

PATHOLOGY AND TREATMENT METHODS OF THYROID GLAND CANCER

Aminova Mohinur Normurod qizi
aminovamohinur133@gmail.com

Safarov Sarvarjon Chori o'g'li
sarvarsafarov2299@gmail.com

Musurmonova Asal Isroilovna
asalmusurmonova@gmail.com

Rahmatullayeva Shahlo Sherzod qizi
rahmatullayevashahlo9@gmail.com

G'ulomov Jaloliddin Jabbor o'g'li
gulomovjalol56@gmail.com

Termez branch of Tashkent Medical Academy

Abstract: Anaplastic thyroid cancer, also known as anaplastic thyroid carcinoma, is an aggressive form of thyroid cancer characterized by uncontrolled growth of cells in the thyroid gland. This form of cancer usually has a very poor prognosis due to its aggressiveness and resistance to cancer treatment. Anaplastic thyroid cancer cells are very abnormal and usually do not look like the original thyroid cells and are poorly differentiated cells that are not specialized for thyroid function.

Key words: Thyroid cancer, ionizing radiation, medullary cell, intoxication, chemotherapy. Epidemiological and experimental studies have shown that hormonal disturbances have a certain importance in the development of pancreatic cancer. It has been confirmed that the increase of thyrotropin hormone produced in the anterior pituitary gland contributes to proliferative processes in the thyroid gland, which, in turn, contribute to the formation of cancer. Among the external environmental factors, the impact of ionizing radiation during childhood is considered the most important. For example, there is a lot of disease in Hiroshima and Chernobyl. Other risk factors include endemic goiter. In endemic regions where the disease is common, there is a high incidence of calcaneal gland cancer.

Thyroid cancer usually arises from epithelial cells and mainly occurs in 4 histological types: follicular, papillary, medullary and undifferentiated cancer. In thyroid cancer, the histological structure of the tumor to a certain extent determines the clinical picture, course and outcome of the disease. Follicular and papillary types make up 80% of malignant growths of the thyroid gland, they grow slowly and do not quickly penetrate the surrounding tissues. Follicular cancer often metastasizes to bone and bone in 7-17% of patients with vascular metastases. Papillary

cancer mainly metastasizes to regional lymph nodes (in 40-60% of patients). The undifferentiated form makes up 10-12%, grows very quickly, deeply infiltrates the thyroid gland and quickly metastasizes to the surrounding area, causing unpleasant consequences. Medullary cell cancer occurs in 8-10% of patients. Its distinguishing feature from other cancers is that its hormone level reaches 100 mg/l or more. This is considered much higher than the norm. Medullary cancer grows slowly, metastasizes to regional lymph nodes in 40-55% of patients. Metastases to distant organs are rare.

In the initial stage, the clinical picture of thyroid gland cancer is not very clear. The only sign is the appearance of a lump in the gland. Cancer is characterized by the appearance of a hard, consistent, uneven surface nodule, and it does not hurt when palpated. The size is small and the nodule cannot be detected when it is inside the shell, but the cervical lymph nodes may be enlarged. A large cancer often burns or invades the surrounding tissues and organs. It is expressed in clinical severity by muffled voice, feeling of pain when swallowing, hoarseness, limitation when moving the gland. Normally, thyroid function is not disturbed when the cancer grows due to the compensatory capacity of tissues, they retain their thyroid hormone producing properties. Therefore, hypothyroidism is rarely observed in thyroid cancer. Symptoms of intoxication (loss of body weight, weakness, loss of appetite) are rare in pancreatic cancer and are detected when the disease is too late. Diarrhea is characteristic of medullary cancer, and it is dependent on the hormone calcitonin, which the tumor produces. Thyroid cancer often has no symptoms or is diagnosed late because it looks like a benign tumor. Patients with thyroid gland cancer turn to surgeons, therapists, endocrinologists, otolaryngologists and other specialists, who often do not use modern methods of cancer diagnosis and therefore make a mistake in choosing a treatment method.

When thyroid cancer is suspected, smear, palpable node puncture, ultrasound, radioisotope, cytological and histological examinations are used. A puncture biopsy of the thyroid gland helps to make a definitive diagnosis in 55-90% of patients. In many patients, the histological structure of the tumor can be determined on the basis of cytological examinations. Puncture of enlarged lymph nodes in the neck is important. In this way, it is possible to diagnose non-palpable cancers of the thyroid gland, identify the presence or severity of lymphogranulomatosis, tuberculosis and other diseases. Radioisotope scintigraphy is based on the accumulation of radioactive iodine and other substances in the thyroid tissue. Iodine in cancer tissue is in small quantities, but it accumulates well in the tissue of the gland, which helps to identify growths larger than 1.5 cm in diameter. Scintigraphy is of great importance in identifying the remaining part of the calcaneal gland and metastases after surgery.

Treatment. Stages I-II of thyroid cancer can only be treated with surgery. Irradiation, chemotherapy and hormonal therapy are carried out in stages III-IV of the disease. In stages I-II of thyroid cancer, 2 different surgical methods are used: subtotal resection and thyroidectomy. Often a subtotal resection operation is performed. In this case, the damaged spring and joint of the gland are cut. When a thyroidectomy is performed, the thyroid gland is completely removed. In patients with metastases in the neck lymph nodes, it is cut together with the neck cell. Combined treatment is carried out in the III stage of thyroid gland cancer and in its undifferentiated type. The treatment begins with giving 30-40 Gr of light therapy to the calcaneal gland. Subtotal resection is performed after 2-3 weeks. If both springs of the thyroid gland are damaged and there is an undifferentiated tumor, thyroidectomy is performed. After that, light therapy is carried out. If there are bone and spleen metastases in stage IV thyroid cancer, first the entire gland and regional lymph nodes are removed, and then radioactive iodine is given to the

patient. Hormonotherapy (thyroxine) is definitely used after radical surgery in all stages of gland cancer.

References:

1. Lindenbraten L. D. "Medical radiology" (textbook). M., 1969.
2. Manual of clinical oncology (International union against cancer — UICC), 1990.
3. Peterson B. Ye. "Oncology" (textbook for Vuzov). M., 1980
4. Napalkov N.P. "Obshaya oncology", Leningrad., 1989
5. Murathodjayev H. K. "Essay on modern oncology". Tashkent, "Science", 1996.