24th NATIONAL CONGRESS OF SURGERY ABSTRACTS

POSTER PRESENTATIONS

[P-001]

A rare mechanical obstruction cause mimicking irritable bowel syndrome: Abdominal coza syndrome

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Objective: Abdominal cocoon syndrome (idiopathic sclerosing peritonitis) is a very rare clinical condition that develops as a result of the external wrapping of small or large bowel loops by fibrotic peritoneal bands or a thickened membrane. Clinical findings are often non-specific. It may present as recurrent abdominal pain, nausea, vomiting, abdominal distension, and subileus attacks. Due to diagnostic difficulties, patients may be diagnosed with functional gastrointestinal disorders, particularly irritable bowel syndrome (IBS), for a long time. A definitive diagnosis is often made by surgical exploration.

Material and Methods: The clinical, radiological, surgical, and pathological findings of a 58-year-old female patient who had intermittent gastrointestinal symptoms for approximately twenty years and had previously been followed up with an IBS diagnosis were retrospectively evaluated.

Results: The patient presented with recurrent episodes of nausea, vomiting, abdominal distension, and inability to pass gas or stool over the past year. Computed tomography and magnetic resonance imaging studies revealed no specific pathology explaining the obstruction. Colonoscopy was normal. Surgical exploration for a subileus attack revealed that the small and large bowel loops were externally wrapped by diffuse fibrotic peritoneal bands, with markedly restricted loop mobility and a cocoon-like appearance. Laparoscopy was converted to open surgery, and all fibrotic bands were excised, and a bridectomy was performed. Pathological examination revealed findings consistent with fibro-connective tissue proliferation and sclerosing peritonitis. No complications developed in the postoperative period, and the patient was discharged on the third day.

Conclusion: Abdominal cocoon syndrome should always be considered in the differential diagnosis of patients who have been followed up with an IBS diagnosis for a long time and who experience recurrent subileus attacks. In cases where radiological findings are insufficient, surgical exploration offers both a diagnostic and therapeutic approach.

Keywords: Abdominal coarctation syndrome, sclerosing peritonitis, mechanical bowel obstruction, subileus, irritable bowel syndrome

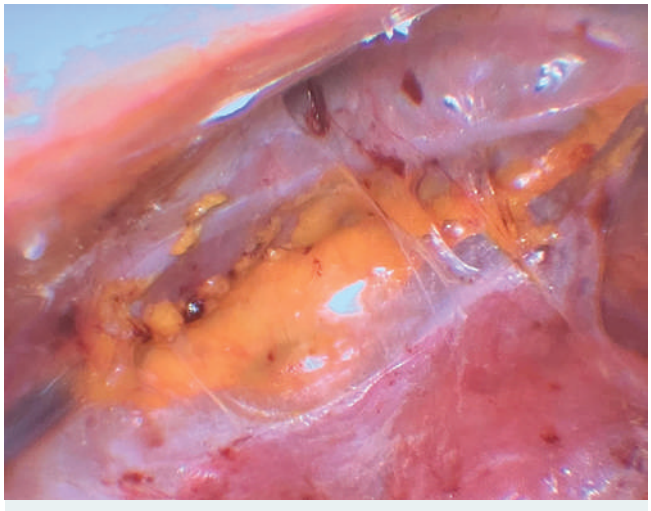

Figure 1. Intraoperative findings. The small and large bowel loops are surrounded externally by widespread peritoneal fibrotic bands and adhesions, giving them a cocoon-like appearance.

[P-002]

Mesenteric vascular disease at a young age: Suspecting the disease; maybe not everything, but it can mean a lot

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Objective: Acute mesenteric ischemia (AMI) is a rare cause of acute abdomen and often occurs due to embolism or thrombosis in the mesenteric vascular structures. Despite advances in diagnosis and treatment, the disease still carries a mortality rate of 50-70%. Since there are no specific physical examination (PE) findings, clinical suspicion at the time of presentation is extremely important for diagnosis and especially for early treatment. Therefore, although the outcome was fatal, we aimed to draw attention to the importance of suspecting this disease at the time of diagnosis by presenting a young case that may highlight this issue.

Material and Methods: Our case was a 25-year-old previously healthy male who presented to the emergency department with sudden-onset, severe abdominal pain that began at night and persisted. He had no passage of gas or stool since the pain started and experienced nausea and vomiting. He smoked one pack per day, and his family history included cerebrovascular disease and deep vein thrombosis in second-degree relatives. He was evaluated with physical examination, laboratory tests, and radiological imaging.

Results: The abdomen was minimally distended with generalized tenderness but no guarding or rebound. The white blood cell count was 26,000/μL. The contrast-enhanced abdominal CT reported through outsourced service as normal; however, due to pain disproportionate to examination findings, we re-evaluated the images and detected a thrombus at the root of the superior mesenteric artery (Figure 1). After radiology consultation, AMI was diagnosed, and tissue plasminogen activator was administered. As the patient did not improve, laparotomy was performed 24 hours later, revealing necrosis of most of the small intestine, right colon, and gallbladder (Figure 2). Following Fogarty catheter thrombectomy, bowel resections and anastomoses were completed. Postoperatively, heparin infusion was initiated, and hematology and genetics consultations were obtained. At second-look surgery 48 hours later, necrosis involved all remaining intestinal segments and the distal stomach, and the operation was terminated. Further tests showed deficiencies of protein C, protein S, and antithrombin III, heterozygous factor II and factor V Leiden mutations, and homozygous MTHFR mutation. The patient died one week after the second-look procedure.

Conclusion: AMI is caused by the sudden interruption of intestinal blood flow. Early diagnosis and treatment are life-saving, and clinical suspicion is essential. Severe abdominal pain disproportionate to PE findings strongly suggests AMI and should be considered the diagnosis until proven otherwise.

Keywords: Abdominal pain, ischemia, mesentery

Figure 1. Thrombus at the origin of the SMA (indicated by the white arrow).

Figure 2. Small intestines with extensive necrosis.

[P-003]

Top 5 ultra-rare intra-abdominal tumors: A clinical review

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Objective: General surgeons frequently manage common abdominal pathologies; however, ultra-rare intra-abdominal tumors present unique diagnostic and therapeutic challenges. These entities often mimic more common conditions, such as gastrointestinal stromal tumors (GIST) or common adenocarcinomas, leading to significant diagnostic delay and complex surgical requirements. This study reviews the clinical presentation and management of five of the rarest documented intra-abdominal malignancies: desmoplastic small round cell tumor (DSRCT), extraosseous ewing sarcoma (EES) of the mesentery, primary retroperitoneal melanoma (PRM), malignant gastric glomus tumor, and primary peritoneal serous carcinoma (PPSC).

Material and Methods: A comprehensive review of surgical literature and pathological case series was conducted to identify intra-abdominal tumors with an incidence typically lower than 1 case per million or those with fewer than 100 documented cases. Data were synthesized focusing on anatomical location, specific immunohistochemical markers required for differentiation, and the extent of surgical resection necessary for local control.

Results: The identified tumors exhibit distinct biological behaviors requiring specialized interventions. DSRCT primarily affects young males and is characterized by the t(11;22)(p13;q12) translocation, requiring aggressive cytoreductive surgery (CRS). EES of the mesentery necessitates wide local excision and is identified via strong CD99 positivity, distinguishing it from GIST. PRM represents a diagnostic enigma, occurring in the retroperitoneum without a detectable cutaneous primary, requiring S100 and HMB-45 staining for confirmation. Malignant gastric glomus tumors are rare variants of perivascular neoplasms that present as submucosal masses, requiring gastrectomy when mitotic activity is high. Finally, PPSC involves widespread peritoneal "caking" while sparing the ovaries, managed through extensive cytoreduction and HIPEC. Across all five entities, R0 resection remains the primary determinant of long-term survival, though the aggressive nature of these tumors often necessitates multi-visceral resection.

Conclusion: Ultra-rare intra-abdominal tumors represent a frontier in general surgery where standardized protocols are often unavailable. Because preoperative imaging is rarely definitive, the surgeon must be prepared for unexpected findings during laparotomy. A multidisciplinary approach involving advanced molecular testing and specialized surgical techniques like CRS/HIPEC is essential. While surgical resection remains the cornerstone of treatment, prognosis remains guarded due to the late presentation and high recurrence rates characteristic of these obscure pathologies.

Keywords: Glomus tumour, melanoma, sarcoma

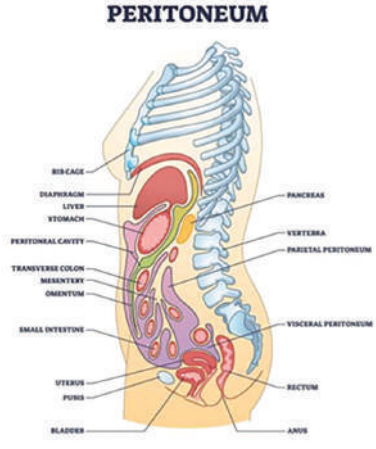

Figure 1. Peritoneal cavity.

[P-004]

Should routine cholecystectomy be performed during total gastrectomy? A retrospective analysis of gastric cancer patients

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Objective: It is well known that gallstone formation and related biliary complications increase after total and subtotal gastrectomy performed for gastric cancer. Vagotomy, rapid weight loss, and impaired gallbladder motility are considered the main contributing factors. Therefore, the necessity of performing concomitant cholecystectomy during gastrectomy remains controversial. This study aimed to evaluate the effect of simultaneous cholecystectomy on biliary complications in patients undergoing gastrectomy for gastric cancer.

Material and Methods: Sixty patients who underwent total or subtotal gastrectomy for gastric cancer at our center between 2023 and 2025 were retrospectively analyzed. Patients were divided into two groups: those who underwent concomitant cholecystectomy (n=15) and those who did not (n=45). The development of biliary complications and mortality rates during follow-up were evaluated. Data were analyzed using percentages (%) and patient numbers (n).

Results: Of the 60 patients, 25% (n=15) underwent concomitant cholecystectomy during gastrectomy, while 75% (n=45) did not. No biliary complications were observed in 100% (n=15) of patients who underwent simultaneous cholecystectomy during the follow-up period. In the group without cholecystectomy, 4.4% (n=2) of patients developed acute cholecystitis. One patient presented to the emergency department in the second postoperative month and the other in the first postoperative year with right upper quadrant pain, fever, and signs of acute abdomen. All patients who developed acute cholecystitis were in the non-cholecystectomy group. The overall mortality rate was 8.3% (n=5). The causes of death were not related to biliary complications.

Conclusion: Concomitant cholecystectomy during gastrectomy for gastric cancer may be considered a safe approach to prevent biliary complications. The absence of biliary complications in patients who underwent cholecystectomy in this study is noteworthy. The decision for routine cholecystectomy should be individualized, taking into account surgical risks and patient characteristics. Larger patient cohorts and longer follow-up periods are required to clarify the effectiveness of this approach.

Keywords: Total gastrectomy, cholecystectomy, gastric cancer, biliary complications, retrospective analysis

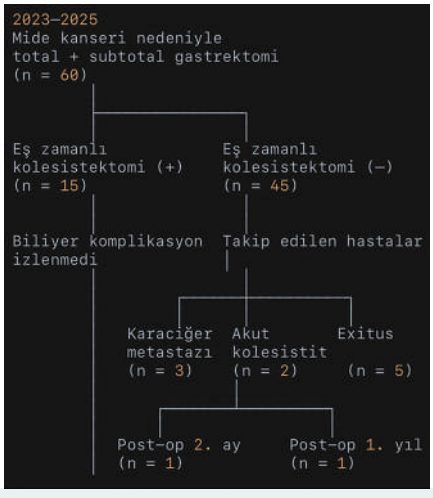

Figure 1. Results.

[P-005]

Time-dependent analgesic effects of botulinum toxin and topical glyceryl trinitrate after excisional hemorrhoidectomy: A systematic review and meta-analysis

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Objective: Postoperative pain following excisional hemorrhoidectomy remains a significant clinical problem, adversely affecting patient comfort, recovery, and return to daily activities. Internal anal sphincter spasm is considered a major contributing factor, along with other multifactorial mechanisms. Chemical sphincter relaxation strategies, including botulinum toxin and topical glyceryl trinitrate (GTN), have been proposed to reduce postoperative pain. However, their time-dependent efficacy has not been clearly established. This study aimed to evaluate and compare the effectiveness of botulinum toxin and GTN in postoperative pain control using a systematic review and meta-analysis.

Material and Methods: This systematic review and meta-analysis was conducted in accordance with PRISMA 2020 guidelines. PubMed was systematically searched for randomized controlled trials evaluating botulinum toxin or topical GTN for pain control after excisional hemorrhoidectomy. Studies involving stapled hemorrhoidopexy or Doppler-guided techniques were excluded. Pain outcomes were standardized to a 0-10 visual analog scale (VAS). Mean differences (MD) with 95% confidence intervals (CI) were calculated using a random-effects model for postoperative days 1, 3, and 7.

Results: Nine randomized controlled trials were included in the systematic review, and eight studies comprising 452 patients were eligible for meta-analysis. On postoperative day 1, GTN significantly reduced pain compared to controls (MD -0.72, 95% CI -1.18 to -0.26; p=0.002; I^2=48%), whereas botulinum toxin showed no significant effect (MD -0.21, 95% CI -0.58 to 0.16; p=0.26). On postoperative day 3, both GTN (MD -0.64, 95% CI -1.09 to -0.19; p=0.005; I^2=52%) and botulinum toxin (MD -0.68, 95% CI -1.12 to -0.24; p=0.003; I^2=46%) significantly reduced pain scores. On postoperative day 7, botulinum toxin demonstrated a greater and more consistent analgesic effect (MD -1.12, 95% CI -1.63 to -0.61; p<0.001; I^2=34%), while GTN was not statistically significant (MD -0.38, 95% CI -0.82 to 0.06; p=0.09). Headache was the most common adverse event with GTN, occasionally leading to discontinuation. Botulinum toxin was not associated with increased serious adverse events.

Conclusion: Chemical sphincter relaxation demonstrates time-dependent effects on postoperative pain following excisional hemorrhoidectomy. GTN provides superior pain relief in the early postoperative period, whereas botulinum toxin offers more sustained analgesia in later stages. Considering its single-dose administration and favorable safety profile, botulinum toxin may represent a more durable analgesic option. Further high-quality randomized controlled trials are required to determine optimal treatment strategies.

Keywords: Botulinum toxin, excisional hemorrhoidectomy, postoperative pain

[P-006]

Inflammatory breast cancer: A single-center experience

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Objective: Inflammatory breast cancer is a disease that requires a multidisciplinary approach due to its aggressive biology and high risk of metastasis. Currently, the standard treatment consists of a trimodality approach including neoadjuvant systemic therapy, surgery, and adjuvant radiotherapy. In recent years, advancements in systemic therapies have led to a significant increase in pathological response rates. This development has raised questions regarding the traditional use of modified radical mastectomy in inflammatory breast cancer. The aim of this study was to evaluate the outcomes of patients with inflammatory breast cancer treated with contemporary trimodality therapy.

Material and Methods: In this retrospective study, 24 patients diagnosed with inflammatory breast cancer between 2021 and 2025 were included. Demographic data, clinical and pathological characteristics, disease progression, recurrence, metastatic status, and survival data were obtained from patient medical records.

Results: All patients received neoadjuvant chemotherapy followed by modified radical mastectomy and adjuvant radiotherapy, achieving trimodality treatment. The mean age of the patients was 54.3 years (range: 36-74). The mean follow-up period was 28.6 months (range: 0.7-60.5). Pathological complete response was achieved in 7 patients (29.2%). Axillary evaluation revealed node-negative disease in 45.8% of patients. One patient developed local axillary recurrence, and distant metastases were detected in three patients. Patients who developed metastases died in the second postoperative year.

Conclusion: Trimodality treatment provides significant pathological response rates in patients with inflammatory breast cancer. The pCR rate of 29.2% observed in our series is consistent with the literature and supports the effectiveness of neoadjuvant therapy. High rates of axillary node negativity support current discussions in the literature suggesting that axillary surgery may be limited in selected patients. Further studies with larger cohorts are needed to re-evaluate the axillary approach in inflammatory breast cancer.

Keywords: Inflammatory breast cancer, trimodality treatment, pathological complete response

[P-007]

Vocal cord paralysis after total thyroidectomy: A bibliometric analysis of the global literature

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Objective: Vocal cord paralysis after total thyroidectomy is a significant complication that directly affects patient quality of life and surgical outcomes. This study aims to bibliometrically analyze the historical evolution, productivity patterns, leading countries, institutions, authors, and thematic trends of the scientific literature on vocal cord paralysis following total thyroidectomy.

Material and Methods: In this bibliometric analysis, studies published in the PubMed database between 1978 and 2025 were reviewed. The search strategy used the keywords: "total thyroidectomy" AND ("vocal cord paralysis" OR "recurrent laryngeal nerve palsy") AND ("complication" OR "postoperative"). Data were analyzed using the Bibliometrix (R) software, evaluating annual publication trends, Bradford's and Lotka's laws, country and institutional productivity, author networks, keyword frequencies, and thematic trends over time.

Results: A total of 536 publications, 202 sources, and 2,565 authors were analyzed. Annual output increased markedly after 2010, with an annual growth rate of 7.72% (Figure 1). The leading contributing countries were Italy, Türkiye, China, France, and the United States. The University of Pisa, the University of Palermo, and the University of Wisconsin-Madison were among the most productive institutions. Bradford's law identified World Journal of Surgery, International Journal of Surgery, and Surgery as core journals (Figure 2). Keyword analysis showed dominance of "humans," "female," "male," "middle aged," "retrospective studies," and "thyroidectomy/methods". Trend analysis indicated an early focus on anatomy and etiology, while recent studies emphasize intraoperative neuromonitoring, prevention strategies, and patient-centered outcomes.

Conclusion: This bibliometric analysis reveals not only the quantitative growth but also the conceptual and methodological evolution of the literature on vocal cord paralysis after total thyroidectomy. The findings show that early research primarily focused on anatomical descriptions and etiological observations, whereas recent studies increasingly emphasize prevention strategies, intraoperative neurophysiological monitoring, standardization of surgical techniques, and patient-centered outcome measures. By systematically identifying the countries, institutions, and journals driving this transition, the study delineates the intellectual hubs and core publication channels of the field. Moreover, keyword and trend analyses indicate a paradigm shift in which vocal cord paralysis is no longer viewed as an inevitable complication but as a predictable, preventable, and manageable surgical outcome. Beyond a descriptive overview of past literature, this analysis provides a strategic roadmap for future clinical research, quality improvement initiatives, and guideline development, offering a robust reference point for advancing surgical outcomes in total thyroidectomy practice.

Keywords: Recurrent laryngeal nerve injury, total thyroidectomy, vocal cord paralysis

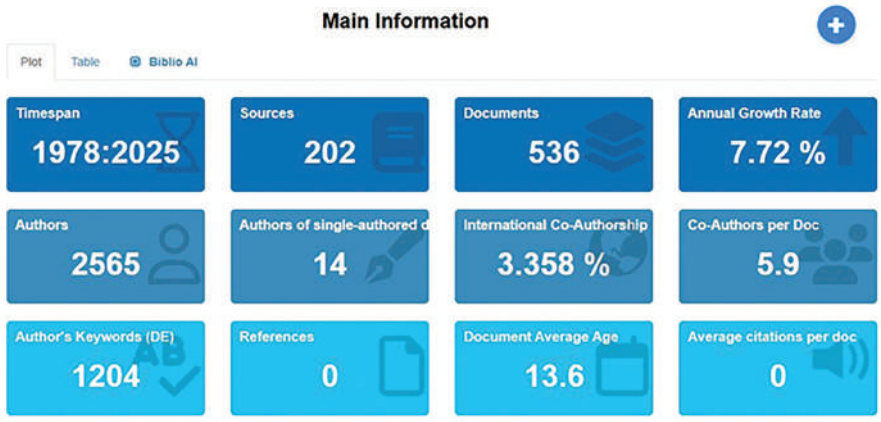

Figure 1. Bibliometric main indicators of the literature on vocal cord paralysis after total thyroidectomy (1978-2025).

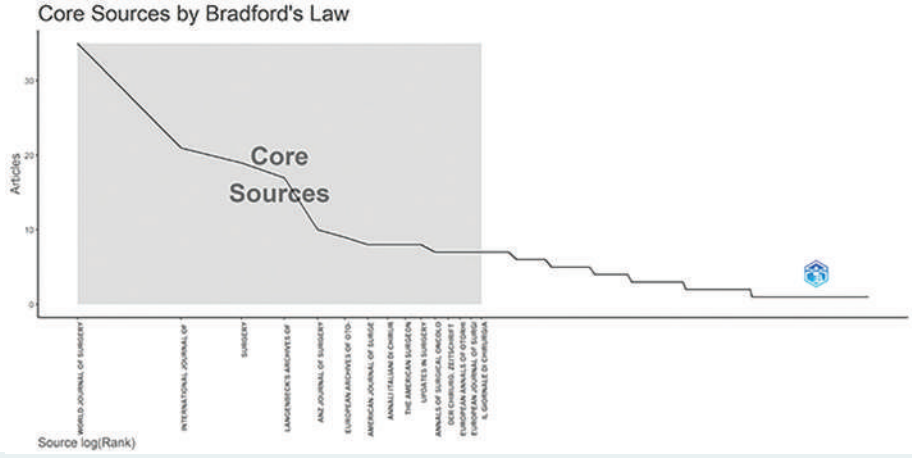

Figure 2. Distribution of core journals in the literature on vocal cord paralysis after total thyroidectomy based on Bradford's law.

[P-008]

Surgical management of complications of endoscopic cystogastrostomy: 7 years of tertiary center experience and technical analysis

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Objective: Endoscopic cystogastrostomy is used as a minimally invasive method for draining peripancreatic collections. However, serious complications can develop during endoscopic cystogastrostomy; which may require "rescue surgery" as an emergency surgical intervention in a field dominated by intense inflammation and anatomical distortion. This study analyzes the surgical management strategies and clinical outcomes of life-threatening complications occurring after endoscopic cystogastrostomy that could not be managed via endoscopic techniques.

Material and Methods: A total of 58 endoscopic cystogastrostomy performed on 49 patients at our hospital between 2019 and 2025 were reviewed; 9 patients (5 males, 4 females) who required surgical exploration due to procedural complications were retrospectively analyzed. Complications were classified as early-stage perforation and late-stage necrotizing/fistulizing processes. The surgical techniques applied, the need for resection, infection control strategy, postoperative morbidity, mortality, and length of hospital stay were examined.

Results: The mean age of the patients was 53.7 years. The most frequent surgical indication was gastric perforation with necrotizing pancreatitis (44.4%), these cases were treated with necrosectomy and open primary gastric repair. In isolated gastric perforation, laparoscopic primary gastric repair was performed (11.1%). In more complex cases, segmental colon resection+splenectomy+gastric wedge resection (11.1%) was performed due to gastrocolic fistula. For duodenal perforation, antrectomy+loop gastrojejunostomy+ choledochal T-tube drainage (11.1%) was performed. In cases of isolated widespread infected necrosis where endoscopic cystogastrostomy was unsuccessful, necrosectomy (11.1%) and necrosectomy+Bogota bag (11.1%) with open abdomen follow-up were performed. In the postoperative period, 22.2% of patients died due to septic shock and multiple organ failure. The average hospital stay for surviving patients was determined to be 15.6 days.

