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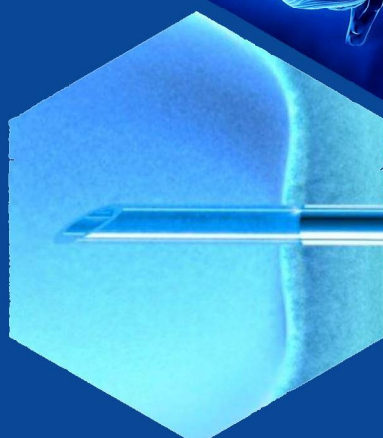
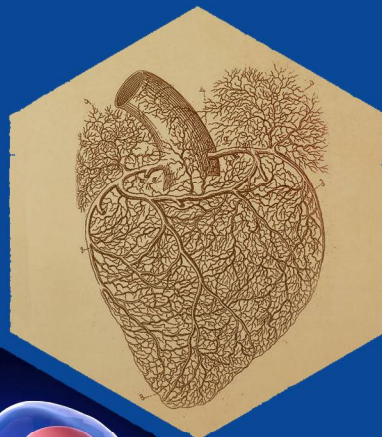
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ЎЗБЕК ТИББИЁТ ЖУРНАЛИ УЗБЕКСКИЙ МЕДИЦИНСКИЙ ЖУРНАЛ UZBEK MEDICAL JOURNAL

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OPTIMIZATION OF DIAGNOSIS OF NODULAR THYROID DISEASES (LITERATURE REVIEW)

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ABSTRACT

Currently in the world there is a steady rise in the number of patients with pathology of the thyroid gland (TG). The total number of people on Earth suffering from goiter exceeds 600 million people and continues to grow. The problem of early diagnosis and timely adequate treatment of pathological formations of the thyroid gland, which today occur in 4-10% of the population, is still relevant. According to S. I. Ismoilov, the incidence of nodular euthyroid diseases ranges from 10 to 62%. Under the term "nodular diseases", nodular colloid goiter (UKZ), adenomas, "pseudonodes" in chronic autoimmune thyroiditis (CHAIT), various morphological variants of PC, as well as their combinations are considered. In this article, the question of modern possibilities of complex diagnostics of thyroid nodules is considered.

Keywords: Nodular formation, thyroid gland, TI-RADS, ultrasound

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ОПТИМИЗАЦИЯ ДИАГНОСТИКИ УЗЛОВЫХ ЗАБОЛЕВАНИЙ ЩИТОВИДНОЙ ЖЕЛЕЗЫ (ОБЗОР ЛИТЕРАТУРЫ)

АННОТАЦИЯ

В настоящее время в мире отмечается неуклонный рост числа больных с патологией щитовидной железы (ЩЖ). Общее количество людей на Земле, страдающих зобом превышает 600 млн. человек и продолжает расти. Проблема ранней диагностики и своевременного адекватного лечения патологических образований ЩЖ, которые на сегодняшний день встречаются у 4-10% населения, до сих пор остается актуальной. По данным С.И.Исmoilова, частота встречаемости узловых эутиреоидных заболеваний составляет от 10 до 62%. Под термином «узловые заболевания» рассматривают узловой коллоидный зоб (УКЗ), аденомы, «псевдоузлы» при хроническом аутоиммунном тиреоидите

(ХАИТ), различные морфологические варианты РЩЖ, а также их сочетания. В данной статье рассматривается вопрос о современных возможностях комплексной диагностики узловых образований щитовидной железы.

Ключевые слова: Узловой образование, щитовидная железа, TI-RADS, УЗИ.

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QALQONSIMON BEZ TUGUNLI KASALLIKLARINI TASHXISLASHNI OPTIMALLASHTIRISH

ANNOTATSIYA

Hozirgi kunda dunyoda qalqonsimon bez patologiyasi bo'lgan bemorlar sonining barqaror o'sishi kuzatilmoqda. Tugunli buqoq bilan og'rig'an yer yuzidagi odamlarning umumiy soni 600 million kishidan oshib, o'sishda davom etmoqda. Bugungi kunda aholining 4-10% da topilgan Qalqonsimon bez tugunli patologik tuzilmalarini erta tashxislash va o'z vaqtida etarli darajada davolash muammosi hali ham dolzarb bo'lib qolmoqda. S. I. Ismoilovning fikriga ko'ra, tugunli eutiroid buqoq kasalliklarning paydo bo'lish darajasi 10 % dan 62% gacha. "Tugunli kasalliklar" atamasi ostida surunkali autoimmun tireoidit (AIT), qalqonsimon bez rakining turli morfologik variantlari va ularning kombinatsiyasi bilan tugunli kolloid buqoq (TKB), adenomalar, "pseudouzllar" hisoblanadi. Ushbu maqolada qalqonsimon bezning tugunli xosilalarning shakllanishini kompleks tashxislashning zamonaviy imkoniyatlari ko'rib chiqiladi.

Kalit so'zlar: Tugunli xosila, qalqonsimon bez, TI-RADS, ultratovush tekshiruv.

