epithelium unchanged, pseudo, eroded ectropion, polyp, exophytic growths).

Bimanual examination.

In the vagina injected II and III fingers of his right hand, give birth to them in the posterior fornix, and the left hand palpate the abdominal wall.

Palpating the cervix, determine its position, shape, size, outer mouth and permeability, the permeability of the cervical canal, palpating the uterus - its position, size, shape, consistency, mobility, tenderness.

Move the fingers in the lateral vaginal fornix, palpate the uterus, determine their shape, texture, size, tenderness, mobility. Unchanged tubes and ovaries are not determined by palpation.

Examine the condition of the vaginal vault (presence of infiltrations, their consistency, tenderness, location in relation to the pelvic bones).

3.3. Requirements for the results of work.

1. Classify and analyze clinical picture of precancerous and malignant diseases of female genital system.
2. Make plan of examination using modern methods of diagnostics, analyze data of laboratory and instrumental tests in precancerous and malignant diseases of female genitals and state preliminary diagnosis;
3. Conduct differential diagnostics of precancerous and malignant diseases of female genital system;
4. Determine tactics of patient management(principles of operative interventions and conservative treatment, rehabilitation measures) in precancerous and malignant diseases of female genital system;
5. Conduct prophylaxis of precancerous and malignant diseases of female genital system;
6. Perform necessary medical manipulations (inspection by means of mirrors)

3.4. Control materials for the final stage of the class: tasks, tests, etc.

Tests

1. In the absence of effect of conservative treatment of endometrial hyperplasia polypous form shown application:
A. hormone
B. Phytotherapy
C. Physiotherapy
+ D. Surgical treatment

E. antispasmodics
2. Endometrial hyperplasia was observed in:
A. polycystic ovaries
B. ovary C. Teratomas Hranulezokletochnoy ovarian tumor
D. uterine fibroids
+ E. cervical erosion
3. The clinical picture of endometrial hyperplasia:
A. oligomenorrhea
+ B. Dysfunctional uterine bleeding
C. Pain
D. leukocyte shift to the left
E. Increase ESR
4. Endometrial polyposis often occurs:
A. In menopause
B. After birth
+ C. In menopause
D. During treatment with progesterone
E. After discontinuation of oral contraceptives
5. Do adenomatous polyps belong to precancerous endometrial?
+ A. So
B. No
C. Not always
D. Only in postmenopausal women only 30 years
6. Wich factors for endometrial cancer does not apply:
+A. Obesity
B. Anovulatory menstrual cycles
C. Ovarian Tumor
D. Endogenous estrogens
E. High levels of progesterone
7. Adenomatosis - is:
+ A. Atypical endometrial hyperplasia
B. Endometrial cancer
C. Internal endometriosis
D. True cervical erosion
E. endometrial polyposis
8. Definition of cross cervical canal, uterine cavity length, presence of tumor in it, use:
A. Cervical Biopsy
B. colposcopy
C. Laparoscopy
+ D. Sounding the uterus

E. Kuldoskopiyu
9. Contraindications to diagnostic curettage:
+ A. Acute and subacute inflammatory diseases of genitals
B. Endometrial Polyps
C. Dysfunctional uterine bleeding
D. cervical polyp
E. endometrial hyperplasia
10. Dysfunctional uterine bleeding in women of childbearing age treatment should begin with:
A. Reduces B. funds hysterectomy
C. hormonal
+ D. Therapeutic and diagnostic curettage endometrial
E. antibiotic therapy

IV. SUMMING UP

Current control: oral examination, testing, assessment of practical skills, solving situational clinical problems, assessment of activity in the classroom.

Criteria for current assessment on the practical lesson:

5	The student is fluent in the material, takes an active part in the discussion and solution of situational clinical problems, confidently demonstrates practical skills during the examination of a pregnant and interpretation of clinical, laboratory and instrumental studies, expresses his opinion on the topic, demonstrates clinical thinking.
4	The student is well versed in the material, participates in the discussion and solution of situational clinical problems, demonstrates practical skills during the examination of a pregnant and interpretation of clinical, laboratory and instrumental studies with some errors, expresses his opinion on the topic, demonstrates clinical thinking.
3	The student isn't well versed in material, insecurely participates in the discussion and solution of a situational clinical problem, demonstrates practical skills during the examination of a pregnant and interpretation of clinical, laboratory and instrumental studies with significant errors.
2	The student isn't versed in material at all, does not participate in the discussion and solution of the situational clinical problem, does not demonstrate practical skills during the examination of a pregnant and the interpretation of clinical, laboratory and instrumental studies.

RECOMMENDED LITERATURE

Basic:

1. Zaporozhan V.M., Miwenko V.P. Collection of test tasks for clinical paints: science-medical collection. - Odessa: Odessa state medical university, 2008.- 176 p.s- Language: eng.
2. Oxford Handbook of Obstetrics and Gynaecology by S. Collins , S. Arulkumaran , K. Hayes , S. Jackson , L. Impey, Oxford University Press, 3rd Edition, 2013
3. Handbook of Gynecology Shoupe, MD, MBA, Donna (Ed.), Springer, 2017
4. Oxford Handbook of Obstetrics and Gynaecology by S. Collins , S. Arulkumaran , K. Hayes , S. Jackson , L. Impey, Oxford University Press, 3rd Edition, 2013
5. Gunner Goggles Obstetrics and Gynecology, Edition 1, By Hao-Hua Wu, Leo Wang, 06 Oct 2018
6. Beckmann and Ling's Obstetrics and Gynecology, Eighth, North American Edition, Dr.Robert Casanova, May 3, 2018 Beckmann and Ling's Obstetrics and Gynecology, Eighth, North American Edition, Dr.Robert Casanova, May 3, 2018
7. The Linde's operative gynecology - John A.Rock, 2003
8. Essential Obstetrics and Gynaecology (4th Edition) - E. Malcolm Symonds, Ian M. Symonds , 2008
9. BENSON & PERNOLL'S handbook of OBSTETRICS & GYNECOLOGY,2008
10. Endoscopic Surgery for Gynecologists. – second ed. /Ed. By C. Sutton, M.P. Diamond. – W.B. Saunders company, 1998.-709 p.
11. Operative gynecology /D.M. Gershenson, A.H. DeCherny, S.L. Curry, L. Brubaker. –second ed. - W.B. Saunders company, 2001.-890p.

Additional:

12. Robboy S.J. Anderson M.C., Russel P. Pathology of the female reproductive tract. – Churchill Livingstone, 2002.- 929 p.
13. Gynecology: підручник англійською мовою (edit by I.B. Ventskivska).- K.: Medicine,2010.-160 p.
14. Progress in Obstetrics and Gynaecology. Vol 10. Ed J Studd. (pounds sterling 26.50.) Churchill Livingstone, 1993. ISBN 0443-04754-5.
15. Recent Advances in Obstetrics and Gynaecology. Vols 16 and 17. Ed J Bonnar. (pounds sterling 22.50.) Churchill Livingstone, 1993. ISBN 0-443-04402-3.

INTERNET SOURCES:

- https://www.cochrane.org/
- https://www.ebcog.org/
- https://www.acog.org/

- https://www.uptodate.com
- https://online.lexi.com/
- https://www.ncbi.nlm.nih.gov/
- https://pubmed.ncbi.nlm.nih.gov/
- https://www.thelancet.com/
- https://www.rcog.org.uk/
- https://www.npwh.org/