Conclusion: Although endoscopic cystogastrostomy is a minimally invasive approach with high success rates, serious complications following endoscopic cystogastrostomy are high-risk situations requiring rapid intervention. Perforations due to stent migration and vascular/visceral injuries can be fatal. Early surgery is life-saving in gastric perforations; however, in cases complicated by late-stage necrotizing processes, "rescue" procedures, including aggressive organ resections, are the most critical factor in limiting mortality. As seen in our study, perforation and sepsis management form the basis of surgical success. The high surgical success rate in our series is based on early recognition of the complication and aggressive surgical debridement strategies. Surgical management is one of the key factors determining the prognosis of these patients, and timely surgical intervention is the gold standard. To ensure the successful management of endoscopic cystogastrostomy complications, it is recommended that the procedure be performed in advanced multidisciplinary centers where general surgery and gastroenterology departments operate in coordination.

Keywords: Endoscopic cystogastrostomy, pancreatic pseudocyst, complication management

[P-009]

Scalpel, numbers, and facts: A 22-month surgical experience of 2. 778 cases from a city hospital general surgery department

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Objective: Regular analysis of surgical departmental activity is essential for quality assurance, resource allocation, and continuous improvement of surgical training programs. This study aims to present a comprehensive statistical analysis of operations performed by four general surgeons (surgeon A, B, C, D) at a city hospital general surgery department.

Material and Methods: Operative notes from all general surgery procedures performed between April 2024 and February 2026 (22 months) were retrospectively reviewed. A total of 2.778 operative notes were extracted from digital records and converted into a structured dataset. For each case, surgeon identity, procedure type, surgical approach (laparoscopic vs. open), urgency status (elective vs. emergency), malignancy status with tumor localization, and perioperative complications were recorded. Emergency cases were further subclassified by indication. Procedures were classified into main categories, and surgeon-specific distributions, year-over-year comparisons, laparoscopic surgery rates, and oncological surgery profiles were analyzed.

Results: The distribution of 2,778 cases among surgeons was: Surgeon A 1.086 (39.1%), surgeon B 997 (35.9%), surgeon C 470 (16.9%), and surgeon D 225 (8.1%). The most common procedures were hernia repair (n=677, 24.4%), cholecystectomy (n=613, 22.1%), thyroid surgery (n=246, 8.9%), appendectomy (n=218, 7.8%), and breast surgery (n=154, 5.5%). Of all cases, 86.9% (n=2,413) were elective and 13.1% (n=365) were emergency procedures. Emergency cases: Acute appendicitis 118 (32.3%), ileus/obstruction 88 (24.1%), acute cholecystitis 67 (18.4%), gastrointestinal perforation 33 (9.0%), and other causes including incarcerated hernia and trauma 59 (16.2%). In cases amenable to laparoscopic approach (cholecystectomy, appendectomy, hernia repair), the overall laparoscopic rate was 64.6%. Procedure-specific laparoscopic rates were 95.9% for cholecystectomy, 79.8% for appendectomy, and 36.6% for hernia repair. Twenty- nine patients (4.2%) had perioperative complications including conversion to open surgery and organ injury. A total of 173 cases (6.2%) involved malignant pathology. Malignancies were breast (n=93, 53.8%), colorectal (n=45, 26.0%), thyroid (n=8), skin/soft tissue (n=6), and gastric (n=5). The monthly average surgical volume increased from 113.3 cases in 2024 to 130.7 in 2025 (a 15.3% increase), while laparoscopic rates remained stable (66.5% vs. 67.9%).

Conclusion: Our department performed a high volume of operations spanning both benign and malignant pathologies over the 22-month study period. The laparoscopic cholecystectomy rate of 95.9% is consistent with current literature standards. The finding that 79.8% of malignant cases were of breast and colorectal origin reflects the department's oncological surgical experience. The low perioperative complication rate (4.2%) and increasing operative volume over time indicate effective and safe surgical practice. Laparoscopic hernia repair was identified as an area for further development.

Keywords: General surgery, surgical activity analysis, laparoscopic surgery, emergency surgery, oncological surgery, perioperative complications

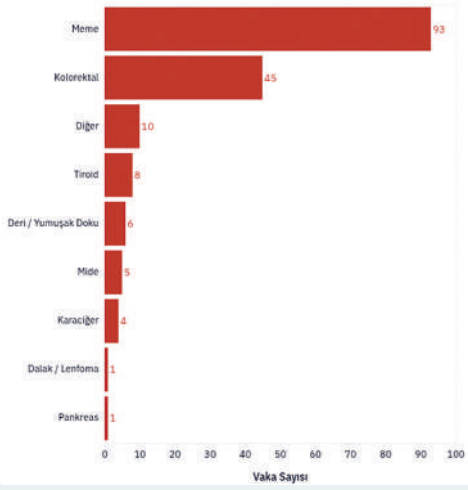

Figure 1. Distribution of the emergency cases.

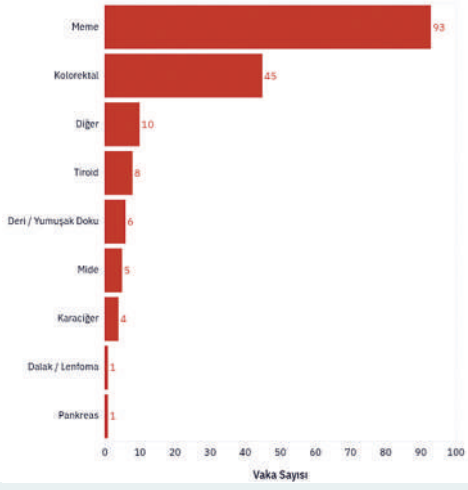

Figure 2. Distribution of the malignant cases.

[P-021]

Clinical, radiological, and histopathological analysis of emergency department-admitted Meckel's diverticulitis cases: A single-center retrospective study

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Objective: Meckel's diverticulitis is a rare congenital gastrointestinal anomaly that may require surgical treatment when complicated. It often presents with an acute abdomen and may mimic other abdominal pathologies. This study aimed to evaluate the demographic, clinical, radiological, and histopathological characteristics of patients with Meckel's diverticulitis who were admitted to the emergency department and treated surgically.

Material and Methods: Patients who were admitted to the emergency department and diagnosed with Meckel's diverticulitis intraoperatively at the General Surgery Clinic of University of Health Sciences Türkiye, Ankara Etlik City Hospital between October 2022 and August 2025 were retrospectively analyzed. In most cases, the preoperative diagnosis was not Meckel's diverticulitis, and acute appendicitis or other causes of acute abdomen were initially suspected. Age, sex, presenting complaints, physical examination findings, computed tomography (CT) reports, and histopathological results were evaluated. Patients who underwent elective surgery were excluded from the study.

Results: A total of 19 patients were included in the study. The mean age was 39.9±18.8 years (18-74) (Table 1). The most common presenting symptoms were abdominal pain, nausea, and vomiting (15.8%). The most frequent physical examination finding was minimal tenderness in the right lower quadrant (26.3%). CT reports suggested Meckel's diverticulitis in only 3 cases (15.8%), whereas other acute abdominal pathologies were reported in the remaining cases (Table 2). Histopathological examination revealed ectopic gastric mucosa in 4 cases and ectopic pancreatic tissue in 1 case. In many cases, necrosis, hemorrhage, and active inflammation were observed. Histopathological analysis played a decisive role in confirming the diagnosis and identifying ectopic tissue and associated complications.

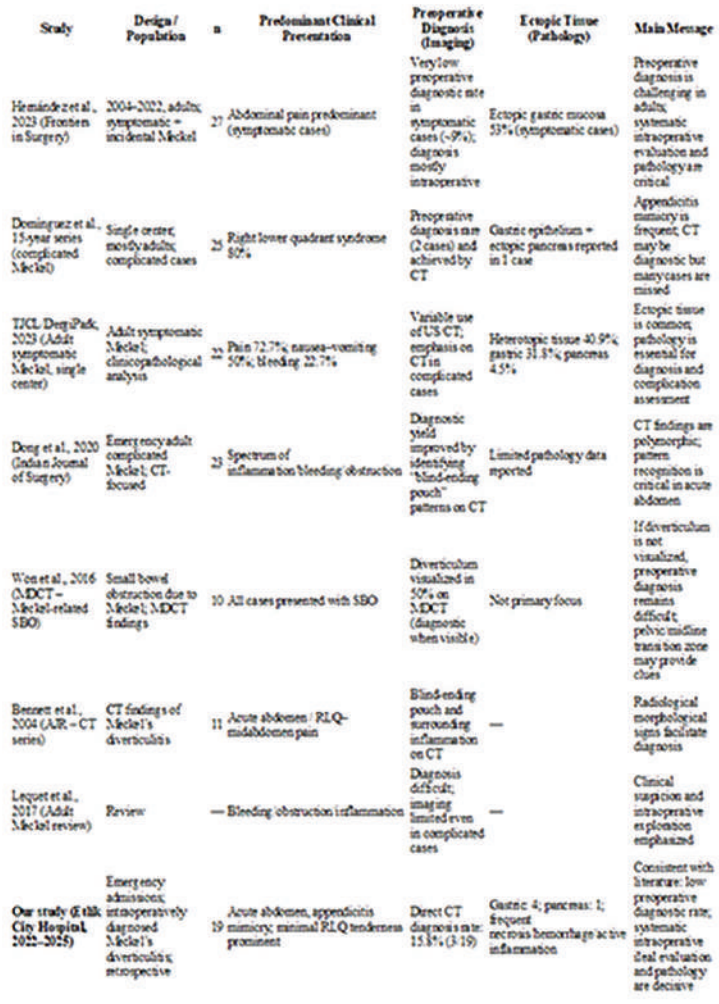
Conclusion: Although Meckel's diverticulitis is rare, it represents an important cause of acute abdomen and can clinically and radiologically mimic acute appendicitis. Consistent with the literature, the rate of preoperative diagnosis using CT was low; in this study, correct preoperative diagnosis was achieved in only 15.8% of cases (Table 3). Therefore, systematic intraoperative evaluation of the ileal loops is critical, particularly when the appendix appears normal. Histopathological examination not only confirms the diagnosis but also reveals ectopic tissue and associated complications such as necrosis, hemorrhage, and active inflammation, thereby supporting clinical management. In conclusion, Meckel's diverticulitis should be considered in the differential diagnosis of acute abdomen, and careful intraoperative assessment combined with histopathological confirmation may reduce diagnostic delay and morbidity.

Keywords: Acute abdomen, emergency surgery, histopathology, Meckel's diverticulitis, retrospective study

Characteristic	Value
Number of patients (n)	19
Age, mean ± SD (min–max)	39.9 ± 18.8 (18–74)
Most common presenting complaint	Abdominal pain, nausea, and vomiting (15.8%)
Most frequent physical examination finding	Minimal tenderness in the right lower quadrant (26.3%)

Characteristic	Value
Number of cases diagnosed as Meckel's diverticulitis preoperatively by CT	3 (15.8%)
Number of cases with alternative acute abdomen diagnoses on CT	16 (84.2%)
Ectopic gastric mucosa on histopathology	4 cases
Ectopic pancreatic tissue on histopathology	1 case
Necrosis, hemorrhage, and active inflammation on histopathology	Observed in multiple cases

Figure 1. Demographic and clinical characteristics, radiological and histopathological findings.



Study	Design / Population	n	Predominant Clinical Presentation	Preoperative Diagnosis (Imaging)	Ectopic Tissue (Pathology)	Main Message
Hernández et al., 2023 (Frontiers in Surgery)	2004–2022, adults; symptomatic = incidental Meckel	27	Abdominal pain predominant (symptomatic cases)	Very low preoperative diagnostic rate in symptomatic cases (~9%); diagnosis mostly intraoperative	Ectopic gastric mucosa 53% (symptomatic cases)	Preoperative diagnosis is challenging in adults; systematic intraoperative evaluation and pathology are critical
Domínguez et al., 15-year series (complicated Meckel)	Single center, mostly adults; complicated cases	25	Right lower quadrant syndrome 80%	Preoperative diagnosis rare (2 cases) and achieved by CT	Gastric epithelium + ectopic pancreas reported in 1 case	Appendicitis mimicry is frequent; CT may be diagnostic but many cases are missed
TJCL DergiPark, 2023 (Adult symptomatic Meckel, single center)	Adult symptomatic Meckel; clinicopathological analysis	22	Pain 72.7%; nausea–vomiting 50%; bleeding 22.7%	Variable use of US/CT; emphasis on CT in complicated cases	Heterotopic tissue 40.9%; gastric 31.8%; pancreas 4.5%	Ectopic tissue is common; pathology is essential for diagnosis and complication assessment
Dong et al., 2020 (Indian Journal of Surgery)	Emergency adult complicated Meckel; CT-focused	23	Spectrum of inflammation/bleeding/obstruction	Diagnostic yield improved by identifying "blind-ending pouch" patterns on CT	Limited pathology data reported	CT findings are polymorphic; pattern recognition is critical in acute abdomen
Won et al., 2016 (MDCT – Meckel-related SBO)	Small bowel obstruction due to Meckel; MDCT findings	10	All cases presented with SBO	Diverticulum visualized in 50% on MDCT (diagnostic when visible)	Not primary focus	If diverticulum is not visualized, preoperative diagnosis remains difficult; pelvic midline transition zone may provide clues
Bennett et al., 2004 (AJR – CT series)	CT findings of Meckel's diverticulitis	11	Acute abdomen / RLQ–midabdomen pain	Blind-ending pouch and surrounding inflammation on CT	—	Radiological morphological signs facilitate diagnosis
Lequet et al., 2017 (Adult Meckel review)	Review	—	Bleeding/obstruction/inflammation	Diagnosis difficult; imaging limited even in complicated cases	—	Clinical suspicion and intraoperative exploration emphasized
Our study (Etlik City Hospital, 2022–2025)	Emergency admissions; intraoperatively diagnosed Meckel's diverticulitis; retrospective	19	Acute abdomen, appendicitis mimicry; minimal RLQ tenderness prominent	Direct CT diagnosis rate: 15.8% (3/19)	Gastric: 4; pancreas: 1; frequent necrosis/hemorrhage/active inflammation	Consistent with literature: low preoperative diagnostic rate; systematic intraoperative final evaluation and pathology are decisive

Figure 2. Comparison with current literature.

[P-022]

Long-term follow-up results after rectal cancer surgery

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Objective: Rectal cancer is among the most common malignancies worldwide and continues to be a significant public health problem. Significant advances have been made in surgical techniques and multimodal treatment strategies over the last decade. This study aimed to evaluate the clinicopathological features and long-term oncological outcomes of patients who underwent surgical resection for rectal cancer at a single center, focusing on five-year follow-up data.

Material and Methods: Patients who underwent surgical resection for rectal cancer at our institution between January and December 2020 were retrospectively evaluated. Demographic data, surgical procedures performed, oncological treatment protocols, pathological staging, tumor grade, lymph node involvement, and tumor status at the distal and peripheral resection margin (CRM) were analyzed. Five-year survival and recurrence data were recorded during periodic follow-ups. Statistical analyses were performed using R software; Student's t-test was used for continuous variables, Fisher's exact test for categorical variables, and the Cox proportional hazards model was applied to determine factors affecting survival. P<0.05 was considered statistically significant.

Results: A total of 61 patients were included in the study [median age: 69 years (39-98)]; 39 (64%) were male and 22 (36%) were female. 34% of the patients received neoadjuvant chemoradiotherapy, while 56% received adjuvant therapy. Pathological evaluation revealed T3-T4 tumors in 62% of patients and lymph node positivity in 41%. During the five-year follow-up period, the local recurrence rate was 10%, and the distant metastasis rate was 23%. 71% of recurrences occurred within the first 24 months. The five-year disease-free survival (DFS) rate was calculated as 67%. In Cox proportional hazard analysis, advanced age (HR: 1.04; p=0.05) and recurrence (HR: 6.31; p<0.005) were identified as independent risk factors for mortality. Recurrence emerged as the strongest predictor of overall survival. Furthermore, CRM positivity, N2b lymph node status, and vascular invasion were strongly associated with disease progression and mortality. Advanced age was consistently associated with increased hazard ratios in all models. Recurrences were observed mostly within the first 24 months, particularly in patients with advanced T and N stages.

Conclusion: Long-term oncological outcomes after rectal cancer surgery are closely related to accurate pathological staging and adherence to multidisciplinary treatment protocols. Given that recurrences are particularly concentrated in the first two years in high-risk patients, stricter and more intensive follow-up strategies are necessary for this patient group.

Keywords: Rectal cancer, 5-year follow-up, LAR, APR, disease-free survival

[P-023]

The role of colonoscopic decompression and surgery in patients with sigmoid volvulus: A single-center experience

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Objective: Sigmoid volvulus is a significant cause of acute mechanical intestinal obstruction and is associated with considerable morbidity and mortality, particularly in elderly patients and those with multiple comorbidities. Management strategies vary depending on the patient's clinical condition, bowel viability, and the presence of complications. Colonoscopic decompression is recommended as the initial treatment in hemodynamically stable patients without signs of peritonitis; however, the optimal timing and role of surgery remain controversial. The aim of this study was to compare the outcomes of colonoscopic decompression and surgical treatment in patients presenting with sigmoid volvulus and to evaluate the effectiveness of different treatment strategies.

Material and Methods: This retrospective, single-center study included 37 patients diagnosed with sigmoid volvulus between January 2021 and December 2025. Demographic data, clinical presentation, treatment modality, length of hospital stay, postoperative complications, and mortality were reviewed. Colonoscopic decompression was performed as the initial treatment in 11 patients (29.7%), while 26 patients (70.3%) underwent primary surgical intervention. The success rate of colonoscopic decompression and the need for conversion to surgery were analyzed. In surgically treated patients, the type of resection—resection with primary anastomosis or Hartmann's procedure—and stoma formation were evaluated.

Results: Successful colonoscopic decompression was achieved in 9 of 11 patients (81.8%). Two patients (18.2%) required early surgical intervention due to failure of endoscopic reduction. Among the 26 patients who underwent surgical treatment, resection with primary anastomosis was performed in 8 patients (30.8%), whereas Hartmann's procedure was performed in 18 patients (69.2%). The mean length of hospital stay was 4.2 days in the colonoscopic decompression group and 8.6 days in the surgical group. The complication rate was lower in the colonoscopic group compared with the surgical group (9.1% vs. 23.1%). The overall mortality rate was 5.4%, and all deaths occurred in the surgical treatment group.

Conclusion: Colonoscopic decompression is a safe and effective initial treatment option in appropriately selected patients with sigmoid volvulus, offering shorter hospital stays and lower complication rates. Surgical intervention remains indispensable in cases of bowel ischemia, perforation, peritonitis, or failed endoscopic decompression. Individualized treatment planning based on patient characteristics and clinical findings is essential to reduce morbidity and mortality in patients with sigmoid volvulus.

Keywords: Acute intestinal obstruction, colonoscopic decompression, Hartmann's procedure, sigmoid volvulus, surgical treatment

Table 1. Treatment modalities and clinical outcomes in patients with sigmoid volvulus

Variables	Colonoscopic Decompression (n=11)	Surgical Treatment (n=26)
Initial treatment modality	11 (29.7%)	26 (70.3%)
Successful clinical outcome*	9 (81.8%)	26 (100%)
Treatment failure / change of modality	2 (18.2%)	–
Surgical technique applied	–	Resection with primary anastomosis: 8 (30.8%) Hartmann's procedure: 18 (69.2%)
Mean length of hospital stay (days)	4.2	8.6
Patients with complications	1 (9.1%)	6 (23.1%)
Mortality	0 (0%)	2 (7.7%)

[P-025]

Surgical treatment outcomes in siewert type III esophagogastric junction tumors: A single-center experience

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Objective: Esophagogastric junction (EGJ) tumors constitute a distinct group of patients from a surgical perspective due to their anatomical location and biological behavior. The Siewert classification serves as a guide in treatment planning for these tumors, and type III tumors are subcardial carcinomas considered to be of gastric origin, with the tumor center located 2-5 cm distal to the EGJ. The aim of this study was to evaluate the clinical characteristics and surgical outcomes of patients with Siewert type III EGJ tumors who were surgically treated at our center.

Material and Methods: Between 2024 and 2025, 18 patients who underwent surgical treatment at our clinic with a diagnosis of Siewert type III EGJ tumor were retrospectively analyzed. Patients' demographic data, pathological stages, surgical procedures performed, postoperative complications, and follow-up outcomes were evaluated. All patients underwent total gastrectomy with D2 lymph node dissection and transhiatal distal esophageal resection. Splenectomy was performed only in patients with involvement of the splenic hilum.

Results: Eleven patients were male (61%) and seven were female (39%), with a mean age of 62.4±8.1 years. According to pathological staging, 56% of the patients were stage III, 33% were stage II, and 11% were stage I. The mean number of harvested lymph nodes was 31±6, and R0 resection was achieved in all patients. The postoperative major complication rate was 11%, with no observed mortality. The mean length of hospital stay was 9.2 days, and the mean follow-up period was 24 months. During this period, the overall survival rate was determined to be 72%.

Conclusion: In Siewert type III EGJ tumors, a surgical approach based on gastric cancer principles provides effective and reliable outcomes with acceptable morbidity rates. A multidisciplinary approach and appropriate surgical technique are decisive factors in achieving treatment success.

Keywords: D2 lymphadenectomy, esophagogastric junction, gastric cancer, siewert type III, total gastrectomy

[P-026]

Assessment of malignancy risk in proliferative breast lesions

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Objective: In our study, we examined clinical and radiological findings to predict the risk of malignancy in proliferative breast lesions.

Material and Methods: Patients who underwent breast tru-cut biopsy at our clinic between August 2020 and 2025 were examined. Fifty cases undergoing wide local excision among patients with biopsy results indicating proliferative breast lesions were included in our study. Patients were evaluated based on four different variables. First, patients with histopathology showing *in situ* or invasive carcinoma were assigned to the malignant group, while patients with other histopathological results were assigned to the benign group. Second, patients were divided into those aged 50 years and older and those younger than 50 years. Third, patients were divided according to the BIRADS category in the mammography findings. Fourth, patients were divided into those with breast density classification A-B and those reported as C-D.

Results: According to histopathological results, the number of patients with malignancy was n=12/50 (24%), and benignity was n=38/50 (76%), and proliferative lesions of the breast were associated with an increased risk of malignancy. In terms of age group, the malignancy rate was n=9/27 (33%) in 27 cases over the age of 50 and n=3/23 (13%) in 23 cases under the age of 50. An increase in malignancy risk was observed with increasing age. The number of patients according to the BIRADS category was BIRADS-0 n=12/50 (24%), BIRADS-3 n=6/50 (12%), BIRADS-4 n=32/50 (64%), while the malignancy rate in the subgroups was BIRADS-0 n=0/12 (0%), BIRADS-3 n=2/6 (33%), BIRADS-4 n=10/32 (31%). The increase in the BIRADS category was parallel to the increase in breast cancer risk. In breast density classification, the number of patients was found to be: A-B pattern n=10/50 (20%), C-D pattern n=40/50 (80%). The incidence of proliferative lesions in the breast was higher in the C-D pattern patient group. Malignancy rates were n=3/10 (30%) in the A-B pattern and n=9/40 (22.5%) in the C-D pattern, with a higher increase in malignancy risk detected in A-B pattern breasts.

Conclusion: Proliferative lesions in the breast increase the risk of breast cancer and are more common in older patients, those with a high BIRADS category, and those with breast density in the C-D pattern. Our study highlights that proliferative lesions in breasts rich in fatty tissue and with an A-B pattern carry a high risk of malignancy. It is recommended that proliferative lesions detected in low-density breasts be evaluated more carefully for malignancy.

