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**STUDY OF THE IMMEDIATE RESULTS OF THE FRONT RESECTIONS PERFORMED IN MALIGNANT LESIONS OF THE DISTAL 1/3 PART OF THE RECTOSIGMOID AND S-SHAPE INTESTINES**

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Laparoscopic anterior resection (LAR) in the malignant lesions of the distal 1/3 part of the rectosigmoid and s-shape intestines is widely spread throughout the world. A comparative study of the immediate results of open and laparoscopic anterior resection in such localized lesions is one of the main priorities of the current research.

**Key words:** Laparoscopic Anterior Resection (LAR), Open-Anterior Resection (AAR), intra-operative loss of blood, duration of operations, oral (enteral) feeding period, first defecation

**Material and methods of the study:** the clinical materials of Clinical medical center and "Elmed" medical center were used in the research. Patients were divided into two groups: I) LAR subjected patients (78 patients). These patients themselves divided into 2 subgroups. 1) 53 patients diagnosed with distal 1/3 cancer of the rectosigmoid and s-shape intestines and 2) 25 patients with a localized endoscopic polyposis diagnosis (malignant tumors), which could not be extracted by relevant localized endoscopic way. II) AAR group (66 patients). These patients also divided into two subgroups. 1) 45 patients diagnosed with distal 1/3 cancer of the rectosigmoid and s-shape intestines. 2) 21 patients with a diagnosis of properly localized (moderate and severe dysplasia polyps) malignant tumor. General clinical examination of the patients included MRI of the pelvis, abdominal cavity and breast CT scan, colonoscopy (biopsy), definition of CEA, CA19-9 olkometers and others was carried out.

**Introduction.** In modern times, treatment of rectum cancer remains relevant as in the past [1.2.3]. There are many reasons for this, because the number of illnesses and death intensity is high. Anterior resection operations performed at distal 1/3 malignant tumors of the rectosigmoid and s-shape intestines and in polyps subjected to heavy dysplasia and which could not be extracted by endoscopic way were considered as standard procedures for their oncological efficacy [4.7.9].

Improving operational technique during anterior resection operations and the application of modern mini-invasive technology have a positive impact on the immediate and remote outcome of treatment. In this regard, the application of laparoscopic technology to the anterior resection operations is of special interest [5.8]. The use of modern equipment (liegasur, harmonic scalpel, bipolar and monopolar coagulation) in the laparoscopic operation, the use of different types of staplers has been shortened to the operating time and has had a positive effect on the treatment results. The decrease in pain syndrome in the application of laparoscopic technology, fast recovery of intestine activity, an increase in the social activity of patients, minimizing of stay of patients in in-patient have been demonstrated by the majority of researchers. At the moment, the whole of the world is trying to carry out anterior resection operations of rectal surgery by laparoscopic way in most cases.

According to information provided by the American Coloproctology Association, 77% of cases of large intestine and rectum involve laparoscopic technology (6.8). Most research reflects the outcomes of several clinical trials provided jointly. Continuous implementation of laparoscopic anterior resection operations, especially in low-income countries, has led to a decrease in individual experience. Impossibility of surgeons working at separate clinics to have more than 2-3 anterior resections during the month, also showing their negative effects on laparoscopic anterior resection operations (in terms of lack of personal experience). Recent findings of LAR and AAR have been compared comparatively analyzed in the current research.

General clinical examination of the patients, CT scan of the thorax and abdominal cavity, pelvis minor MRI, colonoscopy (biopsy), determination of oncomarkers in the blood (CA19-9, CEA) and others was carried out.

**Material and methods of research.** At this part of the study patients (total of 46 patients) diagnosed with dysplastic polyps of various level different distal 1/3 of rectosigmoid and s-shape intestines, which cannot be extracted by endoscopic way and patients (total of 98 patients) diagnosed with adenocarcinoma of various areas have been investigated and analyzed. All patients were divided into two groups: 1) patients with anterior resection of rectum by laparoscopic way (78 patients); 2) patients with open anterior resection (AAR) (66 patients) of rectum. Of the patients included in the LAR group, 10 (12.8%) patients had distal 1/3 of the s-shape intestine, 21 (26.9%) patients had cancer of the respective area, and 15 (19.2%) patients had dysplastic polyp of rectosigmoid area and 32 (41.0%) patients had cancer in the relevant area.

