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APPROACHES TO INCREASING CANCER ALERTNESS AMONG PRIMARY CARE PHYSICIANS

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Annotation. Oncological diseases remain one of the pressing problems of modern medicine. According to WHO, more than 12 million cancer patients are registered annually in the world and 7 million people die from this disease. Despite the emergence of new methods for diagnosing malignant neoplasms (malignant neoplasms) (MRI, PETCT, etc.), the proportion of advanced cases of malignant neoplasms remains high. This is mainly due to the secrecy of the course in the early stages, the lack of oncological alertness among general practitioners, as well as the low level of oncological literacy among the population. Family clinics and consultative and diagnostic centers are the primary link in the process of establishing a diagnosis and timely detection of early symptoms of malignant neoplasms. The fate of the patient depends on the qualifications of the doctors of this unit. It should be noted that more than 90% of patients with various oncological diseases turn to these institutions.

Key words: diseases, fibrosis, nodular, etiological, vascular system

Introduction. At the first careful collection of anamnesis and examination, which, unfortunately, is not always done, cancer can be suspected in a significant number of patients with the so-called “hidden” course of the disease. An important role in this is played by the presence of “oncological alertness” among general practitioners, which includes the following:

1.Knowledge of precancerous diseases.

2.Knowledge of the symptoms of malignant tumors in the early stages.

3. A thorough examination of a patient who has consulted a doctor of any specialty to identify a possible malignant tumor

4. Refusal of unfounded optimism and development of the habit in difficult diagnostic cases to think about the possibility of an atypical or complicated course of a malignant tumor and, if necessary, involve a more experienced specialist.

5. Knowledge of the principles of oncological care and prompt referral of a patient with suspected malignant neoplasms to an oncologist.

Methodology. Almost all malignant neoplasms develop on the basis of perceptible preparatory tissue changes, called precancerous. Unfortunately, many general practitioners do

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not pay attention to underlying diseases that are the source of malignant neoplasms. Therefore, primary care doctors should be aware of the so-called obligate and facultative precancers, and register this category of patients at the dispensary in order to timely recognize early forms of malignant neoplasms. It should be noted that patients with obligate precancer should be treated and observed in an oncology facility.

A retrospective analysis of outpatient records of patients with malignant neoplasms (breast, skin, cervix, rectum) showed that more than 70% of them, during the last two years preceding the diagnosis of cancer, visited family clinics on average 5-6 times for various reasons. reason and not a single doctor “had the idea” to pay attention to the above organs. Although all these organs were visual and accessible.

Another important point is the appropriate staffing of oncologists and oncogynecologists, who must have at least 5 years of experience, since the timely detection of the disease depends on their qualifications.

A critical factor in improving cancer care is close collaboration on a regular basis between primary care physicians and the oncologist.

In this regard, in order to improve cancer care at the primary care level, the following measures must be taken:

1.Organization of screening, that is, identification of patients with pretumor and malignant neoplasms among the total number of patients.

2. Improving oncological qualifications for primary care physicians by completing a cycle of improvement in “Oncology” at the Center for Medical Rehabilitation and Medical Treatment (144 and 72 hours)

3. To promote cancer literacy of the population by holding meetings, lectures and conversations about the curability of cancer, subject to timely consultation with a doctor, and it should be noted that more than 90% of patients with malignant neoplasms in the early stages do not have the symptom of “pain,” which is also one of the reasons late treatment

Based on the above, it should be noted that without close interaction with primary care physicians, it will be difficult for oncologists to solve the problem of early diagnosis and reduction of mortality from malignant neoplasms. Only the presence of “oncological alertness” in the doctor’s practice will help to promptly recognize or suspect malignant neoplasms.

Conclusions The R-gram reveals a cystic cavity, often round or elongated along the length of the lower jaw with clear boundaries (5). It is characteristic that the edge of the cavity adjacent to the base has a peripheral bone compaction, which persists even with large areas of damage to the jaw. At the same time, radiographically, keratocysts, unlike ameloblastoma and

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osteogenic benign tumors, are not characterized by a cellular form of the lesion. In treatment, a two-stage operation is more often used (at the 1st stage, a decompression cystotomy is performed, as a result of which the integrity of the cyst is disrupted and its further growth becomes impossible; at the 2nd stage, after 1-1.5 years, a cystectomy is performed (6).

Other neoplasms in the jaw bones that occur similarly to those described above and with which differential diagnosis is necessary include fibrous dysplasia (the “ground glass” symptom on the R-gram), eosinophilic granuloma (leukocytosis in the blood, an increase in eosinophils up to 6-8 times), less often malignant tumors.

Summarizing the methods and results of differential diagnosis in the jaw bones, it follows:

1) such general signs as prolonged course, asymptomaticity,

late diagnosis is characteristic of most of the above-described neoplasms and, as a result, late diagnosis and lost time for optimal treatment;

2) for the purpose of early diagnosis of neoplasms in the jaw bones and with

Taking into account the exclusive role of teeth in the pathological processes of the maxillofacial area, we strongly recommend that, as part of the ongoing medical examination of schoolchildren, a mandatory orthopantomographic examination of high school students is carried out to obtain comprehensive information about the state of the adolescent’s dental-facial system.

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