Keywords: Proliferative breast lesions, breast density, breast mammography

[P-027]

Our experience with multivisceral resection in retroperitoneal liposarcomas: Surgical management and short-term outcomes of a case series

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Objective: Although retroperitoneal, intraabdominal giant liposarcomas are rare among soft tissue sarcomas, they are among the most challenging tumor groups from a surgical perspective due to their large size, late onset of symptoms, and close anatomical relationship with vital neighboring organs. In particular, dedifferentiated and myxoid histopathological subtypes are characterized by aggressive biological behavior, high local recurrence rates, and frequent multiple organ invasion. This necessitates extensive resection and combined organ resection in surgical treatment. Current literature reports that complete surgical resection is the most important prognostic factor determining survival. This study presents the surgical management and short-term clinical outcomes of giant liposarcoma cases with different histopathological subtypes requiring multiple resection.

Material and Methods: Three giant liposarcoma cases with tumor diameter ≥20 cm, operated on at our clinic between 2021, 2025, were evaluated. The patients' demographic characteristics, tumor location and size, surgical procedures performed, concomitant organ resections, perioperative complications, and pathological findings were analyzed in detail. The primary goal of surgical treatment in all cases was to achieve complete or maximal cytoreductive resection by ensuring the widest possible surgical margins. A multidisciplinary approach was adopted in the surgical planning and implementation process; simultaneous urological and gastrointestinal reconstructions were performed when necessary.

Results: The patients' ages ranged from 26 to 71 years, and all patients were male. The tumors were retroperitoneal and/or intraabdominal, with the largest mass measuring 39 cm in diameter. The basic characteristics of the patients are summarized in Table 1. Colon resection was performed in two cases, small bowel resection in two cases, and ureter reconstruction in two cases (Figure 1). Debulking surgery was performed in one case that had undergone seven previous operations due to multicentric recurrences (Figure 2). Pathological examination revealed high-grade undifferentiated liposarcoma in one case and low-grade myxoid liposarcoma in two cases (Figure 3). In the postoperative period, anastomotic leakage and sepsis developed in one patient, which was successfully controlled with a second surgical intervention. All patients were discharged.

Conclusion: Surgical resection is the primary approach in the treatment of giant liposarcomas; however, due to the tumor's close relationship with adjacent organs, multiple organ resections are often necessary in most cases. Therefore, a multidisciplinary approach is essential in the surgical planning and implementation process. Multidisciplinary management is critical for optimizing surgical outcomes and effectively managing perioperative complications. Furthermore, due to the high risk of local recurrence, long-term and close oncological follow-up is mandatory in these patients and may require sequential surgical interventions.

Keywords: Giant retroperitoneal liposarcoma, multivisceral resection, surgical management, soft tissue sarcoma, short-term outcomes

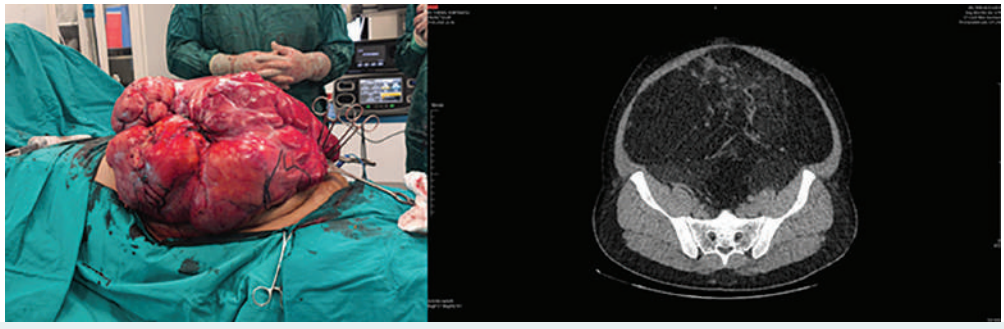

Figure 1. Case 1 magnetic resonance imaging and surgical specimen photos.

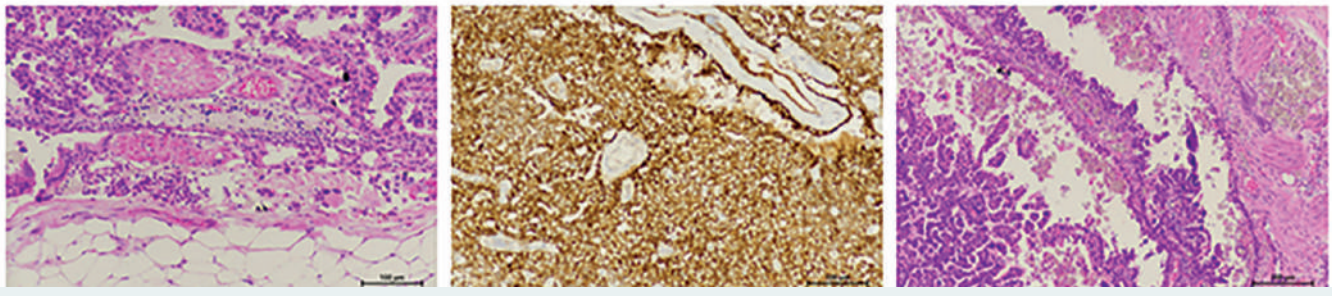

Figure 2. Pathology specimens.

Table 1. Patient characteristics			
Variable	**Case 1**	**Case 2**	**Case 3**
Age/gender	**30/male**	**71/male**	**26/female**
Histopathology	Undifferentiated liposarcoma (G2)	Undifferentiated liposarcoma (high grade)	Low-grade myxoid liposarcoma
Tumor size (cm)	39×29	30×25	Largest 23×22 multiple
Associated resections	Ureteroureterostomy, appendectomy	Hemicolectomy, ureter repair	Hemicolectomy + jejunum excision
Surgical margins	R0	R0	Debulking
Adjuvant therapy	None	None	Yes
Clinical outcome	Alive, disease-free	Exitus (MI, 9th month)	Stable under treatment

[P-028]

Demographic and clinical analysis of cases tested for *BRCA1* and BRCA2 in breast cancer screening and treatment in the Şanlıurfa Region

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Objective: This study aims to evaluate the relationship between demographic characteristics, genetic test results, and breast cancer molecular subtypes in individuals who underwent *BRCA1* and *BRCA2* gene testing due to a diagnosis of breast cancer or a family history in the Şanlıurfa region.

Material and Methods: A total of 266 individuals who underwent *BRCA1* and *BRCA2* gene testing at the Harran University Faculty of Medicine, Department of Medical Genetics between 2022 and 2025 were retrospectively analyzed. The cases were classified into those diagnosed with breast cancer and those with a family history. *BRCA1* and *BRCA2* positivity, variant of uncertain significance (VUS) status, mean ages, and breast cancer molecular subtypes were analyzed.

Results: Of the 266 cases included in the study, 110 (41.4%) were diagnosed with breast cancer, and 156 (58.6%) were individuals tested due to family history. Pathogenic variants were detected in *BRCA1* in eight cases and in *BRCA2* in twelve cases. Among the *BRCA1*-positive cases, four were breast cancer patients, and all were of the triple-negative subtype. Of the five *BRCA2*-positive breast cancer cases, one was triple-negative, two were Luminal A, and two were Luminal B. The mean age was found to be 38 years for *BRCA1*-positive cases and 40 years for *BRCA2*-positive cases. A *BRCA1* VUS was detected in one case (45 years old, Luminal B subtype). *BRCA2* VUS was detected in six cases, three of whom had breast cancer; the mean age was 44 years. Of the *BRCA2* VUS-positive breast cancer cases, two were triple-negative, and one was Luminal B.

Conclusion: The strong association between *BRCA1* mutations and triple-negative breast cancer in the Şanlıurfa region is noteworthy. Conversely, *BRCA2* mutations are associated with more heterogeneous molecular subtypes. The expansion of regional genetic screening programs and long-term clinical follow-up of BRCA VUS cases are of great importance.

Keywords: Breast cancer, *BRCA1*, *BRCA2*, genetic screening

[P-029]

Cholecystoenteric fistulas: A two-center retrospective analysis

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Objective: Cholecystoenteric fistulas are rare clinical entities that usually develop secondary to chronic gallbladder diseases and are often difficult to diagnose. This study aimed to evaluate the clinical characteristics and surgical outcomes of patients treated for cholecystoenteric fistulas in two centers.

Material and Methods: Patients treated for cholecystoenteric fistulas between 2012 and 2025 at Göztepe Prof. Dr. Süleyman Yalçın City Hospital, İstanbul Medeniyet University, and Ümraniye Training and Research Hospital, University of Health Sciences Türkiye, were retrospectively analyzed. A total of 47 patients were included in the study. Demographic characteristics, fistula types, diagnostic modalities, surgical approaches, operative time, and postoperative outcomes were evaluated.

Results: There were 25 males and 22 females. The mean age was 63 years (range: 27-91). Cholecystoduodenal fistula was detected in 25 patients, 7 of whom had concomitant gallstone ileus. Cholecystogastric fistula was present in 8 patients, cholecystocolonic in 9, cholecystocoloduodenal in 3, cholecystogastroduodenal in 1, and cholecystocutaneous fistula in 1 patient. In the preoperative evaluation, ultrasonography was performed in 26 patients, computed tomography in 9, and magnetic resonance imaging in 6, while 7 patients underwent more than one imaging modality. Preoperative suspicion of a fistula was reported in only 5 patients, whereas the diagnosis was established intraoperatively in the remaining cases. Regarding the surgical approach, open surgery was performed in 10 patients and laparoscopic surgery in 8 patients, while conversion from laparoscopy to open surgery was required in 29 patients. The mean operative time was 140 minutes. Early postoperative complications occurred in five patients; bile leakage was observed in two patients and duodenal leakage in one patient. Three patients died in the postoperative period due to comorbidities.

Conclusion: Cholecystoenteric fistulas are rare clinical conditions that are difficult to diagnose and are frequently identified intraoperatively. Although a laparoscopic approach is feasible, conversion rates remain high. Appropriate surgical planning and perioperative management by an experienced and multidisciplinary team are crucial in the management of these patients.

Keywords: Cholecystoduodenal fistula, cholecystoenteric fistula, chronic cholecystitis

[P-030]

A rare surgical emergency: Diagnosis, surgical strategy, and clinical outcomes in cecal volvulus

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Objective: Although rare among colonic volvuluses, cecal volvulus is a surgical emergency that can lead to severe clinical consequences, including intestinal ischemia, perforation, and sepsis, if diagnosis is delayed. This study aims to evaluate the clinical characteristics, surgical management, and postoperative outcomes of cecal volvulus cases treated at the University of Health Sciences Türkiye, Ankara Etlik City Hospital, Department of General Surgery, and to discuss these findings in light of the current literature.

Material and Methods: In this retrospective observational study, four patients who presented to the emergency department between October 2022 and October 2025 and were intraoperatively diagnosed with cecal volvulus were evaluated. All patients underwent surgical treatment. Demographic characteristics, presenting symptoms, laboratory and imaging findings, intraoperative surgical approaches, and postoperative clinical outcomes were analyzed retrospectively. Continuous variables were presented as mean ± standard deviation and median (IQR), while categorical variables were expressed as frequencies and percentages.

Results: The mean age of the patients was 48.0±27.7 years, and 50% were female (Table 1). All patients presented via the emergency department, with a median interval of 2.5 days from admission to surgery. Computed tomography (CT) provided an accurate preoperative diagnosis in all cases (Table 2). Intraoperative evaluation revealed 360 °C cecal rotation in all patients; ischemic bowel was present in 75%, necrosis in 50%, and perforation in 25%. All patients underwent bowel resection: 75% received a right hemicolectomy and 25% an ileocolic resection. A stoma was created in half of the patients (Table 3). The postoperative complication rate was 50%, with a Clavien-Dindo Grade III complication rate of 25%. No 30-day or 90-day mortality occurred (Table 4).

Conclusion: This study demonstrates that despite its rarity, cecal volvulus is a surgical emergency with high rates of intestinal ischemia, necrosis, and resection requirements, offering low tolerance for delay. Consistent with the literature, CT provided high diagnostic accuracy, significantly facilitating the surgical decision-making process. The absence of 30-day and 90-day mortality in our series highlights the decisive role of timely intervention. In the presence of ischemic or necrotic bowel, a resection-based surgical strategy stands out as a safe and effective option with acceptable morbidity. Consequently, early diagnosis, prompt surgical decision, and an appropriate resection strategy based on intraoperative findings are the fundamental elements determining patient prognosis.

Keywords: Bowel ischemia, cecal volvulus, colonic volvulus, emergency surgery, right hemicolectomy

Tablo 1. Hastaların bazal demografik ve klinik özellikleri (n=4)

PARAMETRE	DEĞER
Cinsiyet (Erkek / Kadın)	2 (%50) / 2 (%50)
Yaş (yıl)	48.0 ± 27.7; 43.5 (28.0–63.5); 22–83
Vücut kitle indeksi (kg/m²)	22.3 ± 7.5; 21.1 (17.4–26.1); 14.8–32.0
Hipertansiyon	1 (%25)
Diyabet	0 (%0)
Kalp yetmezliği	0 (%0)
KOAH	0 (%0)
Malignite öyküsü	0 (%0)
Mental retardasyon	0 (%0)
Önceki karın cerrahisi	1 (%25)
Antikoagülan kullanımı	0 (%0)
Steroid kullanımı	0 (%0)

Tablo 2. Başvuru ve preoperatif bulgular (n=4)

PARAMETRE	DEĞER
Başvuru süresi (gün)	2.8 ± 2.2; 2.5 (1.8–3.5); 1–6
Başvuru şekli (Acil / Sevk)	4 (%100) / 0
Karın ağrısı	4 (%100)
Kusma	3 (%75)
Gaz–gaita çıkışı olmaması	3 (%75)
Abdominal distansiyon	4 (%100)
Nabız (/dk)	96 ± 18; 92 (84–110); 78–124
Hemodinamik durum	Stabil: 2 (%50); Pre-şok: 1 (%25); Şok: 1 (%25)
Lökosit (×10³/L)	13.2 ± 4.6; 12.4 (10.8–15.7); 8.9–19.1
CRP (mg/L)	78 ± 61; 55 (32–120); 18–162
Laktat (mmol/L)	2.6 ± 1.4; 2.2 (1.7–3.1); 1.4–4.8
Kreatinin (mg/dL)	1.1 ± 0.4; 1.0 (0.9–1.3); 0.7–1.8
BT çekilme	4 (%100)
BT tanısal doğruluk	4 (%100)
BT'de serbest sıvı	2 (%50)
BT iskemi bulgu skoru (0–4)	2.3 ± 1.0; 2.0 (1.5–3.0); 1–4

Tablo 3. Intraoperatif bulgular ve cerrahi özellikler (n=4)

PARAMETRE	DEĞER
Cerrahi giriş yolu	Açık: 3 (%75); Laparoskopi→dönüş: 1 (%25)
Çekum rotasyon derecesi	360°: 4 (%100)
İskemik bağırsak	3 (%75)
Nekroz	2 (%50)
Gangren uzunluğu (cm)	18 ± 9; 16 (12–24); 8–32
İntraoperatif serbest sıvı	3 (%75)
Perforasyon	1 (%25)
Operasyon süresi (dk)	132 ± 28; 125 (115–150); 105–170
Detorsiyon uygulanması	4 (%100)
Çekopeksi / fiksasyon	1 (%25)
Rezeksiyon	4 (%100)
Rezeksiyon tipi	Sağ hemikolektomi: 3 (%75); İleokolik: 1 (%25)
Anastomoz tipi	Stapler: 3 (%75); El ile: 1 (%25)
Stoma açılması	2 (%50)

Tablo 4. Postoperatif sonuçlar (n=4)

PARAMETRE	DEĞER
Yoğun bakım ihtiyacı	2 (%50)
Yoğun bakım süresi (gün)	2.5 ± 1.3; 2 (2–3); 1–4
Vazopressör ihtiyacı	1 (%25)
İlk gaz çıkışı (gün)	3.0 ± 1.2; 3 (2–4); 2–5
İlk gaita çıkışı (gün)	4.3 ± 1.7; 4 (3–5); 2–7
Oral alım başlama (gün)	4.5 ± 1.9; 4 (3–6); 2–8
Postop komplikasyon	2 (%50)
Clavien–Dindo ≥ III	1 (%25)
Anastomoz kaçağı	0 (%0)
Cerrahi alan enfeksiyonu	1 (%25)
Postop ileus	1 (%25)
Reoperasyon	1 (%25)
Hastanede yatış süresi (gün)	9.8 ± 4.1; 9 (7–12); 5–16
30-gün mortalite	0 (%0)
90-gün mortalite	0 (%0)
Rekürrens	0 (%0)
Stoma kapama	1/2 (%50)

[P-031]

Urachal cyst: A single-center retrospective clinical and surgical experience

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Objective: Urachal cyst is a rare congenital anomaly that may become symptomatic in adulthood or be detected incidentally. This study aimed to evaluate the clinical, surgical, and pathological characteristics and postoperative outcomes of patients who underwent surgery for urachal cyst at the Clinic of General Surgery, University of Health Sciences Türkiye, Ankara Etlik City Hospital between October 2022 and August 2025.

Material and Methods: Twenty-two patients who underwent excision for urachal cyst were retrospectively analyzed. Demographic data, symptoms, surgical approach, performance of umbilectomy, histopathological findings, and postoperative complications were evaluated according to the Clavien-Dindo classification. Descriptive statistics were presented as frequency, percentage, mean ± standard deviation, and median (min-max).

Results: The mean age of the patients was 63.4±14.0 years, and 77.3% were male. The most common presenting symptom was pain (68.2%), followed by hematuria (18.2%) and discharge (9.1%). All patients underwent open surgery, and umbilectomy was performed in 13.6% of cases. Histopathological examination revealed benign pathology in 95.5% and malignancy in 4.5% of patients. Lesions were non-infected in 90.9% and infected in 9.1% of cases. In the postoperative period, Clavien-Dindo Grade I complications were observed in 77.3% of patients, while Grade II (4.5%), Grade III (4.5%), and Grade IV (13.6%) complications were rare. No recurrence was detected. The mean length of hospital stay was 17.5±21.3 days, with a median of 14 (3-100) days.

Conclusion: The detection of malignancy in only one patient (4.5%) among 22 cases suggests that malignant transformation, although rare, should be considered in urachal cysts. Therefore, surgical excision of urachal cysts is important for both diagnostic and therapeutic purposes. The absence of recurrence and the predominance of minor complications (Clavien-Dindo Grade I, 77.3%) support the safety of surgical intervention. Despite being a single-center study with a limited sample size, satisfactory outcomes with low complication rates highlight the effectiveness and reliability of urachal cyst surgery and emphasize the indispensable role of histopathological evaluation in clinical management.

Keywords: Congenital anomalies, postoperative complications, umbilectomy, urachal cyst

Table 1. Demographic characteristics, clinical and surgical characteristics, and postoperative outcomes

Characteristic	Value
Number of patients	22
Age (mean ± SD)	63.4 ± 14.0
Age (median, min–max)	66 (18–79)
Sex	Male: 17 (77.3%), Female: 5 (22.7%)

Characteristic	n (%)
Symptoms	
– Pain	15 (68.2)
– Hematuria	4 (18.2)
– Discharge	2 (9.1)
– Pain + Discharge	1 (4.5)
Surgical approach	
Open	22 (100)
Umbilectomy	
Performed	3 (13.6)
Not performed	19 (86.4)
Pathology	
Malignant	1 (4.5)
Benign	21 (95.5)
Cyst status	
Infected	2 (9.1)
Non-infected	20 (90.9)

Characteristic	n (%)
Complications (Clavien–Dindo)	
– Grade I	17 (77.3)
– Grade II	1 (4.5)
– Grade III	1 (4.5)
– Grade IV	3 (13.6)
Recurrence	Not observed (0/22)
Length of hospital stay	Mean: 17.5 ± 21.3 days; Median: 14 (3–100) days

Table 2. Comparison of surgical experiences in urachal cyst and urachal pathologies

Author (Year)	Center	Sample Size (n)	Mean Age	Surgical Approach	Malignancy (%)	Umbilectomy	Recurrence	Key Findings
Ashley et al. (2006)	Multicenter	130	58	Open + Laparoscopic	51	Selected	Present	Aggressive surgery and umbilical resection recommended in urachal malignancies
Siefker-Radtke et al. (2012)	Single center	42	61	Open	100*	Routine	Present	Impact of wide resection on survival in malignant urachal tumors
Molina et al. (2015)	Single center	29	54	Predominantly laparoscopic	7	Selected	None	Minimally invasive surgery safe in benign cases
Yu et al. (2018)	Multicenter	67	56	Open / Laparoscopic	9	Selected	Low	Surgical excision recommended in symptomatic urachal cysts
Blichert-Toft & Nielsen (2019)	Review	–	–	–	1–10	–	–	Malignant transformation rare but possible
Qureshi et al. (2021)	Single center	24	59	Laparoscopic	4	No	None	Laparoscopic excision feasible with low morbidity
Kim et al. (2023)	Multicenter	81	60	Open + Laparoscopic	6	Selected	Very low	Histopathology decisive in clinical management
Our study (2025)	Single center	22	63.4	Open	4.5	13.6%	None	Low complication rate, no recurrence, histopathology critical

[P-032]

Prognostic role of histopathological features on survival in gallbladder cancer: A single-center retrospective study

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Objective: Gallbladder cancer (GBC) is a rare gastrointestinal malignancy characterized by aggressive behavior, frequent diagnosis at advanced stages, and poor prognosis. Although surgical resection is the only potentially curative treatment, survival outcomes vary considerably depending on histopathological features. However, reliable prognostic histopathological parameters remain limited. This study aimed to evaluate the prognostic impact of histopathological features on survival in patients undergoing surgery for gallbladder tumors.

Material and Methods: Patients who underwent cholecystectomy for gallbladder lesions between 2021 and 2025 were retrospectively analyzed. Cases with biliary intraepithelial neoplasia (BilIN) and non-epithelial tumors were excluded. In patients with invasive GBC, histological type, tumor stage (pT), lymph node status (pN), surgical margin status, lymphovascular invasion (LVI), and perineural invasion (PNI) were recorded. Overall survival (OS) was defined as the time from the start of postoperative follow-up to death or last follow-up. Survival was analyzed using the Kaplan-Meier method and compared using the log-rank test. Due to the small sample size, Cox regression analyses were considered exploratory.

Results: A total of 12 patients were evaluated; 9 with invasive GBC were included in the survival analysis. Histologically, 66.7% were adenocarcinoma, 22.2% adenosquamous carcinoma, and 11.1% carcinosarcoma. Tumors were classified as pT3 in 66.7% of patients. Lymph node metastasis was detected in 33.3%, and positive surgical margins (R1) in 55.6%. Lymphovascular invasion was present in 44.4% and perineural invasion in 66.7% of patients. Among 8 patients with available OS data, 5 deaths occurred during follow-up, and the median OS was 257 days (approximately 8.5 months). Although shorter survival was observed in patients with advanced stage (pT3), positive margins, lymph node metastasis, and PNI, these associations were not statistically significant ($p>0.05$).

Conclusion: This single-center retrospective study suggests that adverse histopathological features, including advanced tumor stage, positive surgical margins, lymph node involvement, and perineural invasion, may be associated with poorer survival in GBC. Although statistical significance was not achieved, the findings are clinically relevant and consistent with the literature. Further multicenter studies with larger cohorts are needed to confirm these results.