Among the patients included in the AAR group, 7 (10.6%) patients had distal 1/3 dysplastic polyps of the s-shape intestine, 14 (21.2%) patients had 1/3 of the dysplastic polyp, 14 (21.2%) patients had cancer in the relevant area, 18 (27.2%) patients had dysplastic polyps of rectosigmoid area and 27 (40.9%) had cancer in the relevant area. Patients have been studied for age, sex and stage and place of tumor, as well as frequency of occurrence of concomitant diseases and previous surgeries, features of surgical operations and pathohistologic features of the tumor. (Table 1).

Table. 1

**Distribution of patients by age and sex to AAR and LAR groups**

Age	LTME (P) n=78				ATME (P) n=66			
	Male	Female	Male	Female	Male	Female	Male	Female
	M	M	%	%	M	M	%	%
20-29	1	1	1.33	1.33	1	-	1.54	-
30-39	5	5	6.67	6.67	2	3	3.10	4.61
40-49	8	8	10.7	10.7	6	7	9.23	10.8
50-59	10	8	12.8	10.7	9	8	13.8	12.3
60-70	11	14	14.1	18.7	10	12	15.1	18.5
70>	3	4	4.0	5.33	4	4	6.15	6.15

Depending on localization of tumor, the patients were divided into 2 sub-groups in both groups: on AAR group 1) diagnosed with distal 1/3 cancer of the s-shape intestine - 18 patients; 2) diagnosed with cancer of the rectosigmoid area - 27 patients. Accordingly, on LAR group 1) diagnosed with distal 1/3 cancer of the s-shape intestine - 21 patients; 2) diagnosed with cancer of the rectosigmoid area - 32 patients (Table 2).

Table 2.

**Distribution of patients depending on the localization of the tumor in the AAR and LAR groups**

Localisation of tumor	LAR n=78		AAR n=66	
	M	%	M	%
s-shape intestine distal 1/3	31	39.7	25	37.9
Rectosigmoid	47	60.3	41	62.1
Total	78	100	66	100

The frequency of occurrence and distribution of surgical operations performed by AAR and LAR groups are shown in Table 3.

Table 3

**Frequency of occurrence of previously performed surgeries for both groups**

Operations	LAR n=78		AAR n=66	
	M	%	M	%
Hernia operations	3	3.85	5	7.57
Appendectomy	6	7.69	5	7.57
Cholesistectomy	3	3.85	3	4.54
Stomach ulcer köžənməsi	-	-	1	1.51
Fetus extripation	2	2.56	4	6.06
Removal of ovary cyst	1	1.28	2	3.03
Previous laparoscopic operations	5	6.41	4	6.06
Echinococcectomy	1	1.78	-	-
Stomach resection	-	-	1	1.51

Distribution of tumor in rectosigmoid and s-shape distal 1/3 cancers depending on depth of invasion is shown in Table 4.

Table 4

**Distribution of patients on AAR and LAR groups, depending on the depth of invasion**

TNM	LAR n=53		AAR n=45	
	M	%	M	%
T <sub>1</sub> N <sub>0</sub> M <sub>0</sub>	2	3.77	1	2.22
T <sub>2</sub> N <sub>0</sub> M <sub>0</sub>	1	1.88	1	2.22
T <sub>2</sub> N <sub>1-2</sub> M <sub>0</sub>	5	9.43	3	6.72
T <sub>3</sub> N <sub>0</sub> M <sub>0</sub>	14	26.4	10	22.2
T <sub>3</sub> N <sub>1-2</sub> M <sub>0</sub>	23	43.45	19	42.2
T <sub>4</sub> N <sub>0</sub> M <sub>0</sub>	2	3.77	2	4.44
T <sub>4</sub> N <sub>1-2</sub> M <sub>0</sub>	6	11.3	9	20.0
Total	53	100	45	100

The distribution of patients on the stages is shown in Table 5. Our observations show that most patients applied at stage III.

