

BASICS OF SURGICAL TREATMENT OF LOCALLY ADVANCED STOMACH CANCER

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ABSTRACT

An important clinical material studied the peculiarities of local spread of the tumor, depending on the localization of gastric cancer, the type of macroscopic growth and the degree of histopathological differentiation of the tumor. Direct and long-term results of surgical treatment of patients with locally advanced gastric cancer were analyzed. The main prognostic factors were identified taking into account the differentiated approach to the use of the surgical method in patients with locally advanced gastric cancer. The role of palliative combined interventions has been shown to improve long-term outcomes of treatment for patients in this category.

Keywords: surgery, stomach cancer, treatment, radiation diagnostics.

INTRODUCTION

Stomach cancer remains an urgent problem of modern domestic medicine. Uzbekistan ranks in the top ten for the rate of infection with this pathology and ranks as the leader in Central Asia for death from stomach cancer [2]. At the time of diagnosis, the majority of patients have stages of the disease (III and IV) [5], of which 53.5% die within 1 year of diagnosis (Axel E. M., 2008). According to the literature, the specific severity of stomach cancer is between 20 and 60% among newly identified patients [4]. In modern literature, data on direct and long-term outcomes of surgical treatment vary. Thus, according to various authors, the rate of complications after combined radical operations [1] ranges from 5% to 59.4%, while the postoperative mortality rate ranges from 3.3% to 24.2%. In a number of studies, patients with radical surgery do not have a 5-year survival rate, while in others it reaches 49.3% [6].

Currently, aggressive surgical tactics are becoming more and more accurate, its supporters are promoting the removal of a stomach tumor as completely as possible in a locally advanced process. At the same time, not all surgeons share this approach. Indications for combined resection, palliative interventions remain contradictory. The results of surgical treatment of locally advanced cancer cannot be considered satisfactory. Due to the spread of the tumor process, there is a very frequent (38-60%) refusal of surgical treatment. Even after potentially radical operations, most patients with locally advanced stomach cancer die from tumor progression and recurrence.

The relevance of the problem is reflected in the IV International Congress on stomach cancer, held in New York City (4th International Gastric Cancer Congress) in the United States in 2011, in which the entire section is devoted to the problem of surgical treatment of widespread

(including locally common) stomach cancer. The absence of a single surgical tactic, the inconsistency of the direct and long-term results of treatment have determined the relevance of continuing research. Despite the decrease in the level of stomach cancer in recent years, the negligence rate of this disease remains at a high level.

Currently, in 60-90% of newly identified patients, stages III and IV of gastric cancer are recorded, the proportion of Stage IV does not have a downward trend and is 50-60% (Chissov V. I. etc., 2012; Davydov M. I. etc., 2008; Styliidi I. S. etc., 2019; Lawrence W. et al., 1995). If the 5-year and even 10-year survival rates in Phase I and II reach 80-95%, the 5-year survival rate in Phase III is 15-50%, while Phase IV does not exceed 4% (Lawrence W. et al., 1995). In recent years, high hopes have been expressed for improving the diagnosis of stomach cancer in the early stages, when its prognosis is still favorable. At the same time, screening large groups of the population is economically impossible for Russia, since its high cost and low detection of the early stages of cancer

(early stomach cancer can only be detected in 0.15-0.2% of the total mass of those examined) [3.7].

E.L.Berezov (1997), I. B. Shchepotin et al. (1998) shows a 20% incidence of locally spread stomach cancer among all newly identified patients of this pathology, E. S. Petelnikova et al. (2003) 44.5%, G. V. Bondar et al. (2016), in Europe it is 50-60%. A.F.Lazarev et al. (2006), studied the results of surgical treatment of cardioesophageal cancer and found local tumor spread in 20.4% of cases. V.A.Tarasov et al. (2011) a study of groups of patients with Stage III and IV of the disease found that 8% of patients had locally advanced gastric cancer. Currently, surgery alone is recognized as a potentially radical treatment for stomach cancer, as this tumor has a pronounced chemoradioresistance [5].

If in the localized stages of the disease most of the authors tend to undergo surgical treatment in various variants, then in common forms (locally advanced and metastatic gastric cancer includes) the question remains open. Given the prevalence characteristics of the tumor process in most patients with locally advanced gastric cancer, a significant impact of the surgical method on long-term treatment outcomes relative to the metastatic cancer population can be expected, since in this case the theoretical generalization of the tumor process is obvious. Among this category of patients, there are separate groups, the surgical treatment of which is justified in terms of improving the quality of life and increasing its duration. Identification of such groups on the basis of determining prognostic factors is in the first place.

The purpose of the study. To improve the results of surgical treatment of locally advanced stomach cancer.

Materials and methods of research. The study is based on a clinical and laboratory examination and observation of 58 patients with bladder cancer who applied to the Andijan Regional Oncological Dispensary from 2011 to 2021.