Nodular goiter is a collective clinical concept that combines various morphological structures of nodular formations of the thyroid gland (thyroid gland), which are removed by palpation and instrumental diagnostic methods, primarily ultrasound(ultrasound).[8.] Currently, there is a steady increase in the number of patients with thyroid gland pathology in the world [13].The total number of people on Earth suffering from goiter exceeds 600 million people and continues to grow [14]. Numerous studies show that the prevalence of focal lesions of the thyroid gland is extremely high in many countries of the world. So in France, on average, 35% of the nodal formations of the thyroid gland account for 1 thousand people, in the United States for 100 people - 21 % (4-7% of the total population), in Japan for 450 people-19%. In Uzbekistan, on average, up to 10% of focal pathology per 2 thousand people [6].

The prevalence of thyroid cancer among thyroid nodules, according to different authors, ranges from 2.4% to 31.4%. According to V. V. Dvorin (2001), the growth rate of thyroid cancer over the last decade was 131-133%, which is significantly higher than other oncological diseases. According to the American Cancer Society, there are about 17,000 new cases and about 1,300 deaths associated with thyroid cancer in the United States each year. In this regard, the problem of differential diagnosis of thyroid cancer becomes particularly relevant. The problem of early diagnosis and timely adequate treatment of pathological formations of the thyroid gland, which today occur in 4-10% of the population, is still relevant. According to S. I. Ismoilov, the incidence of nodular euthyroid diseases ranges from 10 to 62%. The term "nodular diseases" refers to nodular colloidal goiter(UKZ), adenomas, "pseudonodes" in chronic autoimmune thyroiditis (CHAIT), various morphological variants of PC, as well as their combinations are considered.[28].

Nodular goiter on palpation is detected in at least 2-5% of the general population; according to ultrasound data, the prevalence of nodular goiter in certain subgroups of the population can reach 50% or more. With age, the prevalence of nodular goiter increases; in women, nodular goiter is 5-10 times more common. The frequency of new cases of palpable nodules is about 0.1% of the

population per year. In the structure of nodular goiter, colloidal proliferating goiter accounts for about 85% -90%, adenomas-5%-8%, and malignant tumors -1%-5%. [9].

In the world, there is no single universally recognized protocol for the examination and treatment of patients with nodular diseases of the thyroid gland. This is clearly confirmed by the results of periodic questionnaire surveys of members of the European and American Associations of Thyroidologists [5]. This is due to the unfavorable environmental situation, decreased immunity, the presence of stressful situations, hereditary predisposition and iodine deficiency [18]. All factors leading to the formation of nodes in the thyroid gland are divided into 3 groups: genetic (44.2 %), dyshormonal disorders (61.2 %) and exogenous factors (37.8 %). The main cause of nodular colloidal goiter is iodine deficiency of various origins. With insufficient iodine intake to maintain the euthyroid state, the production of less iodized, but biologically more active T3 increases, while the T4 content decreases. The feedback mechanism increases the secretion of TSH, which leads to an increase in the number of thyrocytes. In addition to TSH, there are polypeptides that increase the functional activity and ability to multiply thyroid cells – “epidermal growth factor”, “growth stimulating immunoglobulin”, somatotrophic hormone. Increased levels of fluoride and calcium in drinking water lead to the development of thyroid nodules. Antithyroid drugs and sulfonamides can also give a goitre effect. [28].

In the structure of all nodular formations of the thyroid gland, nodular colloidal goiter and tumors (benign and malignant) are distinguished to varying degrees. According to the International Histological Classification of Tumors (WHO, 1988), presented below, thyroid tumors are divided into epithelial and non-epithelial. [15].

Nodular forms of thyroid diseases WHO classification.

I. Nodular colloidal to varying degrees proliferating goiter

II. Tumors:

1. Epithelial tumors

A. Benign:

* Follicular adenoma

• Other

B. Malignant:

Fol Follicular cancer

Pap Papillary cancer

Med Medullary cancer

□ Undifferentiated (anaplastic) cancer

□ Other

2. Non-epithelial tumors

A. Benign

B. Malignant

III. Mixed tumors

IV. Secondary tumors

V. Unclassifiable tumors

VI. Tumor-like lesions.

According to the number of nodules, the nodular goiter is divided into:

* solitary (single) node of the thyroid gland;

* multi-node goiter;

• conglomerate nodular goiter presented in the form of a space-occupying lesions, consisting of several parts, soldered together.

There are also two classifications of the severity of nodular goiter: one of them was proposed by O. V. Nikolaev in 1955, the other was adopted by the WHO (World Health Organization) in 2001.[10][17][27]

So, O. V. Nikolaeva there are six degrees of disease depending on the size of the goiter:

* 0 degree — the thyroid gland can not be determined at any time.

- * visual examination, nor palpation; grade 1-the thyroid gland is not visualized, but it can be determine by palpation;
 - * Grade 2 — the thyroid gland can be visually noticed by time swallowing;
 - * grade 3-the goiter becomes obvious, the contour of the neck increases;
 - * grade 4-visually noticeable goiter deforms the neck;
 - * Grade 5-the thyroid gland is enlarged and squeezes the neighboring organs.
- According to the WHO classification, there are three degrees of nodular goiter:
- * 0 degree — no goiter detected;
 - * grade 1-the goiter is palpable, but not visualized, the size of one or two lobes of the thyroid gland is larger than the distal phalanx of the patient's thumb;
 - * Grade 2-the goiter is palpable and visually noticeable.