Table 5

**Distribution of patients according to the stage of cancer in both groups**

Stages	LAR n=53		AAR n=45	
	M	%	M	%
I	3	5.66	2	4.44
II	16	30.1	12	26.6
III	34	64.1	31	68.8
Total	53		45	

The results obtained during the pathohistological examination of the extracted material are shown in Table 6. Most commonly differentiated adenocarcinomas were found according to the type of histology. Accordingly, 46.6% and 43.3% of the AAR and LAR groups. Adenocarcinomas with high differentiation and low differentiation were found to be 28.3%, 28.8% and 20.7%, respectively in LAR and AAR groups, and 17.7% mitotic cancer cases were found to be 7.54% and 6.66% respectively.

Table 5

**Distribution of patients according to results of pathophysiological examination in LAR and AAR groups**

Morphological properties of tumor		LAR n=53		AAR n=45	
		M	%	M	%
Adenocarcinoma	High differentiated	15	28.3	13	28.8
	Medium differentiated	23	43.3	21	46.6
	Low differentiated	11	20.7	8	17.7
Mitotic cancer		4	7.54	3	6.66
Total		53	100	45	100

**Result of the study and discussion.** Our research has been instrumental in view of place of occurrence of pathological process and influence of operation methods on immediate results. Our observations show that the nature and location of the pathological process does not have a significant impact on this indication, but the operation method has a significant impact on the outcome.

There is a significant difference in the amount of intraoperative loss of blood in patients who underwent laparoscopic and open anterior resection of the rectum (Table 6).

Table 6

**The amount of intraoperative loss of blood in both groups**

Location and nature of the lesion	Laparoscopic group (amount of loss blood, ml)	n	Open group (amount of loss blood, ml)	n
Polyps of s-shape intestine subjected to distal 1/3 dysplasia	226.8±118.5	10	322.5±149.3	7
Polyps of rectosigmoid area subjected to dysplasia	229.5±105.7	15	328.7±154.4	14
s-shape intestine distal 1/3 cancer	231.5±121.4	21	334.5±139.7	18
Cancer of rectosigmoid area	235.7±125.7	32	340.1±151.8	27
Total		78		66

There were no statistically significant differences in the comparative analysis of the amount of lost blood in the group. In the AAR group, where there is a difference between the groups, the amount of blood lost was found to be higher (e.g. 340.1 ± 51.8 ml in the rectosigmoid cancer in AAR group and 235.7 ± 125.7 ml in LAR group). Our observations show that the LAR group had less intra-operative blood loss. Comparative analysis of the duration of operations on both groups showed that the LAR group was slightly higher. These differences are more apparent in LTME (Laparoscopic Total Mesorectal Excision) groups (Table 7).

Table 7

**Duration of operations in AAR and LAR groups**

Location and nature of lesion	Laparoscopic group (operation duration, min)	n	Open group (operation duration, min)	n
Dysplasia polyps of s-shape intestine dist. 1/3	211.8±49.5	10	201.7±61.5	7
Dysplasia polyps of rectosigmoid area	217.5±38.7	15	206.5±58.8	14
Cancer of s-shape intestine dist.1/3	225.5±47.7	21	210.7±49.7	18
Rectosigmoid area cancer	227.5±50.1	32	207±62.7	27
Total		78		66

Our observations show that in patients with open anterior resection the pain syndrome is two times more. When evaluated by 10 points (0-10) scale, the 1st day in LAR group pain syndrome had 3.6 points

and 6.2 points in AAR group, 3rd day in LAR group - 2.3 points, in AAR group- 5.2 points, 4th day in LAR group - 1.9 points, in AAR group- 4.1 points, 5th day in LAR group - 1.6 points, in AAR group - 3.4 points,

6th day in LAR group – 1.5 point and in AAR group – 3.1 points. The presence of a large central cut in the abdominal wall, and the expansion of the abdominal wall with special mirrors during surgery, its stretching and the use of buffers and sheets have resulted in severe pain after surgery. Absence of large cut in the wall of the abdomen during laparoscopic surgery, operation through the smaller holes with fine-grained

instruments makes it easier for the patient to be less painful to expand the area of operation.

In this regard, the need for narcotic analgesics in the LAR group has dropped by about 2 times. Our observations show that there is no significant difference between the need for narcotic analgesics, regardless of the nature and localisation of the pathology (Table 8).

