The American Journal of Medical Sciences and Pharmaceutical Research
(ISSN – 2689-1026)
Published: October 13, 2020 | **Pages:** 19-28
Doi: https://doi.org/10.37547/TAJMSPR/Volume02Issue10-03

IMPACT FACTOR
2020: 5. 286

OCLC - 1121105510

Analysis Of Primary Oncological Disability In Andijan Region In 2017-2018

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ABSTRACT

Malignant neoplasms are one of the most relevant areas of modern medicine. More than 120 thousand people annually. recognized as disabled due to oncological diseases. In the structure of mortality from this class of diseases, about 30% are people of working age [1,5,9].

In the structure of primary disability, malignant neoplasms occupy the 2nd place after diseases of the circulatory system (16-20% of the total number of those who were first recognized as disabled) [1,2,9].

Affected mainly by the population in active working age, up to 90-95% of patients at the initial examination are recognized as invalids of groups I-II [22].

In men, the main disabling disease is lung cancer - 27.8%, in second place - stomach cancer - 11.3%, in third - cancer of the rectum and colon - 11.0%, in fourth - cancer of the larynx - 7.3%. In women, the leading disabling disease is breast cancer - 39.5% and female genital cancer - 26.3%. Cancer of the rectum and colon occupies 9.2% in the structure of primary disability in women [11,12,18].

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KEYWORDS

Treatment, temporary disability, biological properties, locoregional, oncoetiological, osteogenic.

INTRODUCTION

During the initial examination of a patient who has undergone radical treatment for a malignant neoplasm, oncological prognosis criteria and the degree of radicality of the treatment performed come to the fore when making an expert decision [20].

During subsequent re-examination, the main thing in making an expert decision is the presence and severity of the consequences of the treatment, the role of oncological factors is significantly reduced [13,18].

The period of temporary disability of 10-12 months is in most cases sufficient to complete special anticancer treatment and the formation of mechanisms for compensating for the impaired or lost as a result of this treatment of body functions [4,9].

In the future, the patient can return to his previous place of work in non-contraindicated conditions of production, resuming work in full or reduced volume (after the establishment of III group of disability) without harm to his health [5,8].

If the patient has pronounced consequences of the treatment, the ITU issues are resolved on a common basis. Doubtful clinical prognosis of a patient cannot serve as a basis for a ban on labor activity in the absence of contraindicated factors in labor [10].

The main criteria influencing the possibility of employment are the nature of work and the place of residence of the patient.

The prognostic factors characterizing the biological properties of the tumor (histological structure, degree of differentiation, type of relapse, etc.) significantly affect the size of the group of patients conditionally promising in terms of labor rehabilitation, and to a lesser extent - on the frequency and timing of recurrence. labor activity of the patient [7,9,15].

If there is a dubious clinical prognosis (stage III of the disease, a low degree of differentiation and an infiltrative type of tumor growth) in a patient with a negative work orientation, it becomes necessary to establish a II group of disability.

The terms for establishing the II group of disability in this case should not exceed 2-3 years, since at this time the absolute majority of all relapses and tumor metastases is realized [3,9,13].

The presence of complications in the patient in the form of fistulas (fecal, urinary), which give rise to untidiness, cannulation after extirpation of the larynx, as well as severe cosmetic defects after operations in the head and neck area, in some cases prevent employment in normal working conditions, which dictates the need to establish a II group of disability (with the recommendation of work in specially created conditions or at home) [1,5].

After the detection of tumor recurrence and repeated radical treatment in non-working patients or with a negative attitude towards

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work, it is advisable to establish a II group of disability.

Factors unfavorable for the clinical and labor prognosis are a combination of locoregional tumor recurrence with distant metastases, distant metastases without locoregional recurrence, a combination of local tumor recurrence with metastases in regional lymph nodes, low tumor differentiation, pre-retirement, and a retirement age of the patient, as well as living in rural areas. terrain [3,7].

Determination of the II disability group is advisable if it is necessary to retrain the patient (with the subsequent establishment of the III disability group) due to the presence of absolutely contraindicated factors in the main profession [14].

The terms for establishing the II group of disability should not exceed 2-4 years (depending on the type of detected recurrence) from the moment of radical treatment of the last registered tumor recurrence. Transfer of the patient to the III group of disability 2-3 years before reaching the retirement age is inappropriate [19,22].

With a positive attitude to work, the absence of contraindicated factors in work, the radicality of the antitumor treatment performed and the absence of pronounced complications and consequences, it is possible to complete the treatment of the patient for temporary disability with a subsequent return to the previous work in full or reduced volume (after the establishment of III group of disability) [20].

