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101 – ї
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Матеріали 101 – ї підсумкової наукової конференції професорсько-викладацького персоналу вищого державного навчального закладу України «Буковинський державний медичний університет» (м. Чернівці, 10, 12, 17 лютого 2020 р.) – Чернівці: Медуніверситет, 2020. – 488 с. іл.

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У збірнику представлені матеріали 101 – ї підсумкової наукової конференції професорсько-викладацького персоналу вищого державного навчального закладу України «Буковинський державний медичний університет» (м.Чернівці, 10, 12, 17 лютого 2020 р.) із стилістикою та орфографією у авторській редакції. Публікації присвячені актуальним проблемам фундаментальної, теоретичної та клінічної медицини.

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anthropometry, morphometry, vascular injection, macroscopy, microscopy, image and 3D-reconstruction and statistical analysis.

The anlage of GB and CD takes place in embryos with 4.5 mm of CRL (the end of the 4th week), which is consistent with the data of L.J. Skandalakis et al. (2014), Tsyhykalo O. V. et al. (2014). In the 10th week of its development GB looks like a twig with a sac-like diverticulum which is biger in size than the hepatic duct. After 11 weeks of its growth the GB is cylinder- shaped at the level of its duct and pear-shaped on the periphery, as a result it resembles an elongated drop. At the end of the fifth week of growth one can find islets of blood formation in the mesenchymal layer – lumens of capillary blood vessels which is indicative of the formation of intra-organ blood stream. At the end of the embryonic period – at the beginning of the pre-fetal one a junction of extra- and intra-organ vessels can be observed. The anlage of the GB and CD veins was found in embryos in the late 4th - early 5th weeks of fetal development which looked like wide slits, surrounded by a row of mesenchymal cells. At the end of the embryonal and the beginning of the pre-fetal period of development in the structure of arteries and veins significant features of differentiation can be observed: the venous wall is much thinner and formed by a row of mesenchymocytes. At the beginning of the fetal period of the intrauterine growth the venous diameter becomes bigger than that of the arteries. The special spatial structure of the CD lumen creates resistance to the flow of bile out of the GB. Understanding the characteristics of the fluid in the biliary system, and in particular in the CD is very important when we explain the pathogenesis of stone formation in the GB. Anatomy of the CD is extremely variable due to a spiral fold. It is formed by the folds of the mucous membrane in the duct, which are placed in a spiral manner and are leaf-shaped. The role of these folds, which act as active or passive impedance device providing a comprehensive resistance of bile has been discussed in numerous studies. On the sections of the CD we would find from 3 to 14 such septa which provide important geometric shape of the CD lumen and a clearance between the wall surfaces and those of the folds. The angle between the GB and CD varies widely - from 5% to 180%.

Thus, the vascular bed of the gallbladder and cystic duct are represented by an arterial network and a chain of longitudinal arterial anastomoses that accompany their walls, by vascular plexuses in all membranes of the walls. Venous plexuses are located outside of the arterial plexuses. Around the cystic duct we found topographical and anatomical differences in angioarchitectonics: in 76.2 % we could detect arterial rings connecting the upper section of its own hepatic artery and the cystic artery. Around the cystic duct, unlike other segments of extrahepatic bile duct the venous network lies deeper than the arterial one. At the beginning of the second trimester the cystic duct in male individuals is located the lowest skeletotopically in the fetuses with the highest and lowest coefficients of the constitutional type, whereas in female fetuses it does not depend on the constitutional type. The period of intensive growth of the gallbladder and cystic duct within 4-5 weeks of development can be considered as one of the critical periods in the development of extrahepatic bile ducts.

Pavliukovych O.V.

THE FORMATION OF STUDENTS' FORENSIC EXPERT THINKING BY MEANS OF SITUATIONAL TASKS USAGE

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The aim of the work, the purpose of this work is to discuss the possibility of situational tasks applying for the formation of forensic expert thinking among students.

One of the main tasks of medical students training at the department of forensic medicine and medical law is the formation of their forensic expert thinking, which allows to continue working independently during the on-site inspection of the corpse both during internship and medical practice. Taking into consideration that conduction of practical classes involves test control

of knowledge in each class on the one hand, and on the other hand – the development of practical skills, this in some way restricts the development of forensic expert thinking in the students.

Current control is not only testing of the level of mastering of the material in the class, it is also the continuation of training, repetition of the main issues of the topic, systematization of knowledge and skills, and also their consolidation.

Control by help of situational tasks is designed to sum up the mastering of each section of the class, to sum up the students' knowledge, to give them opportunity to systematize their ideas about mechanisms of death and description of the victim's body, to allow them to make adjustments to the understanding of the laws of the functioning of the organism as a whole.

Thus, the partial role of the forensic expert thinking in situational problems solving is very significant, and its significance is not limited only to controlling current training on a topic, but is an intermediate training activity in the training system.

Thus, clinical situational tasks can be used not only for controlling of the knowledge, but also for the formation of the students' forensic expert thinking.

Popelyuk O.-M.V.

EMBRYONIC FEATURES OF THE HARD PALATE DEVELOPMENT AND ITS CLINICAL RELEVANCE

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Over the past decade, the proportion of birth defects has increased significantly and cause perinatal and neonatal diseases and mortality. A modern clinics require an accurate data on individual anatomical variability in the prenatal period. Cleft lip and/or cleft palate are one of the most common visible congenital deformities of the face. We have aimed to explore the sources, terms and positions of the hard palate origin, study the patterns and features of their shape and topography formation during the development and to identify periods of rapid and slow growth as well as critical periods.

We have studied 15 embryos and 15 fetuses from the museum of Mykola Turkevich human anatomy department BSMU for this purpose, as well as series of sequential histological and topographic anatomical sections with the adequate methods such as: literature review, case history's study, macroscopy, microscopy of series of sequential histological and topographic anatomical sections were used.

Scrutinizing the available information it was detected that, at the end of the 4^{th} week, facial prominences appear and consist primarily of neural crest-derived mesenchyme and are formed mainly by the first pair of pharyngeal arches.

The formation of the future oral cavity begins in embryos 4,5 mm of crown-rump length (CRL) with the formation of an oral fossa. During the following 2 weeks, the maxillary prominences continue to increase in size. Simultaneously, they grow in a medial direction, thereby compressing the medial nasal prominences toward the midline. Subsequently, the cleft between the medial nasal prominence and the maxillary prominence is lost, and the two fuse. As a result of medial growth of the maxillary prominences, the two medial nasal prominences merge not only at the surface but also at a deeper level. The structure formed by the two merged prominences is known as the intermaxillary segment. It is composed of a labial component, which forms the philtrum of the upper lip; an upper jaw component, which carries the four incisor teeth; and a palatal component, which forms the triangular primary palate. Cranially, the intermaxillary segment is continuous with the rostral portion of the nasal septum, which is formed by the frontal prominence.

Hence, the upper lip is formed by the two medial nasal prominences and the two maxillary prominences. The lateral nasal prominences do not participate in formation of the upper lip. The lower lip and jaw are formed from the mandibular prominences that merge across the midline. At the end of the embryonic development period a combination of the primary oral cavity with the