

RESULTS OF CARDIOVASCULAR WAR, TG AND TPO-ANTIBODIES TITERS WITH HORMONES T3, T4 AND TTG, OBTAINED BY GROUPS IN THE POSTOPERATIVE RETSEDIV CONDITION

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Relevance and necessity of the topic. Surgical treatment results are significantly influenced by the size of the thyroid residue, the ratio of serum T3 to serum T4, TSG-antibodies yitri satxi, as well as the activity of thyroid-stimulating antibodies [4], at-rttg titers, and the ratio of antibodies to thyroid peroxidase (TPO) [3].

Another immunological sign of surgical prediction of DTB treatment is TPO-antibodies titer, which is at high risk of postoperative hypothyroidism or recurrence of postoperative thyreotoxicosis [2;5].

TPO is a membrane-bound protein that accelerates the memorization of the TG molecule [7], what leads to an increase in the antigenicity properties of Tg [10]. TPO is actively involved

in complement-dependent and antibody-based cytotoxicity processes [5]. Great importance is given to Tg and TPO, which are matrices for the synthesis of Thyreoid hormones [8]. TPO accelerates the memorization of the TG molecule, which leads to an increase in the antigenic properties of Tg [9]. Thyroid-stimulating hormone receptors (TTGS) are also an important protein component of the thyroid [6]. Thyreoglobulin antibodies belong to Class G Ig [1].

The purpose of scientific research. Development of measures to improve the results of surgical treatment by studying cardiovascular warfare, the results of TG and TPO-antibodies titers with T3, T4 and Ttg hormones, obtained by groups of postoperative retsediv in the diffuse toxic bull.Tadqiqot materiallari.

Andijan State Medical Institute Y. Otabekov's Department of surgery III also featured the medical history, operational journal data, and associated outpatient cards of 263 patients who underwent diffuse toxic throat (DTB) surgery from 2010 to 2019. A retrospective assessment of 263 patients who left the treatment found that 120 had ST tasrix, of which: 76 were left with up to 1.0 gr in the thyroid seat, 30 with up to 1.1+2.0 gr, and 14 with up to 2.1+3.0 gr. Patients who underwent this ST surgery became known as Group 1.



In 65 patients after 263 patients, an additional cut-off 1,0-gram gland autotransplantate was planted over the subtotal thyroidectomy tasrix. These were left in 41 of the 1.0 gr. on the gland +1,0 + 2,0 gr. autotransplantat, 1.1+2.0 gr left in 13 persons. on the gland +1,0 + 2,0 gr. autotransplantat, 2.1+3.0 gr left in 11 persons. on the gland +1,0 + 2,0 gr. autotransplantat is planted with glandular tissue. We have designated patients with this subtotal thyroidectomy + performed as Group 2.

In 78 patients after 263 patients, total thyroidectomy was isolated from under the gland by attaching a silky thread knot with an uninterrupted connection in addition to the tasrix, but not separated from the glandular base. That is, up to +1.0 gr over the node (n=51), up to 1.1+2.0 gr (n=15), up to 2.1+3.0 gr (N=12) left the patient untouched in the glandular seat without extension. Total thyroidectomy was referred to as glandular Autoplant leaving Group 3 (TTAP) in conjunction with the transfer.

Between 2010 and 2019, when we divided 263 patients who had diffuse toxic throat surgery into women and men: 228 (86.7%) were women and 35 (13.3%) were men and 7:1 ratio when women were men. Enlargement of the thyroid gland at Level II-19 (7.2%) individuals, enlargement at Level III – 124 (47.1%) individuals, enlargement at Level IV-92 (35%) individuals, and Enlargement at Level V – 28 (10.6%) patients. It was noted from the table that the largest number of patients applied with an increase in Level III and Level IV.

Research methods.

The complaints and medical history of the 263 patients who applied were thoroughly studied, the following examination methods were used.

Clinical objective and subjective examinations were carried out in 263 patients (examination, palpation).

Instrumental examinations: ultrasound examination (UTT) and electrocardio-gram (ECG) were used in 263 patients.