Keywords: Gallbladder, gallbladder cancer

[P-041]

Complex hepatic resection for alveolar echinococcosis: A single-center experience with vascular reconstruction in 14 patients

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Objective: Alveolar echinococcosis (AE) is a rare zoonosis caused by the larval form of Echinococcus multilocularis, but it has a high mortality rate if left untreated. This study evaluated the epidemiological characteristics, radiological findings, surgical approaches, and early outcomes of hepatic AE cases operated on at our center.

Material and Methods: This retrospective, single-center cohort study included patients over 18 years of age who underwent elective liver resection for hepatic AE at Acıbadem Ankara Hospital between 2019 and 2024. Patients who received only medical treatment were excluded. All cases were evaluated in a multidisciplinary council, and preoperative staging was performed according to the WHO-IWGE PNM classification. Surgical margins, need for vascular and biliary reconstruction, complications (Clavien-Dindo), and length of hospital stay were analyzed.

Results: A total of 14 patients were included in the study. The mean age was 32.8±9.1 years, and the mean BMI was 25.2±4.5 kg/m²; 42.8% of the patients were female. All cases were referred from Kyrgyzstan, and 50% had recurrent disease. The mean tumor diameter was 11.1±3.3 cm. Local invasion of adjacent organs was detected in 35.7%, and major vascular invasion in 71%. One patient (7.1%) had pulmonary metastasis. Segmentectomy (50%) was the most frequently performed procedure among resection types. Vascular reconstruction was frequently necessary; there were cases where inferior vena cava and/or portal vein repair was performed. Biliary reconstruction was performed in 35.7% of cases. The mean hospital stay was 7.5 days (5-15). Three patients (21%) developed early major complications. Histopathologically, AE was confirmed in all cases; R1 resection was present in 92.8%. All patients received postoperative albendazole treatment.

Conclusion: Complete resection is the only curative treatment option for hepatic AE when possible; however, advanced stage and vascular invasion are common. Multidisciplinary evaluation and aggressive surgical approach with major vascular/biliary reconstruction when necessary can be safely applied. Long-term postoperative albendazole treatment plays a critical role in disease control, especially in the presence of positive surgical margins. Early diagnosis and appropriate surgical planning in young patient populations from endemic regions can improve long-term survival.

Keywords: Alveolar echinococcosis, hepatectomy, vascular reconstruction

[P-042]

Safety, efficacy, and outcomes of percutaneous endoscopic gastrostomy (PEG) performed under local anesthesia in ASA III-IV patients

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Objective: Percutaneous endoscopic gastrostomy (PEG) is an effective method for providing long-term enteral nutritional support in patients who are unable to receive adequate and safe oral nutrition. However, due to advanced age, high ASA scores, and accompanying comorbidities, the use of sedation may pose significant risks in this patient population. The aim of this study was to evaluate the safety, efficacy, and complication rates of PEG performed under local anesthesia in ASA III-IV patients and to identify potential risk factors associated with the procedure.

Material and Methods: In our clinic, 196 patients in ASA III-IV risk group who underwent PEG after indication was determined between 2024 and 2025 were retrospectively analyzed. Thirty eight patients who could not tolerate topical pharyngeal anesthesia and required sedation during the procedure were excluded from the study, leaving 158 patients for analysis. In all cases, upper gastrointestinal endoscopy was performed under topical pharyngeal anesthesia. After identifying the appropriate entry site, local infiltrative anesthesia with lidocaine and adrenaline was administered to the anterior abdominal wall, and the PEG catheter was placed using the standard pull technique. Demographic characteristics, body mass index (BMI), procedure duration, hospitalization unit, comorbidities, and early and late complications were recorded. Factors associated with complications were analyzed using univariate and multivariate statistical methods.

Results: The mean age of the patients was 81.6±9.7 years, and the mean BMI was 24.7±3.6 kg/m². The average procedure duration was 15.4±3.6 minutes. Of the patients, 29.7% were hospitalized in the intensive care unit, while 70.3% were followed in palliative care units. Early complications occurred in 7.0%, late complications in 13.3%, and the overall complication rate was 19.6%. No statistically significant association was found between complication development and age, hospitalization unit, comorbidities, or procedure duration ($p>0.05$). While the presence of a tracheostomy did not affect complication rates, procedure duration was significantly longer in patients with tracheostomy (19.0±2.4 minutes). No significant correlation was observed between BMI and procedure duration. Furthermore, triple analyses did not identify any independent predictors of complication development.

Conclusion: Performed under local anesthesia, the PEG procedure is a safe and feasible procedure with procedure times similar to those reported in the literature and acceptable complication rates. In patient populations at high risk for sedation, a local anesthesia-based PEG approach represents an effective and strong alternative in clinical practice.

Keywords: PEG, local anesthesia, ASA 3-4

[P-043]

Deep learning-based detection of perianal fistula on pelvic MRI using a transfer learning approach

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Objective: Accurate detection of perianal fistula on pelvic MRI is critical for surgical planning and recurrence prevention. Deep learning-based image analysis may provide objective support for radiologic assessment; however, capturing complex or subtle fistulous tracts using only two-dimensional (2D) images remains a significant challenge.

Material and Methods: In this retrospective study, pelvic MRI images from patients with suspected perianal fistula were labeled according to expert radiologic evaluation. The dataset was divided into training (n=312), validation (n=39), and independent test (n=39) sets. Individual MRI slices were classified using a transfer learning approach based on a pretrained ResNet18 architecture. Model performance on the independent test set was evaluated using accuracy, sensitivity (recall for fistula), specificity, area under the receiver operating characteristic curve (AUC-ROC), precision, and F1-score. The confusion matrix for the test set is presented in Figure 1.

Results: On the independent test set (n=39), the model achieved an overall accuracy of 64.1% and an AUC-ROC of 0.772. Sensitivity for fistula detection was 54% (14/26), and specificity was 85% (11/13). Precision was 0.88 and the F1-score was 0.67. The model demonstrated higher specificity than sensitivity, indicating better performance in ruling out fistula absence (Figure 1). Training and validation loss and accuracy curves showed stable convergence without evident overfitting (Figure 2). The relatively low sensitivity may reflect limitations inherent to slice-based 2D analysis; in some cases, fistulous tracts were not clearly visualized on individual slices due to their tortuous course and plane dependency. An example of a perianal fistula MRI image (left: original; right: annotated) is shown in Figure 3.

Conclusion: The transfer learning-based CNN demonstrated moderate diagnostic performance in detecting perianal fistula on 2D pelvic MRI slices, with particularly strong specificity and acceptable discriminative ability (AUC-ROC). This approach may serve as an adjunct tool for radiologic assessment, particularly in excluding fistula presence. However, limited sensitivity highlights the constraints of single-slice classification in fully representing complex fistula anatomy. Future improvements may include multi-slice or 3D volumetric analysis, incorporation of additional MRI sequences, and more advanced architectures. Larger, multicenter validation studies are warranted.

Keywords: Perianal fistula, deep learning, artificial intelligence in surgery

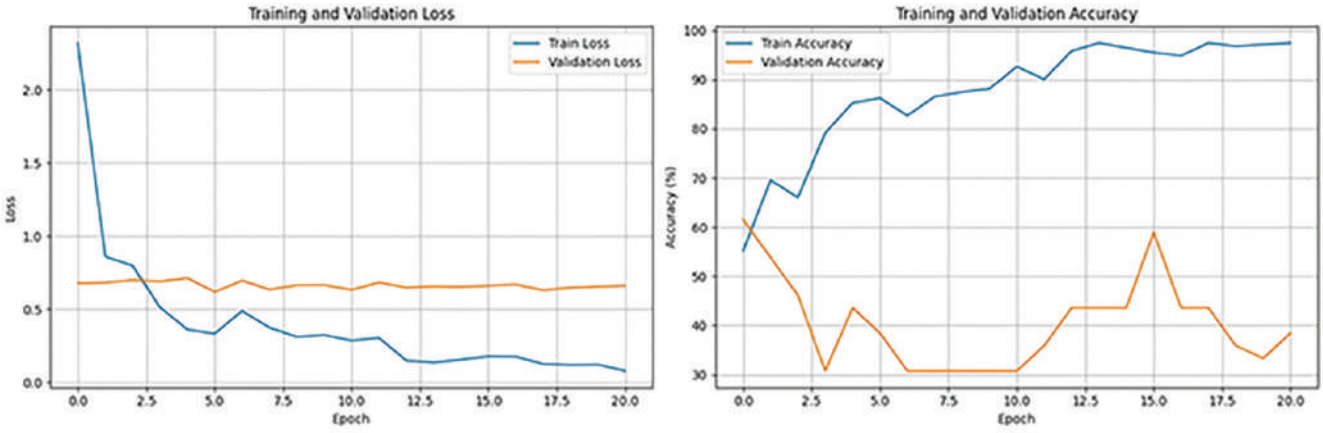

Figure 1. Training and validation accuracy.

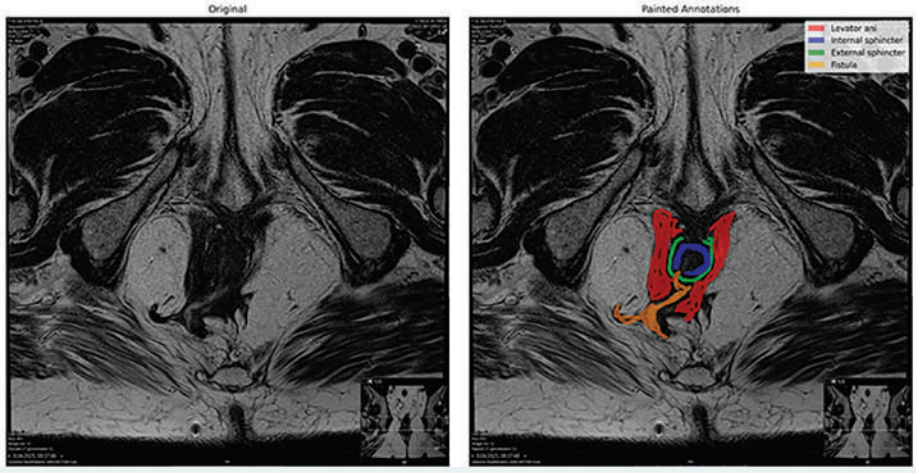

Figure 2. Training and validation accuracy sample patient.

[P-044]

A rare cause of mechanical ileus: Small intestine epithelioid mesothelioma

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Objective: Mesothelioma is a rare and aggressive malignancy that primarily affects the pleura and peritoneum. Peritoneal mesothelioma usually presents with diffuse involvement. Focal involvement of the small bowel is extremely rare and may present with mechanical ileus. Rare malignancies should be considered in the differential diagnosis of mechanical ileus cases developing in patients without a history of abdominal surgery. This case presents a mechanical ileus due to an epithelioid-type mesothelioma located in the ileum.

Material and Methods: The clinical, imaging, endoscopic, and surgical findings, as well as the histopathological result, of a 67-year-old male patient with intermittent cramping abdominal pain, abdominal distension, vomiting, and constipation for approximately two months were retrospectively evaluated.

Results: The patient had no history of abdominal surgery. Physical examination revealed abdominal distension and widespread tenderness. Rebound tenderness and abdominal guarding were not observed. Laboratory values were within normal limits. Contrast-enhanced abdominal computed tomography (CT) showed a mass consistent with asymmetric wall thickening at the ileal level. Significant small bowel dilatation was observed proximally. Enteroscopy revealed a semianular stricture in the distal ileum that significantly narrowed the lumen, which was marked with a hemoclip. Surgical exploration for mechanical ileus revealed a methylene blue-marked ileal mass and proximal dilatation. Two implants were also identified adjacent to the mass. Segmental small bowel resection and primary anastomosis were performed to include the mass and implants. Histopathological examination showed that the mass and implants were consistent with epithelioid-type mesothelioma. Intestinal function improved on the third postoperative day, and the patient was discharged without complications on the sixth day.

Conclusion: Small bowel epithelioid mesothelioma is an extremely rare malignancy that can present with mechanical ileus. Rare malignancies should be considered in the differential diagnosis of patients presenting with unexplained mechanical ileus findings and no history of surgery. Surgical resection is the primary diagnostic and therapeutic approach in these cases.

Keywords: Small intestine, mechanical ileus, peritoneal mesothelioma, epithelioid type, ileal mass

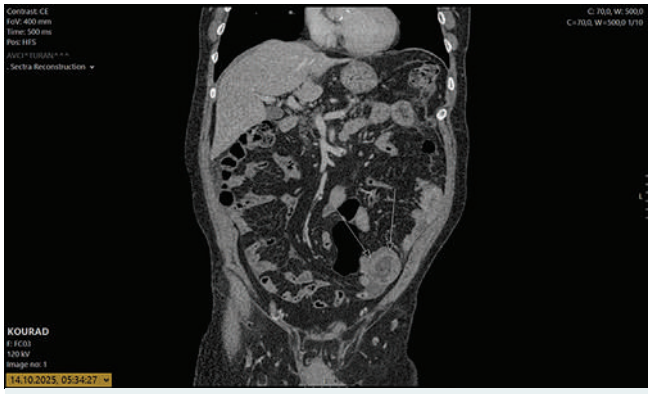

Figure 1. Preoperative contrast-enhanced abdominal CT scan findings 1a. Coronal section; air-fluid levels in small bowel loops proximal to the lesion, increased mucosal thickness and marked dilation 1a.

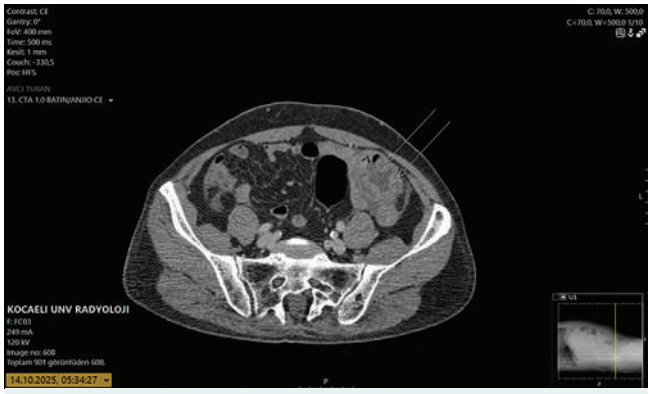

Figure 2. Preoperative contrast-enhanced abdominal CT scan findings 2a. Axial section; asymmetric wall thickness increase in small intestine segment 2a.

Figure 3. Preoperative contrast-enhanced abdominal CT scan findings 3a. Axial section; multiple clips were observed in the ileal loops, and thickening of the small bowel walls was observed at this level 3a.

Figure 4. Intraoperative Findings 4a. Ileal mass labeled with methylene blue 4a.

Figure 5. Intraoperative Findings 5a. Ileal mass labeled with methylene blue, proximal dilation 5a.

[P-045]

Carcinoid tumors detected after appendectomy: A single-center experience of 11 cases

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Objective: Although incidental detection of carcinoid tumors after emergency appendectomy performed for acute appendicitis is rare, it is of critical importance in determining the appropriate post-pathological treatment strategy. This study aimed to comprehensively evaluate the clinical, surgical, and histopathological characteristics of patients diagnosed with carcinoid tumors following appendectomy at our institution.

Material and Methods: Patients who underwent surgery with a preliminary diagnosis of acute appendicitis at University of Health Sciences Türkiye, Ankara Etlik City Hospital General Surgery Department between October 2022 and October 2025 and were diagnosed with carcinoid tumors on histopathological examination were retrospectively analyzed. Demographic characteristics, presenting symptoms, surgical technique, tumor localization and size, histological grade, Ki-67 proliferation index, presence of lymphovascular and perineural invasion, and surgical margin status were evaluated.

Results: A total of 11 patients (3 males, 8 females) were included in the study (Table 1). The mean age was 30.5±12.4 years, with a median age of 25 years. The most common presenting symptom was right lower quadrant tenderness (Table 2). Laparoscopic appendectomy was performed in 9 patients (82%), while open appendectomy was performed in 2 patients (18%). Tumor size was ≤1 cm in 2 patients, 1-2 cm in 5 patients, and ≥2 cm in 4 patients (Table 3). Most tumors were located distally. The Ki-67 proliferation index was below 5% in 91% of cases. No lymphovascular or perineural invasion was detected. Surgical margins were negative in all patients, and no additional resection was required.

Conclusion: Incidental carcinoid tumors detected after appendectomy for acute appendicitis are more commonly observed in young female patients and small-sized lesions. Low proliferative activity and absence of invasive features eliminate the need for additional surgical intervention in most cases. These findings are consistent with current guidelines and large case series reporting that the majority of appendiceal neuroendocrine tumors are low-grade and low-proliferative, and appendectomy alone is usually sufficient in patients without risk factors (Table 4). Our results emphasize the indispensable role of routine histopathological evaluation of appendectomy specimens in diagnosis and treatment planning.

Keywords: Carcinoid tumor, histopathology, incidental tumor, Ki-67 proliferation index, neuroendocrine tumor

Tablo 1. Akut apandisit nedeniyle opere edilen ve patolojide karsinoid tümör saptanan 11 olgunun özet klinik ve histopatolojik özellikleri

Değişken	Bulgular
Toplam hasta sayısı	11
Yaş (ortalama ± SS, medyan)	30,5 ± 12,4 (medyan: 25)
Cinsiyet	3 erkek (%27), 8 kadın (%73)
Cerrahi teknik	Laparoskopik apendektomi: 9 (%82), Açık apendektomi: 2 (%18)
Tümör boyutu	≤1 cm: 2 hasta (%18), 1–2 cm: 5 hasta (%45), ≥2 cm: 4 hasta (%36)
Tümör yerleşimi	En sık distal yerleşim (proksimal yerleşim yok)
Ki-67 proliferasyon indeksi	%5'in altında: 10 hasta (%91), yüksek: 1 hasta (%9)
Lenfovasküler invazyon	Izlenmedi
Cerrahi sınır durumu	Tüm olgularda intakt
Ek rezeksiyon gereksinimi	Gerekmemiş

Table 1. Summary of Clinical and Histopathological Characteristics of 11 Patients

Variable	Findings
Total number of patients	11
Age (mean ± SD, median)	30.5 ± 12.4 (median: 25)
Sex	3 male (27%), 8 female (73%)
Surgical technique	Laparoscopic appendectomy: 9 (82%), Open appendectomy: 2 (18%)
Tumor size	≤1 cm: 2 (18%), 1–2 cm: 5 (45%), ≥2 cm: 4 (36%)
Tumor localization	Predominantly distal (no proximal localization)
Ki-67 proliferation index	<5%: 10 patients (91%), High: 1 patient (9%)
Lymphovascular invasion	Not detected
Surgical margin status	Negative in all cases
Additional resection requirement	Not required

Tablo 2. Akut apandisit nedeniyle opere edilen ve patolojide karsinoid tümör saptanan olguların demografik ve klinik özellikleri

Değişken	Bulgular
Toplam hasta sayısı	11
Yaş grubu ≤18	3 hasta
Yaş grubu 19–40	6 hasta
Yaş grubu 41–60	0 hasta
Yaş grubu ≥61	2 hasta
Cinsiyet – Erkek	3 hasta (%27)
Cinsiyet – Kadın	8 hasta (%73)
Başvuru semptomu: Sağ alt kadran hassasiyeti	11 hasta (%100)
Başvuru semptomu: Bulantı / Kusma	9 hasta (%82)
Preoperatif karsinoid şüphesi – Var	0 hasta
Preoperatif karsinoid şüphesi – Yok	11 hasta

Table 2. Demographic and clinical characteristics of patients operated on for acute appendicitis in whom a carcinoid tumor was detected on histopathological examination

Variable	Findings
Total number of patients	11
Age group ≤18 years	3 patients
Age group 19–40 years	6 patients
Age group 41–60 years	0 patients
Age group ≥61 years	2 patients
Male	3 patients (27%)
Female	8 patients (73%)
Presenting symptom: Right lower quadrant tenderness	11 patients (100%)
Presenting symptom: Nausea / Vomiting	9 patients (82%)
Preoperative suspicion of carcinoid – Yes	0 patients
Preoperative suspicion of carcinoid – No	11 patients

Figure 1. Clinical, histopathological and demographic characteristics.

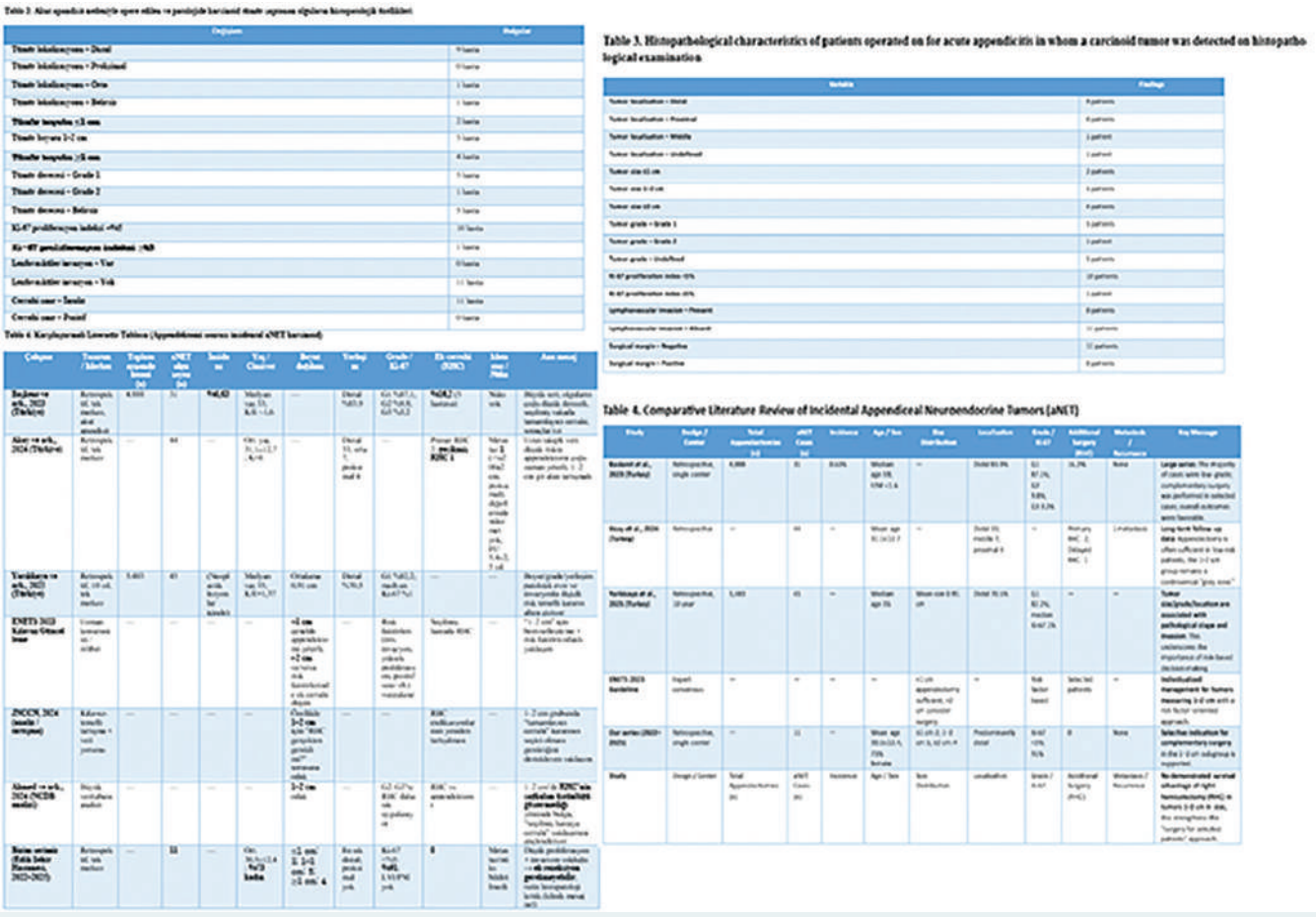

Table 3. Histopathological characteristics of patients operated on for acute appendicitis in whom a carcinoid tumor was detected on histopathological examination

Variable	Findings
Tumor localization – Distal	9 patients
Tumor localization – Proximal	6 patients
Tumor localization – Middle	2 patient
Tumor localization – Undefined	1 patient
Tumor size ≤1 cm	2 patients
Tumor size 1–2 cm	6 patients
Tumor size >2 cm	4 patients
Tumor grade – Grade 1	5 patients
Tumor grade – Grade 2	2 patient
Tumor grade – Undefined	9 patients
Ki-67 proliferation index <3%	10 patients
Ki-67 proliferation index >3%	2 patient
Lymphovascular invasion – Present	8 patients
Lymphovascular invasion – Absent	12 patients
Surgical margin – Negative	12 patients
Surgical margin – Positive	8 patients

Table 4. Comparative Literature Review of Incidental Appendiceal Neuroendocrine Tumors (aNET)

Study	Design / Center	Total Appendectomies (n)	aNET Cases (n)	Incidence	Age / Sex	Size Distribution	Localization	Grade / Ki-67	Additional Surgery (Rate)	Metastasis / Recurrence	Key Message
Bozkurt et al., 2020 (Turkey)	Retrospective, single center	5,000	31	0.62%	Median age 39; F/M ≈1.4	—	Distal 80.9%	G1 87.1%, G2 9.8%, G3 3.2%	16.2%	None	Large series. The majority of cases were low-grade; complete surgery was performed in selected cases; overall outcomes were favorable.
Akay et al., 2024 (Turkey)	Retrospective	—	44	—	Mean age 31.1±12.7	—	Distal 93; middle 5; proximal 6	—	Post-op RHC: 2; Delayed RHC: 1	1 metachronic	Long-term follow-up data: Appendectomy is often sufficient in low-risk patients; the 1–2 cm group remains a controversial "gray zone."
Yurtkuran et al., 2025 (Turkey)	Retrospective, 10-year	5,000	45	—	Median age 39;	Mean size 0.95 cm	Distal 91.1%	G1 82.2%, median Ki-67 2%	—	—	Tumor size/grade/location are associated with pathological stage and invasion. This underscores the importance of risk-based decision-making.
ENETS 2023 Guideline	Expert consensus	—	—	—	—	<1 cm: appendectomy sufficient; >2 cm: consider surgery	—	Risk factor–based	Selected patients	—	Individualized management for tumors measuring 1–2 cm with a risk factor–oriented approach.
Our series (2022–2025)	Retrospective, single center	—	11	—	Mean age 35 (22–51 y), 6/5 (54% female)	Predominantly distal	Distal >70%, 95%	G1	0	None	Selective indication for complementary surgery in the 1–2 cm subgroup is supported.
Study	Design / Center	Total Appendectomies (n)	aNET Cases (n)	Incidence	Age / Sex	Size Distribution	Localization	Grade / Ki-67	Additional Surgery (Rate)	Metastasis / Recurrence	No demonstrated survival advantage of right hemicolectomy (RHC) in tumors 1–2 cm in size, this strengthens the "surgery for selected patients" approach.

