aches (47.16%), joint pain (11.32%), headaches (39.62%), acne (79.24%), abdominal cramps (92.45%), diarrhea (20.75%), constipation (3.77%).

Conclusion. Regular menstrual cycle is very important to save the health of every woman. But as a result of our examination we have high level of menstrual cycle disorders especially in young patients. So we have to think about the diagnostics of menstrual cycle disorders and correct treatment.

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POLYCYSTIC OVARIAN SYNDROME AND MENSTRUAL IRREGULARITIES

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Introduction. Polycystic ovarian syndrome (PCOS) is the most common endocrine disorder affecting women of reproductive age, significantly impacting their quality of life. It is characterized by ovulatory dysfunction, hyperandrogenism and polycystic ovarian morphology. The hallmark feature of PCOS is menstrual irregularities, including oligomenorrhea, amenorrhea and menorrhagia. This is responsible for 80% of all cases of anovulatory subfertility and associated complications with metabolic, cardiovascular, obesity and psychological comorbidities. USS evidence of polycystic ovaries seen in 20-30% of all women but not associated with full syndrome.

Aim of the study. Our target to study cases of polycystic ovarian syndrome, complications and treatment.

Materials and methods. We have examined 60 cases of polycystic ovarian syndrome, ginecological and extragenital pathology, treatment.

Results and discussion. The reasons of EP are different. One primary cause is anatomical obstruction and tubal damage. Inflammatory conditions like Pelvic Inflammatory Disease (78%), endometriosis(32%), previous pelvic surgeries (10%) lead to formation of adhesions and endothelial damage. Procedures such as salpingostomy, sterilization, tubal reversal and intrauterine contraceptive device (IUD) can cause obstruction leading to risk of EP. Diagnosis of PCOS depend on clinical, biochemical and imaging findings. From the following 3 features, at least 2/3 should be positive to diagnose PCOS. Oligo or anovulation. Clinical and biochemical evidence of hyperandrogenism (elevated serum androgens, hirstuism or acne). Polycystic ovaries on ultra sound (more than or equal 12 follicles in each ovary, measuring 2-9 mm in diameter or increased ovarian volume more than 10mm). Diagnostic investigations: USD, increase serum total and free testosterone, increased FBC, OGTT or HbA1c – to assess insulin resistance, biochemical changes, increased testosterone, androstenedione, increased luteinizing hormone, increased insulin and IGF/

Management: Weight loss through exercise and diet is the first-line intervention for overweight or obese women with PCOS. Even 5% weight loss can improve symptoms. So weight loss through diet should be encouraged. Pharmacological therapy: COCP – first line treatment for menstrual irregularities and hyperandrogenism, antiandrogens, insulin sensitizers. Metformin-most widely used (but unlicensensed in UK) It improves insulin resistance and restore ovulation. Metformin combined with letrozole or clomiphene citrate and improves ovulation and pregnancy rates. Gonadotropins (FSH). Use in clomiphene citrate resistant cases. It is a recombinant injection. Ovarian hyper stimulation and multiple pregnancy are adverse effects of this. Inositol- Natural insulin sensitizers helping in restoring menstrual irregularities. Surgical managment: Laparoscopic ovarian drilling. They used in clomiphene citrate resistant cases.

Conclusion. Conclusion: PCOS is a complex endocrine disorder that significantly affects reproductive, metabolic and psychological health. Menstrual irregularities is the hallmark feature of PCOS and should prevent long term complications. Further research should focus on pathophysiology of PCOS, which will aid in early diagnosis and the development of novel treatment strategies.

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