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^{th} 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.

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THE RISK OF BREAST CANCER METASTASIS IN WOMEN DEPENDING ON AGE

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The risk of developing breast cancer (BC) in women over 65 years of age is 150 times higher than in those under 30 years of age. The mortality rate in the older age group is almost three times higher than the mortality rate in the younger age group. The incidence of breast cancer among women aged 40-50 years in Ukraine is about 60 per 100 thousand of the population, and at the age of 50-60 almost 120 per 100 thousand. This means that women at this age are the most vulnerable and need to be screened. It is necessary to popularize and encourage modern methods of diagnosing oncopathology. It is necessary to develop a conscious desire for self-control in susceptible age groups, as in our country the number of older people in relation to the young is growing. In its turn, there is a tendency to "rejuvenate all malignant tumors." Age periods are used to predict the course of the disease.

Materials and methods: 503 cases of BC were studied. The peculiarities of metastasis in different age groups were studied. The age of the youngest patient with was 32 years, the oldest - 87 years. The mean age of women in the entire sample (n = 503) was 57.25 years (± 3.34). The average age of women with ductal breast cancer with metastases is lower by 6.34 years and is (50.09 years). Whereas women in the group without metastases - 59.63 years. When analyzing age values between 10 years, the situation regarding the disease is different. The number of observations in percentage, in the group with metastases in the range of 30-39 years. - 8.35% of observations, and in the group without metastases - 4.62%, in the age range of 40-49 years, in the group with metastases - 19.49%, without metastases - 9.13%. At the age of 50-59 in the group with metastases - 26.87%, without

metastases - 26.55%. In the age range of 60-69 years in the group with metastases - 31.89% without metastases - 36.60%, and in the period of 70-79 years in the group with metastases - 13.4% and in the group without metastases - 20%. The result is that in the group with metastases up to 60 years, the percentage of women is almost twice the percentage of the group without metastases. After 60 years, the group without metastases takes the lead.

The risk of breast cancer metastasis depend on age, at a younger age there are more aggressive morphological forms of carcinoma, which may be explained by the earlier age of patients. Therefore, metastatic cancer is more common at a young age and attention to detection and timely treatment should be strengthened. However, at the age range of 50-59 years, the number of cases with and without metastases in both groups is similar.

Leka M.Yu.

FETAL TOPOGRAPHY OF ANTEROLATERAL ABDOMINAL WALL NERVES' MUSCLES

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The polemic of incising the anterior abdominal wall in order to access the abdominal organs remains relevant until now. It should be noted that laparotomy and lumbotomy often damage the intercostal nerves and their branches, as well as the iliac branches, iliac nerves, which are involved in the abdominal wall innervation of the muscles and skin.

The aim of the investigation was to determine the sources of innervation of the muscles of the anterolateral abdominal walls in human fetuses 7-10 months. The study was performed on 24 preparations of human fetuses 7-10 months 231.0-375.0 mm parietal-coccygeal length without external signs of anatomical abnormalities or the skeleton irregularities of the chest, organs and thoracoabdominal structures cavities using macromicroscopic preparation, superficial staining of dissected nerves, as well as morphometry. The right and left intercostal nerves were studied along their entire length from the site of origin to the end branches in the muscles of the anterior-lateral parts of the torso. As a result, it was found that in the thickness of the muscles in abdominal anterolateral wall from the trunks of the intercostal nerves, iliopsoas and inguinal nerves depart at obtuse and acute angles of descending and ascending branches. The latter, in turn, are divided into branches of the 3rd and 4th orders, branching in the thickness of the abdominal muscles. In the studied fetuses, single and numerous connecting branches were observed mainly in the lower parts of the muscles of the anterior abdominal wall between the branches of one nerve trunk and between different nerves. This reveals the main and placer forms of branching of the main nerve trunks with irregular distribution of branches in the abdominal muscles. One should mention, that the concentration of nerves and their branches gradually increases in the caudal direction from the upper abdomen to the lower, as well as from the lateral side to the midline of the abdomen. When making incisions one should take into account the course and distribution of nerves and their branches in the upper anterior abdominal wall, where the connecting branches between the intercostal nerves, iliac and inguinal nerves are much smaller compared to the lower parts, where the neural network is developed better and more connecting branches, therefore, it is possible to make incisions that provide greater access to the organs of the abdominal cavity.

A variability of intercostal nerves topography, of iliopsoas and inguinal nerves and their number in the thickness of the muscles of the anterior and lateral walls of the abdomen was established. In particular, in some cases, in the innervation of anterolateral muscles of the abdomen walls involved VI (V) – XII intercostal nerves and iliopsoas nerve, and in other observations – VII-XII intercostal nerves, iliopsoas and iliac-inguinal nerve.

In the external and internal abdominal oblique muscles and the rectus abdominis, the nerves usually enter from the posterior surface, and the transverse abdominal muscle from the outer surface. Furthermore, in the external and internal abdominal oblique muscles, the nerves enter mainly at an obtuse angle to their longitudinal axis and at an acute angle relative to the muscle bundles. The nerves usually enter the transverse abdominal muscle and the rectus abdominis muscle