Figure 2. Histopathological characteristics and literature comparison.

[P-046]

Sessile serrated adenoma in the etiology of acute appendicitis: Clinical and histopathological analysis of six cases

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Objective: Luminal obstruction is the most common etiological factor in the pathogenesis of acute appendicitis. In rare cases, neoplastic lesions located within the appendiceal lumen may also lead to acute appendicitis. Although sessile serrated adenoma (SSA) is recognized as an important precursor lesion in colorectal carcinogenesis, its association with appendicitis etiology has been reported only rarely. The aim of this study was to present cases of acute appendicitis associated with SSA along with their clinical, laboratory, and histopathological characteristics, and to discuss the potential implications for surgical practice.

Material and Methods: Patients who underwent appendectomy with a preliminary diagnosis of acute appendicitis between October 2022 and October 2025 and were found to have SSA on histopathological examination were retrospectively evaluated. Demographic data, clinical symptoms, laboratory parameters (WBC, CRP), imaging findings, macroscopic examination results, histopathological findings, presence of accompanying inflammation, postoperative colonoscopy findings, mortality, and follow-up data were analyzed.

Results: Six patients (three female and three male) were included. The mean age was 64.8±20.2 years, and the median age was 72.5 years. Presenting symptoms were typical in three cases and atypical in three cases. Imaging findings were consistent with acute appendicitis in five patients, while one patient exhibited atypical imaging features. Laboratory evaluation revealed the pattern “normal WBC - elevated CRP” (n=3); two patients had elevations in both WBC and CRP, whereas one patient had normal values for both parameters. Macroscopically, four cases demonstrated normal specimens, one case showed inflammatory changes, and one case exhibited a thick-walled cystic appearance.Histopathology revealed “SSA with low-grade dysplasia” in three cases and “SSA without dysplasia” in three cases. Accompanying inflammation was present in three patients. Postoperative colonoscopy was performed in all patients, and a polyp/lesion was detected in one patient. During follow-up, no recurrence or lesions were observed. One patient died during follow-up.

Conclusion: SSA represents a rare but significant cause of acute appendicitis. Our findings indicate these cases tend to occur at an older age than appendicitis, frequently present with elevated CRP levels in the presence of normal WBC values, and demonstrate a rate of low-grade dysplasia on histopathology. Furthermore, the detection of lesions on postoperative colonoscopy in one patient suggests that this patient population may carry an increased risk for colorectal neoplasia. These results emphasize, in cases of appendicitis, particularly in the presence of age, atypical clinical presentation, and elevated CRP levels, SSA should be considered, and all such patients should undergo postoperative colonoscopic surveillance following evaluation.

Keywords: Acute appendicitis, colorectal neoplasia, histopathology, luminal obstruction, sessile serrated adenoma

Tablo 1. Demografik Özellikler

Değişken	Değer
Hasta sayısı	6
Yaş (ortalama ± ss)	64,8 ± 20,2
Yaş (medyan [IQR])	72,5 [53,0 – 77,5]
Cinsiyet – Kadın	3
Cinsiyet – Erkek	3

Tablo 2. Klinik Bulgular

Kategori	Alt Grup	Sayı
Semptom tipi	Klasik apandisit	3
	Atipik	3
Görüntüleme	Apandisit ile uyumlu	5
	Atipik bulgular	1
Laboratuvar (WBC/CRP)	WBC normal – CRP yüksek	3
	WBC yüksek – CRP yüksek	2
	Normal	1

Table 1. Demographic Characteristics

Variable	Value
Number of patients	6
Age (mean ± SD)	64.8 ± 20.2
Age (median [IQR])	72.5 [53.0 – 77.5]
Sex – Female	3
Sex – Male	3

Table 2. Clinical Findings

Category	Subgroup	Number
Symptom type	Typical appendicitis	3
	Atypical	3
Imaging	Compatible with appendicitis	5
	Atypical findings	1
Laboratory (WBC/CRP)	Normal WBC – Elevated CRP	3
	Elevated WBC – Elevated CRP	2
	Normal	1

Figure 1. Demographic characteristics and clinical findings.

Tablo 3. Histopatoloji ve Makroskopik Bulgular

Kategori	Alt Grup	Sayı
Histopatoloji	SSA – Düşük dereceli displazili	3
	SSA – Displazisiz	3
Makroskopi	Normal appendix materyali	4
	İnflame appendix materyali	1
	Kalın duvarlı – kistik görünüm	1
Eşlik eden inflamasyon	Var	3
	Yok	3

Tablo 4. Postoperatif Bulgular ve Takip

Kategori	Alt Grup	Sayı
Kolonoskopi sonucu	Ek polip/lezon mevcut	1
	Ek lezyon saptanmadı	5
Mortalite	Yaşıyor	5
	Exitus	1
Takipte nüks/yeni lezyon	Yok	6

Table 3. Histopathological and Macroscopic Findings

Category	Subgroup	Number
Histopathology	SSA – With low-grade dysplasia	3
	SSA – Without dysplasia	3
Macroscopy	Normal appendix specimen	4
	Inflamed appendix specimen	1
	Thick-walled – cystic appearance	1
Accompanying inflammation	Present	3
	Absent	3

Table 4. Postoperative Findings and Follow-Up

Category	Subgroup	Number
Colonoscopy result	Additional polyp/lesion present	1
	No additional lesion detected	5
Mortality	Alive	5
	Deceased	1
Recurrence/new lesion during follow-up	None	6

Figure 2. Histopathological findings and postoperative follow-up.

[P-047]

In the treatment of pilonidal sinus, the distance from the pilonidal line for primary closure and flap techniques: 2 cm rule

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Objective: The basic principle accepted in the treatment of pilonidal sinus is to shift the line of gravity from the midline to the lateral side by performing asymmetric excision and primary closure or by applying a flap technique. However, primary closure is not possible in cases where the sinus pathways reach distant points. In this study, we wanted to present the techniques we applied in two different patient groups according to whether the sinus was located 2 cm below or above the midline.

Material and Methods: From January 2019 to December 2023, 104 patients with pilonidal sinus disease were operated on according to the distance of the sinus from the interglutealmedian line. We wanted to prospectively present the experiences of two general surgeons from a single center. In cases where pilonidal sinus openings were less than 2 cm from the intergluteal line, we applied the asymmetric excision and primary closure technique (group 1), and in cases where the sinuses were at least 2 cm away from the midline, we applied the flap technique (group 2). The demographic characteristics of the patients, postoperative course and recurrence rates were recorded. The average follow-up period was 24 months.

Results: In group I (N:67, 40M/27F), the mean age was 21 (range 18-35), and in group II (N:37, 30M/17F), it was 27 (range 18-51). There was no significant difference in terms of postoperative infection (5% vs. 3%), wound dehiscence (3% vs. 2%), and recurrence rate (2% vs. 1%). Hospital stay was longer in group 2.

Conclusion: The key point in pilonidal cyst treatment is to reposition the intergluteal line of gravity in a way that prevents recurrence.In cases where primary closure is difficult, and in pilonidal openings exceeding 2 cm from the midline, the flap technique, which prevents possible tension, wound dehiscence, and recurrence, can be reliably applied.

Keyword: New techniques in pilonidal sinus surgery

[P-048]

Our results of open lateral internal sphincterotomy performed under local anesthesia in the surgical treatment of chronic anal fissure

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Objective: Chronic anal fissure is one of the most frequently encountered diseases in general surgery outpatient clinics. Although many medical treatment options have been developed in recent years, open lateral internal sphincterotomy remains one of the best treatment options. This technique is performed under spinal anesthesia in most places, or less frequently under general anesthesia. The aim of this study is to evaluate our results of lateral internal sphincterotomy performed under local anesthesia.

Material and Methods: This study includes 94 patients who underwent surgery in the minor surgical intervention room of the Clinic of General Surgery at Kocaeli State Hospital between January 2021 and April 2023. 75 of the patients were women and 19 were men. These patients were operated on by two different specialists. Before the operation, patients were not asked to fast except for a rectal enema. In all patients, a silicone cushion-supported Sims position and band stretching were used. Before local anesthesia, a cream containing 25 mg lidocaine and 25 mg prilocaine, which provides a highly effective anesthetic to the mucous membranes, was applied (approximately 15 minutes beforehand). (This cream used before local anesthesia greatly relieved the anal local anesthesia). Afterwards, 4-quadrant anorectal anesthesia was applied. Along with LIS, anal papilla excision and possible external hemorrhoid packets were also excised. Patients were called for follow-up at certain intervals. The findings were recorded digitally.

Results: Demographic data, clinical complaints, surgical data, early and late complications, recurrence rates, and follow-up periods of the patients were recorded. The patients' incontinence status was evaluated using the Cleveland continence score. Only 1 patient experienced an early complication (perianal infection), while 1 patient experienced recurrence. Permanent incontinence was not observed in any patient.

Conclusion: Open lateral internal sphincterotomy performed under local anesthesia is an effective, outpatient procedure with an extremely low recurrence rate for the treatment of chronic anal fissures.

Keyword: Rapid relief with minimal procedures in the treatment of chronic anal fissures

[P-049]

Applicability of oncoplastic breast surgery at different technical levels and clinical outcomes: Findings from a tertiary care center

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Objective: Breast cancer is the most common malignancy in women, and surgery remains the primary treatment in eligible patients. In recent years, oncoplastic breast-conserving surgery (O-BCS), which preserves oncological safety while improving cosmetic outcomes, has gained increasing importance. O-BCS includes the techniques that allow adequate tumor excision with simultaneous reshaping of the breast. This study aimed to demonstrate the feasibility and present the clinical outcomes of oncoplastic surgery performed using different techniques and levels in a tertiary care center.

Material and Methods: Patients who underwent O-BCS at the 3rd Department of Surgery of University of Health Sciences Türkiye, Başakşehir Çam and Sakura City Hospital between August 1, 2022 and August 31, 2025 were retrospectively evaluated. Demographic characteristics, tumor laterality, operative time, length of hospital stay, pathological diagnosis, and surgical procedures were analyzed.

Results: A total of 69 patients were included, with a mean age of 55.07±12.55 years. Forty patients had left-sided, 27 right-sided, and 2 bilateral breast cancer. The mean operative time was 129.20±72.41 minutes and the mean hospital stay was 2.26±1.90 days. Pathological evaluation revealed invasive ductal carcinoma in 57 patients, invasive lobular carcinoma in 5, ductal carcinoma *in situ* in 2, angiosarcoma in 1, lobular carcinoma *in situ* in 1, mucinous carcinoma in 1, synchronous IDC + ILC in 1, and ILC + DCIS in 1 patient. Modified radical mastectomy was performed in 11 patients and breast-conserving surgery in 58. Among patients undergoing BCS, sentinel lymph node biopsy was performed in 52, axillary dissection in 4, and BCS alone in 2. Four patients underwent bilateral subcutaneous mastectomy with reconstruction (three implant-based and one DIEP flap). Considering all procedures, reconstruction was performed using a latissimus dorsi flap in 4 patients, prepectoral implant in 3, DIEP flap in 3, and racquet mammoplasty in 2, while volume displacement techniques were used in 29 patients.

Conclusion: O-BCS is based on three main principles: tumor excision within reduction mammoplasty patterns, the use of modified techniques to facilitate resection, and volume replacement with local perforator flaps. Optimal outcomes require a multidisciplinary approach involving breast and plastic surgeons or surgeons trained in both fields. Patients should be informed about the possible aesthetic and oncological changes and complications. O-BCS can be performed at different levels according to the surgeon's training and experience. In our clinic, oncoplastic procedures at all levels can be safely performed, with plastic surgery support particularly important for advanced techniques. In selected patients, O-BCS provides satisfactory oncological and cosmetic outcomes.

Keywords: Breast cancer, oncoplastic breast surgery, surgical techniques

Tablo 1. Rekonstrüksiyon ve onkoplastik teknikler

Teknik	n (%)
Latissimus dorsi flebi	4 (%5,8)
Prepektoral implant	3 (%4,3)
DİEP flebi	3 (%4,3)
Raket mamoplasti	2 (%2,9)
Doku kaydırma (volume displacement)	29 (%42,0)

[P-050]

Late-onset giant lateral metastasis of papillary thyroid carcinoma: The significance of dynamic surveillance in light of the 2025 ATA guidelines

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Objective: Although papillary thyroid carcinoma (PTC) is generally considered an indolent malignancy, it may manifest aggressive regional recurrences after latent periods exceeding a decade. Regardless of the initial staging, the 2025 ATA guidelines emphasize the importance of lifelong "dynamic risk stratification" and "individualized management" approaches. This case presents a giant metastatic recurrence emerging 11 years after primary surgery, encasing neurovascular structures and presenting with a cutaneous fistula, discussed in the context of current guideline principles.

Material and Methods: A 75-year-old female presented with a rapidly enlarging, painful neck mass on the left side, which had fistulized to the skin. Her medical history included bilateral total thyroidectomy and 100 mCi RAI therapy for PTC in 2011; however, she had been lost to follow-up in recent years due to pandemic-related conditions. Radiologic evaluations (CT and PET/CT) identified a necrotic mass approximately 7 cm in size at levels 3-4 on the left side, characterized by 360-degree encasement of the carotid artery, invasion of the internal jugular vein, and infiltration of the sternocleidomastoid muscle (SUV_{max}: 33.3) (Figure 1). Following confirmation of metastasis via FNAB and Tg-washout (1752 ng/mL), a radical left lateral neck dissection was performed (Figure 2).

Results: Histopathological examination revealed metastasis in 7 of the 40 resected lymph nodes. The largest metastatic focus measured 4.5 cm in diameter, with extensive extracapsular extension and soft tissue invasion. Immunohistochemical analysis demonstrated TTF-1 positivity, while the absence of thyroglobulin, PAX-8, and Napsin-A expression—combined with high metabolic activity—was interpreted as "aggressive biological transformation" or "dedifferentiation".

Conclusion: The 2025 ATA guidelines advocate for an "individualized dynamic surveillance" model based on temporal disease evolution rather than "static staging" in modern thyroid cancer management. This case proves that even patients previously categorized as having an "excellent response" can develop structural recurrences with vascular invasion risks more than ten years later. Specifically, a metastatic lymph node size exceeding 3-cm and the loss of Tg/PAX-8 expression are critical parameters indicating that the tumor has entered a dedifferentiation process and transformed into an aggressive phenotype resistant to standard therapies.In conclusion, a lack of follow-up, even in low-risk cases, delays the detection of recurrences and necessitates radical surgical procedures with high morbidity. In accordance with 2025 ATA principles, continuity of oncological surveillance and risk-adaptive approaches are vital for capturing recurrences while still within "resectability limits" and for preserving patient survival.

Keywords: Papillary thyroid carcinoma, 2025 ATA guidelines, dynamic risk stratification, late metastasis

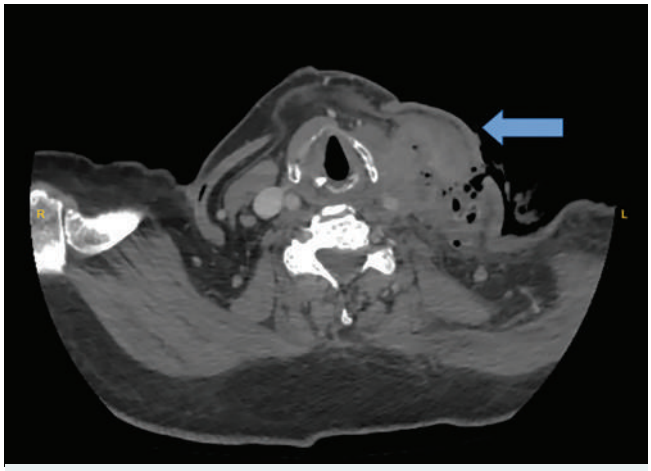

Figure 1. Axial contrast-enhanced neck CT scan demonstrating a giant metastatic focus in the left cervical region with 360-degree carotid artery encasement, internal necrotic air densities, and invasion of the sternocleidomastoid muscle with cutaneous fistulization.

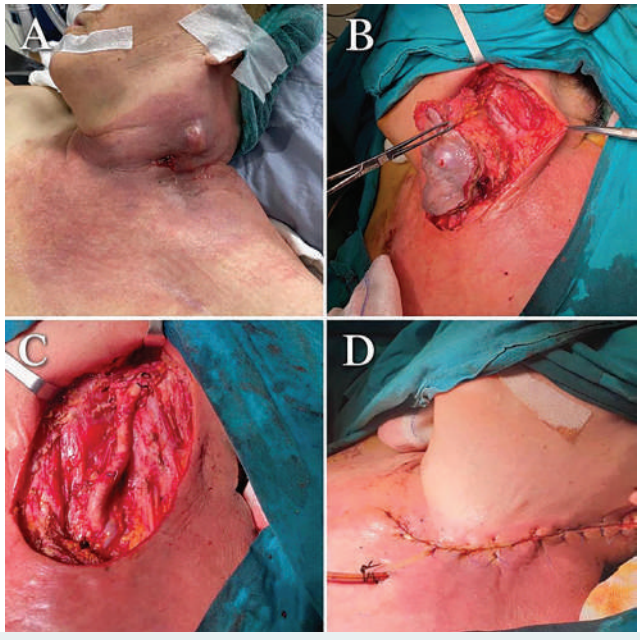

Figure 2. Giant exophytic mass in the left cervical region with cutaneous fistulization (A), Intraoperative view demonstrating deep tissue invasion and neurovascular proximity (B), Resection bed following radical lateral neck dissection (C), Early postoperative appearance after excision of the fistulized skin segment (D).

[P-051]

Effect of preoperative radiological imaging on surgical success in minimally invasive parathyroidectomy: A retrospective single-center experience

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Objective: Minimally invasive parathyroidectomy is an effective surgical approach for the treatment of primary hyperparathyroidism when appropriate patient selection is achieved. Accurate preoperative localization of the parathyroid adenoma is one of the most important determinants of surgical success. Ultrasonography, parathyroid scintigraphy, and advanced cross-sectional imaging techniques are commonly used; however, the impact of these modalities on surgical outcomes remains unclear. This study aimed to evaluate the effect of preoperative radiological imaging on surgical success in patients undergoing minimally invasive parathyroidectomy.

Material and Methods: This retrospective single-center study included patients who underwent minimally invasive parathyroidectomy for primary hyperparathyroidism at our institution within the last two years. Demographic data, biochemical parameters, and preoperative radiological imaging modalities (ultrasonography, parathyroid scintigraphy, and/or computed tomography) were recorded. Concordance between radiological localization and intraoperative findings was assessed. Surgical success was defined as postoperative normocalcemia with a significant decrease in parathyroid hormone (PTH) levels.

Results: A total of 96 patients were included in the study. The median age was 54 (46-63) years. Preoperative imaging correctly localized the parathyroid adenoma in 78 patients (81.3%). The surgical success rate was 94.9% in patients with accurate preoperative localization, compared to 76.5% in patients with inconclusive or discordant imaging findings. A significant association was observed between concordant preoperative imaging and surgical success.

Conclusion: Preoperative radiological imaging plays a significant role in determining surgical success in minimally invasive parathyroidectomy. Accurate localization of the parathyroid adenoma is critical for achieving optimal surgical outcomes. Appropriate imaging strategies may enhance the effectiveness of minimally invasive approaches.

Keywords: Minimally invasive parathyroidectomy, primary hyperparathyroidism, preoperative imaging, parathyroid adenoma, surgical success

[P-052]

Multimodal imaging-guided and intraoperatively verified resection of mediastinal ectopic parathyroid adenomas: A five-case series

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Objective: To present the diagnostic approach, surgical management, and early outcomes of patients with mediastinal ectopic parathyroid adenoma (MEPA) causing primary hyperparathyroidism.

Material and Methods: Between January 2015 and January 2025, among 458 patients who underwent surgery for a solitary parathyroid adenoma, cases of MEPA due to mediastinal location were retrospectively evaluated, and five cases (1%; n=5) were identified. Diagnostic evaluation included cervical ultrasonography, single-photon emission computed tomography/computed tomography (SPECT/CT), and computed tomography (CT). The surgical strategy was individualized according to lesion location and proximity to major vascular structures. Intraoperative confirmation was achieved using radioguided surgery, frozen section analysis, and intraoperative parathyroid hormone (ioPTH) monitoring. Patients were followed for one year with serial serum calcium and PTH measurements.