For the clinician, according to Hopkins C. R. and Reading S. S. [16], the diagnostic line includes: examination, laboratory tests, ultrasound and fine needle aspiration puncture under the control of ultrasound (TAB-ultrasound). Today, ultrasound and fine needle puncture aspiration biopsy (TAPB) are the main methods for detecting and verifying thyroid nodules [23].

At the beginning of the 21st century, a solution was found - the creation of stratification expert systems that take into account the sonographic and morphological features of the thyroid nodes, on the basis of which it became possible to give them an objective assessment, which reduced the risk of error and allowed us to justify treatment tactics. In 2009, E. Horvat et al. They suggested using ranking when evaluating images of the thyroid gland, which was called the Thyroid Image Reporting and Data System (TIRADS). According to the idea of the system, ultrasound provides only approximate information about the nature of the process and specifies the subsequent actions of the clinician. The task of implementing TIRADS is to clarify the indications for cytological research. In parallel, cytologists formulated the basic principles of The Bethesda system for reporting thyroid cytopathology (TBSRTC), which aims to form therapeutic tactics based on knowledge of the morphological structure of the thyroid nodule. [2] The main ultrasound signs of malignancy of thyroid nodules, which were taken into account in our studies, were as follows: unevenness and indistinctness of the node contour (invasive growth); the predominance in the size of the node height over the length (in relation to the sensor in the cross-section); pronounced hypoechogenicity of the nodular tissue; the presence of microcalcifies in it; a completely solid structure of the node and / or a high stiffness index in elastography. Points were awarded for each feature and TI-RADS categories were determined by the sum of the points [24].

The main task of TI-RADS is to determine the risk of malignancy of thyroid nodules and patient management tactics, including the formation of indications for TAPB. According to this classification, all thyroid nodes according to ultrasound data were divided into 7 types (Table 1.):

Table 1.

Category TIRADS	ESTIMATION	Risk of malignancy
TIRADS 1	Unchanged THYROID	0 %
TIRADS 2	Benign education	0%
TI-RADS 3	Probably benign formation Less than	5 %
TIRADS 4A	Suspicious formation (1 suspicious sign)	5-10 %
TIRADS 4B	Suspicious formation (2-4 suspicious signs)	10-80%
TIRADS 5	Likely malignancy (5 signs)	>80%
TIRADS 6	Malignancy confirmed by TAPB results	>95%

To date, thin-needle aspiration puncture biopsy is a globally recognized method of collecting material for cytological examination [11, 26]. TAPB is a research method, on which further treatment depends [1]. The main goal of the cytological study is to identify tumor lesions and to obtain a basis for choosing surgical interventions (or refusing them) in patients with non-tumor processes. TAPB with subsequent cytological examination of the aspirate is the "gold standard" in the diagnosis of thyroid nodules and is included in most of the Recommendations and Protocols of Associations of Endocrinologists, Oncological Surgeons of various countries of the world. Today, we have accumulated a lot of experience in the use of TAPB, and conducted multicenter studies that prove its necessity. It is widely believed throughout the world that the puncture of the thyroid gland node is not only diagnostic, but in a large number of cases also therapeutic value [7] in the presence of appropriate indications. Today, no method surpasses TAPB in the possibility of detecting thyroid malignancies [12]. Therefore, it is believed that TAPB should be performed with all available thyroid nodes, since under the control of ultrasound, it allows you to obtain reliable information with thyroid nodes from 2-3 mm [19]. With all the advantages of cytological examination, the evaluation of the results of TAPB and postoperative pathomorphological examination showed that the coincidence of conclusions is from 60 to 99%, and in the case of breast cancer from 40 to 89% [29]. In children, the sensitivity of TAPB to PCR is 72.1 % [23].

Today, most medical institutions in the world use the image gradation called The Bethesda System for Reporting Thyroid Cytopathology (TBSRTC), which was adopted at a conference of the US National Cancer Institute in 2007, for the cytological examination of smears from thyroid nodes [21]. Gradually, it is being introduced in Russia [22]. Most researchers emphasize [3] that in the TBSRTC, the cytologist's conclusion about smears as a result of the formulation should fit into one of the 6 categories, and this in turn requires the cytologist to follow precise and specific terms that are understandable for a doctor of any specialty. Evaluation of the effectiveness of TBSRTC [25] showed a high degree of correlation between cytological and histological studies and a good predictive ability of cytological research in relation to malignant nodes, the specificity was 93%. In recent years, there are works where a more precise morphological differentiation of the concept of UO SHZH is carried out, and on the basis of this, the volume of the operation is determined. currently two polar points of view on the extent of surgery in pathology of the thyroid (economy or extended resection) did not exclude that the volume of surgical intervention should be individualized depending on the morphological shape EE TG.

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