

Rationale For Simultaneous Pulpectomy for Prostate Cancer

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Abstract: The article is devoted to the problem of using the median incision along the Veslingline for simultaneous performance of surgery on the organs of both halves of the scrotum (- 8 etc.). The results of simultaneous operations on the scrotum organs in 32 patients indicate the cosmetic advantages of this skin incision and prompt access, the efficiency of the surgical material and the duration of the operation itself.

Key words: Prostate cancer, Wesling's line, simultantpulpectomy

Relevance.

Prostate cancer (PC) is currently one of the most pressing diseases in urology oncology. Its detectability increases annually, which is associated with the constant improvement of early diagnosis. The average incidence of prostate cancer in the world is 25.3 per 100 thousand population [Nelen V. 2007.]. In Russia, there are still high rates of PC detection at late stages: at stage III - in 34.9-37.6% and at IV -V 18.5-19.7% of patients [Chissov V.I., Starinskiy V.V., Petrova G.V. 2009], which does not allow the full use of radical methods of treatment. Currently, the main method of treatment is antiandrogenic drug therapy. Due to the high cost of drugs, surgical castration is also widely used in clinical practice. The medical and legal basis of pulpectomy is not defined, i.e. surgical castration for prostate cancer. Removal of both testicles as a whole can lead to stress in some patients, in connection with which there is a need to develop medico-legal aspects of this problem. Orchiectomy helps to control the course of the disease and reduce its symptoms in about 90% of cases.

Prostate cancer is still relevant in the entire set of problems, as evidenced by numerous congresses on its diagnosis and treatment (1-4). This disease is a complex problem of modern medicine, being the most frequent pathology among tumors of the genitourinary system (5). Improvement of living conditions and the related increase in its duration in developed countries leads to an aging population, and, consequently, to an increase in the incidence of malignant neoplasms; PC is no exception in this: in 2010, 26,268 new cases of PC were registered in the Russian Federation (6). About 500 thousand cases of prostate cancer are diagnosed in the world every year (7). The increase in the incidence of prostate cancer reaches 3% per year, which makes it possible to predict a doubling of the number of registered cases by 2030 (8). Due to the prevalence of the process, less than 50% of patients manage to carry out radical treatment, and this leads to an increase in the rate of disability and a decrease in the quality of life. The peak incidence occurs in the 6-7th decade of life. Many men at this age have concomitant diseases, which does not allow radical surgery. Alternative methods are radiation therapy or its combination with hormonal therapy. Among all hormone-dependent tumors, prostate cancer is the most sensitive to hormonal influences (9,13).

Due to the peculiarities of the clinical course, 60 to 80% of patients with prostate cancer have common forms of the disease at the initial treatment. Despite the fact that HT effectively eliminates the symptoms of the disease in patients with metastatic prostate cancer, there are still no convincing data on the effect of HT on life expectancy (9). The growth, proliferation and development of pancreatic cells are largely dependent on androgens. Testosterone is not directly responsible for the onset of prostate cancer, but plays an essential role in regulating the mechanism of growth and development of tumor cells (12). The choice of methods of treatment for locally advanced and disseminated prostate cancer and their sequence depend on the general condition of the patient and the sensitivity of the tumor to one or another effect. The main directions in the treatment of locally advanced and advanced prostate cancer: pathogenetic, cytoreductive, symptomatic. The essence of therapeutic measures is to maximally reduce the concentration of endogenous testosterone - the so-called androgenic blockade. For common forms of the disease, patients are treated with various options for hormonal drug therapy. Ideal therapy for prostate cancer involves blocking the action of androgens at the cellular level of the prostate gland, which is realized by a decrease in the binding of dihydrotestosterone to the nuclear receptor during competitive inhibition or a decrease in the concentration of the cytoplasmic androgen receptor. Orchiectomy is an effective method of reducing the main biologically active androgen, testosterone, in the blood, but does not affect the production of adrenal androgens. Surgical castration is still considered the "gold standard" for antiandrogen therapy (2,15). Removal of the testes, which are the main source of androgens, leads to a significant decrease in testosterone levels and causes a hypogonadal state, although a negligible testosterone level remains (castration level). Bilateral orchiectomy is an easy surgical operation performed under local anesthesia and has virtually no complications. This is a quick (less than 12 hours) way to achieve castration testosterone levels. The standard castration level is considered to be <20 ng / dL (10). The main disadvantage of this method is the negative psychological effect. The irreversibility of surgical castration is an obstacle to intermittent therapy. A tumor reduction of 50-70% can be achieved with hormone therapy (2). Most researchers confirm that the reaction of the body and the prostate can be determined using available methods: by objectively reducing the tumor, reducing the level of circulating PSA, or simply by improving indicators of quality of life, such as pain, appetite, increased work capacity. testosterone by 95%, androgens synthesized by the adrenal glands continue to be metabolized to DHT in the pancreas tissue, stimulating cell growth and proliferation. The action of adrenal androgens can be blocked by the use of antiandrogens after surgical or medical castration, which is called MAB. With all the effectiveness of antiandrogen therapy, which is basically palliative, it is able to stop the growth of cancer cells, change the biological potential of the tumor, suspend the processes of further metastasis, "reduce" the stage of the tumor process. In recent years, thanks to the introduction of new diagnostic methods into clinical practice (TRUS , CT, MRI, study of blood PSA concentration), the disease began to be detected much more often at earlier stages. Nevertheless, 50-70% of patients seek medical help for the developed complications caused by prostate cancer (10,16,17,18).