Results: The median age was 62 years (40-70), and three patients were female. Bone pain and fatigue were the most common presenting symptoms, while one patient was asymptomatic. Preoperative albumin-corrected serum calcium levels ranged from 11.24 to 13.43 mg/dL, and PTH levels ranged from 161 to 1493 pg/mL. Lesion sizes varied between 8×8 mm and 35×22 mm, with anterior mediastinal localization in four cases. Four patients were treated via J-shaped median sternotomy and one via a transcervical approach. The 10-minute ioPTH decline ranged from 48.3% to 85.5%. No major surgical complications were observed. All patients remained normocalcemic and clinically stable at one-year follow-up.

Conclusion: In MEPA cases, the combined use of functional and anatomical imaging, supported by multiple intraoperative confirmation modalities, may facilitate curative resection with low morbidity through individualized surgical strategies.

Keywords: Ectopic parathyroid adenoma, hyperparathyroidism, primary, mediastinum

[P-053]

Have surgical thresholds changed for IPMN with a 5-9 mm main pancreatic duct? A comparative analysis of the Fukuoka 2017, European 2018 and Kyoto 2024 guidelines

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Objective: Intraductal papillary mucinous neoplasms (IPMN) with a main pancreatic duct (MPD) diameter of 5-9 mm constitute a clinical "gray zone" with heterogeneous malignant potential. As recommendations for this range differ across guidelines, operative decision-making may vary between centers. We compared the surgical thresholds and decision frameworks proposed by the Fukuoka 2017, European 2018 and Kyoto 2024 IPMN guidelines for patients with MPD 5-9 mm dilatation and outlined potential implications for practice.

Material and Methods: Full-text versions of the three guidelines were reviewed using a structured comparative approach. We extracted how MPD 5-9 mm is categorized; definitions of surgical indications (high-risk features, "worrisome features", and relative indications); recommended downstream assessment [particularly endoscopic ultrasonography (EUS)]; and surveillance strategies. Additional risk markers embedded in the algorithms (mural nodules, serum CA19-9, symptoms, cyst growth dynamics, concomitant pancreatitis and new-onset diabetes) were mapped. Statements were tabulated in a standardized format and decision pathways were examined side-by-side; reported evidence grading, when available, was recorded.

Results: In Fukuoka 2017, MPD 5-9 mm is not a stand-alone indication for resection; it is addressed within the "worrisome features" framework and prompts further risk confirmation, most commonly with EUS. The European 2018 guideline defines MPD 5-9.9 mm as a "relative indication" for surgery and supports a lower operative threshold when additional risk factors coexist, including mural nodularity, elevated CA19-9, symptoms, or rapid growth. The Kyoto 2024 update frames MPD 5-9 mm as a heterogeneous risk category and shifts emphasis from a single morphologic cut-off to individualized, multiparametric risk assessment; surgical decision-making is positioned within multidisciplinary discussion integrating imaging, biomarkers, operative risk and patient preferences. These differences may influence EUS utilization, surveillance intensity, and the balance between overtreatment and missed malignancy in the MPD 5-9 mm subgroup.

Conclusion: Across guideline iterations, thresholds for MPD 5-9 mm IPMN have moved away from fixed duct-size cut-offs toward risk-based, individualized decision-making. MPD diameter should not be used in isolation; decisions should be guided by EUS findings, mural nodules, CA19-9, symptoms and longitudinal change, within a multidisciplinary and shared decision-making framework. Given that the underlying evidence base remains largely observational, prospective multicenter studies using standardized outcomes, structured EUS reporting and validated risk models are needed to refine operative thresholds, particularly in patients at higher surgical risk.

Keywords: IPMN, main pancreatic duct, guideline comparison

[P-054]

The changing definition of "elderly patient" and the problem of the future: Acute appendicitis in the geriatric population

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Objective: Globally, a growing elderly patient population has emerged, increasingly burdening healthcare services. The definition of the term "geriatrics" is somewhat complex. While traditionally 65 years and older were considered "elderly," WHO and the Japanese Geriatric Society now recommend 75 years and older as a threshold for old age due to increased physical capacity over the last 10-20 years. Based on this new definition of old age, geriatric emergencies managed in surgical departments are increasing,and appendectomy, the most frequently performed surgery worldwide, is becoming more common. In our study, we aimed to examine the outcomes of appendectomies due to acute appendicitis, which are increasingly performed in patients over 75 years of age, and to draw attention to the silent but rapid increase in geriatric emergency surgeries in our country.

Material and Methods: Data from patients over 65 years of age who underwent surgery for acute appendicitis at our institution between January 1, 2021, and January 1, 2026, were retrospectively reviewed. Demographic characteristics, type of operation, chronic diseases, presence of perforation, length of hospital stay, 30-day postoperative complications and pathology results were recorded.In this population group, data from patients over, and under 75 years of age were compared. Patients under 65 years of age and those without a 30-day postoperative follow-up result were excluded from the study.

Results: A total of 88 patients were included in the study, 30 of whom were over 75 years old (34%). The mean age was 72.2±6.06. 21 (23.9%) of the surgeries were performed laparoscopically. The rate of laparoscopy was 10% in those over 75 years old and 31% in those under 75 years old, and the difference was statistically significant (p<0.05). The most common chronic disease was in both patient groups was; hypertension. COPD was particularly prevalent in 23.3% of patients over 75 years old, while the rate was 10.3% in those under 75 years old (p>0.05). Appendix perforation was observed in 43.3% of patients over 75 years old, while this rate was 35.5% in the other group, but the difference wasn't significant (p>0.05). The development of complications was higher in those over 75 years of age, but the difference wasn't significant [(50-29.3%) (p>0.05)]. The mean length of hospital stay was significantly higher in patients over 75 years of age [6.8±10.43 vs. 3.48±4.07 days (p<0.05)].

Conclusion: Our current study shows that perforation rates and hospital stays are increased in patients over 75 years of age. It is thought that the tendency towards open surgery increases with age among surgeons. It should be remembered that in these patients with high comorbidities, speed can lead to complications; delay can lead to perforation.

Keywords: Acute appendicitis, appendectomy, elderly, geriatric emergencies

Table 1. Demographic data and general results

Age (mean ± SD)		**72.2±6.06**	
		n	**%**
Age	>75	30	34
	<75	58	66
Gender	Male	57	64.8
	Female	31	35.2
Type of surgery	Laparoscopic	21	23.9
	Open	67	76.1
Comorbidity	DM	18	20.5
	HT	58	65.9
	COPD	13	14.8
	CAD	28	31.8
Peroperative findings	Presence of perforation	33	37.5
Postoperative results	Complications presence	32	34.6
	SSI	26	29.5
Pathology results	Mucinous neoplasia and adenocarcinoma	5	5.7

DM: Diabetes mellitus, HT: Hypertension, COPD: Chronic obstructive pulmonary disease, SSI: Coronary artery disease, CAD: Coronary artery disease, SD: Standard deviation.

Table 2. Comparison of groups

Age		**≥75**		**<75**		
		n	**%**	**n**	**%**	**p**
Gender	Male	21	70	36	62.1	0.491*
	Female	9	30	22	37.9	
Type of surgery	Laparoscopic	3	10	18	31	**0.035***
	Open	27	90	40	69	
Comorbidite	DM	5	16.7	13	22.4	0.589*
	HT	22	73.3	36	62.1	0.348*
	COPD	7	23.3	6	10.3	0.122*
	CAD	11	36.7	17	29.3	0.482*
Peroperative findings	Presence of perforation	13	43.3	20	35.5	0.488*
Postoperative results	Complications presence	15	50	17	29.3	0.065*
	SSI	10	33.3	16	27.6	0.626*
Length of stay (mean ± SD) (day)		6.8±10.4		3.48±4.07		**0.036****

*: Chi-square, **: Student t-test, DM: Diabetes mellitus, HT: Hypertension, COPD: Chronic obstructive pulmonary disease, SSI: Coronary artery disease, CAD: Coronary artery disease, SD: Standard deviation.

[P-055]

Scientific response to the 2023 Kahramanmaraş earthquake: A bibliometric study

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Objective: On February 6, 2023, Türkiye experienced two devastating earthquakes with epicenters in Pazarcık and Elbistan, measuring 7.7 and 7.6 on the Richter scale. These earthquakes caused over 50,000 deaths and widespread destruction of infrastructure. The disaster triggered a large-scale humanitarian crisis, with significant medical and psychological challenges. Understanding the scientific response to such events is essential for improving future disaster preparedness and management.

Material and Methods: A systematic search was conducted in the Web of Science database using the terms "Kahramanmaraş earthquake," "Pazarcık earthquake," "Elbistan earthquake," and "Türkiye earthquake 2023" The search covered the period from February 6, 2023 and focused on medical literature. A total of 371 articles were initially identified, of which 350 were included after excluding geological, engineering, and social science studies. Bibliometric analysis was performed using the Bibliometrix package in R Studio and visualized with Biblioshiny. Key indicators analyzed included publication volume, citation count, author collaboration, and thematic clustering.

Results: The analysis identified 350 articles from 173 journals, involving contributions from 1,739 authors. The average number of co-authors per document was 6.03, indicating high collaboration, but only 5.429% of studies involved international authors. The annual growth rate of publications was -11.11%, reflecting a projected decline in research activity. The most cited article was Emergency Medicine Association of Türkiye Disaster Committee Summary of Field Observations of February 6th Kahramanmaraş Earthquakes, highlighting emergency response challenges. Psychological studies were more numerous, but emergency response and trauma care publications received higher citation counts. Keyword analysis revealed a focus on trauma care, PTSD, surgical management, and public health (Figure 1). The SAFE-QUAKE scoring system for predicting dialysis needs and the mangled extremity severity score (MESS) for amputation triage were notable clinical advancements (Figure 2).

Conclusion: The research response to the Kahramanmaraş earthquakes followed a clear pattern: Early focus on emergency response and public health, followed by injury and surgical management, and later emphasis on psychological recovery. Despite the strong domestic research effort, low international collaboration limits broader knowledge exchange. Sustained funding, enhanced global collaboration, and integrated mental health and trauma care strategies are essential for improving future disaster preparedness and healthcare resilience.

Keywords: Kahramanmaraş earthquake, disaster response, post-traumatic stress disorder, trauma care, bibliometric analysis

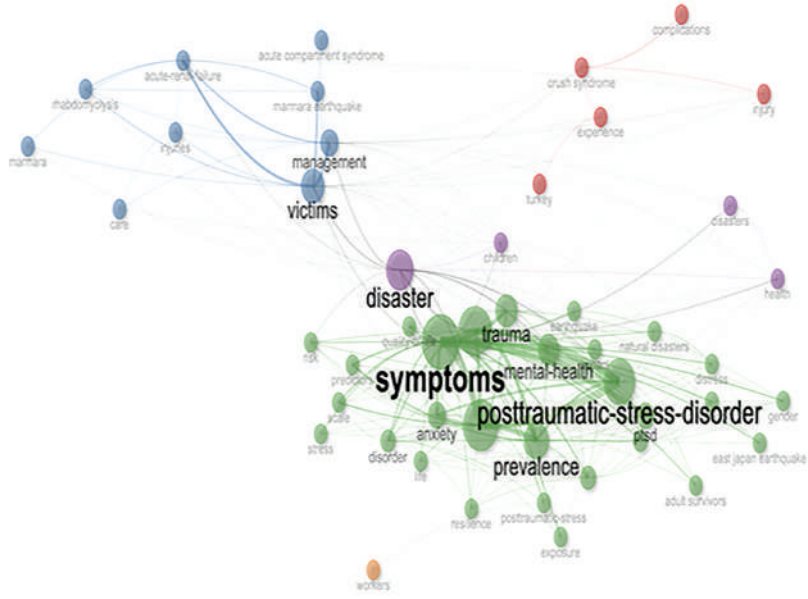

Figure 1.

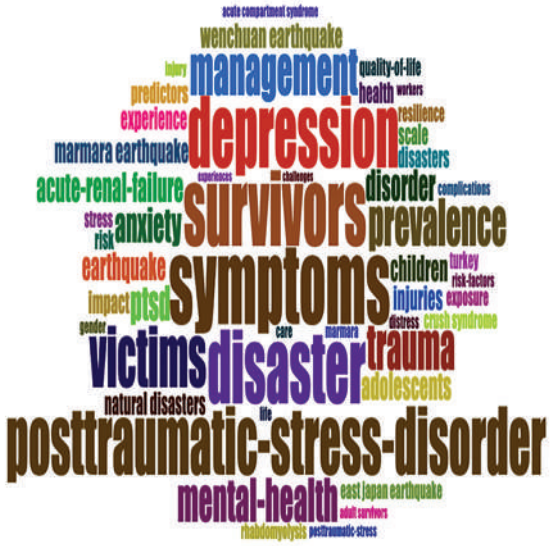

Figure 2.

[P-056]

Mortality by etiology in emergency-operated intestinal obstruction: A single-center experience

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Objective: Intestinal obstruction is a heterogeneous emergency surgical condition arising from diverse etiologies and pathophysiological mechanisms. Among patients presenting with similar clinical symptoms, the underlying cause of obstruction and the presence of concomitant ischemia or strangulation are the main determinants of prognosis. Therefore, etiology-based risk stratification plays a crucial role in guiding emergency triage, surgical timing, resuscitation strategies, and intensive care planning. This study aimed to evaluate the impact of etiology on 30-day mortality in patients undergoing emergency surgery for intestinal obstruction.

Material and Methods: A retrospective analysis was conducted on 94 adult patients (aged ≥18 years) who underwent emergency surgery for intestinal obstruction between January and December 2024. Cases and mortality data were classified according to etiology (Tables 1 and 2). Complication severity was assessed using the Clavien-Dindo classification. Length of hospital stay, requirement for intensive care, and 30-day mortality were recorded.

Results: Of the 94 patients included, 50 were male (53.2%) and 44 were female (46.8%). The mean length of hospital stay was 13.8 days. Postoperative intensive care was required in 31 patients (33.0%). Adhesions were the most common etiological factor, accounting for 63.8% of cases (n=60). The overall 30-day mortality rate was 11.7% (11/94). Mortality varied significantly by etiology and was highest in the mesenteric ischemia group (71.4%), followed by incarcerated hernia and malignancy-related obstruction. Our findings demonstrate that mortality in emergency-operated intestinal obstruction varies considerably according to etiology. Although adhesion-related obstruction was the most frequent cause, the mortality burden was predominantly concentrated in patients with mesenteric ischemia. These results are consistent with previous studies reporting high mortality rates in ischemic obstruction, while adhesion-related cases generally exhibit a more favorable prognosis. Early identification of ischemia or strangulation through clinical assessment, laboratory markers, and contrast-enhanced CT or CT angiography is essential for timely surgical intervention and improved outcomes.

Conclusion: Early etiology-oriented diagnosis, prompt surgical management, and prioritization of intensive care resources for high-risk patients are critical in the management of intestinal obstruction. Although limited by its single-center design, this study highlights the prognostic importance of etiology and supports the need for further multicenter investigations.

Keywords: Emergency surgery, obstruction, small intestine

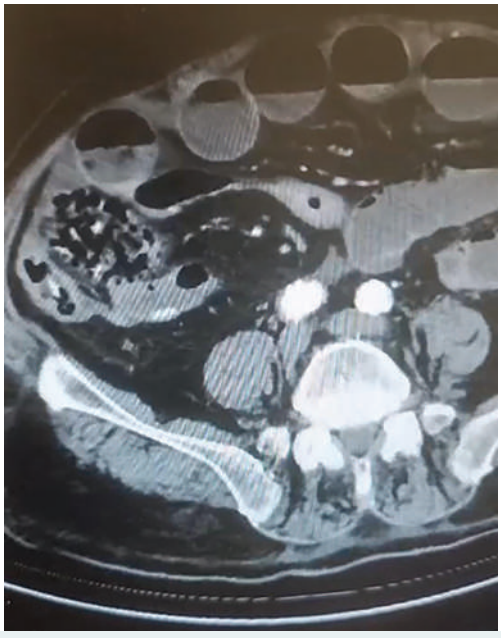

Figure 1.

Table 1. Etiology distribution

Etiology	n	%
Adhesions	60	63.8
Incarcerated hernia	10	10.6
Mesenteric ischemia	7	7.4
Internal herniation	4	4.3
Bezoar	3	3.2
Inflammatory bowel disease	3	3.2
Malignancy	2	2.1
Intussusception	2	2.1
Perforated appendicitis	2	2.1
Gallstone ileus	1	1.1

Table 2. Mortality

Group	n	Mortality n (%)
Mesenteric ischemia	7	5 (71.4%)
Adhesions	60	3 (5%)
Incarcerated hernia	10	2 (20%)
Malignancy	2	1 (50%)
Other etiologies	15	0 (0%)
Total cohort	94	11 (11.7%)

[P-075]

Evaluation of MSI study in colon adenocarcinoma

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Objective: Colon cancer is one of the most common malignancies worldwide. Microsatellite instability (MSI) is an important molecular subtype resulting from defects in the DNA mismatch repair system and has clinical significance in terms of prognosis, treatment response, and the identification of hereditary cancer syndromes. This study aimed to evaluate the application rate and results of MSI studies in colon cancer cases.

Material and Methods: The study included a total of 86 patients diagnosed with colon adenocarcinoma in the pathology archives within the last 5 years. MSI studies were performed in 34 of the cases, while 52 cases did not undergo MSI. In patients who underwent MSI, the expression of MLH1, PMS2, MSH2, and MSH6 proteins was evaluated using immunohistochemical methods. The obtained data were analyzed retrospectively.

Results: Of the 86 colon cancer cases, 39.5% underwent MSI testing, while 60.5% did not. Of those who underwent MSI, 6 (17.5%) had positive results. No defects were observed in 83.5%. An examination of the results and clinicopathological features of the cases that underwent MSI testing revealed that the test was applied to a limited number of patients. It was observed that a large proportion of the cases that did not undergo MSI testing had earlier diagnoses. Current guidelines recommend MSI or MMR assessment in all cases of colon cancer. The absence of MSI assessment in a significant proportion of the cases in our study suggests a potential deficiency, particularly in terms of Lynch syndrome screening and patient selection for immunotherapy.

Conclusion: In colon cancer cases, the MSI (mean scale indicator) test is an important parameter in terms of both prognostic and predictive aspects. Our study once again demonstrates the necessity of routinely applying the MSI test to all colon cancer patients.

Keywords: Adenocarcinoma, MSI, colon cancer, pathology, patient

[P-081]

Clinical, diagnostic, and surgical characteristics of phyllodes tumors: A single-center retrospective experience

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Objective: Phyllodes tumors are breast tumors that complicate clinical management due to their rarity, histopathological heterogeneity, and the inability of preoperative diagnostic methods to reliably predict tumor grade. The aim of this study was to evaluate the demographic, diagnostic, surgical, and pathological characteristics of patients who underwent surgical treatment for phyllodes tumors at the University of Health Sciences Türkiye, Ankara Etlik City Hospital; to investigate the concordance between preoperative imaging methods and tru-cut biopsy with final pathology; and to determine differences in surgical approach and clinical outcomes according to pathological grade.

Material and Methods: Fifty patients who underwent surgery with a diagnosis of phyllodes tumor at the General Surgery Clinic of University of Health Sciences Türkiye, Ankara Etlik City Hospital between January 2023 and November 2025 were retrospectively analyzed. Demographic data, preoperative imaging findings, tru-cut biopsy results, surgical procedures, surgical margin status, re-excision requirement, and follow-up outcomes were evaluated. According to final pathology, cases were classified as benign, borderline, and malignant phyllodes tumors. Comparative analyses were performed between benign and borderline/malign groups.

Results: All patients were female, with a mean age of 40.98±11.39 years. Final pathological distribution was 68% benign, 24% borderline, and 8% malignant phyllodes tumors. Tru-cut biopsy was performed in 84% of patients, and discordance between tru-cut biopsy and final pathology was observed in 34%. A substantial proportion of discordant cases resulted from undergrading on tru-cut biopsy, which was more prominent in borderline and malignant cases. Discordance between preoperative imaging and final pathology was observed in 16% of patients. Additionally, 28% of cases initially assessed as benign or suspicious in the preoperative period were diagnosed as borderline or malignant on final pathology. Wide local excision was the most frequently performed surgical procedure (72%). As pathological grade increased, mastectomy rates and re-excision requirements increased significantly. During a median follow-up period of 18.5 months, no local recurrence was observed.

Conclusion: This study demonstrates that preoperative diagnostic methods, including tru-cut biopsy and imaging, are limited in predicting final pathology in phyllodes tumors due to histopathological heterogeneity, particularly in borderline and malignant cases. In line with the literature, the tendency of tru-cut biopsy to undergrade tumors and imaging-pathology discordance may lead to misclassification of surgical risk. However, individualized surgical management based on pathological grade and adequate surgical margin control were associated with low local recurrence rates in short- and mid-term follow-up, even in borderline and malignant cases. These findings strongly support the need to actively consider preoperative diagnostic uncertainty and prioritize surgical margin safety in the management of phyllodes tumors.

Keywords: Breast tumors, phyllodes tumor, preoperative imaging, surgical margin, tru-cut biopsy

Table 1. Demographic and clinical characteristics of patients with phyllodes tumors and diagnostic process and preoperative evaluation findings

Variable	Value
Age (years), mean ± SD	40.98 ± 11.39
Age (years), median (min–max)	42 (18–65)
Sex, Female	50 (100.0%)
Side – Right	24 (48.0%)
Side – Left	24 (48.0%)
Side – Bilateral	2 (4.0%)
Location – Upper outer quadrant	16 (32.0%)
Location – Upper inner quadrant	16 (32.0%)
Location – Central	8 (16.0%)
Location – Lower outer quadrant	4 (8.0%)
Location – Lower inner quadrant	4 (8.0%)
Preoperative US performed	49 (98.0%)
US BI-RADS 3	7 (14.0%)
US BI-RADS 4	41 (82.0%)
US BI-RADS 5	1 (2.0%)
Largest diameter on US (cm), n	11
Largest diameter on US (cm), mean ± SD	7.09 ± 12.43
Follow-up duration (months), mean ± SD	16.78 ± 10.29
Follow-up duration (months), median (min–max)	18.5 (1–42)

Variable	n (%)
Tru-cut biopsy performed	42 (84.0%)
Tru-cut biopsy not performed	7 (14.0%)
Tru-cut result – Fibroadenoma	8 (19.0%)
Tru-cut result – Suspicious for phyllodes tumor	27 (64.3%)
Tru-cut result – Benign phyllodes tumor	6 (14.3%)
Tru-cut result – Borderline phyllodes tumor	1 (2.4%)
Tru-cut – concordant with final pathology	26 (52.0%)
Tru-cut – discordant with final pathology	17 (34.0%)
Tru-cut discordance (undergrading)	12 (24.0%)
Tru-cut discordance (overgrading)	7 (14.0%)
Preoperative imaging – concordant with final pathology	41 (82.0%)
Preoperative imaging – discordant with final pathology	8 (16.0%)
Preoperative benign/suspicious but final borderline–malignant	14 (28.0%)

Table 2. Comparison of clinical, diagnostic, and surgical characteristics according to final pathology

Variable	n (%)
Tru-cut biopsy performed	42 (84.0%)
Tru-cut biopsy not performed	7 (14.0%)
Tru-cut result – Fibroadenoma	8 (19.0%)
Tru-cut result – Suspicious for phyllodes tumor	27 (64.3%)
Tru-cut result – Benign phyllodes tumor	6 (14.3%)
Tru-cut result – Borderline phyllodes tumor	1 (2.4%)
Tru-cut – concordant with final pathology	26 (52.0%)
Tru-cut – discordant with final pathology	17 (34.0%)
Tru-cut discordance (undergrading)	12 (24.0%)
Tru-cut discordance (overgrading)	7 (14.0%)
Preoperative imaging – concordant with final pathology	41 (82.0%)
Preoperative imaging – discordant with final pathology	8 (16.0%)
Preoperative benign/suspicious but final borderline–malignant	14 (28.0%)

[P-082]

Gestational gigantomastia: Prolactin correlation in massive breast hypertrophy and surgical management strategy

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Objective: Gestational gigantomastia (GG) is an exceptionally rare phenomenon occurring in ~1/100,000 pregnancies, characterized by rapid, pathological breast tissue proliferation. Literature typically defines gigantomastia as requiring single-breast excision of ≥1500 g. Although its exact pathogenesis is not fully elucidated, hypersensitivity of estrogen, progesterone, and particularly prolactin receptors, alongside autoimmune processes, are hypothesized to trigger this growth. Beyond aesthetics, GG causes functional morbidities including spinal-deformities and neural-compression. This report discusses the outcomes of surgical management in a case of GG that persisted significantly into the postpartum period.

