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### Early diagnostics of a breast cancer

The analysis of the primary medical documentation and the questioning data of women with breast cancer are carried out. It is found out that patients with a disease incipient stage (I-IIA) regularly passed professional surveys and consultations of the gynecologist. With augmentation of a cancer stage (IIB-III A) the quantity of women, to whom preventive examinations were not made or were made formally, increases.

**Keywords:** breast cancer, preventive examinations, early diagnostics.

### References:

5. Dulganov K.P. Epidemiology of malignant tumours in Republic Buryatiya / K.P. Dulganov, P.K. Dulganov, V.K. Dulganov. - Ulan-Ude: Publishing house of the Buryat. state university, 2001. - 371 p.
6. Epidemiological features of malignant tumours of mammary gland in region of Siberia and the Far East // L.F. Pisareva [et al.]. - Tomsk: Publishing house of Tomsk university, 2006.-206 p.

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### Surgical anatomy of extrahepatic bile ducts

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**Resume.** Anatomic peculiarities of extrahepatic bile ducts were examined on 50 cadavers who died from different diseases at age between 40 to 60 years without pathologies in abdominal cavity.

In most cases (98%) bifurcation and lobar hepatic bile ducts located out of hepatic tissue with length domination in left side, that allows to conduct reconstructive operations of injures and strictures of extrhepatic bile ducts.

**Keywords:** lobar hepatic bile duct, anatomy

**Introduction.** Lately, biliary passages diseases take one of the leading positions in abdominal surgery and are followed by the steady growth of extrahepatic bile ducts surgery.

Despite of long-established and ever-improving technology of cholecystectomy, bile ducts injuries rate have no tendency to decline. Moreover, implementation of laparoscopic cholecystectomy increased the frequency of iatrogenic bile ducts injures by 2-4 times and composes 0, 1-3%. Many authors consider faulty interpretation of topographic anatomy and

anatomic peculiarities of extrahepatic bile ducts as one of the causes leading to extrahepatic bile ducts injuries, during both traditional and laparoscopic cholecystectomy [1, 3, 4, 5, 6].

The consequences of iatrogenic bile ducts injuries can be catastrophic for patient's health. To treat bile ducts injuries, as well as their consequences in form of strictures, it is necessary to conduct reparative operations on the level of lobar hepatic bile ducts and their bifurcation. Therefore, the study of extrahepatic bile ducts anatomy and knowledge of their peculiarities is important during operations, especially, during commonly used nowadays different kinds of minimally invasive approaches.

Thus, the aim of this research was to prove optimal methods for reparative operations of bile passages injuries and strictures by studying anatomic peculiarities of extrahepatic bile ducts on autopsy material.

**Materials and methods.** The study of extrahepatic bile ducts anatomic peculiarities was conducted on 50 corpses, who died from different diseases at the age between 40 and 60 years with no pathologies in abdominal cavity. After extracting organocomplex and opening porta hepatis, lengths of right and left bile ducts, as well as the length of common hepatic duct, were measured. Separate form was filled out for each case and gross specimen photography was taken with Canon camera.

**Results and discussions.** In most cases (98%) lobar hepatic bile ducts located extrahepatic and their length varied from 0.5 to 3.0 cm. One case of intrahepatic lobar bile ducts, including their bifurcation, was found out (Table1).

Table 1

Length of right (RBD) and left (LBD) hepatic bile ducts

|     | Intrahepatic location | Less than 1,0 cm | 1-1,5 cm | 1,5-2 cm | 2-2,5 cm | 2,5-3 cm | More than 3,0 cm |
|-----|-----------------------|------------------|----------|----------|----------|----------|------------------|
| RBD | 1(2%)                 | 3(6%)            | 15(30%)  | 18(36%)  | 11(22%)  | 2(4%)    | -                |
| LBD | 1(2%)                 | 3(6%)            | 14(28%)  | 12(24%)  | 9(18%)   | 7(14%)   | 4(8%)            |

It is clear from the Table, that the left hepatic duct was usually longer than the right one. For instance, the right hepatic duct was longer than 2 cm in 26% cases, whereas left one - in 40% respectively. While right hepatic duct was 3 cm or less, left one in 8% cases was longer than 3 cm. (Figure 1). Average length of the left hepatic duct (1.63 cm.) was longer than same of the right one (1.44 cm.). As S.Koposova describes in her research [2], the left lobe of the liver differed with constancy of bile passages, so variations of left hepatic duct formation were much rare than those of the right one and mainly were caused by the order segmental canals entered

into left hepatic duct. According to the author, the left hepatic duct was longer than the right one, led to the left side of liver, situated anteriorly and higher than all elements of portal trilogy [2]. Anatomic peculiarities (topography and relatively long length) of left hepatic duct appear to be more profitable for reparative operations and application of gastrointestinal anastomosis. This corresponds to studies of foreign authors, which, in case of II, III and IV stricture types, recommend to apply longitudinal dissection in order to expand gastrointestinal anastomosis [7]. In case of short left hepatic duct, dissection of duct can be extended to the field of bifurcation (Figure 2) in order to form sufficiently wide anastomosis.