Therapeutic tactics for prostate cancer complicated by urinary retention, which is currently discussed in the literature, and determines the prognosis, duration of remission, and social adaptation of the patient. In the case of acute urinary retention for the first time with suspected prostate cancer, Alyaev Yu.G. et al. recommend draining the bladder through the urethra with a ureteral catheter No. 6 according to Sharier. This provides a gradual evacuation of urine, thereby creating peace for the detrusor, restores its tone, avoids the rapid development of purulent urethritis as a result of ischemia of the walls of the urethra with a pressure catheter and the addition of infection. MI Karelin and others in the scope of medical care include the introduction of a balloon catheter into the bladder in combination with androgen blockade. Drainage of the bladder allows for a comprehensive examination, the purpose of which is to determine the prevalence of the process. However, the duration of drainage is limited, which requires the rapid development of further treatment tactics.

Thus, despite the fact that urological complications of prostate cancer are well known, to date there is no diagnostic algorithm and reasonable treatment tactics, taking into account the factors of time of detection, the choice of the method of intervention, as well as indications and contraindications for both surgical and conservative methods to improve the quality. the life of this difficult group of patients. These circumstances determine the relevance of the selected problem.

The relevance of the introduction of endovideosurgical technologies during simultaneous (simultaneous) operations is due to the increasing number of patients with concomitant surgical diseases. According to the WHO, almost 63% of patients admitted to a surgical hospital require one-step operations. Before the introduction of endovideosurgical technologies, it was believed that performing simultaneous operations significantly increases surgical aggression, leads to an increase in the number of intra and postoperative complications, and worsens the results of surgical treatment, especially when it is necessary to use two surgical approaches [1]. With the development of endovideosurgical technique, the question arose about the possibility of expanding the indications for simultaneous operations.

Prostate cancer (PC) is one of the most common malignant neoplasms in men of advanced and old age, which accounts for 4.5% of all malignant neoplasms or 12% of all malignant tumors in men. The peak incidence is observed after 70 years. About 500 thousand cases of prostate cancer are diagnosed in the world every year. In 1971, Professor A. Shelly isolated native LHRH, and in 1977 he received the Nobel Prize for his work on the study of peptide hormones in the brain. This has led to the development of LHRH agonist therapy as a means of medical castration. Hormone therapy is currently the main treatment for locally advanced cancer. The choice of the type and timing of hormone therapy (HT) is based on the opinion of the physician and the informed consent of the patient. In the case of development of resistance to HT, the survival rate decreases. Thus, prevention of hormone resistance and new therapies are important areas of research.