Material and Methods: A 39-year-old female patient presented with progressive breast enlargement that initiated during the 14th week of her first pregnancy and failed to regress during the 4-year postpartum period. The patient had no history of systemic disease, specific medication use, or family history of malignancy. Physical examination revealed bilateral massive ptosis and prominent subcutaneous venous dilatation (Figure 1). Anthropometric measurements showed a sternal notch-to-nipple (SN-N) distance of 32-cm on the right and 30-cm on the left (BMI: 26.8 kg/m²). Laboratory analysis revealed a significantly elevated prolactin level of 110 ng/mL (normal: 1.2-29.9 ng/mL). A pituitary MRI was performed to rule out prolactinoma. Radiological investigations confirmed bilateral massive hypertrophy and secondary flattening of cervical lordosis due to the extreme weight of the breast tissue.

Results: The patient underwent reduction mammoplasty using the inferior pedicle technique, resulting in the excision of a total of 2830 g of tissue (right: 1450 g, left: 1380 g). Histopathological examination documented complex hyperplastic processes, including sclerosing adenosis, microcalcifications, and papillary apocrine metaplasia accompanied by increased stromal vascularization. The patient was discharged without complications on the 2nd postoperative day. During follow-up, a dramatic regression in shoulder pressure and chronic back pain was observed, significantly improving the patient's quality of life and functional independence (Figure 2).

Conclusion: Gestational gigantomastia is a rare entity requiring multidisciplinary management, as hormonal and histopathological changes can persist long after pregnancy ends. The detected hyperprolactinemia of 110 ng/mL reflects the profound pathophysiological depth of the proliferative response in the target tissue. While a 1500 g resection threshold per breast is often used for diagnosis, the total material of 2830 g in this case, combined with the loss of cervical lordosis and an SN-N distance of 32-cm, confirms the diagnosis clinically and radiologically. In conclusion, where conservative follow-up is insufficient, inferior pedicle reduction mammoplasty remains the gold-standard treatment for both halting skeletal deformities and restoring the patient's functional autonomy.

Keywords: Gestational gigantomastia, reduction mammoplasty, hyperprolactinemia

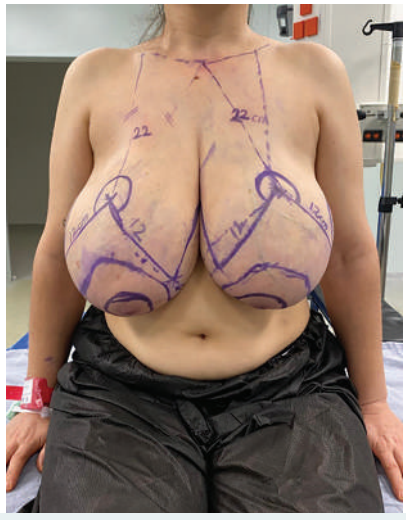

Figure 1. Preoperative appearance; bilateral massive breast hypertrophy, prominent subcutaneous venous structures, and severe ptosis (SN-N: 32-cm).

SN-N: Sternal notch-to-nipple.

Figure 2. Postoperative day 2; appearance and symptomatic improvement after inferior pedicle reduction mammoplasty.

[P-085]

Retrospective analysis of laparoscopic inguinal hernia repair in patients with prior lower abdominal surgery

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Objective: Inguinal hernia repair is one of the most frequently performed surgical procedures worldwide. Laparoscopic techniques, including total extraperitoneal (TEP) and transabdominal preperitoneal (TAPP) approaches, have gained widespread acceptance due to their advantages over open surgery, such as reduced postoperative pain, shorter hospital stay, and faster recovery. However, the feasibility and safety of laparoscopic inguinal hernia repair, particularly the TEP technique, in patients with a history of prior lower abdominal surgery remain a subject of debate. Prior lower abdominal surgeries can lead to adhesions and altered anatomical planes, potentially increasing the difficulty and risks associated with TEP repair. This study aimed to evaluate the safety and feasibility of TEP inguinal hernia repair in patients with prior lower abdominal surgery and to determine the necessity of conversion to open surgery.

Material and Methods: This retrospective study included 150 patients who underwent TEP inguinal hernia repair between 2020 and 2024. The cohort consisted of 25 females and 125 males, with 60 patients having a history of prior lower abdominal surgery. These surgeries included cesarean section, appendectomy, lower abdominal laparotomy, radical prostatectomy, total abdominal hysterectomy with bilateral salpingo-oophorectomy (TAH+BSO), and laparoscopic low anterior resection. All patients initially underwent the classic TEP procedure.

Results: Among the 90 patients without prior lower abdominal surgery (45 right, 45 left inguinal hernias), ten were converted to the TAPP method due to complications (nine scrotal hernias and one sliding hernia). In the 60 patients with prior lower abdominal surgery, 24 required conversion to TAPP. All cases were completed laparoscopically, negating the need for open conversion. The average operation time was 72 minutes (range: 32-134 minutes), and the average hospital stay was 1.2 days. Complications included hematoma in five patients and seroma in five.

Conclusion: TEP inguinal hernia repair is a safe option for patients with a history of prior lower abdominal surgery. Although the likelihood of conversion to TAPP may be higher in these patients, this risk decreases with experience. The study supports the use of laparoscopic techniques in such cases, eliminating the need for open surgery.

Keywords: Abdominal surgery, inguinal hernia, laparoscopic hernia repair

Table 1. Patient demographic data and surgical history

Feature	Total (n=150)	No prior lower abdominal surgery (n=90)	Prior lower abdominal surgery (n=60)
Gender (male/female)	125/25	82/8	43/17
Mean age (years) ± SD	47.6±16.7	44.3±16.6	52.6±15.7
Right inguinal hernia (n)	72	45	27
Left inguinal hernia (n)	78	45	33
Prior surgery type (n)			
- Cesarean section	12	-	12
- Appendectomy	15	-	15
- Lower abdominal laparotomy	14	-	14
- Radical prostatectomy	12	-	12
- Total abdominal hysterectomy + bilateral salpingo-oophorectomy (TAH+BSO)	3	-	3
- Laparoscopic low anterior resection	4	-	4

TAH+BSO: Total abdominal hysterectomy with bilateral salpingo-oophorectomy, SD: Standard deviation.

Table 2. Surgical outcomes and complications

Feature	Total (n=150)	No prior lower abdominal surgery (n=90)	Prior lower abdominal surgery (n=60)
Conversion from TEP to TAPP (n)	34	10	24
Average operation time (min) ± SD	72.7±31.4	TEP: 73.4±13.8, TAPP: 75.7±41.7	TEP: 66.3±22.0, TAPP: 70.0±14.2
Average hospital stay (days) ± SD	1.2±0.4	1.22±0.4	1.1±0.4
Hematoma (n)	5	0	5
Seroma (n)	5	3	2

TEP: Total extraperitoneal, TAPP: Transabdominal preperitoneal, SD: Standard deviation, min: Minimum.

[P-086]

The effect of long vs. short gastric pouch on bile reflux in mini gastric bypass surgery

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Objective: The impact of gastric pouch length created during mini gastric bypass (MGB) surgery on bile reflux remains controversial. This study aimed to compare the effects of gastric pouches longer than 18-cm (long pouch) and shorter than 18-cm (short pouch) on clinical and endoscopic bile reflux.

Material and Methods: A total of 120 patients who underwent mini gastric bypass surgery were included in the study. Patients were divided into two groups according to gastric pouch length:

• Long pouch group (≥18 cm): 80 patients.

• Short pouch group (<18 cm): 40 patients.

All patients were evaluated clinically and endoscopically. Clinical evaluation: Bile vomiting and reflux symptoms were assessed two hours after meals. Endoscopic evaluation:

• Presence of bile in the stomach.

• Observation of bilious content.

• Presence of reflux esophagitis.

Results: Clinical findings:

• Long pouch group (n=80): Bile reflux was detected in 5 patients (6.25%). In these patients, reflux symptoms occurred after consumption of fatty foods and resolved with dietary modification.

• Short pouch group (n=40): Bile reflux was detected in 32 patients (80%). Although symptoms were associated with dietary intake, they persisted despite dietary modification.

Endoscopic findings:

• Long pouch group (n=40 patients who underwent endoscopy): Bile was observed in the stomach in 22 patients (55%). No bile was detected in 18 patients (45%). Reflux esophagitis was identified in 2 patients (5%).

• Short pouch group (n=40): Bile was detected in the stomach in all patients (100%). Reflux esophagitis was identified in 10 patients (25%).

Conclusion: Gastric pouch length appears to be a significant factor in the development of bile reflux following mini gastric bypass surgery. In patients with a gastric pouch length of 18-cm or more, the rate of clinical bile reflux was significantly lower, and symptoms generally resolved with dietary modification. In contrast, patients with a pouch shorter than 18-cm exhibited markedly higher rates of both clinical and endoscopic bile reflux, and symptoms persisted despite dietary intervention. These findings suggest that creating a longer gastric pouch during mini gastric bypass surgery may be an effective surgical strategy to reduce bile reflux.

Keywords: Mini gastric bypass, bile reflux, gastric pouch lenght

[P-087]

What prolongs drain duration after breast cancer surgery? The role of reconstruction and nodal disease

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Objective: Drain placement is a standard practice in breast cancer surgery to prevent seroma and hematoma formation. However, the timing of drain removal may be influenced by patient-related factors such as tumor stage, obesity, and lymph node involvement, in addition to the surgical technique. The aim of this study was to compare drain removal times among different surgical procedures and to identify factors associated with prolonged drain duration.

Material and Methods: This single-center retrospective study included 226 patients who underwent breast cancer surgery in 2020-2025. Patients were divided into four groups: simple mastectomy (n=67), modified radical mastectomy (MRM) (n=87), implant-based reconstruction (n=32), and latissimus dorsi (LD) flap reconstruction (n=40). Demographic characteristics, tumor stage, body mass index (BMI), American Society of Anesthesiologists (ASA) score, and lymph node status were evaluated. Drain removal days were compared among groups.

Results: The mean drain removal time was 10.8±3.3 days in the simple mastectomy group, 11.4±4.7 days in the MRM group, 12.1±3.7 days in the implant-based reconstruction group, and 15.2±6.2 days in the LD flap reconstruction group. The difference among groups was statistically significant ($p<0.001$). Additional analyses revealed that higher tumor stage and positive lymph node status were significantly associated with prolonged drain duration, whereas BMI and ASA scores were comparable among groups.

Conclusion: Drain duration in breast cancer surgery is influenced not only by the type of surgical procedure but also by tumor stage and lymph node status. Prolonged drain duration is particularly observed in patients undergoing LD flap reconstruction and in those undergoing MRM with positive lymph nodes. These findings may contribute to improved postoperative patient management and more accurate discharge planning.

Keywords: Breast cancer, oncoplastic surgery, drain, mastectomy

[P-088]

Surgical management and outcomes of colonoscopy-related perforations: An eight-year single-center retrospective study

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Objective: Colonoscopy-related colonic perforation is a rare but potentially life-threatening complication associated with significant morbidity and mortality. This study aimed to evaluate the clinical characteristics and outcomes of patients who underwent surgical treatment for colonoscopy-related perforations.

Material and Methods: Between January 1, 2018, and December 31, 2025, 10,098 procedures performed in the general surgery endoscopy unit were evaluated. Patients who underwent surgery due to colon perforation related to colonoscopy were retrospectively examined. Clinical data, surgical approaches, and postoperative outcomes were analyzed.

Results: A total of 18 patients were included in the study. Most perforations were located in the sigmoid colon. Primary repair and segmental resection were the most commonly performed surgical procedures. Patients who developed sepsis demonstrated increased intensive care requirements, prolonged hospital stay, and higher mortality rates.

Conclusion: Early diagnosis and appropriate surgical management are critical in the treatment of colonoscopy-related perforations. Consistent with the literature, the sigmoid colon was the most frequent site of perforation in our cohort. The presence of sepsis was associated with significantly worse clinical outcomes. These findings emphasize the importance of rapid clinical assessment and timely surgical decision-making in patients with suspected perforation.

Keywords: Colonoscopy, colonic perforation, surgical treatment

[P-089]

Silent but dangerous: Clinical, laboratory, and management characteristics of toxic megacolon cases - A single-center experience

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Objective: Toxic megacolon is a life-threatening clinical condition that,although rare,requires early diagnosis and appropriate management due to its rapid progression and high risk of mortality. This study aimed to evaluate the demographic characteristics, clinical findings, laboratory dynamics, treatment approaches, and clinical outcomes of patients followed in our clinic with a diagnosis of toxic megacolon.

Material and Methods: In this retrospective observational study,four patients followed in our clinic with a diagnosis of toxic megacolon were evaluated. Demographic data, comorbidity burden (ASA score, Charlson comorbidity index), clinical findings (fever, tachycardia, hypotension, mental status, peritonitis), etiology, laboratory parameters (WBC, CRP_0-CRP_{24}, and ΔCRP, $lactate_0$-$lactate_{24}$, and Δlactate), timing of sepsis, treatments administered, intensive care unit requirement, complications, and mortality were recorded. Descriptive statistics were presented as median (interquartile range) or n (%).

Results: Four patients diagnosed with toxic megacolon were evaluated; 2 were female and 2 were male. The median age was 61.5 years, and the median BMI was 21.0 kg/m². The patients had a high-risk profile, with an ASA distribution of ASA-II in 25% and ASA-IV in 75%, while the Charlson comorbidity index varied among cases. At presentation, tachycardia and hypotension were not observed in any patient,and fever was present in only 25%; however, signs of peritonitis and altered mental status were noted in most cases. Imaging revealed marked colonic dilatation (median colon diameter: 9.25-cm) without free air. Laboratory evaluation showed elevated inflammatory markers, with considerable heterogeneity in 24-hour CRP and lactate dynamics among patients. Half of the patients were managed with emergency surgery and half with medical treatment; 50% required intensive care unit admission. Complications occurred in one patient (25%), and no mortality was observed.

Conclusion: This case series demonstrates that toxic megacolon may progress with severe clinical burden and a need for surgical intervention even in the absence findings such as fever, tachycardia, and hemodynamic instability. Although systemic inflammatory signs are highlighted in the literature as key diagnostic features of toxic megacolon,the relative absence of these findings in our study—contrasted with the predominance of peritonitis and altered mental status—is noteworthy. Furthermore, our observations suggest that short-term dynamic changes in inflammatory and perfusion markers (CRP and lactate), rather than their absolute values, may be more informative for clinical decision-making. This supports the importance of time-dependent monitoring strategies over static threshold-based assessments in the evaluation of toxic megacolon. The fact that half of the patients required emergency surgery and intensive care underscores the discrepancy between clinical "silence" and disease severity, which may increase the risk of delayed intervention in practice. In conclusion, the absence of classical systemic signs in patients with toxic megacolon should not create a false sense of clinical security. Altered mental status, signs of peritonitis, and dynamic laboratory trends should be regarded as decisive indicators for early and aggressive management. Our findings highlight the heterogeneous clinical spectrum of toxic megacolon and support the critical role of early recognition, close monitoring, and individualized treatment strategies in improving patient outcomes.

Keywords: Advanced age, altered mental status, ileus, peritonitis, toxic megacolon

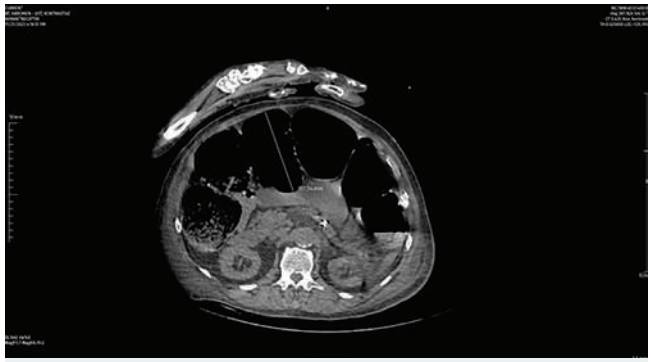

Figure 1. CT image of one of the cases.

CT: Computed tomography.

Table 1. Demographic characteristics and comorbidity burden (n=4)

Parametre	Değer
Yaş (yıl), Medyan (ÇAA/IQR)	61,5 (36,0–77,5)
Cinsiyet, n (%)	Kadın: 2 (%50) · Erkek: 2 (%50)
BKİ (kg/m²), Medyan (ÇAA/IQR)	21,0 (20,0–22,5)
ASA dağılımı, n (%)	ASA 2: 1 (%25) · ASA 4: 3 (%75)
Charlson dağılımı, n (%)	0: 1 (%25) · 2: 1 (%25) · 4: 1 (%25) · 12: 1 (%25)

Table 2. Clinical findings and physical examination characteristics (n=4)

Parametre	n (%)
Ateş	
Var	1 (%25)
Yok	3 (%75)
Taşikardi	
Var	0 (%0)
Yok	4 (%100)
Hipotansiyon	
Var	0 (%0)
Yok	4 (%100)
Mental durum değişikliği	
Var	1 (%25)
Yok	3 (%75)
Peritonit bulgusu	
Var	1 (%25)
Yok	3 (%75)
Etiyoloji	
İnflamatuvar barsak hastalığı ilişkili	4 (%100)

Table 3. Laboratory findings and dynamic variables (n=4)

Parametre	Değer
WBC (/mm³), Ort ± SS	14.718 ± 7.023
WBC, Medyan (Min–Maks)	13.650 (7.800–25.300)
Hemoglobin (g/dL), Ort ± SS	11,4 ± 1,7
Trombosit (/mm³), Ort ± SS	312.000 ± 96.000
Sodyum (mmol/L), Ort ± SS	134,5 ± 3,9
Potasyum (mmol/L), Ort ± SS	4,1 ± 0,6
CRP_0 (mg/L), Ort ± SS	49,8 ± 52,7
CRP_{24} (mg/L), Ort ± SS	99,9 ± 101,6
Δ CRP, Medyan (Min–Maks)	11,5 (0,5–184)
$Laktat_0$ (mmol/L), Ort ± SS	2,54 ± 2,10
$Laktat_{24}$ (mmol/L), Ort ± SS	1,88 ± 0,63
Δ Laktat, Medyan (Min–Maks)	0,65 (0,12–3,21)

Table 4. Treatment course, complications, and clinical outcomes (n=4)

Parametre	Değer
İmmünsüpresyon	
Yok	4 (%100)
Kan transfüzyonu	
Evet	1 (%25)
Hayır	3 (%75)
Sepsis	
Yok	2 (%50)
Başvuru anında	2 (%50)
Yoğun bakım yatışı	
Evet	2 (%50)
YBÜ yatış süresi (gün), Ort ± SS	4,0 ± 6,7
YBÜ yatış süresi, Medyan (Min–Maks)	1 (0–14)
Majör komplikasyon	
Var	1 (%25)
Yok	3 (%75)
Mortalite	
Var	0 (%0)

Table 5. Comparison of our toxic megacolon cases with the literature

Çalışma	Yıl	Popülasyon / Tasarım	Hasta sayısı (n)	Kolektomi / Cerrahi	Mortalite	Not
Ahmed ve ark.	2020	*C. difficile* ilişkili TM; çok merkezli/retrospektif (colectomy zamanlaması)	163	~%85 total abdominal kolektomi	**30-gün mortalite ~%39** (erken: %21 vs geç: %45)	"Septik şok gelişmeden erken kolektomi mortaliteyi azaltır."
Kuy ve ark. (JAMA Surgery)	2015 (online) / 2016 (cilt)	ABD ulusal veri; *C. difficile*-ilişkili megakolon	1051 TM (alt grupta CDI-megakolon)	Colectomy **%18,36** (CDI-megakolon)	**Hastane içi mortalite %24,45** (CDI-megakolon)	İnsidans ve mortalite artış trendi; büyük veri.
Watanabe ve ark.	2024	Ülseratif kolit ilişkili TM; tek merkez/retrospektif, cerrahi olgular	14	Cerrahi olgular (1985–2020)	Perforasyon varlığında mortalite **%50** (1/2); toplam 1 ölüm	SIRS kriterlerini karşılayan **%71,4**; qSOFA düşük yakalıyor (7,1%).
Desai ve ark. (derleme)	2020	Yönetim/klinik spektrum derlemesi	—	—	—	TM'de klinik kötüleşmeyle **ateş/taşikardi/hipotansiyon** gelişebileceği; bulgular steroid/analjezi ile maskelenebilir.
Bizim çalışmamız	2026	Tek merkez olgu serisi	**4**	**Acil cerrahi %50; kolektomi %50**	**%0**	Sistemik instabilite (taşikardi/hipotansiyon) yokken ağır klinik bulgular (peritonit/mental durum) baskın; CRP/laktat dinamikleri heterojen.

[P-092]

Feasibility of unsedated colonoscopy: A retrospective analysis of 296 patients

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Objective: Colonoscopy is commonly performed with sedation in most centers. Although sedation improves patient comfort, it may lead to cardiopulmonary depression, hypotension, hypoxia, prolonged recovery time, and, rarely, serious complications. Therefore, unsedated colonoscopy has emerged as an alternative approach in selected patients. This study aimed to evaluate the procedural success and feasibility of unsedated colonoscopy.

Material and Methods: A total of 296 patients who underwent unsedated colonoscopy were retrospectively analyzed. Patient demographics, including age and sex, as well as indications for colonoscopy, were recorded. Successful completion of the procedure was defined as cecal intubation.

Results: The mean age of the patients was 50.79±12.44 years. Of the patients, 163 were male and 133 were female. The indications for colonoscopy were anemia (n=79), lower gastrointestinal bleeding (n=69), abdominal pain (n=44), constipation (n=23), positive fecal occult blood test (n=19), detection of a mass on digital rectal examination (n=16), weight loss (n=5), and other causes (n=41). Cecal intubation was successfully achieved in 255 patients (86.1%), while the procedure could not be completed in 41 patients (13.9%). Among patients in whom the procedure was incomplete, 26 were male and 15 were female. No major complications were observed in any patient.

Conclusion: The cecal intubation rate in unsedated colonoscopy was 86.1%, and no major complications were detected. With appropriate patient selection and adequate operator experience, unsedated colonoscopy is a safe and feasible procedure.

Keywords: Endoscopy, colonoscopy, sedation

[P-093]

Is routine preoperative colonoscopy necessary before temporary stoma closure?