The prognostically favorable factors, in this case, include local recurrence or a single regional metastasis of highly differentiated cancer, the average age of the patient, and living in an urban area [11,15,19].

In the event that after the detection of tumor recurrence, repeated treatment is symptomatic or palliative, it becomes necessary to establish an I or II, disability group.

Thus, a qualified and scientifically grounded decision of a medical and social examination is impossible without determining the patient's clinical and labor prognosis, taking into account his labor orientation in each specific case.

The greatest efforts of all state and non-state services carrying out the rehabilitation of an oncological patient, both in the case of the initial diagnosis of a malignant neoplasm and in the event of a tumor recurrence, should be made during the first three years since it is during these periods that all rehabilitation measures are most effective [19,20].

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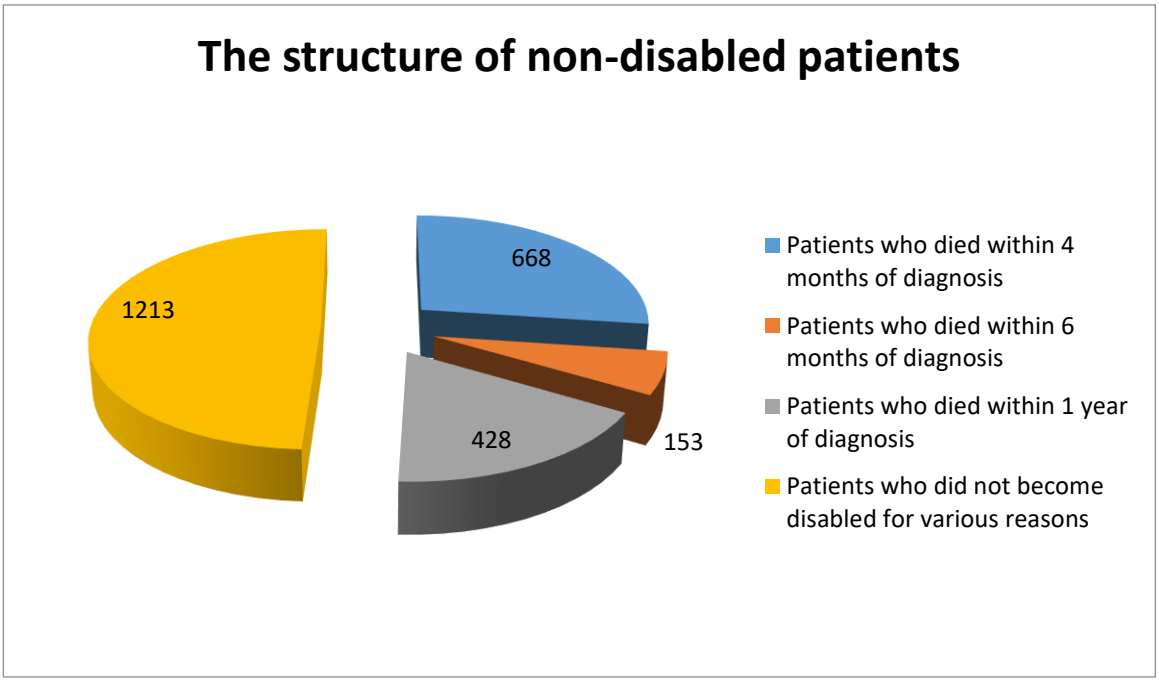
Figure 1

The structure of non-disabled patients



MATERIALS AND METHODS

During 2017-2018, a total of 3505 primary patients were identified in the Andijan region, of which 1043 (29.7%) were disabled. 2462 (70.3%) patients did not receive or become disabled for various reasons (due to death). The number of patients who died within 4 months of disease confirmation was 668 (27.1%), with the majority (84.7%) diagnosed with late stages of the disease, i.e., stages III and IV. The number of patients who died between 4 months and 6 months was 153 (6.2%) and the number of patients who died from the disease between 6 months and 1 year was 428 (17.4%). 1213 (49.3%) patients did not become disabled for certain reasons; these are mainly two: the first is the mentality of the population. This notion includes not only disability among patients but also disability due to the patient and their relatives hiding the disease from others; the second is excessive paperwork in the process of collecting the set of documents required to be submitted by the patient and their relatives to the representatives of MSES.