Biochemical analyzes: an examination of serum "cholesterol" levels was carried out in 242 patients. Total serum calcium(Ca+) levels as well as those in the forehead were tested in 263 patients and phosphorus(r+) levels were tested in 12 patients.

Radioimmunological tests: T3, T4, TTG, anti-TPO, anti-TGS were tested in 225 patients, paratgormoni-in 3 patients.

Contrast computed tomography: performed in 36 patients with the aim of examining the cervical, spinal, spinal and thoracic Sox.





58 patients with thin needle puncture biopsy (IIPB) were examined in an outpatient manner.

Postoperative hysto-pathomorphological testing was performed in 263 patients.

Statistical analysis. The results from the checks were used in the calculation of the "Excel" program and reliable differences in the WINDOWS_XP environment, the T – criterion of the Student. The comparative difference between the groups was checked by the magnitude of the Student criterion $p < 0.05$, $p < 0.01$, $p < 0.001$.

Results and references. Results of cardiovascular war obtained by groups of postoperative resected cases. Patients with relapsed resectives occurring in Group 1 with up to 1.0 gr of Gland left after ST had a reliable high ($p < 0.002$) of 30 beats (72.0 ± 1.2 z/D) when compared to the number of heart contractions (102.4 ± 4.96 z/d) SG. Patients with resectives occurring in Group 1, which was left glandular after ST to 1.1-2.0 gr, reliably elevated the number of heart contractions by 21 strokes compared to SG ($p < 0.01$). Patients with resectives occurring in the 1st Group, which was left with 1.1-2.0 gr of Gland after ST, were accelerated in one-93, in the other-92, in the second-102 shots. After ST, the gland is left to 2.1-3.0 gr Patients with relapse occurring in Group 1 had a reliable increase of 43 strokes ($p < 0.01$) when comparing the number of heart contractions (115.0 ± 8.81 z/d) to SG. A reliable high of 13 strokes ($p < 0.20$) was noted when comparing the number of cardiac contractions with the number of cardiac contractions with the number of cardiac contractions with the number of patients with relapses with 2.1-3.0 gr after ST. Patients with resectives occurring in the 1st Group, which was left glandular after St. 1.1-2.0 gr, showed high when compared to the number of heart contractions.

Up to 1.0 gr of Gland left after STAT + 1.0+2.0 gr of Gland planted 1 patient with resectiv in Group 2 accelerated the number of heart contractions to 118 beats. The number of heart contractions of 2 patients with tissue plantings up to + 1.0+2.0 gr, in which 1.1-2.0 gr were glandular, accelerated to 93 beats in one and 99 beats in the other. 1 patient with resectiv occurring in Group 2 with tissue plantings of + 1.0+2.0 gr left glandular 2.1-3.0 gr after STAT, the number of heart contractions accelerated to 96 beats.

Up to +1.0 gr and +2.1+3.0 gr after TTAP 2 patients with resectiv occurring in Group 2 who were glandular were reported with 112 strokes in one of the number of heart contractions and up to 100 in the other. Resectiv has not been





observed in patients who have been defecated from the same group to +1.0 gr and +1.1+2.0 gr.

Results of the hormone T3 obtained by groups in the postoperative retsediv state. Patients with retsediv that occurred in Group 1, which was glandular up to 1.0 gr after ST, had a reliable high ($p<0.001$) of 1.36 titres when compared to T3 hormone titer (2.96 ± 0.09 nmol/l) SG (1.6 ± 0.01 nmol/L). Patients with recedives that occur in Group 1 after St, where 1.1-2.0 gr is left glandular, the T3 hormone titer is increased to one-2.8, in the second-3.22, in the third – 3.4 titers. The titers were raised even when compared to the SG. Patients with recedives occurring in the 1st Group, which were bearded to 2.1-3.0 gr after ST, had a reliable increase in T3 hormone titer (2.92 ± 0.06 nmol/l) to 1.32 titer when compared to SG ($p<0.001$). Patients with retsedives occurring in Group 1 who were glandular at 2.1-3.0 gr after St. T3 hormone titers were noted to have a reliable elevation of 0.04 titers ($p<0.40$) when compared to T3 hormone titers occurring in Group 1 after St. Patients with recedives that occur in Group 1 after ST, where 1.1-2.0 gr are glandular, have T3 hormone titers that are one-to-one, lower titers than the other, and lower titers than the tip.

