

**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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дорослих переважають вертикальні і горизонтальні).

Компактний шар розвинений слабо, і там, де він відсутній, є прошарок сполучної тканини, з якою зливаються поздовжні зв'язки. Верхня і нижня поверхні тіл до самих країв закриті товстими гіаліновими пластинками, за рахунок яких відбувається ріст хребця у висоту.

**Lavriv L.P.**

## **MORPHOGENETIC PECULIARITIES OF THE PAROTID GLAND STRUCTURE**

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Formation of the organs is a very complicated process which is not definitively studied nowadays. It is very important to study the structure of the organs and systems in association with the basic processes of morphogenesis on the basis of the findings of embryogenesis. The study of the development and forming of the topography of the parotid gland during the prenatal period human ontogenesis is of great importance for integral understanding of the structural – functional organization of the salivary apparatus and the oral cavity on the whole. The analysis of scientific literature dealing with the parotid gland anatomy is indicative of a fragmentariness and discrepancy of the data, pertaining to the syntopy and chronology of the topographic-anatomical changes during the fetal period of human ontogenesis.

The objective of the study was to investigate variant anatomy and topographic-anatomical peculiarities of the human parotid gland and surrounding structures in fetuses.

The parotid gland was examined on 25 human fetuses, 130,0-375,0 mm of the parietal-coccygeal length (PCL). The following methods were applied in the course of the study: thing section of the parotid gland and parotid-masticatory area under the control of a binocular magnifying glass; macro- and microscopy; morphometry; computed 3-D design.

The parotid gland is found to be located in fetuses with 130,0-375,0 mm of PCL in a deep depression posteriorly the branch of the lower jaw, in the posterior mandibular fossa. A greater part of the gland is located between the mandible and sternocleidomastoid muscle penetrating deeply between these structures. The skin of this particular region is thin, movable. The subcutaneous pot is thin and fused with the skin. The structure of the parotid gland of 4-10 month human fetuses is anatomically changeable which is manifested by different shape (oval, leaf-shaped, horseshoe-like, triangle, irregular tetragonal), location and syntopy. Computed 3-D design of the gland presents its volumetric description which is the most practical one – in the shape of trilateral pyramid turned to the malar arch by its base, and to the mandibular angle – by its apex. A number of structures pass through the tissue of the parotid gland including facial nerve, posterior mandibular vein, external carotid artery, auricular-temporal nerve. The parotid duct is formed due to the fusion of two extra-organ lobular branches which in their turn are formed by means of fusion of several upper and lower lobular ducts emerging from the gland tissue passing through its capsule. The direction of the parotid gland is arch-like, with upward convexity. Passing along the external surface of the mastication muscle the parotid duct touches the upper extremity of the adipose body of the cheek and penetrates through the buccal muscle into the oral vestibule where it opens in the shape of a papilla of the parotid duct. The length of the parotid duct in the fetuses of the third trimester is 8,0-26,0 mm, diameter of the lumen is within 0,8-2,5 mm. The parotid duct is projected on the skin of the face from both sides along the line from antilobium to the mouth angle. The wall of the parotid duct consists of the connective tissue rich in elastic fibers and epithelium lying the lumen of the duct. The epithelium consists of two layers – deep cubic and superficial cylindrical.

Therefore, morphogenesis and topographic formation of the human parotid gland in fetuses are influenced by a total effect of spatial-temporal factors associated with the dynamics and close syntopic correlation of organs, vascular-nervous formations and fascial-cellular structures of the parotid area. At the end of the 10<sup>th</sup> month of the prenatal development the parotid gland under the microscope demonstrates its practically definite shape, although histological processes of



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