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ИНТЕРВЈУ СО ПРОФ. Д-Р ТАНЕ МАРКОСКИ

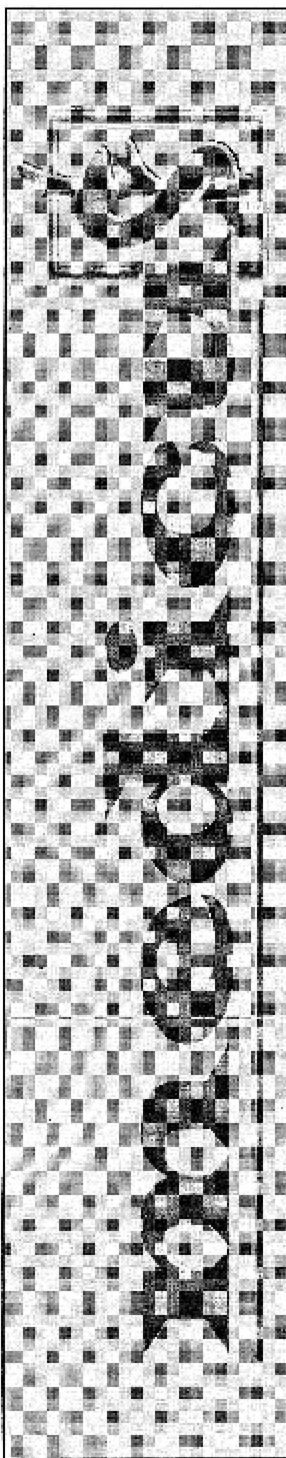
ОСВРТ НА ДЕВЕТМЕСЕЧНАТА РАБОТА НА РАКОВОДНИОТ ТИМ НА ЈЗУ КЛИНИЧКА БОЛНИЦА ШТИП

СПЕЦИЈАЛЕН ПРИЛОГ : СОВРЕМЕНИ ДИЈАГНОСТИЧКИ МЕТОДИ

РАНО ДИЈАГНОСТИЦИРАЊЕ И НАВРЕМЕНО ЛЕКУВАЊЕ НА НЕ-ХОЧКИНОВ ЛИМФОМ (ХНЛ)

СТИГМА...

СЕЌАВАЊЕ ЗА ПРИМ. Д-Р НИКИФОР ТИМЧЕВ



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STIGMA- Bod, ubod, -
Прво петно, жигосан, обележан, прокажан !!!

НАЈВИСОКО ПРИЗНАНИЕ „Д-Р ТРИФУН ПАНОВСКИ„
ЗА ПРИМ. Д-Р ПАНЧЕ ПУЗДЕРЛИСКИ

„ ЈАС СУМ ПРВИОТ ПОСЛЕВОЕН (ДИПЛОМИРАН) ФАРМАЦЕВТ „

ГЛЕДИШТЕТО НА СОЦИЈАЛНИОТ ПЕДАГОГ
ЗА ПРОБЛЕМОТ "СОЦИЈАЛНО ИСКЛУЧЕНИ ЛИЦА"

РАНО ДИЈАГНОСТИЦИРАЊЕ И НАВРЕМЕНО ЛЕКУВАЊЕ НАНЕ-ХОЧКИНОВИОТ ЛИМФОМ (НХЛ)

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ВО ОСТЕОИНТЕГРАЦИЈАТА I дел

Ризици во тек на ортодонтскиот третман

Representation of colorectal cancer

БОЈАТА НА ЗАБИТЕ КАКО ФАКТОР НА ЕСТЕТИКАТА (I ДЕЛ)

Representation of colorectal cancer

Doc.dr.H.Stojanov,[1]d-r N.Panov,[1] G.Panova[2]
Medical faculty- department of general surgery[1]
Trakia University,Stara Zagora R.Bugarija
Faculty of Medical Sciences
Univerzity-Goce Delcev- Stip R.Makedonija

Introduction:

Colorectal cancer is one of the most common cancers worldwide. According to WHO statistics for 2006 incidence in men was 20.1 new cases per 100,000 men, and for women 14.6 per 100,000. Annual mortality was 8.9 and 8.1 respectively in women of 100,000 patients.In recent decades the incidence of stable disease showed a rising trend. For our country, colorectal cancer is the second most common cancer in men and third in women (after lung cancer and breast cancer and cervical cancer).