Table 8

**The need for narcotic analgesics in LAR and AAR groups (mg)**

Location and nature of lesion	Laparoscopic group (need for narcotics, mg)	n	Open group (need for narcotics, mg)	n
Dysplasia polyps of s-shape intestine dist. 1\3	62.8±1.8	10	105.4±2.2	7
Dysplasia polyps of rectosigmoid area	63.4±1.6	15	106.0±2.3	14
Cancer of s-shape intestine dist.1\3	67.8±2.1	21	112.0±2.8	18
Rectosigmoid area cancer	65.9±2.3	32	115±2.5	27
Total		78		66

Table 8 shows that differences between the groups are statistically significant in terms of the need for narcotic analgesics. The use of less invasive techniques in the operations has also influenced the onset of intestine movements. From this point of view, the nature and localization of the pathology did not have any significance. (Table 9).

Table 9

**The duration of beginning peristalsis in both groups**

Location and nature of lesion	Laparoscopic group (time of beginning of peristalsis, hour)	n	Open group (time of beginning of peristalsis, hour)	n
Dysplasia polyps of s-shape intestine dist. 1\3	32.7±1.8	10	64.3±2.2	7
Dysplasia polyps of rectosigmoid area	33.5±1.2	15	62.8±2.1	14
Cancer of s-shape intestine dist.1\3	31.7±1.4	21	59.3±1.8	18
Rectosigmoid area cancer	29.8±1.3	32	58.7±1.9	27
Total		78		66

Patients who underwent anterior resection of the intestine using laparoscopic technology are less likely to be in intensive care halls since they have shorter rehabilitation cycles (Table 10).

Table 10.

**Intensive therapy duration in AAR and LAR groups**

Location and nature of lesion	Laparoscopic group (intensive infusion therapy, hour)	n	Open group (intensive infusion therapy, hour)	n
Dysplasia polyps of s-shape intestine dist. 1\3	37.7±1.3	10	60.8±1.2	7
Dysplasia polyps of rectosigmoid area	39.5±1.2	15	61.3±1.5	14
Cancer of s-shape intestine dist.1\3	38.7±0.9	21	58.9±1.3	18
Rectosigmoid area cancer	40.1±1.1	32	59.3±1.9	27
Total		78		66

Our observations show that the nature and localization of the pathology does not have a significant effect on the duration of intensive therapy. However, the operation method has a significant impact on this indicator. Traumaticity of laparoscopic operations and the quicker recovery of life function make it easier for post-operative periods.

The study of physical activity in patients shows a clearer difference between surgical methods. This is the main criterion showing the effectiveness of the operation method. Our observations show that patients having less pain syndrome at post-operation period, with quicker restoration of intestinal functions, and

becoming active in a shorter time, have also rapidly recovered their life functions. On the 1st day after surgery the physical activity of 31 patients (39.7%) and 27 (40.9%) patients in the AAR group (physical activity by 4.0 points respectively), on the 2nd day of 48 patients (61.5%) in LAR group, of 38 (57.5%) patients (physical activity 3.6 points and 3.9 points respectively) in AAR group, on 3rd day of 51 (65.3%) patients in LAR group and 48 patients (72.7%) in AAR group (physical activity was 2.5 and 3.5 points respectively); on 4th day of 33 (42.3%) patients in the LAR group and 40 (60.6%) in AAR group (physical activity 1.8 and 2.6 respectively), on 5th day of 56

(71.7%) patients in the LAR group and 55 (83.3%) patients in the AAR group (physical activity by 1.6 points and 2.4 points respectively), on 6th day of 59 (75.6%) patients in LAR group and of 61 (92.4%) patients in the AAR group (physical activity by 1.4 points and 2.0 points respectively) were studied.

During the first 2 days after the operation, the patients had not a physical activity almost. On the 3rd day 20 (25.6%) patients in LAR group, on 4th day 41 (52.5%) patients, on 5th day in 67 (85.8%) patients and on 6th day in 75 (96.1%) patients self-treatment was observed. There were slight differences in the AAR group. This group started to be observed on a

specific 4th day, 18 (27.7%) patients had been noted to have a physical activity, on 5th day this indicator showed itself in 39 (59%) patients and on 6th day in 50 (75.7%) patients.