Androgen deprivation (BP) is effective in more than 90% of patients (including advanced prostate cancer). There is evidence of the role of neoadjuvant and adjuvant hormone therapy in addition to local surgery or radiation therapy, and studies are underway on alternative hormone therapy regimens (intermittent therapy). The main options for androgen deprivation are:

1. Medicated castration
2. Surgical castration
3. Flare blockade + medical castration
4. Antiandrogen monotherapy
5. Antiandrogens + 5 alpha reductase inhibitors
6. Combined androgen deprivation
7. Intermittent androgen deprivation
8. Triplet drug therapy

Neoadjuvant therapy has been used to reduce the incidence of positive surgical margins and possibly improve the outcome of radical prostatectomy. Seven randomized trials have demonstrated that neoadjuvant therapy reduces the incidence of positive surgical margins for the clinically localized stage; the data for locally advanced disease are less convincing. The goal of adjuvant therapy is to target residual microscopic cancer foci after local primary treatment. Patients who received therapy immediately after surgery showed a significant advantage in all cases and better cancer-specific survival compared with those who received delayed treatment (62 vs 71%; $p < 0.001$)

From 2016 to 2018 we performed simulated pulpectomy with prostate cancer T4N0M0 in 24 patients. Surgical treatment was carried out by means of a single extra-scrotal access through the Vesling's line (J. Vesling (1598-1649)



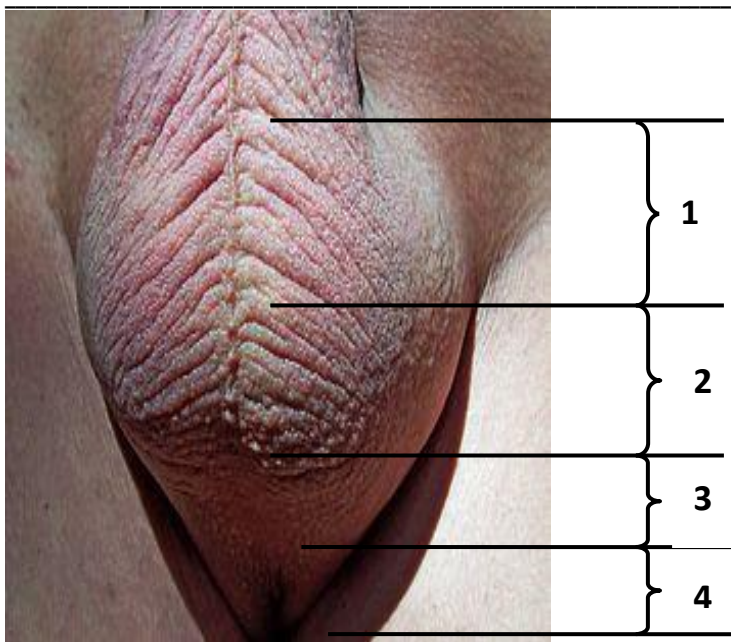


Photo 2. Raphe scroti - midline of the scrotum Wesling's line: 1-anterior, 2-at the bottom of the scrotum, 3-posterior, 4-perineal.

Photo. 3. An incision of the skin of the scrotum along the back of the Wesling's line

Unlike all other authors, we decided to make an incision along the Wesling's line along the back, which does not at all affect the accessibility of the scrotal organs, but at the same time enhances the cosmetic appearance of the postoperative scar, i.e. its visibility is absolutely lost, especially when the body is upright (Fig. 3) In patients with prostate cancer T4N0M0, bilateral pulpectomy followed by antiandrogen treatment was performed using this approach. It should be noted that regardless of the method of suturing the skin of the scrotum with a single operative access along the Wesling's line, the formed postoperative scar looked like a suture of the scrotum [6-13]. When the patients were re-examined 1 and 3 months after the surgery, a good cosmetic effect was noted. This approach is especially convenient for performing bilateral orchiectomy or pulpectomy in advanced stages of prostate cancer or in case of testicular tumors. In addition, when suturing the skin of the scrotum, such an access leaves an almost imperceptible postoperative scar resembling a Wesling's line.

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