New cases annually reach over 1 million which represents 10% of all malignancies. Represent 529,000 deaths worldwide (in 2007). In the United States suffer from colorectal cancer 15% of all cancer patients. In Bulgaria last three decades, the incidence of colorectal cancer has increased almost the triple. Moreover, supervise surgical and increased incidence of the disease among young people. The high incidence of colorectal cancer among the Bulgarian population above the world average, its late diagnosis surgical treatment conducted in non-specialised centers, lack of subspecialitis teams has major clinical units relatively high mortality KRK determined as socially significant disease.

The factors influencing the occurrence of colorectal cancer are assumed to be multifunctional disease markets importance of lifestyle and diet, and other genetic heredity, some authors emphasize the importance of direct correlation between high GDP and incidence of colorectal cancer.

Therapeutic approach usually includes various amounts surgery (resection) in a combination of chemotherapy and radiotherapy, depending on the stage of the disease, hitological verification the tumor location and more. Undoubtedly, it is essential progress stage of tumor-infiltrating process in depth of the intestinal wall infiltration outside bodies towards neighboring authorities, involving regional lymph nodes or distant ones. A major factor on survival and development of relapse appears arisen for lymphatic metastasis. In order to improve the results of surgical treatment and improved quality of life in rectal cancer studies are carried out to optimize the volume of lymph node dissection in this type of tumors. Modern methods of surgical technique following operative care and

treatment reduced perioperative opinion operational in most clinical centers under 2% and five year survival in patients with radical operations is almost the 70% [1].

Surgery is the basis of operational treatment of rectal cancer. Resection of rectal carcinoma with surrounding mezorektum with a distal margin of at least 2 cm below the tumor, and we strive to keep tsirkumferentnata border. Strictly following these principles of surgical treatment achieve the so-called triple cancer clearance.

Multiinstitutsionals study of Japanese authors [2] based on the dissection of pelvic external LV in 5789 of a total of 11,567 patients reported that the LV lateral pelvic are regional in the rectum distal carcinom and they must be removed in order to increase survival, reduce local recurrence and improve the quality of life of patients.

Described by Heald concept of total mesorectal excision (TME) and the achievement of triple cancer clearances decreased local recurrence rate of less than 10% in specialized centers.

Summarizing what has been said here that we achieve the R-0 resection for carcinoma of the rectum is required to achieve clearance carcinoma in three directions

* Distal margin of at least 2 cm below the lower pole of the tumor

* TME-in full

* Pelvic lymph node dissection with off-peripheral removal of external pelvic lymph nodes in order to achieve pure peripheral (side) boundaries.

Purpose:

To perform a retrospective analysis of the impact of colorectal subspetsializatio and TME on two grups patients (1979-1990 and 2001-2009) and early postoperative follow the results in patients with colorectal cancer.

Material and Methods:

Retrospective traces the two time periods - from 1979 to 1990 and from 2001 to 2009, respectively, before and after the introduction of total mesorectal excision and colorectal subspetsialis in surgical treatment of rectal cancer. Data for the first study period were taken from a retrospective study concerning the period [3]. Data for the second period were collected from journals and operational histories. 212 patients were studied oparated of rectal cancer. Exclusion criteria were patients operated on emergency and those with recurrence after anterior resection of the rectum. So for the purposes of the study were 189 patients. Intraoperative blood loss was recorded from the anesthesic operating lists, the need for transfusion and the mean duration of the operation.

Patients were divided into two groups, palliative and radical surgery. For the first time in a planned sequence were operated 179 patients with rectal cancer, including 134 radical (74.86%) and 45 palliative (25.14%). For the second period plans are operated 189 patients who were performed 169 radical (89.42%) and 20 palliative operations (10.58%).

Results:

During the period 1979 to 1990 to establish a relatively high rate of postoperative mortality 8.8%, respectively 8.9% for patients with palliative operation and died the same rate radical operated. Analyzing the reasons for the relatively high rate of postoperative mortality believe that the lack of experience on the part of the surgical team and by anesthesiologists and intensivists involved in the healing process is paramount. Second is the lack of subspecialization team working in the field of colorectal surgery. Gradually over the years, these gaps were removed, so in 2001, despite the 2009 volume of the enlarged lymph node dissection with removal of foreign Ilyich LV striving to achieve the requirements of triple cancer klians results of surgical treatment are better.