Common hepatic duct formed extrahepatic in 98% cases by confluence of right and left hepatic ducts. Its length before cystic duct confluence varied from 1 to 5 cm. In 74% cases the length of common hepatic duct was longer than 3cm, that is of great importance during surgery in the this field.

**Conclusions.** The results of investigation show that in most cases (98%) bifurcation and lobar hepatic bile ducts located out of liver tissue with length domination on the left side, that allows to conduct reparative operations under conditions of extrahepatic bile ducts injures and strictures.

#### References.

1. Galperin E. Bile duct diseases after cholecystectomy/ E.Galperin, N.Volkova – Moscow: Medicine, 1988. – 271.
2. Koposova S. Clinico-anatomic peculiarities of newborn, children and adolescents bile ducts topography: Dissertation abstract. / S.Koposova – Saint-Petersburg, 2009. – 20.
3. Kuzovlev N. Bile ducts scarry stricture. Meticulous biliary-digestive anastamoses / N.Kuzovlev // Annals of surgical hepatology. – 1996. – Vol.1;. p.108-114.

4. Movchun A. The causes, treatment and preventive measures from scarly strictures and bile ducts fistula/ A.Movchun, A. Timoshin, N.Ratnikova // Annals of Russian Research Center for Surgery Russian Academy of Medical Science. – 2000. - №9; p.53-59.
5. Fedorov I. Bile ducts injures during laparoscopic cholecectomy / I.Fedorov – Moscow.: Medicine, 2003.
6. Chernyshev V. Injures and scarly sctriictures of bile ducts / V.Chernyshev, V.Romanov. . – Samara, 2001.
7. Bismuth H. Biliary strictures: classification based on principless of surgical treatment / H. Bismuth, P. Majno // World J. Surg. – 2001. – V.25. – N.10.; p.1241-1244.

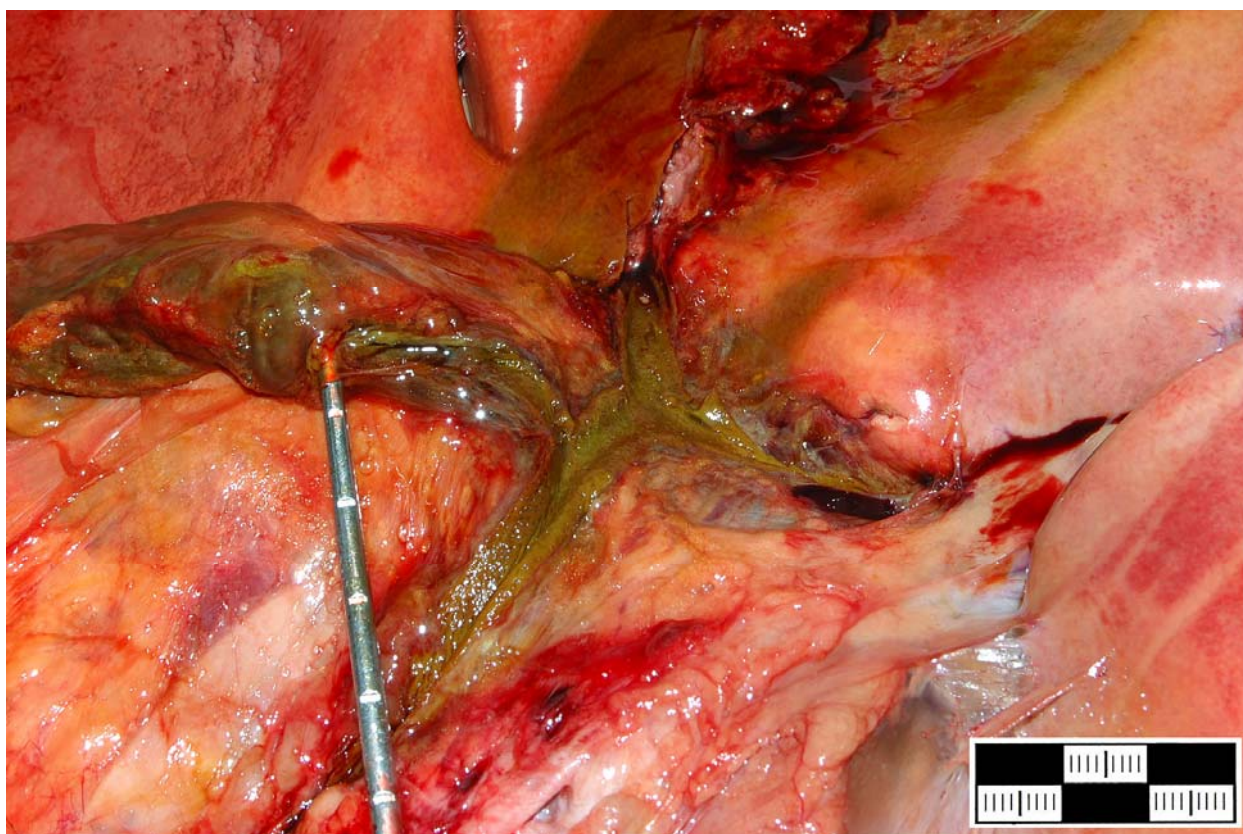


Figure1. Anatomic peculiarities of extrahepatic bile ducts. Left hepatic bile duct is longer than right one.

