

bronchial branches go to the left main bronchus, while there is, as a rule, one branch from the third right back intercostal artery to the right main bronchus. In the vast majority of the investigated fetuses, 2 left bronchial branches were found, which most often depart from the thoracic aorta at the fourth and fifth levels of the thoracic vertebrae and run along the left main bronchus, branching together with the bronchi, providing arterial blood supply to trachea, bronchi, lung tissue and pleura. Correspondingly, single small branches depart from bronchial branches to the esophageal core, the mediastinal part of the parietal pleura, tracheobronchial and bronchopulmonary lymph nodes. During macro microscopic preparation of the thoracic aorta in fetuses of different ages, anatomical variants of bronchial branches were revealed. In particular, in the fetus 210.0 mm PCL right and left bronchial branches departed from the thoracic aorta independently at the level the fourth thoracic vertebra. In another fetus 240.0 mm PCL left upper and right bronchial branches began from the thoracic aorta with a common trunk at the fourth level of the thoracic vertebra. Similarly, in this fetus at the fifth level of the thoracic vertebra the left lower bronchial branch departed from the thoracic aorta to the left main bronchus.

A little below (at the fourth and eighth levels of the thoracic vertebrae) the place of the ultimate end of the bronchial branches, from the anterior wall of the thoracic aorta originate esophageal branches, numbering from 1 to 5, which go to the walls of the esophagus at different levels. In 21 cases of the 35 fetuses, the blood supply to the thoracic esophagus is carried out by one esophageal branch, which departs from the thoracic aorta in the period from V to X thoracic vertebrae, usually at the seventh or eighth levels of the thoracic vertebra. In 8 studied fetuses 2 esophageal branches branched from the thoracic aorta, in 5 observations – 3 esophageal branches, in the fetus 180.0 mm PCL – 4 esophageal branches and in the fetus 95.0 mm PCL – 5 esophageal branches.

In the esophageal wall, the esophageal branches emerge into ascending and descending branches, and form an arterial network. At the same time small branches go to a core and the mediastinal fiber. During the preparation, anastomoses of the esophageal branches were found, namely: in the upper part of the organ – with the esophageal branches of the inferior thyroid artery from the thyroid-cervical trunk of the subclavian artery, and in the lower part of the esophagus – with the branches of the left gastric artery from the abdominal trunk.

At the level of the posterior inferior mediastinum from the anterior wall of the thoracic aorta depart numerous core branches, and from the anterior and lateral walls of the aorta – the mediastinal branches.

Zabrodska O.S.

ANATOMICAL ASPECTS OF THE UMBILIC VEIN STUDY

Department of Anatomy, Clinical Anatomy and Operative Surgery

Bukovinian State Medical University

The relevance of the study of the umbilical vein lies in the fact that this structure is used in surgical practice in children and adults. UV allows, bypassing physiological filters, to bring the necessary medicinal substances in high concentration to the pathological focus with their long-term deposition in damaged organs and tissues.

When performing scientific work, it is planned to investigate 50 objects of fetuses and 100 objects of a human after birth. Macro- and micropreparation, histological, morphometry, radiography, vascular injection, photographic documentation, statistical, corrosion methods.

The umbilical vein, as an integral part of the umbilical cord vessel, delivers arterial blood enriched with oxygen and nutrients from the mother's placenta to the fetus. After the baby is born, the function of the umbilical vein (and the umbilical cord) ceases. According to most authors, the umbilical vein is obliterated, further called the round ligament of the liver. But the research of Dovineer, Ostroverkhov, Nikolsky proved that after birth, only functional closure of the umbilical vein occurs, so it can be recanalized. This fact is especially important for clinical medicine, since it creates favorable conditions for extraperitoneal intubation of the portal system through the umbilical vein. The umbilical vein originates in the placenta and joins it with the left branch portal

hepatic vein, carrying arterial blood. The right umbilical vein carries reverse development in the first half of embryonic life. Remains left umbilical vein, at the entrance to the liver is divided into two branches: one flows into the left the trunk of the portal hepatic vein, providing the liver with arterial blood. The second branch (main) with the help of the venous duct is directed to the lower vein cava, where it flows. The umbilical vein after birth forms the round ligament of the liver, which located along the free edge of the falciform ligament, ductus venosus turns into a venous ligament. Comprehensive study of the typical and variant anatomy of the umbilical vein and its combinations in the pre- and postnatal period of ontogenesis. Determination of the features of the organometric parameters of the umbilical vein and its combinations in the age aspect. The results of the research performed will have theoretical significance, since they will significantly supplement information about the topographic and anatomical features of the umbilical vein and its branches, and can be used in the educational and scientific process of morphological and surgical departments.

Thus, in the fetus, venous blood flow in the liver is unique, because it is provided by two embryonically and functionally different systems: umbilical and portal / yolk systems. 5 to 10 weeks of pregnancy in the liver, a network of anastomoses forms between the umbilical and the vitelline system, and the volume of placental blood flow also increases, then it enters the heart through this hepatic system.

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270,0-375,0

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270,0-310,0

22,5±0,5

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 - 1,8±0,1 , - 4,1±0,2 , - 4,3±0,1 ,
 - 2,3±0,05 , - 12,2±0,2 .

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8,9±0,1 , 20,0±0,5 , : - 4,2±0,1 , -
 - 6,1±0,1 , - 1,7±0,2 , - 3,8±0,2
 , - 4,9±0,1 , - 2,2±0,1 ,
 - 12,1±0,2 .

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