The overall postoperative mortality rate for the period 2001-2009 was 1.08%, 1.18% respectively to radically operated and 0% for palliative operation. Deaths are generally two patients nohirurrgical complications. Intraoperative transfusion during the period 1979-1990 was 100%, while in the second period with the requirement for TME and pelvic lymph node dissection, 52% (average blood 2F).

The mean operative time in the first period after analyzing the operating anesthesia truth is nearly 50 minutes more than in the second period 2001-2009. For the period 1979-90 average 5h and 10 min and 4 h for the second period and 20 min

Therefore, the introduction of colorectal subspecialization and TME with extended pelvic lymph node dissection improves healing outcomes significantly surgery of rectal cancer, reduction of post-operative mortality rate of 8.8% to 1.06%, shortening the average running time of about one hour, reducing intraoperative blood loss and need for transfusion.

The relatively high incidence of rectal cancer predelikatsions it as a place for development of malignant tumors. Approximately 35% at the time of diagnosis are usually incurable due to the development of multi-organ system metastases or local tumor progressivity. A high percentage of patients - more than 50% despite the many publications on optimizing the surgery die from the disease. In the U.S. every year 40,000 new patients registered per 8,000 die before the end of the first year.

Despite the development of systemic drug therapy, surgery remains the leader in rectal cancer. Essential for nmamlyavane of local recurrence is the optimization of the various components of the operating technique, TME, colorectal subspecialization, precise performance of pelvic lymph node dissection, achieving clear resection margins and borders tsirkumferents guarantee of good postoperative results and lower recurrence rate of lymph .

In low localized tumor processes in the rectum tumors t.n.distalni problem in keeping with the principles of oncological radicality and lit a sphincter. Modern concepts cartridge spread of rectal cancer and observes principles governing triple carcinoma clearance determine the sphincter persistent radical operations. In recent years there has been a clear trend and strive to increase WHO processes in tumor located in the distal rectum. The choice of WHO for distal rectal carcinomas also depends on the location and number of other factors such as tumor progressivity process presence lymphatic metastasis of disseminated, Staging and grading of the tumor presence local complications polimorbidnost the patient and others factors. It is important to note that the survey results after the

operation with WHO and output anus preter roughly equal in terms of local recurrence and survival. The type of surgery does not affect prognosis, but the quality of life in patients with a reserved function of the anal sphincter is incomparably higher. In order to achieve a high quality of life and reduce the rate of local recurrence rates well below 10% (4). (Typically, the frequency of local recurrence moves from 10-15-35%) introduced into clinical practice the principle of specialized teams to perform colorectal surgery in 2001-2009, which achieved much better results in comparison to 79-90g. to prevent insufficiency of the distal anastomosis especially rectum resection (surgery for advanced-en bloc resection or performing small pelvic total evisceration) temporarily interrupted intestinal passage removal of protective colostomy, ileostomy and lately, which closes after endoscopic control lack of insufficiency of the anastomosis. Last carried out using disposable circular stapler HC31. Where is carried colostomy or ileostomy protective occurred insuitsientsiya colorectal anastomosis at 8.03% (15 patients) of patients who mastered conservative and have relaparotomiya.

Comments:

The first description of topics is mezorektum done the Romanian surgeon Thoma Jonnesco. Later Gerota and Waldeyer Jonnesco cite in their monographs on the anatomy of the rectum. Jonnesco first noticed that the rectum is surrounded by a thin fascia, which separates it from other pelvic organs and allows it to be mobilized without damaging pre-sacral vessels [4].

Although Heald promote total mesorectal excision [5], Abel first procedure performed in 1931 [6]. Heald posted some of the lowest rates of local recurrence for the time-series of 112 patients and the rate of local recurrence 5 years, 2.7% and 5 year survival 87.5% [7]. Some have questioned the incredible relultati of Heald [8]

The introduction of colorectal team performing TME influence of early postoperative results of surgical treatment of rectal cancer, as evidenced by the data above. Our study recorded reduced postoperative mortality, need for transfusions, and shortened operative time.