Patients with recedives occurring in Group 2, in which up to 1.0 gr of the gland was left after STAT, up to + 1.0+2.0 gr, in which up to 1.1-2.0 gr of the gland was left, up to + 1.0+2.0 gr, in the second-3.0, in the second-2.9, in the third-2.84 titers.

Up to + 1.0 gr after TTAP and up to + 2.1+3.0 gr, 2 patients with retsediv occurring in Group 2 who were glandular had T3 hormone titers of 3.01 in one and 3.5 in the other, 2 times higher than SG.

Results of the hormone T4 obtained by groups in the postoperative retsediv state. Patients with retsedives occurring in Group 1, where up to 1.0 gr of gland was left after ST, had a reliable high ($p<0.002$) of 64.3 titres when compared to T4 hormone titer (178.6 ± 20.42 nmol/l) SG (114.3 ± 0.4 nmol/L). Patients with recedives that occurred in Group 1, after St, where 1.1-2.0 gr was left glandular, had a T4 hormone titer higher in one-184, in the other-162, in the second – 172 titers. The titers were raised even when compared to the SG. Patients with recedives occurring in the 1st Group, which were bearded to 2.1-3.0 gr after ST, had a reliable increase in T4 hormone titer (183.5 ± 8.19 nmol/l) to 69 titer when compared to SG ($p<0.001$). Patients with recedives occurring in Group 1 after ST with 2.1-3.0 gr glandular T4 hormone titer were noted to have a reliable high of 5 titer ($p<0.20$) when compared to T4 hormone titer in retsediv patients with T4 hormone titer occurring in Group 1 after St. Patients with recedives that occur in





Group 1 after ST, where up to 1.1-2.0 gr are glandular, have T4 hormone titers that are one-to-one, second and higher than the terminus.

Patients with recedives that occur in Group 2, in which up to 1.0 gr of the gland is planted after STAT, up to + 1.0+2.0 gr, the hormone titer T4 has been elevated to titers in one-211, in the second-189.3, in the second-208.4, in the fourth-183.

2 patients with retsediv occurring in Group 2 who were glandular up to + 1.0 gr after TTAP and + 2.1+3.0 gr had T4 hormone titers of 201 in one and 172 in the other, 2 times higher than SG.

Results of the hormone TTG obtained by groups in the postoperative retsediv state. Patients with retsediv that occurred in Group 1, which was glandular up to 1.0 gr after ST, had a reliable high ($p < 0.001$) of 1.45 titres when compared to TTG hormone titer (0.15 ± 0.07 mM/l) SG (1.6 ± 0.19 mM/l). Patients with recedives that occurred in Group 1, which was left with glands up to 1.1-2.0 gr after ST, had TTG hormone titer in one-0.5, in the other-0.08, in the second-0.07 titer. The titers were raised even when compared to the SG. Patients with recedives occurring in the 1st Group, which were bearded to 2.1-3.0 gr after ST, had a reliable increase in TTG hormone titer (0.16 ± 0.10 mM/L) to 1.44 titer when compared to SG ($p < 0.001$). Patients with recedives occurring in Group 1 after ST with 2.1-3.0 gr glandular TTG hormone titer were reported to have a reliable elevation of 0.01 titer ($p < 0.20$) when compared to TTG hormone titer in retsediv patients with TTG hormone titer occurring in Group 1 after St. Patients with retsedives that occur in Group 1 after ST, where up to 1.1-2.0 gr are glandular, have TTG hormone titers that are one-to-one, second and higher than the recipient.

Patients with recedives occurring in the 2nd group, in which up to 1.0 gr of the gland is planted after STAT, up to + 1.0+2.0 gr, the TTG hormone titer was increased to -0.31 in one, -0.02 in the second, -0.07 in the third, -0.07 in the fourth.