RESULTS AND DISCUSSIONS

821 (33.3%) non-disabled patients died within the first 6 months after diagnosis The need to revise the regulation adopted by the Cabinet and the fact that the majority of deaths were in the late stage was based on the first discharge papers after the diagnosis was confirmed in these patients. it would be expedient to give.

Based on the Medical and social examination service (MSES) database, a total of 1,043 oncology patients in the region were provided with disability groups in 2017-2018, of which 22 (2.1%) were disabled for up to 4 months. Resolution of the Cabinet of Ministers No. 195 of July 1, 2011, which is mainly used in the activities of MSES, stipulates that patients

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working in public institutions should be assigned a disability group within 4 months after the initial diagnosis, although the number of oncology patients working in budget organizations did.

Table 1

The structure of patients with disabilities.

Term of disability / Disability group	4 months	6 months	after 6 months	Total
1st group	3	149	16	168
2nd group	16	776	54	846
3rd group	3	22	4	29
Total	22	947	74	1043

Of these 22 patients, 3 (13.6%) were given group 1 disability, 16 (72.6%) were given group 2 disability, and another 3 (13.6%) were given group 3 disability. Within 6 months of the initial diagnosis, 947 patients with disabilities were diagnosed, of which 149 (15.7%) had group 1, 776 (81.9%) had group 2, and 22 (2.3%) had group 3 symptoms.

Of the 1,043 patients with disabilities, 168 (16.1%) received group 1 disability, 846 (81.1%) received group 2 disability, and 29 (2.8%) received group 3 disability.

Interviews with Group 1 disabled people and an analysis of their status revealed that all patients were assigned a disability group appropriate to the patient's condition, but there is another issue that needs to be highlighted. As an example, there are two cases: the first is a group 1 disability benefit as a result of amputation of the upper part of the thigh due to an injury received due to a specific accident; the second is to receive a group 1 disability benefit after a foot exarticulation procedure due to oncoetiological, osteogenic sarcoma. In the first case, the patient clearly needs the help of others, but does not need regular medical examination and treatment. , metastatic changes) should also be considered. We, therefore, consider it appropriate to revise the financial incentive tariff for patients with disabilities among oncology patients (due to standard-based treatment and persistent risk) because survival in patients with malignant tumors differs sharply from that in patients with malignancies due to nonclinical diseases.

A specific proportion of patients with Group 2 disability benefits were studied and the following errors and omissions were identified. For example, among patients with group 2 disabilities, 46 cases of breast cancer, tumor-infiltrative form, low differentiation were identified. In the world literature, all patients with this diagnosis are given group 1 disability, regardless of the stage of the disease, due to the aggressiveness of the disease and low survival rate in patients.

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Clinical example № 1. Patient T., 47 years old, breast cancer rT4N1M1 (OSS), infiltrative form of tumor, Histological examination revealed - primary with low differentiated infiltrative carcinoma conclusion.

Complaints on arrival: Left breast cancer, general weakness, loss of appetite, pain in the lower back, and legs.

Status localis: The mammary glands are symmetrically developed when viewed. The left breast is pulled into the pusher. The left mammary gland contains a 14x10.0 cm, irregularly shaped, uneven structure, adhering to the surrounding tissue, limited mobility. In the left axillary region, there is a conglomerate of lymph nodes measuring 2.5x5.5 cm. The right mammary gland is unchanged.

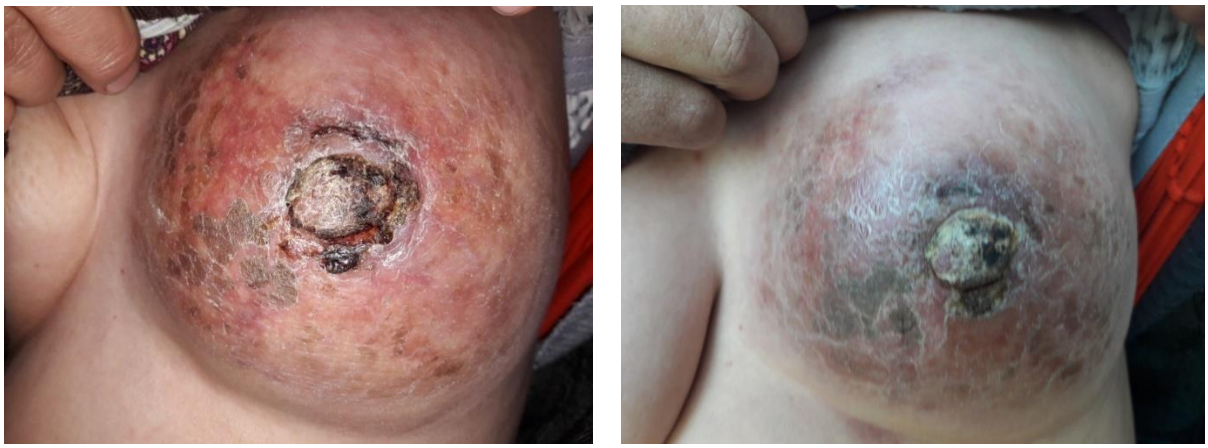

Figure 2. Macroscopic manifestations of infiltrative malignant tumor of the left breast tumor.