Pre-sacral plexus lesion is rare with the introduction of TME, the bleeding can be controlled by the method described in detail by Xu and Lin [9]

Allogeneic transfusion is associated with a worse prognosis in patients undergoing surgery for colorectal cancer, probably due to immunological reasons [10.11]. Sound hypothesis is that it creates an immunosuppressive-like state able to modify tumor growth, recurrence and metastasis [12] and increasing susceptibility to postoperative infection [13]. Perioperative transfusion is an independent prognostic factor in colorectal cancer [14] However, account must be taken of the circumstances necessitated transfusion and transfusion not only as such. Reason for intraoperative blood loss may be technical or skill of the surgeon [15], being the factors influencing the development of local recurrence. Quirkea concluded that no advanced TNM stage of the disease and the ability of the surgeon to remain in the defined term plan mesorectal resection. [16]

Halm et al. the view that the number of patients operated on by the surgeon has little effect on the procedures that are less risky [17] Although rectal surgery is less risky than the pancreas and esophagus, correlation between volume and early surgery posoperativ results exist [18].

Selwyn et al. note that surgeons performing fewer than 13 operations for rectal cancer that perid of 4 years are statistically significant predictor of 30-day postoperative mortality. [19]

Vivien et al found no significant improvement in surgical and oncological outcomes of colorectal subspetcialization, probably due to the routine use of TME [20].

We recorded mortality -1.06% - not differs the results of other centers, even comes close to the percentages of high-volume centers [21].

The two recorded deaths directly associated with patient age and comorbidity in the absence of documented complications of the surgery. This confirms the view of Jensen, who stated that the presence of disease kardiovaskular quadrupled risk for major abdominal surgery in elderly patients. [22]

The relationship between duration of surgery and the occurrence of wound infection is the validated repeatedly. Although this was not the criteria set out in our study, it should be noted that the dependence found Cruse and Foord (23). They prove that the increased risk of wound infection doubles with every passing hour running time .. For operations lasting 1 hour probability of wound infection was 1.3%, and operating time 3 hours 4%.

In the palliative group, 20 patients operated on in the second period TME was performed in 6 to local control of the disease. Registered mortality is zero. TME technique is safe is a procedure with zero mortality in the hands of an experienced colorectal surgeon.

When tumor location in part Extraperitoneal accepting that it is a cancer of the distal rectum. Surgical treatment aims to achieve similar localization of triple cancer clearance. R-0 resection requires oncological radicality in three directions