The nature and localisation of the pathology had no impact on physical activity. The main indication of beginning of enteral feeding was the occurrence of intestinal peristalsis and extraction of gases.

Our observations show that there are significant differences between the LAR and AAR groups in terms of beginning of enteral feeding, and the nature and localization of the pathology have a significant effect on this indicator (Table 11).

Table 11

**Enteral feeding duration of patients in AAR and LAR groups**

Location and nature of lesion	Laparoscopic group (enteral feeding time, hour)	n	Open group (enteral feeding time, hour)	n
Dysplasia polyps of s-shape intestine dist. 1\3	48.2±2.3	10	68.2±4.5	7
Dysplasia polyps of rectosigmoid area	46.5±1.8	15	66.3±3.8	14
Cancer of s-shape intestine dist. 1\3	47.7±2.2	21	67.6±4.1	18
Rectosigmoid area cancer	44.8±1.9	32	65.5±4.0	27
Total		78		66

The first defecation did not affect the nature of pathology and localization in both groups.

Table 12.

**First defecation period in LAR and AAR groups**

Location and nature of lesion	Laparoscopic group (first defecation, day)	n	Open group (intensive first defecation, day)	n
Dysplasia polyps of s-shape intestine dist. 1\3	4.7±0.9	10	5.7±1.2	7
Dysplasia polyps of rectosigmoid area	4.8±0.8	15	5.6±1.1	14
Cancer of s-shape intestine dist. 1\3	4.9±1.0	21	5.8±1.0	18
Rectosigmoid area cancer	4.8±0.7	32	5.9±1.4	27
Total		78		66

Laparoscopic or open execution of the operations may significantly affect the duration of the first defecation.

We believe that the absence of a wide area of operation, the mandatory use of anastomoses with staplers, less traumas of intestine, and less activation of the sympatoadrenal system have led to faster defecation in laparoscopic anterior resection operations.

The duration of hospitalization of patients after the anterior resection of the rectum implemented by laparoscopic technique was always less than in the open group (Table 13).

Table 13

**The duration of inpatient stay in the LAR and AAR groups**

Location and nature of lesion	Laparoscopic group		n	Open group		n
	Total surgery days	Post-operation bed days		Total surgery days	Post-operation bed days	
Dysplasia polyps of s-shape intestine dist. 1\3	21.3±4.5	10.7±3.3	10	23.5±5.5	12.8±4.5	7
Dysplasia polyps of rectosigmoid area	20.2±4.2	11.3±3.8	15	22.4±4.9	11.9±5.6	14
Cancer of s-shape intestine dist. 1\3	22.3±4.1	11.9±3.7	21	23.9±4.4	12.9±4.3	18
Rectosigmoid cancer	22.7±3.9	12.1±4.2	32	24.1±4.3	13.1±4.8	27
Total			78			66

As you can see from the Table, the differences within the group, depending on the nature and localization of the pathology, have not been statistically significant.

LAR and AAR groups have found significant differences in terms of inpatient stay. These differences were in favor of laparoscopic technology.

Although the differences were found that define the oncological radicality of the extracted material during laparoscopic and open anterior resection of rectum, they had no statistical significance. (Table 14).

Table 14

**Comparative study of average parameters of resection borders and volume of LAR and AAR groups**

Location and nature of lesion	Laparoscopic group			n	Open group			n
	Resect-ion proximal border	Resect-ion distal border	Total ex-tracted intestine		Resection proximal border	Resection distal border	Total ex-tracted intestine	
Dysplasia polyps of s-shape intestine dist. 1/3	9.1±2.8	5.3±1.7	18.1±4.4	10	10.4±3.6	5.9±1.5	19.2±4.8	7
Dysplasia polyps of rectosigmo-id area	12.3±2.6	4.7±1.9	18.8±4.2	15	12.9±3.7	4.1±1.7	19.8±5.1	14
Cancer of s-shape intestine dist. 1/3	8.7±2.5	5.1±1.9	18.0±3.9	21	9.9±3.2	5.7±1.6	20.1±3.7	18
Rectosigmo-id cancer	11.2±2.8	4.9±1.8	19.0±3.2	32	13.1±3.5	3.8±1.4	21.0±3.3	27
Total				78				66

There was no significant difference in comparative analysis of lymph nodes extracted in both groups' patients (Table 15).

