

УДК: 616.31-006.04+616-097+616-08-039.75

EVALUATION OF THE RESULTS OF PREDICTION OF RECURRENCE OF CANCER OF THE ORAL MUCOSA

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Abstract. *Response to treatment is certainly an important and practical indicator, but needs to be supplemented by other factors when building an accurate individual prognostic model. In view of the above, it becomes obvious that there is a need to develop a complementary prognostic model that can take into account parameters reflecting not only the anatomical and histological characteristics of the tumor, but also the systemic response of the body.*

Keywords: *oral mucosal cancer, oncology, treatment, relapse, outcome.*

ОЦЕНКА РЕЗУЛЬТАТОВ ПРОГНОЗИРОВАНИЯ РЕЦИДИВА РАКА СЛИЗИСТОЙ ОБОЛОЧКИ ПОЛОСТИ РТА

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Аннотация. *Ответ на лечение является безусловно важным и практическим показателем, но нуждается в дополнении другими факторами при построении точной индивидуальной прогностической модели. С учетом вышеизложенного становится очевидной*

необходимость разработки дополняющей прогностической модели, способной учитывать параметры, отражающие не только анатомические и гистологические характеристики опухоли, но и системную реакцию организма.

Ключевые слова: *рак слизистой оболочки полости рта, онкология, лечение, рецидив, исход.*

**OG'IZ BO'SHLIG'I SHILLIQ QAVATI SARATONI
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Annotatsiya. *Davolash samaradorligi, albatta, muhim va amaliy ko'rsatkichdir, ammo aniq individual prognostik modelni yaratishda uni boshqa omillar bilan to'ldirish kerak. Yuqoridagilarni hisobga olgan holda, o'simtaning nafaqat anatomik va gistologik xususiyatlarini, balki tananing tizimli reaksiyasini ham aks ettiruvchi parametrlarni hisobga oladigan qo'shimcha prognostik modelni ishlab chiqish zarurati tug'iladi.*

Kalit so'zlar: *og'iz bo'shlig'i shilliq qavati saratoni, onkologiya, davolash, relaps, natija.*

The aim of this study is to improve the prediction of outcomes of complex treatment for RCMP by developing pathogenetically based methods based on regular changes in immune system parameters.

Materials and Methods The study included 124 patients with oncological lesions of the oral mucosa, who were examined and treated at the Bukhara regional branch of the Republican Specialized Scientific and Practical Medical Center of Oncology and Radiology of the Ministry of Health of the Republic of Uzbekistan for the period from 2020 to 2022. All patients were verified and classified by outcomes during a three-year follow-up (until 2025) depending on the outcome of complex treatment into comparative and main groups. The criteria for inclusion of patients in the study were: morphologically verified diagnosis of malignant neoplasm of the oral mucosa (RSOPR, lateral surface of the tongue, cheeks, etc.), corresponding to ICD-10 (C01-C06); primary referral for specialized oncological care, without previous treatment (including chemotherapy, radiotherapy and immunotherapy); the age of patients from 18 to 75 years; Comprehensive treatment including surgery, radiation therapy, and/or chemotherapy, carried out within the framework of standards of oncological care; the possibility of a 3-year follow-up after completion of the main course of treatment (to assess the prognosis and outcome); verifiably obtained informed consent to participate in the study, including immunological examination and subsequent data processing.

Study results. In patients who underwent surgical treatment, the relapse prediction based on early clinical response was 20.7%, while actual relapse occurred in 10.3% of patients. This may indicate a significant overestimation of the prediction system (more than 2-fold), or, in relative terms, by 10.4 percentage points. A similar discrepancy was noted in patients who received combination therapy: the prediction was 28.6%, while the actual relapse rate was 7.1%, that is, almost 4 times less than expected. Regardless of the relative assessment method used, the obtained data demonstrate a clear overestimation of the prognostic significance of clinical response during intensive therapy (Table 1). Against this background, in patients who received chemotherapy alone, the difference between the predicted and actual response rate was 22.3

percentage points (the predicted response rate was 77.8%, while the actual response rate was 55.6%). In other words, almost one in three patients, despite an unfavorable prognosis for clinical response, did not experience a relapse during the subsequent follow-up period.

With isolated radiation therapy, the difference was less pronounced, with the predicted response rate being 64.3% versus the actual response rate of 42.9%, equivalent to a 1.5-fold overestimation of risk.

Similar trends were observed when analyzing anatomical subgroups. For example, for tumors localized on the tongue, the difference in predicted response rate was 9.1 percentage points, while for lesions on the floor of the mouth, the predicted response rate was 61.5%, while the actual response rate was 69.2%.

Thus, the obtained preliminary data may indicate that the actual risk of recurrence, as shown by the lesion data, exceeded the predicted value, which is likely due to the anatomical complexity of the lesion and the difficulty in assessing residual tumor after treatment.

The differences in TNM staging were less pronounced: for stages I-II, the predicted recurrence rate was 18.5%, while the actual recurrence rate was 11.1%, while for stages III-IV, the respective rates were 57.1% and 52.4%. This demonstrates acceptable assessment accuracy in the early stages, but a tendency toward overestimation with progression. Such changes were characteristic of a number of clinical cases, for which we provide a description of one.

Conclusion. Treatment response is undoubtedly an important and practical indicator, but it requires complementary factors when constructing an accurate individual prognostic model. Given the above, the need for a complementary prognostic model capable of incorporating parameters reflecting not only the anatomical and histological characteristics of the tumor but also the body's systemic response is clear.

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