1. Free of tumor infiltration distal margin

2. TME

3. Border clearance for cirkumferense

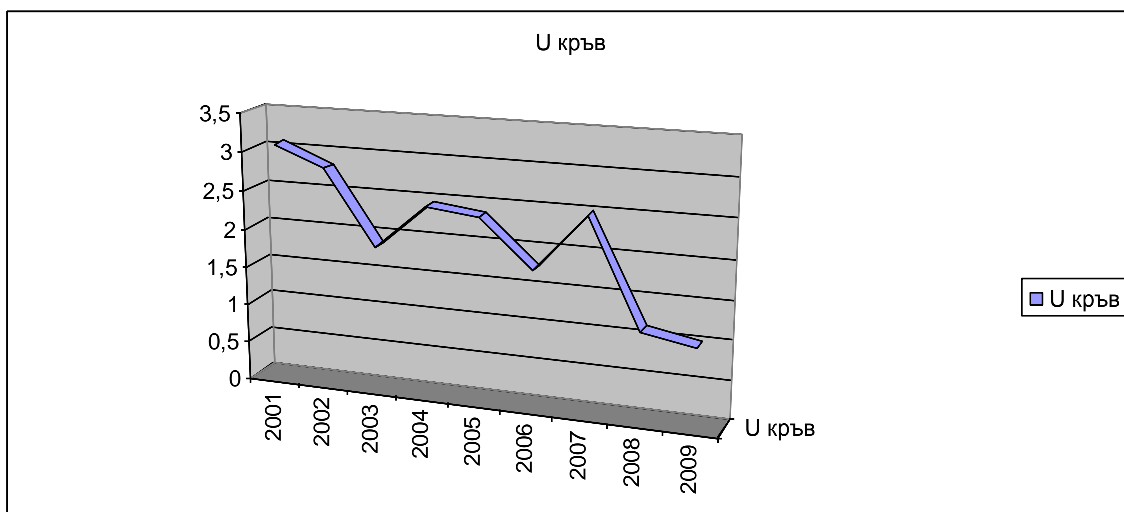

Figure 1 - Air units transfused intraoperatively-table for the period 2001-2009

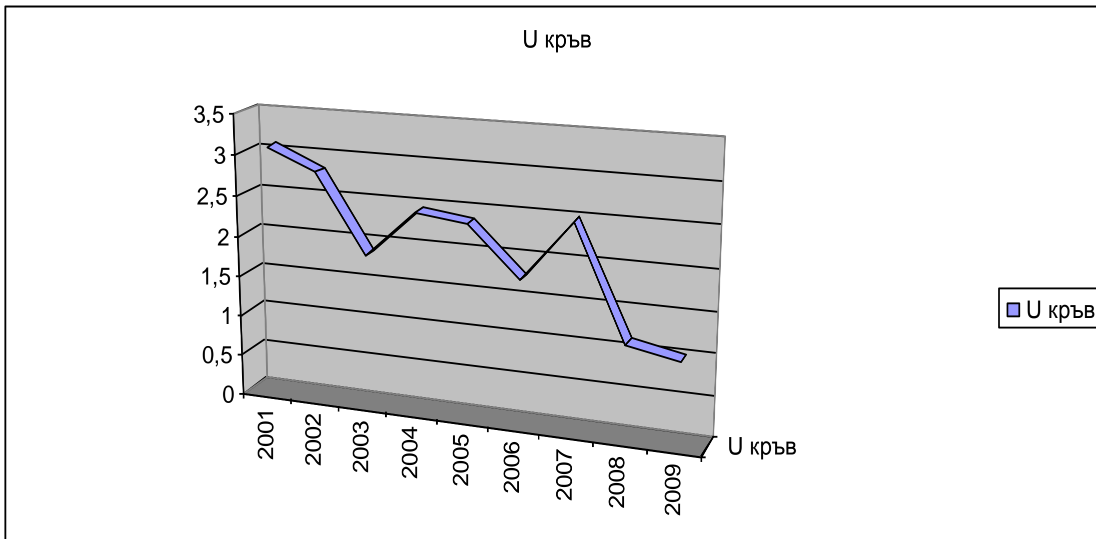

Fig.2 Intraoperative blood loss for the period 2001-2009

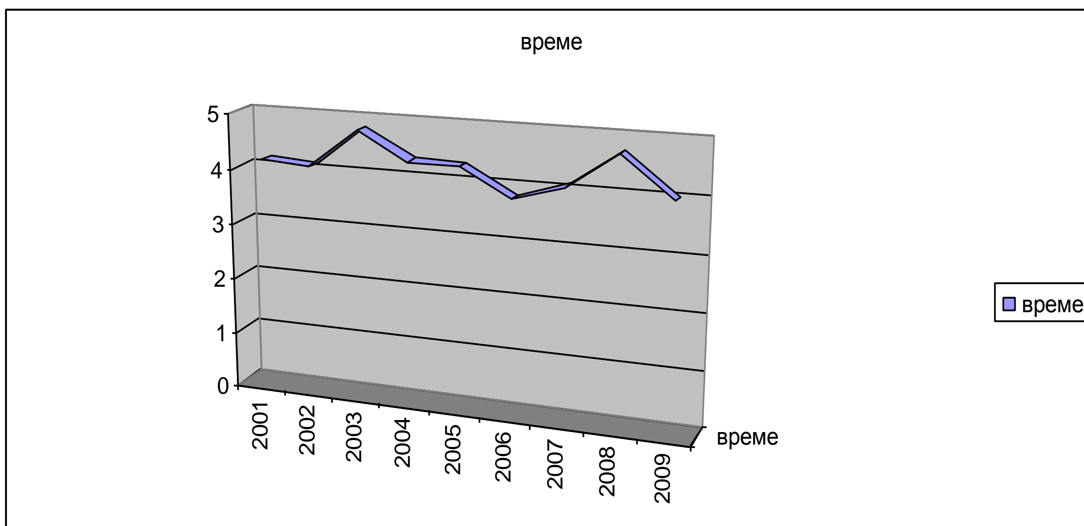

Fig.3 Field during the period 2001-2009

Conclusions:

1.Very benefits associated with the introduction colorectal team performing TME in surgical treatment of carcinoma of the rectum. Colorectal subspetsializatsiya introduction of TME reduces postoperative complications and mortality in the surgical treatment of rectal cancer.

2.Patsients operated in specialized clinics and centers are better indicators of morbidity and mortality rate than others.

3. Requirements for triple carcinoma clearance have not yet received attention of a large part of total surgeons performing operations for colorectal cancer, which has a negative treatment outcome.

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