Table 15

**Comparative study of lymph nodes extracted in patients subjected to laparoscopic and open-anterior resections**

Location and nature of lesion	Laparoscopic group (extracted lymph nodes)	n	Open group (extracted lymph nodes)	n
Local dysplasia polyps of s-shape distal 1/3	4.5±2.9	10	4.7±3.5	7
Dysplasia polyps of rectosigmoid area	5.8±2.8	15	6.1±3.3	14
Distal 1/3 cancer of s-shape intestine	4.9±2.7	21	5.6±3.9	18
Rectosigmoid area cancer	5.9±3.1	32	6.8±3.8	27
Total		78		66

When comparing the amount of extracted material and the number of lymph nodes, we found that the oncological principles were observed in the same way either in the laparoscopic or open resection of rectum.

Summarizing the results we have obtained, it can be said that laparoscopic anterior resection operations can be successfully applied in rectosigmoidal and s-shape distal 1/3 part of the intestine.

### Results

1. The amount of intra-operative loss of blood in the LAR group is less than the AAR group.

2. The duration of operations is much higher in the LAR group than in the AAR group.

3. Physical activity, enteral feeding time, and initial defecation are more frequent in the LAR group than in the AAR group.

4. Pain syndrome (points), accordingly, the need for narcotic analgesics is significantly higher in the AAR group.

The number of extracted lymph nodes and the volume of the extracted material were described in

close numbers in both groups, and there were no statistical significant differences between the groups.

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## ПРИЧИННЫЕ ФАКТОРЫ РАЗВИТИЯ ЦЕРВИКАЛЬНОЙ ИНТРАЭПИТЕЛИАЛЬНОЙ НЕОПЛАЗИИ

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## CAUSAL FACTORS OF DEVELOPMENT OF CERVICAL INTRAEPITHELIAL NEOPLASIA

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### АННОТАЦИЯ.

В статье проанализированы причинные факторы развития цервикальной интраэпителиальной неоплазии I и II степени, что является ведущим патогенетическим звеном в возникновении рака шейки матки. Оценивается актуальность применения иммуномодуляторов с противовирусной активностью пациенткам с CIN I и CIN II.

### ANNOTATION.

The article analyzes the causal factors of the development of cervical intraepithelial neoplasia I and II degree, which is leading to the pathogenetic link in the occurrence of cervical cancer. The relevance of the use of immunomodulators with antiviral activity to patients with CIN I and CIN II is evaluated.

**Ключевые слова:** Папилломавирусная инфекция, цервикальная интраэпителиальная неоплазия, вирус папилломы человека, кольпоскопия, койлоцитоз, биопсия, полимеразная цепная реакция, иммуномодуляторы.

**Keywords:** Human papilloma virus infection, cervical intraepithelial neoplasia, human papillomavirus, colposcopy, koilocytosis, biopsy, polymerase chain reaction, immunomodulators.

Цервикальные интраэпителиальные неоплазии - это патологическое состояние, при котором происходит нарушение дифференцировки клеток эпителия, развития в них атипии в результате пролиферации камбиальных элементов и нарушения гистоструктуры.

По данным ВОЗ CIN- это изменение, при котором часть эпителия замещена клетками, с различной степенью атипии и утратой стратификации и полярности, но строма при этом процессе остается не измененной. В зависимости от интенсивности пролиферации клеток, выраженности клеточной и структурной атипии, различают CIN I, CIN II, CIN III.

Цервикальная интраэпителиальная неоплазия расценивается как предраковое заболевание шейки матки. Рак шейки матки неуклонно занимает лидирующие позиции в структуре акушерства и гинекологии. В мире находится на 4 месте среди наиболее распространенных видов рака у женщин и на 7 в целом. С 2014 по 2017 гг. по оценкам специалистов РФ было зарегистрировано 175 тысяч 427 новых случаев РШМ. Достаточно внушительной цифрой является то, что в среднем в год от РШМ погибает 275 тысяч женщин в мире, 17 россиянок умирают ежедневно от данной патологии. Средний возраст заболеваемости 35.3 года, однако, в последнее время наметилась тревожная тенден-