TUMORS OF THE REPRODUCTIVE SYSTEM IN GIRLS.

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Annotation: The rarity of genital tumors in girls (3-5%) is the reason that tumors of this localization are most often described as single observations or, when analyzing morbidity and treatment, are described in groups with a single morphological structure of the tumor regardless of the localization of the process, for example, germinogenic tumors, rhabdomyosarcoma, etc. The definition of childhood age is also important in these studies, adopted in different countries, therefore, there are differences in the proportion of certain tumors in children during these studies. This approach makes it difficult to analyze the structure of the incidence of genital tumors in children, the age characteristics of tumor lesions depending on the localization of the tumor.

Keywords: tumor, germinogenic tumors, rhabdomyosarcoma.

Most tumors of the genital organs are malformations and are combined with malformations, therefore, this category of children requires additional examination to choose the optimal treatment regimen. Genetic counseling, hormone determination is absolutely necessary to determine the tactics of treatment of children with genital tumors. Removal of an unaffected gonad in a child when a Y chromosome is detected is the prevention of the development of a tumor in another unaffected gonad.

The rarity of genital tumors is the reason for ignorance of the clinical picture of the disease and, consequently, late diagnosis of the process. Most of the children with ovarian tumors were operated at their place of residence with a diagnosis of ovarian cyst, abdominal tumor, appendicular infiltrate, etc. As a rule, by this time the size of the ovarian tumor in children exceeded 15 cm in diameter. In a third of patients, an ovarian tumor is established only after emergency surgery performed after twisting the tumor leg and/or rupture of the tumor capsule. Even tumors of external localization (vulva, vagina lesion) are diagnosed after several relapses after removal of a papilloma or polyp. Stein-Leventhal syndrome (insufficiency of the enzyme systems of the ovary). Hyperandrogenism of adrenal genesis is manifested by a postnatal form of adrenogenital syndrome. Hyperandrogenism of diencephalic genesis. This is the result of neurotropic infections that were transferred during puberty. In girls who became ill before menarche, there is an acceleration of puberty. Menarche occurs earlier than usual, there is no regular menstrual cycle, juvenile bleeding is often noted, minor hirsutism, obesity is noted, hypertrophy of the mammary glands is detected, stretch marks on the skin of the mammary glands, abdomen, thighs.

This review summarizes the epidemiology of cancer of the female reproductive system and associated lifestyle factors. It also assesses the available evidence for occupational factors associated with these cancers. Cervical, endometrial, and ovarian cancers are relatively common, and cause significant cancer morbidity and mortality worldwide, whereas vulvar, vaginal, fallopian tube cancers, and choriocarcinomas are very rare. As several lifestyle factors are known to play a major role in the etiology of these cancers, very few published studies have investigated possible relationships with occupational factors. Some occupational exposures have been associated with increased risks of these cancers, but apart from the available evidence on the relationships between asbestos fibers and ovarian cancer, and tetrachloroethylene and cervical cancer, the data is rather scarce. Given the multifactorial nature of cancers of the female reproductive system, it is of the utmost importance to conduct occupational studies that will gather detailed data on potential individual confounding factors, in particular reproductive history and other factors that influence the body's hormonal environment, together with information on socio-economic status and lifestyle factors, including physical activity from multiple sources. Studies on the mechanisms of carcinogenesis in the female reproductive organs are also needed in order to elucidate the possible role of chemical exposures in the development of these cancers.A large morphological diversity of genital tumors in girls, different ages require different approaches to treatment. To do this, it is necessary to clarify the risk factors affecting the prognosis of the disease. The determination of tumor markers (AFP, HCG) allows children to form groups with different prognosis.

Taking into account the small age of patients, the need to preserve the function of the ovaries for the proper development of secondary sexual characteristics, as well as the preservation of menstrual and reproductive functions, the main direction in the treatment of children with genital lesions is organ-preserving and functionally preserving. Treatment of children with genital tumors at the place of residence was carried out, as a rule, in various hospitals, because there are no trained specialists and specialized departments in the regions that solve the full scope of examination and treatment of children with genital tumors. Gynecologists, oncologists or oncogynecologists specializing in the field of tumor pathology of the genitals in adults. Pediatric oncologists, if there are pediatric oncologists in the region, as a rule, do not know this section of pathology due to the lack of necessary training in the field of gynecology. Thus, the treatment of children at the place of residence cannot be classified as specialized treatment. Treatment at the place of residence was very often accompanied by a violation in the dosages of drugs, violations of treatment regimens, unjustified expansion of the volume of surgical interventions. After surgical interventions performed in pediatric surgical or gynecological hospitals, children were discharged until the results of histological examination were obtained. Getting information about the results of the study and referral to a pediatric oncologist took up to 1 month or more, and at that moment no one was responsible for the further treatment of the child. All of the above was reflected

in the results of treatment carried out at the place of residence in patients with tumors of the genitals. Surgical intervention has never been performed at the first stage of treatment.