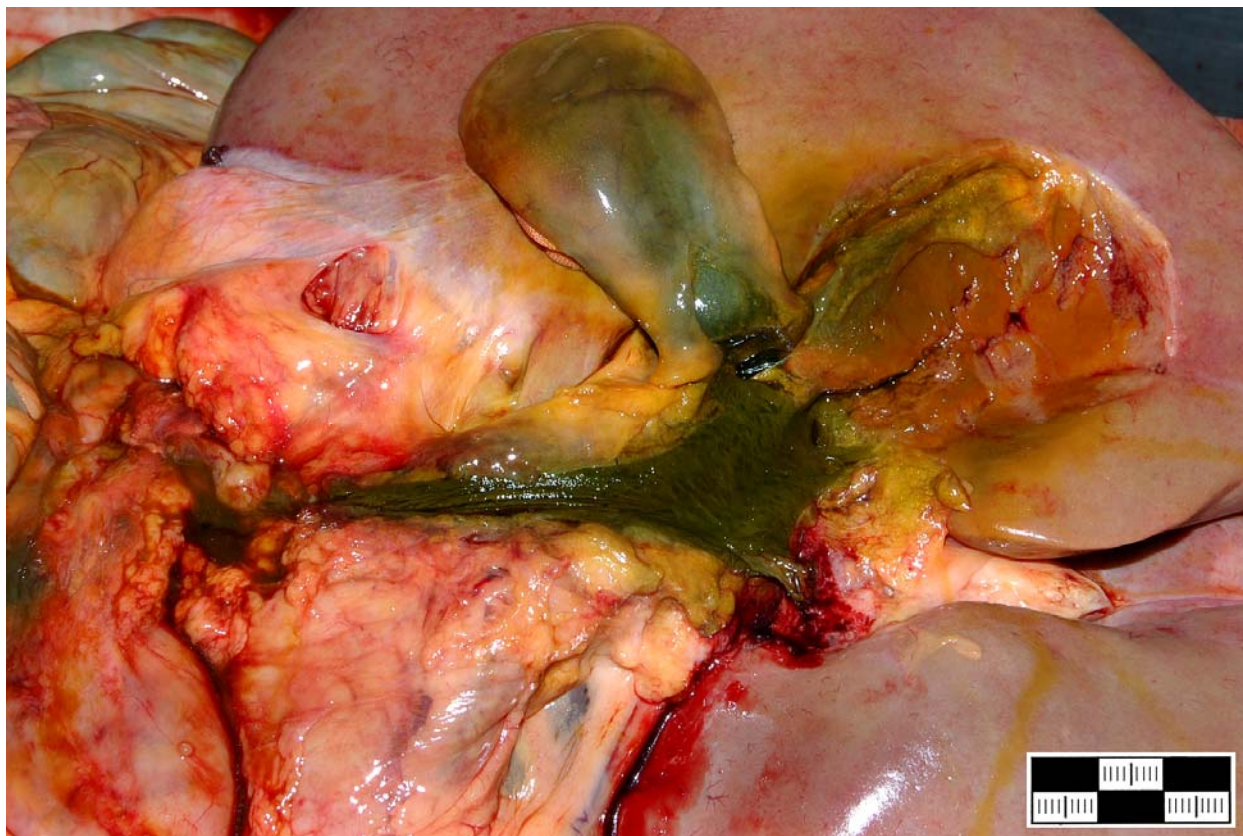


Figure 2. Anatomic peculiarities of extrahepatic bile ducts. Short left hepatic bile duct and wide bifurcation.

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### **Distinctive features in morphogenesis of pulmonary tuberculomas in patients from non-aboriginal population of the Extreme North**

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For a decade (1997-2007), morphogenesis features of different types of tuberculomas were studied in 125 non-aboriginal patients living in the environmental conditions of the Extreme North. The study showed that morphogenesis of tuberculoma in non-aboriginal patients started more often as a result of specific alterations following lymphohematogenous tuberculosis ( $72.9 \pm 3.2\%$ ;  $p < 0.01$ ). Interestingly, tuberculous alterations in the lungs developed amid unaltered lung tissue. As a rule, formation of tuberculomas in patients from non-aboriginal population is not associated with the development of marked fibrosis of lung tissue. These distinctive features of tuberculoma formation were determined by predomination of the processes of healing and alveolar epithelium renewal over inflammatory changes, thanks to which a better repair of the structure of lung parenchyma could be attained in the end.

**Keywords:** morphogenesis, clinical course, pulmonary tuberculoma, Extreme North.