Up to + 1.0 gr after TTAP and up to + 2.1+3.0 gr, 2 patients with retsediv occurring in Group 2 who were glandular had TTG hormone titers of 0.3 in one and 0.04 in the other, 2 times higher than SG.

Results of TG-antithela titration obtained by groups in the postoperative retsediv state. Patients with recedives occurring in the 1st Group, which was left glandular up to 1.0 gr after ST, had a reliable high ($p < 0.05$) of 333 titres when compared to Tg-antitela titer (398.56 ± 109.96 mE/ml) SG (69.5 ± 2.8 mE/ml). Patients with recedives that occurred in Group 1, which was left with 1.1-2.0 gr of Gland after ST, had a TG-antitela titre higher in one-493.4, in the other-193.2,



in the second-392.8 titres. The titers were raised even when compared to the SG. A reliable increase of 206 titers ($p<0.001$) when comparing TG-antitela titer (275.62 ± 45.85 mE/ml) to SG occurred in Group 1, which was left glandular after ST to 2.1-3.0 gr. A reliable elevation of 123 titres ($p<0.20$) was noted when patients with retsediv occurring in Group 1 after TG-antithela titrini ST were compared to TG-antithela titr after ST. Patients with recedives that occur in Group 1 after ST, where 1.1-2.0 gr are glandular, have TG-antitela titers-lower than the first and third, and higher titers than the second.

Up to 1.0 gr of Gland left after STAT + 1.0+2.0 gr of patients with recedives that occurred in the 2nd group of Gland plantings, TG-antibodies were raised to titers in one-650.7, in the second-312.9, in the second-600.8, in the fourth-204.

Up to + 1.0 gr after TTAP and up to + 2.1+3.0 gr, 2 patients with retsediv occurring in Group 2 who were glandular had TG-antitela titrini of 2441.3 in one and 268.3 in the other, 35 times higher than SG.

Results of the TPO-antithela titration obtained by groups in the postoperative retsediv state. Patients with relapsed retsedives occurring in Group 1 with up to 1.0 gr of Gland left after ST had a reliable high ($p<0.002$) of 1309 titres when compared to TPO-antitela titer (1340.74 ± 847.19 mE/ml) SG (31.4 ± 2.3 mE/ml). Patients with recedives that occurred in Group 1 after St, where 1.1-2.0 gr were left without glands, had a TPO-antitela titer higher in one-1399, in the other-941.8, in the second – 102.2 titers. The titers were raised even when compared to the SG. A reliable increase of 600 titers ($p<0.001$) when comparing TPO-antitela titer (631.77 ± 292.50 mE/ml) to SG occurred in Group 1 of patients with relapsed St to 2.1-3.0 gr after ST ($p < 0.001$). A reliable elevation of 709 titres ($p<0.05$) was recorded when patients with recedives occurring in Group 1 after ST with TPO-antitela titrini occurring in Group 1, who were glandular at 2.1-3.0 gr after ST. Patients with recedives that occur in Group 1 after ST, where 1.1-2.0 gr are glandular, have TPO-antitela titers that are higher than the first and second-lower than the third.

Patients with recedives that occur in Group 2, in which up to 1.0 gr of the gland is planted after STAT, up to + 1.0+2.0 gr, the TPO-antibodies are raised to titers in one-234.1, in the second-170, in the third-1199.9, in the fourth-261.

Up to + 1.0 gr after TTAP and up to + 2.1+3.0 gr, 2 patients with retsediv occurring in Group 2 who were glandular had TPO-antitela titrini of 770 titr in one and 144 titr in the other, 21 times taller than SG.

Conclusion. Thus, diffuse toxic gave the throat the opportunity to revise the Diagnostic and treatment algorithm and optimize surgical tactics as a result of





the development of measures to improve the results of surgical treatment, beating the results of cardiovascular warfare, TG and TPO-antibodies with hormones T3, T4 and Ttg, obtained in groups of postoperative retsediv cases.

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