

**МІНІСТЕРСТВО ОХОРОНИ ЗДОРОВ'Я УКРАЇНИ  
ВИЩИЙ ДЕРЖАВНИЙ НАВЧАЛЬНИЙ ЗАКЛАД УКРАЇНИ  
«БУКОВИНСЬКИЙ ДЕРЖАВНИЙ МЕДИЧНИЙ УНІВЕРСИТЕТ»**



## **МАТЕРІАЛИ**

**100 – ї**

**підсумкової наукової конференції**

**професорсько-викладацького персоналу**

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У збірнику представлені матеріали 100 – ї підсумкової наукової конференції професорсько-викладацького персоналу вищого державного навчального закладу України «Буковинський державний медичний університет», присвяченої 75-річчю БДМУ (м.Чернівці, 11, 13, 18 лютого 2019 р.) із стилістикою та орфографією у авторській редакції. Публікації присвячені актуальним проблемам фундаментальної, теоретичної та клінічної медицини.

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differentiation in it are not completed yet. A study of the specific characteristics and consistent patterns of the morphogenesis and dynamics of the spatiotemporal changes of the salivary glands will make it possible to reveal new findings, pertaining to the emergence of variants of their structure, the preconditions of the onset of the congenital malformations and acquired diseases.

**Lazaruk O.V.**

**INVESTIGATION OF MEDICAL PATHOMORPHOSIS  
IN PATIENTS WITH INVASIVE DUCTAL BREAST CARCINOMA**

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Almost in all cases in patients with the diagnosis of invasive ductal breast carcinoma treatment is initiated before surgical removal of the tumour. This may be chemo and/or radiation therapy in various combinations depending on the stage of the disease with tumour size greater than two centimeters in diameter and the presence of tumour growth in at least one regional lymph node.

Medical pathomorphosis can affect the reliability of the results of histochemical and immunohistochemical research methods. The latter play an important role now and are used to choose the tactics of tumour treatment.

There is no possibility to compare the results obtained before treatment and at the stage of the morphological study. The main criteria to estimate are the development of dystrophic changes and the vascular component.

Morphological observation of 162 cases with invasive ductal breast carcinoma, including those with metastases (97 cases) and without them (65 cases) was carried out in the research. Medical pathomorphosis was studied considering microscopic features in tumour tissue. Analysing 162 observations dystrophic changes in stroma of the tumour cells (15.4%) were found. In 32,1% moderate dystrophic changes were observed, and in 18,5% pronounced dystrophic changes were determined. Dystrophic changes in tumour stromal component in other 33% of the observations were not detected.

Medical pathomorphosis was investigated in 2/3 of the studies. Due to the use of pre-operative treatment, the status of microvessels in the tumour was not investigated because they were changed as a result of cytostatics and/or radiation therapy.

**Lazaruk O.V.**

**THE CHOICE OF TACTICS PREDICTING METASTASIS  
OF INVASIVE DUCTAL BREAST CARCINOMA**

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The main causes of death due to ductal breast cancer are metastasis and complications associated with it. Some of the researchers believe, if treatment tactics are chosen considering the risk of metastases, their number will be lower.

The prognosis of metastases remains an unexplored direction in prevention of complication nowadays. The same factors are used to estimate the metastatic process as for the prediction of the course of breast cancer. The choice of treatment tactics is based on information concerning tumour status and metastases morphologically and clinically confirmed.

To study the prediction of metastasis the features of the protein and receptor status of breast tissue in women with ductal breast carcinoma were suggested to study and to establish the difference between the cases with metastases and without them. 162 cases with invasive ductal breast carcinoma were chosen, including those with metastases and without them.

The result of the research related to the "Registration threshold". This value is individual for each research method, which indicates the maximum difference in the groups by the quantitative



value. The established "Registration threshold" can be used by scientists or doctors to compare their investigation results as a benchmark for predicting metastases.

**Lopushniak L.Ya.**

## **PHYSIOLOGICAL ATRESIA IN HUMAN ONTOGENESIS**

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The time of onset of intestinal atresia refers to the period of organogenesis at the 10-11th week of intrauterine development, when one of the processes of formation of the intestinal wall, gut lumen, bowel rotation is disturbed. Between the 6th and 10th weeks of intrauterine development, the intestine breaks out to the umbilical cord, returns to the abdominal cavity and is fixed to the base of the mesentery. The digestive tube in the process of development passes a solid stage, when during the proliferation of the epithelium, the lumen of the intestine completely closes. The process of vacuolization ends with the restoration of the lumen of the intestinal tube, but under certain conditions the latter phase is disturbed and the intestinal lumen remains closed. If the recanalization process is altered on a small area, the intestinal lumen is covered by a thin membrane, then there is a membrane atresia. In those cases where the process of recanalization has begun, and in the membrane holes of different sizes are formed, then there is a membranous stenosis. When closing the lumen on a large section, atresia has the nature of a fibrous lobe.

The reason for this form of atresia may be the underdevelopment of the corresponding branch of the mesenteric vessel.

Intestinal atresia can also be multiple ("nipple form").

Non-rotation occurs at a frequency of 0.2%. The defect is often accompanied by other defects: duodenal atresia and stenosis, diverticulum of the ileum, biliary atresia, ringed pancreas and nonperforated effector. The absence of rotation of the umbilical hinge is observed only in conjunction with the innate umbilical hernia. Stopping of intestinal rotation in stage II (malrotation) occurs when the cecum returns and is fixed, but this does not happen from the duodenum, which leads to its contraction - the bundles of Ledda. The less common case when the blind and the duodenum return in the opposite direction, causing the blockade of the large intestine, due to compression from the outside of the upper mesenteric vessels, or the duodenal loop returns in the opposite direction in the normal rotation of the intestine.

Violation of intestinal rotation often leads to significant compression of the duodenum with a long crus of the mesentery, causing a clinical picture of arterial obstruction, leading to ischemic necrosis of the small intestine. For the clinic, it is important to study morphometry and neurovascular relationships in conditions of intestinal atresia.

In the structure of physiological atresia of the organs of the digestive system in human embryogenesis the main feature is the formation of vacuoles. There are three stages of the development of physiological atresia: 1-nd - relative rest, when in the epithelial layer of the esophagus, duodenal ulcer, gallbladder, ventricular channel vacuoles there - embryos 7-10 mm of PCL; 2nd - internal reconstruction characterized by intensive development of organs – prefetuses of 10-27 mm of PCL; 3rd - the process of restoration of the lumen organs and duct - prenatal 29-39 mm of PCL. In the digestive organs of the newborn, dystrophic changes in the structure of the wall are most pronounced in the area of atresia and the preatretic segment, and less in the postretic segment. In the area of atresia, multiple hearth of fibrosis and necrosis, stratification of the intestinal membranes, desquamation of the epithelium of the mucous membrane, and angiogenesis have been detected. In the postretic segment, mucosal thinning, muscle atrophy, disintegration of the neurovascular plexus, and reduction of blood supply to the nervous nodes are observed.