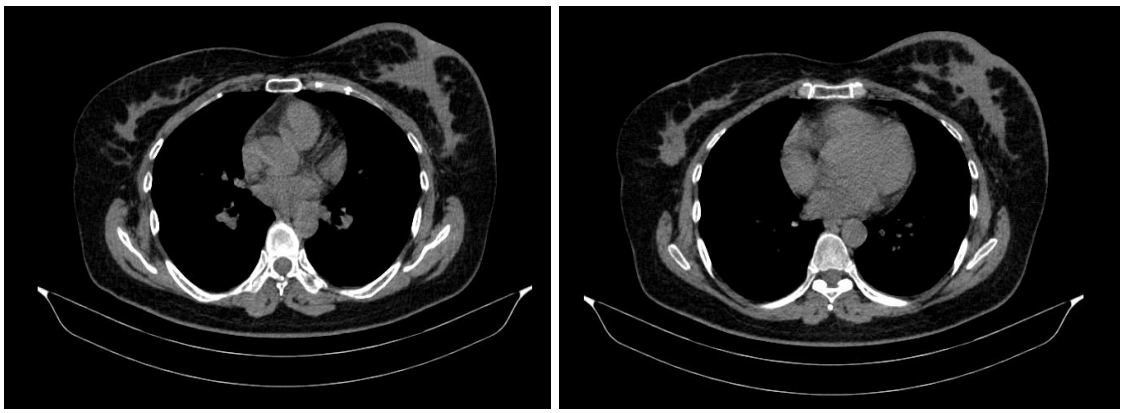

Figure 3: Left breast tumor infiltrative malignant tumor

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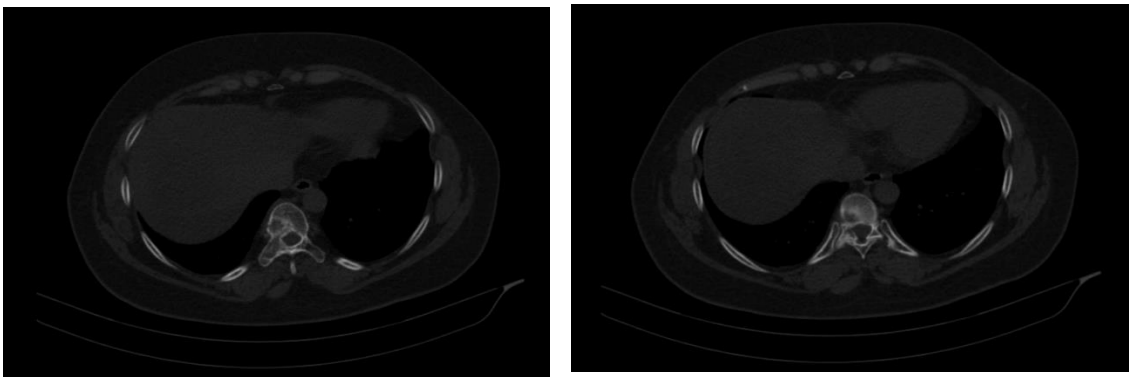

Figure 4. VTh X metastatic lesion of the spine.

ECG: Right sinus rhythm, HR-78, HE-horizontal position, slight ischemia in the myocardium.

Mammography: Virads-4s Left mammary gland product.

Blood analysis: 84.0g / l, erythrocytes -3.7 million, c/i-0.77; leucocytes-6.1; ESR- 8 mm / s. General urinalysis - in moderation.

Blood biochemical analysis: total bilirubin mmol / l; bound-7.0, ALT-0.6. AST-0.8; Creatinine - 74.9 µmol / l, urea-6.6 mmol / l; blood sugar - 4.8 mmol / l, Sa - 2.8 mmol / l

The patient received palliative care (bisphosphonates) with the above initial examination findings and became disabled within 6 months after the diagnosis was confirmed (March 2017). The patient died within 8 months of the initial diagnosis (November 2017) due to the aggressiveness of the disease, which was a late stage. This means that the patient received financial disability care for 2 months. In our opinion, given that the first half-year period of diagnosis for a patient is the time when all treatment procedures are planned and carried out, this situation is a reason to amend the regulations applied by MSES.