Research results. The first group included 23 (45.0%) patients who underwent radical combined interventions. The second group consisted of 17 (33.3%) patients who performed palliative (R1 and R2) combined operations. The third group consists of 11 (21.6%) patients to

whom surgical treatment is limited to exploratory and symptomatic (non-resected) interventions and is a comparative group by survival criterion.

The first group is most often represented by patients (23 people), to whom surgical treatment was considered radical (combined re-interventions were performed on all patients). The median age of patients in this group was 62.9 ± 0.7 years, the minimum age was 44 years, and the maximum age was 81 years. Males in this group are 15 (65.1%), females are 8 (34.9%), with a ratio of 1.9:1. Patients in the first group, according to the 2002 UICC classification, are staged by the esophageal tumor, it is divided into four subgroups, depending on the GI level of pathological differentiation.

More than half (55%) of patients had a low degree of tumor differentiation (G3). The average GI stage (G2) was reported in 29% of patients with radical surgery, with undifferentiated stomach cancer (G4) being found in 12.4% of cases. High-level tumor differentiation (G1) among patients of the first group is less common than in others - in 3.6% of cases.

Comorbid pathology of the cardiovascular system was reported in 21 of the 23 patients in the first group (89.3%). In addition, 6 (30.1%) of patients in this group had concomitant pathology of the respiratory tract, 40 (23.7%) digestive, 12 (7.1%) endocrine, 12 (7.1%) nervous. The presence of two or more comorbidities was diagnosed in 132 (78.1%) patients. In 14 (58.3%) cases, the palliativity of the operation was due to the omission of a macroscopic residual tumor (S2). In the remaining 10 (41.7%) patients in the second group, a radical, histological examination of surgical material in an intra-rational manner showed the presence of a microscopic residual tumor along the resection line.

The median age of the second group of patients was 62.8 ± 1.9 years, minimum 35 years, maximum 76 years. In this group, males were 11 (45.8%) and females were 13 (54.2%). The male to female ratio was 1:1.2. In the second group, as in the first group, patients from 61 to 70 years old dominated, they accounted for 50.0 percent of the total number of patients in the group. The third Research Group was introduced to 30 patients who were unable to perform resection intervention and was a control group in the study of long-term results of surgical treatment of patients with local-spatial gastric cancer. In the case of patients in this group, surgical treatment is limited to symptomatic operations (bypass, formation of nourishing stomata) or explorative laparotomy. In 17 (56.7%) cases, the refusal to perform resection intervention was due to the spread of the tumor to large vessels (aortic, gated and inferior vena cava, uterine trunk).

In the remaining 13 (43.3%) patients in this group, tumor invasion spread to three or more adjacent organs with the formation of a stationary tumor conglomerate and participation in all cases of pancreatic head. It appears that gastroenteroanastomosis, which is bypassed with intergental retardation according to Brown by Belfler, was performed by 15 (50%) patients, with minor enterostomy by 2 (6.7%) patients, and trial laparotomy in 13 (43.3%) cases.

In patients of the third group, 28 (93.3%) patients have joint diseases of the cardiovascular system, respiratory - 14 (46.7%), digestive - 11 (36.7%), endocrine - 7 (23.3%), nervous - 8 (26.7%). The presence of two or more concomitant diseases at the same time was observed in 28 (93.3%) cases.

Thus, patients of these three groups did not differ significantly in sex, age, existing somatic pathology. A special selection of patients for a specific type of intervention was not carried out.

CONCLUSIONS

Locally advanced gastric cancer is characterized by a predominance of prognostically unfavorable morphological variants of the tumor (infiltrative tumor growth variants were reported in 87.9% of cases, with G2 and G4 histopathological differentiation rates reported in 69.5%). The spread of the tumor to two or more adjacent organs is frequent with General cancer (65.2±9.7%), histopathological differentiation of a low-grade tumor (44.9±4.5%), and undifferentiated (G4) cancer (45.9±8.2%). In the upper third of the stomach (66.2±5.4%), the growth of the exophytic (Voggtapp I) tumor (100%), in the upper level of histopathological differentiation, damage to only one adjacent structure with tumor localization is reliably dominant ($p < 0.05$) (66.7±21.3%).

Post-surgical complications for patients with locally advanced gastric cancer are reported in 25.6±2.5% of cases, with postoperative mortality at 5.8±0.7%. Patients with locally advanced gastric cancer have a 5-year survival rate of 17.4±2.0%. The average survival rate for this category of patients is 12 months.

Unsatisfactory long-term results of exploration and symptomatic operations justify the implementation of palliative combined interventions for locally advanced gastric cancer, which are not only able to cope with life-threatening complications of the tumor process, but also improve patient survival without increasing postoperative complications and mortality.

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