After the biopsy and receiving the results of histological examination, 2 to 4 courses of chemotherapy were performed to reduce the size of the exophytic part of the tumor, then the exophytic part of the tumor in the vagina was removed. At the moment, we believe that it is necessary to conduct up to 4 courses of chemotherapy, and then decide on the scope of surgery. Unlike other authors, we have never performed the removal of the vagina and uterus. The purpose of our approach in surgical treatment is to exclude the crippling volume of surgical intervention and create conditions for intra-cavity irradiation, which was developed and applied for the first time in our country on the basis of the radiosurgery department of the N.N. Blokhin Research Institute of the Russian Academy of Medical Sciences. When the cervix was affected, the uterus was removed without appendages at the first stages of the study. However, after receiving a recurrence in the fallopian tube area, the scope of surgical intervention is expanded. With the defeat of the cervix, the extirpation of the uterus with the fallopian tubes and the upper third of the vagina began to be performed. Uterus extirpation without appendages was performed in 4 (10.25%) children. Extirpation of the uterus with fallopian tubes and the upper third of the vagina was performed in 8 (20.51%) children with cervical tumor lesion uterus. Considering the need for radiation therapy in patients with vaginal tumors, ovariole was performed in 4 (10.25%) patients to prevent radiation castration. However, we subsequently abandoned this tactic, since in one case a child who received nothing but surgical treatment was diagnosed with cystadenoma of the right ovary 2 years after the operation. The child was re-operated. We believe that ovarian cystadenoma could be a consequence of circulatory disorders after ovarian ovariole.

The use of chemotherapy drugs isocyanide and etoposide allowed in some cases to obtain good results without mutilation and radiation therapy. Of course, this can be done with small tumor sizes having a thin leg, i.e. in the absence of infiltrative growth along the walls of the organ. The experience of using these drugs is less, but despite the shorter treatment time, the results obtained allow us to consider chemotherapy with these drugs as effective. After 4 courses of chemotherapy, it is necessary to evaluate the effect of the treatment and, in case of full effect, conduct another 2 courses of chemotherapy. The condition for carrying out only chemotherapeutic treatment is the possibility of careful and regular dynamic monitoring.

The need for radiation therapy in most cases in a total dose of up to 50-60 Gy with remote irradiation is accompanied by the development of complications: radiation cystitis, recites and radiation castration. A decrease in the intensity of radiation complications from adjacent organs is possible with the use of intracavitary therapy. Intracavitary irradiation in children was first used in the treatment of tumors of the vagina, and then of the cervix. Various types of radionuclide sources were used in contact radiation therapy: cobalt-60

and iridium-192. The advantage of cobalt-60 and iridium-192 is high specific activity, which allows the use of small sources required for children's applicators.

The available human evidence considered by the IARC Working Group to classify tetrachloroethylene as probably carcinogenic to the cervix uteri comes from 3 cohort studies. However, exposure to other chlorinated solvents in these studies could not be excluded, nor was it possible to control for potential confounding factors. Two cohort studies of dry cleaners showed an excess risk of 60 to 70%, based on 8 and 21 deaths, respectively, whereas a cohort of workers monitored for tetrachloroethylene exposure reported 2 cases of cervical cancer .

Other occupational exposures Several job titles have been associated with an increased risk of cervical cancer in more than 1 study, but most of these studies were exploratory in nature and did not adjust for important potential confounders such as socio-economic status and HPV infection. Examples of these job titles are: hotel/restaurant personnel and waitresses, food preparers, machine operators, cleaners, upholsterers, dry cleaners, beverage workers, other construction workers, and drivers .Women working in agriculture also appear to be at an increased risk . A cohort study of professional firefighters in Florida reported a 5-fold increased risk of cervical cancer, unadjusted for lifestyle habits [55]. A Swedish registry-based cohort study found a 39% non-significant increase in risk associated with shift work (SIR 1.39, 95% CI 0.82-2.19), however, the definition of shift work used in the study was very rough, including occupations in which at least 40% of the workers reported working rotating shifts (3 shifts per day), or workers who worked at least 1 night in the week preceding the interview [56].

A Finnish record-linkage study reported excess risks of cervical cancer of about 20 to 40% with exposures to aliphatic and alicyclic, aromatic, and chlorinated hydrocarbon solvents. The authors reported similar excess risks with silica and wood dust exposures, after standardization by birth cohort, follow-up period, and socio-economic status [57]. A study using a similar design reported a 48% increased risk of cervical cancer among Swedish workers exposed to diesel exhaust fumes, with a suggestion of a dose-response relationship. Certain textile workers exposed to organic dusts, solvents, and dyes have been found to have small increases in cervical cancer risk in record-linkage studies .A cohort study of textile workers also reported an excess risk (SIR 1.82, 95% CI 1.19-2.67) that was further increased in women who had worked in the industry for 10 years or more (SIR 2.44, 95% CI 1.21-4.35). Once again, the estimates were not adjusted for potential confounding factors.

An exposure circumstance that had not been identified previously is also worth mentioning. A Finnish record-linkage study explored cancer risk among workers exposed to molds of agricultural and industrial origin, and to bacteria of non-human origin, attributing exposures using a job-exposure matrix. The authors reported that women in the highest category of mold and of bacterial exposure had cervical .Regarding cervical

cancer, we can conclude that, apart from occupational exposure to tetrachloroethylene, which has been classified as probably carcinogenic to the human cervix uteri (Group 2A agent), all other occupational exposures for which there is some evidence of an association require well-designed confirmatory studies with proper adjustment for potential confounding factors.

Endometrial cancer

None of the agents or circumstances classified as carcinogenic to the corpus uteri by the IARC are related to occupational exposures. Some exposures have been associated with an increased risk of endometrial cancer in a few studies, but the results were not solid enough to support their classification as carcinogenic. It is generally believed that the role of further environmental or occupational factors in the causation of endometrial cancer is unclear and probably small .

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