Clinical example № 2. Patient R., 51 years old, left primary kidney with a diagnosis of rT2N0M0 was considered primary (January 2018). Histopathology: hypernephroid carcinoma.

Complaints: Pain in the lower back, weakness.

Analysis of clinical laboratory tests:

CBC: erythrocyte-3.8, c/i-0.8, thrombocytes-270, leucocytes-4.6 , ESR-28 mm / s

CBC AST-27.0 ALT-31.5 urea-7.1 creatinine-73.6 total oxyl-glucose-4.5. Sa-1.9

HbsAg, HCV-Ab - negative

HIV is negative. WR-negative.

Abdominal MSCT examination: Right kidney product, size 82x66 mm, with clear borders, homogeneous structure, spherical shape. Posterior peripheral lymph nodes unchanged.

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Figure 5. A - Derivative of the lower pole of the left kidney; B - Postoperative condition of left-sided radical nephrectomy.

Excretory urography: Concentration-secreting functions of the kidneys are preserved.

Chest radiography: Age-specific changes in the heart and lungs.

ECG- true sinus rhythm. The axis of the heart is horizontal. Left ventricular hypertrophy.

The patient underwent a left-sided radical nephrectomy in January 2018 and the diagnosis was morphologically confirmed in the patient. The patient applied to MSES for disability benefits due to his illness. Based on the statute, in order to receive the disability, benefit due to non-payment of the term (6 months), he was once again required to receive inpatient treatment and an extract from it. In this case, the patient applies to the branch for an extract and is treated in bed, although the patient has absolutely no instructions for inpatient treatment. With this extract, the patient applied to the MSES organization and received a 2nd disability group. Hence, this requirement specified in the statute should also be reconsidered, as patients who do not have instructions for inpatient treatment are admitted to the dispensary anyway (various false complaints made by patients), which in turn leads to misuse of space and funds.

The 5 most common types of diseases were analyzed during the follow-up years. During this time, 561 breast cancers were diagnosed, of which 186 (33.1%) were disabled, while 342 (60.9%) patients underwent radical examination (radical mastectomy). 346 women were diagnosed with cervical cancer, and 112 (32.4%) patients received disability benefits. Among non-disabled patients, 72 women underwent radical examination (with uterine extirpation, excess). A total of 239 patients were diagnosed with lung cancer, of whom 52 (21.8%) were registered as disabled. This means that only 1 in 5 patients has a disability, which may be due to the low survival rate in patients. A total of 353 patients were diagnosed with gastric cancer, of whom 73 (20.7%) had a disability. The reason for the low level of these indicators may be that patients are diagnosed in the late stages and cannot live until the period specified in the statute.

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CONCLUSIONS

Based on the results of this analysis, recommendations were developed to prevent bureaucracy and corruption in disability, as well as to organize care for patients for the 5 most common malignant tumors and other oncological diseases mentioned above.

1. Breast cancer. Patients diagnosed primarily in the late stages, i.e., patients diagnosed with primary III and IV stages, have a tumor-infiltrative low-differentiated histological type of the disease when there are signs of tumor rupture and bleeding from it.
2. Cervical cancer. Stages 3-4, local diffuse process, tumor erosion, with signs of genital bleeding, nephrostomy,
3. Malignant tumors of the lungs. Stages III and IV, clearly manifested clinic (bleeding, 2-3 degrees of shortness of breath), nooperable and nonresectable cases, incurability.
4. Esophagus, stages III and IV, nooperabel and noresectabel cases, local diffuse process, gastrostomy, incurability.
5. Stomach cancer. Stage IV, nooperable and nonresectable cases, local diffuse process, vomiting, and blood in the stool when positive, radical, and palliative examinations of the disease, incurability.
6. In general, a radical diagnosis (removal of a specific organ) performed for all oncological diseases, giving patients a permanent disability benefit after treatment, as the progression and recurrence of the disease, which is always present in these patients, serves as a basis for this.

ACKNOWLEDGMENT

There are important points that need to be reiterated. For example, if a patient is considered with the second clinical group, the patient will not receive the disability benefit immediately, incapacitated patients will not receive the recommended treatment, and after a certain period of time, the patient will be transferred to group 4 with the progression of the disease. and it must be borne in mind that the provision will not be promising, even if it is several times more material.

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