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Objective: Permanent or temporary stomas (ileostomy, colostomy) are frequently performed in general surgical practice for benign or malignant indications. Temporary stomas may be scheduled for closure after the recovery period or following adjuvant/systemic therapy. Prior to stoma closure, routine preoperative colonoscopic evaluation is commonly performed in many centers to assess colonic integrity, evaluate the colorectal anastomosis, and exclude recurrence or metachronous colorectal tumors. In this study, patients who underwent temporary stoma creation for any indication and subsequently had stoma closure following preoperative colonoscopic evaluation were retrospectively analyzed, and the necessity of routine colonoscopy prior to stoma closure was discussed, except for selected clinical criteria.

Material and Methods: A total of 147 patients who underwent stoma closure at University of Health Sciences Türkiye, Ankara Etlik City Hospital between January 2022 and July 2025 were identified. Thirty-one patients who underwent stoma closure without preoperative colonoscopic evaluation were excluded from the study. The demographic characteristics of the included patients (age and sex), indication for stoma creation (benign or malignant), type of stoma creation (emergency or elective), interval between stoma creation and closure, and the presence of pathologies that could preclude stoma closure detected during preoperative colonoscopy (such as anastomotic stricture or metachronous tumor) were retrospectively analyzed.

Results: A total of 116 patients who met the inclusion criteria were included in the study. The demographic and clinical characteristics of the patients are presented in Table 1, and conditions preventing stoma closure according to stoma indication are shown in Table 2. In the preoperative colonoscopic evaluation, no pathology preventing stoma closure was detected in 113 patients (97.4%), whereas only 3 patients (2.6%) had findings that contraindicated stoma closure. Of these patients, two had stomas created for benign indications and one for a malignant indication.

Conclusion: Stoma closure is generally performed before the expected time frame for local recurrence or development of metachronous secondary tumors following the primary surgery. Therefore, the clinical benefit of routine preoperative colonoscopic evaluation in asymptomatic patients remains controversial. In our study, the low rate of pathologies preventing stoma closure (2.6%) suggests that routine colonoscopy alters clinical management in only a limited subset of patients. However, colonoscopic evaluation should be selectively considered in patients with alarm symptoms, suspected anastomotic integrity issues, or in high-risk malignant patient groups. Routine preoperative colonoscopy rarely changes surgical decision-making in asymptomatic patients.

Keywords: Stoma closure, colonoscopy

Table 1. Demographic and clinical characteristics of patients (n=116)		
Variable	**n=116**	**%**
Sex		
Male	78	67.2
Female	38	32.8
Type of stoma creation		
Emergency	62	53.4
Elective	54	46.6
Indication for stoma		
Benign	47	40.5
Malignant	69	59.5
Time interval to stoma closure		
<6 months	44	37.9
6-12 months	45	38.8
>12 months	27	23.3
Colonoscopy findings		
No pathology	113	97.4
Pathology present	3	2.6

Table 2. Patients with identified contraindications according to stoma indication (n=116)			
Stoma indication	**No contraindication, n (%)**	**Contraindication present, n (%)**	**Total**
Benign	45 (95.7)	2 (4.3)	47
Malignant	68 (98.6)	1 (1.4)	69
Total	113	3	116

[P-094]

Low-grade mucinous neoplasms detected after appendectomy: A single-center retrospective evaluation

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Objective: A small proportion of patients undergoing surgery for acute appendicitis are histopathologically diagnosed with low-grade appendiceal mucinous neoplasms (LAMN). This study aimed to comprehensively evaluate the clinical, radiological, surgical, and histopathological characteristics of patients who underwent surgery with a preliminary diagnosis of acute appendicitis and were subsequently diagnosed with LAMN on postoperative pathological examination, and to discuss these findings in the context of the current literature.

Material and Methods: A total of 19 patients who underwent surgery with a preliminary diagnosis of acute appendicitis between October 2022 and October 2025 and were diagnosed with LAMN on pathological examination were retrospectively analyzed. Demographic characteristics, presenting symptoms, computed tomography (CT) findings, surgical technique, intraoperative macroscopic appearance, histopathological tumor size, surgical margin status, presence of extraluminal mucin, follow-up duration, and clinical outcomes were evaluated.

Results: The mean age of the patients was 60.7 years (range: 29-86), with 63% being female (n=12) and 37% male (n=7). Presenting complaints were consistent with acute appendicitis in 42% of cases, whereas 58% presented with other abdominal symptoms. On preoperative CT imaging, the mean appendiceal diameter was 21-mm; wall thickening was detected in 37% of cases, and a mucocele appearance was observed in 53%. Surgically, 53% of patients underwent open appendectomy and 47% underwent laparoscopic appendectomy. On pathological macroscopic examination, the mean tumor size was 7.1-cm, and positive surgical margins were observed in only 1 patient (5%). The presence of extraluminal mucin/pseudomyxoma peritonei was detected in 16% (n=3) of patients. The mean follow-up duration was 13 months. During follow-up, no recurrence was observed in 17 patients (89%), while 2 patients (11%) died.

Conclusion: LAMN is a neoplasm that may be incidentally detected among patients undergoing surgery for acute appendicitis, yet it is of critical importance in terms of clinical course and long-term prognosis. In our study, the presence of a mucocele appearance and increased wall thickness on preoperative CT imaging were identified as potentially valuable predictors in favor of LAMN. Surgical margin positivity and the presence of extraluminal mucin represent key determinants affecting prognosis and recurrence risk. Our findings demonstrate that histopathological examination following acute appendicitis surgery is indispensable not only for diagnostic purposes but also for prognostic assessment. Therefore, careful evaluation of surgical margins and the continuation of long-term oncological follow-up are essential in patients with LAMN.

Keywords: Acute appendicitis, emergency surgery, histopathology, LAMN, rare case

Table 1. Demographic characteristics and presenting findings

Tablo 1. Hastaların Demografik Özellikleri

Özellik	Değer
Toplam hasta sayısı	19
Yaş (ortalama, min–maks)	60,7 (29–86)
Cinsiyet	Kadın: 12 (%63) Erkek: 7 (%37)

Table 1. Demographic Characteristics of the Patients

Characteristic	Value
Total number of patients	19
Age (mean, min–max)	60.7 (29–86)
Sex	Female: 12 (63%) Male: 7 (37%)

Tablo 2. Başvuru ve Radyolojik Bulgular

Özellik	n	%
Başvuru şekli – Akut apandisit	8	42
Başvuru şekli – Diğer yakınmalar	11	58
Apendiks çapı (BT, ortalama)	21 mm	–
Duvar kalınlığı artışı (VAR)	7	37
Mukosel görünümü (VAR)	10	53

Table 2. Clinical Presentation and Radiological Findings

Characteristic	N	%
Mode of presentation – Acute appendicitis	8	42
Mode of presentation – Other complaints	11	58
Appendiceal diameter (CT, mean)	21 mm	–
Wall thickening (PRESENT)	7	37
Mucocele appearance (PRESENT)	10	53

Table 2. Surgical findings and follow-up findings

Tablo 3. Cerrahi Bulgular

Özellik	n	%
Cerrahi teknik – Açık	10	53
Cerrahi teknik – Laparoskopik	9	47
Makroskopik tümör boyutu (ortalama)	7,1 cm	–
Cerrahi sınır – Negatif	18	95
Cerrahi sınır – Pozitif	1	5

Table 3. Surgical Findings

Characteristic	N	%
Surgical technique – Open	10	53
Surgical technique – Laparoscopic	9	47
Macroscopic tumor size (mean)	7.1 cm	–
Surgical margin – Negative	18	95
Surgical margin – Positive	1	5

Tablo 4. Patoloji ve Takip Bulguları

Özellik	n	%
Ekstralüminal müsin / PMP – VAR	3	16
Ekstralüminal müsin / PMP – YOK	16	84
Ortalama takip süresi (ay)	13	–
Nüks – YOK	17	89
Eksitus	2	11

Table 4. Pathological and Follow-Up Findings

Characteristic	N	%
Extraluminal mucin / PMP – PRESENT	3	16
Extraluminal mucin / PMP – ABSENT	16	84
Mean follow-up duration (months)	13	–
Recurrence – ABSENT	17	89
Mortality	2	11

[P-095]

Adjunctive botulinum toxin injection with surgical repair for recurrent rectovaginal fistulas

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Objective: Rectovaginal fistula is an abnormal connection between the rectum and the vagina. Through this connection, passage of flatus or stool from the rectum to the vagina may occur. Patient history and physical examination are usually sufficient for diagnosis. Although many surgical options have been described (e.g., sphincteroplasty, advancement flap, muscle interposition, fibrin glue, plugs), fistula closure remains challenging due to high surgical failure rates. To report the outcomes of a novel treatment approach combining surgical repair with botulinum toxin injection into the lateral internal anal sphincter for the management of recurrent rectovaginal fistula.

Material and Methods: Between 2013 and 2019, eight patients with recurrent rectovaginal fistula underwent a total of ten surgical repairs combined with injection of 100 units of botulinum toxin. Patient characteristics, fistula etiology, prior surgical history, fistula size, and treatment outcomes were analyzed (Figure 1).

Results: Eight patients with recurrent rectovaginal fistula were treated. Etiologies included obstetric trauma (n=3), radiotherapy and rectal surgery (n=2), vaginal reconstruction (n=2), and Crohn's disease (n=1). The median number of previous operations was 1.5 (range: 1-3). Fistula size ranged from 0.5×1 cm to 2×3 cm. Following the combined approach, successful fistula closure was achieved in all cases (100%) (Figure 2).

Conclusion: Botulinum toxin injection into the lateral internal anal sphincter can be successfully used as an adjunct to surgical repair in the treatment of recurrent rectovaginal fistulas.

Keywords: Rectovaginal fistula, botulinum toxin

Table 1. Clinical characteristics of 8 patients with recurrent rectovaginal fistula

Age	BMI	Etiology	Prior operation for RVF	No of fistula repair	Size of Fistula (cm)	Location of RVF	Surgery Type	Additional disease	Chronic medication use
19	29	Neovagen operation	Seton +TVR ERAF	3	3x2	low	TVR 2 month later ERAF	Congenital	cortisone
54	28	RT+ Low Anterior resection	TVR TVR	2	2x2	low	ERAF 2 month ERAF	Rectum ca HT	RT
65	34	RT+ Low Anterior resection	TVR	1	1x1	high	ERAF	Rectum Ca DM + HT	RT
33	23	obstetrical trauma	TVR	1	2x1	low	TVR	no	no
25	23	Neovagen operation	Seton + TVR	2	2x2	high	ERAF	No	Estrogen
31	22	obstetrical trauma	TVR	1	2x1	low	ERAF	no	no
35	28	obstetrical trauma	TVR	1	1x0.5	low	TVR	Romotoit artrit + Multiple sclerosis	Cortisone
39	28	Chron disease + pelvic surgerey	Seton	1	2x1	Low	ERAF		Mesalazine Prednisolone /infliximap

Appriviations

RVF: Rectovaginal Fistula
TVR: Transvaginal Repair
ERAF: Endorectal Advancement flap
DM: diabetes
HT: Hypertension
RT: Radiation Therapy

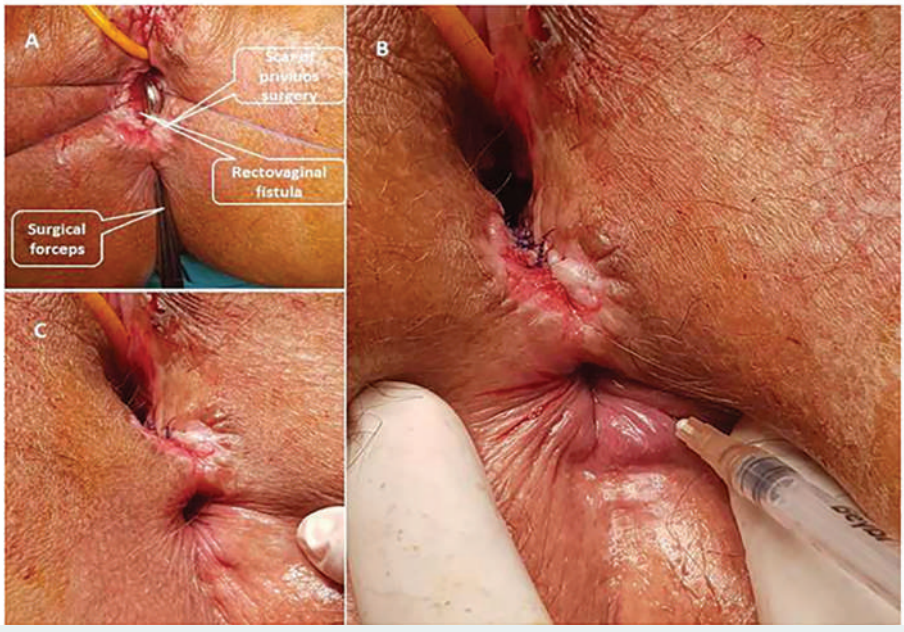

Figure 1. A) Rectovaginal fistula is seen, surgical forceps passing through the fistula. B) After transvaginal repair of the fistula, bilateral botulinum toxin injection in to the internal sphincter muscle is seen. C) After surgical repair and botulinum toxin injection finished.

[P-096]

Complication profile and associated clinical variables in oncoplastic breast surgery: A single-center retrospective study

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Objective: Oncoplastic breast surgery is a multidisciplinary approach aimed at improving aesthetic outcomes while preserving oncologic safety. This single-center retrospective study evaluated the profile of postoperative complications and the clinical variables potentially associated with these complications in patients who underwent oncoplastic breast surgery at our institution between 2019 and 2026.

Material and Methods: This retrospective, single-center study included 16 patients who underwent oncoplastic breast surgery between 2019 and 2026. All procedures were performed by a multidisciplinary team consisting of general and plastic surgeons. Demographic characteristics (age, body mass index), comorbidities (smoking status, diabetes mellitus), surgical features (axillary surgery, implant use), neoadjuvant and adjuvant treatment details, and postoperative complications were recorded. Complications were assessed during the early postoperative period (within 3 months) and graded according to the Clavien-Dindo classification.

Results: All 16 patients were female (100%), with a mean age of 44.5 years and a mean body mass index of 26.83 kg/m². A history of smoking was present in 25% of patients.Surgical management was carried out by a multidisciplinary team in all cases. Sentinel lymph node biopsy and/or axillary dissection were performed in selected patients according to tumor characteristics and clinical stage. Neoadjuvant and adjuvant treatments were planned based on pathological findings and molecular subtype. Early postoperative complications occurred in 18.75% of patients. Most were classified as Clavien-Dindo grade II-IIIb and were successfully managed with medical or surgical intervention. Reoperation within the first year was infrequent, and implant loss was rare. No mortality was observed (0%). During follow-up, the rate of early local recurrence was low, while a limited number of patients developed late distant metastases. The mean follow-up duration was 34.5 months. Oncoplastic surgery was performed more frequently in 2021, 2023, and 2026. Higher body mass index, smoking, and performance of axillary surgery appeared to be associated with morbidity. Although patients receiving neoadjuvant or adjuvant therapy showed a trend toward higher complication rates, advanced statistical analysis was not feasible due to the limited sample size.

Conclusion: This single-center experience demonstrates that oncoplastic breast surgery can be performed safely with acceptable morbidity and zero mortality when a multidisciplinary approach is applied. Complications were generally manageable. Patient-related and surgical factors may influence morbidity. Larger multicenter prospective studies are required to validate these findings and better define risk factors.

Keywords: Morbidity, multidisciplinary surgery, oncoplastic breast surgery, postoperative complications

Table 1. Demographic and clinical characteristics of the patients complication profile

Hasta sayısı	16
Cinsiyet (kadın), n (%)	16 (%100)
Ortalama yaş (yıl)	44.5
Ortalama vücut kitle indeksi (kg/m²)	26.83
Sigara içme durumu, n (%)	4 (%25)
Diyabet mellitus, n (%)	0 (%0)
Koltuk altı ameliyatı, n (%)	3 (%18,75)
Komplikasyonların varlığı, n (%)	5 (%31,25)
Ölümlülük	Hiçbiri

Table 2. Distribution of postoperative complications according to the Clavien-Dindo classification

Clavien-Türkiye sınıfı	Hasta sayısı (n)	%
1. sınıf	11	%68,75
II. sınıf	2	%12,5
Sınıf IIIb	3	%18,75
4-5. sınıf	0	%0

[P-097]

Early clinical and biochemical outcomes of patients undergoing parathyroidectomy for parathyroid hyperplasia: A single-center experience

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Objective: In cases of secondary and tertiary hyperparathyroidism due to parathyroid hyperplasia, surgical treatment becomes a consideration when adequate control cannot be achieved despite medical therapy. Although biochemical improvement is expected following parathyroidectomy, early postoperative hypocalcemia may represent a significant cause of morbidity. The aim of this study was to evaluate the early postoperative clinical and biochemical outcomes of patients operated on at our center and to investigate factors associated with the development of postoperative hypocalcemia.

Material and Methods: Twenty-five patients who underwent parathyroidectomy with a diagnosis of parathyroid hyperplasia were retrospectively reviewed. Demographic characteristics, type of hyperparathyroidism, history of hemodialysis, medical treatments received, preoperative laboratory parameters (calcium, phosphorus, PTH, and ALP), as well as postoperative biochemical course and complications were recorded. Risk factors associated with the development of postoperative hypocalcemia were analyzed.

Results: The mean age of the patients was 56 years, and the majority were operated on for tertiary hyperparathyroidism. The mean preoperative PTH and ALP levels were 1.740 pg/mL and 389 U/L, respectively. A marked decrease in parathormone and phosphorus levels was observed after surgery. The mean calcium level on postoperative day 1 was 8.4 mg/dL. Hypocalcemia developed in six patients (24%), requiring calcium replacement therapy. Patients who developed hypocalcemia had higher preoperative PTH and ALP levels. No major surgical complications were observed.

Conclusion: Parathyroidectomy is an effective and safe treatment option for hyperparathyroidism due to parathyroid hyperplasia. However, postoperative hypocalcemia is frequently observed in patients with a high preoperative disease burden. Close biochemical monitoring and early replacement therapy are essential in these patients.

Keywords: Parathyroidectomy, hyperparathyroidism, hypocalcemia

[P-098]

Global scientific attention to the Israel-Gaza conflict: A bibliometric and thematic analysis of health and humanitarian research

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Objective: Armed conflicts and humanitarian crises, particularly in the Middle East, have led to profound disruptions in civilian health and psychosocial well-being. In recent years, the Gaza region has become a focal point of such disruptions, prompting increasing academic attention. This study provides a comprehensive bibliometric analysis of the global scientific output related to war-affected civilian populations in the Middle East, with a special emphasis on Gaza and Palestine.

Material and Methods: We conducted a bibliometric analysis of 488 peer-reviewed articles published between 1961 and 2025, retrieved from PubMed database. Quantitative metrics such as annual scientific production, author productivity (Lotka's Law), institutional contributions, international collaborations, keyword co-occurrence, and thematic evolution were assessed using Bibliometrix (R package). Visualization techniques included co-authorship networks, thematic maps, treemaps, and trend analysis.

Results: Scientific interest in war-related civilian health surged significantly after 2023, reflecting the global academic response to escalating humanitarian crises in Gaza. A small group of highly productive authors and institutions (primarily based in Gaza, Israel, and Western academic centers) contributed disproportionately to the literature (Figure 1). Core themes include psychosocial trauma, gender disparities, child vulnerability, warfare-related epidemiology, and health service disruption. Keywords such as "humans," "female," "warfare," "child," "Middle East," and "mental health" emerged as dominant focal points (Figure 2). International collaboration rates reached 20.9%, with a noticeable rise in publications from high-impact journals.

Conclusion: The intersection of warfare, civilian suffering, and public health has generated a distinct, rapidly expanding body of research. This bibliometric study maps the scientific terrain of conflict-related health literature. These bibliometric patterns are consistent with humanitarian data from the United Nations and UNICEF, which indicate that women and children constitute a significant portion of civilian casualties in Gaza. Future studies must prioritize inclusive research agendas that center the voices of affected populations and address structural inequities in global health scholarship.

Keywords: Gaza, Middle East, war, mental health, bibliometric analysis, public health

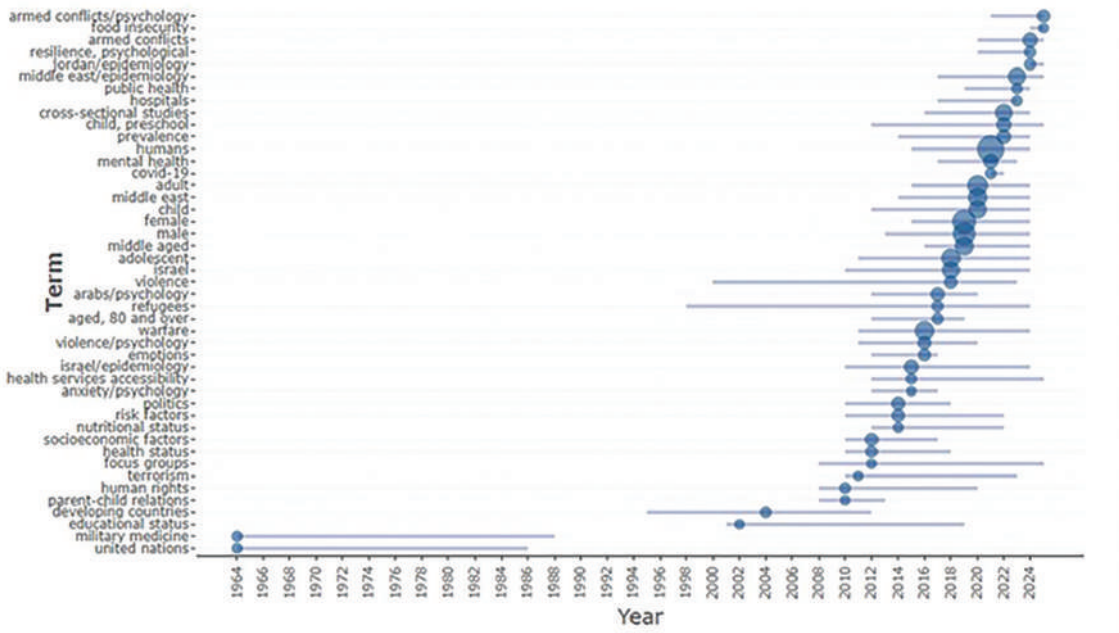

Figure 1.

Figure 2.

[P-099]

The ultimate killer in surgery: A sepsis-like syndrome or cytokine storm induced by surgery

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Objective: Surgical trauma triggers a cascade of immunological responses that can escalate into a cytokine storm—a life-threatening hyperinflammatory state characterized by massive elevations of pro- and anti-inflammatory mediators. This phenomenon shares pathophysiological features with sepsis-like syndrome and systemic inflammatory response syndrome (SIRS), contributing significantly to postoperative multiple organ dysfunction syndrome (MODS). Understanding the temporal dynamics of surgery-induced cytokine release and implementing damage control strategies are critical for improving patient outcomes, particularly in high-risk populations undergoing major abdominal or cardiac procedures. When we look backwards, the most common cause of mortality in our clinical surgical practice has often been sudden and unexpected intraoperative and early postoperative cytokine storms.

Material and Methods: This review synthesizes evidence from prospective observational studies, randomized controlled trials, and systematic reviews examining cytokine storm characteristics in surgical patients. Studies analyzed plasma cytokine levels (IL-1, IL-6, IL-8, IL-10, IL-16, TNF-α) at multiple time points using Luminex technology and ELISA. Patient cohorts included those undergoing cardiac surgery with cardiopulmonary bypass, abdominal surgery for intra-abdominal sepsis, and trauma patients requiring damage control surgery. Principal component analysis was employed to establish cytokine storm intensity curves. Therapeutic interventions including hemoadsorption (CytoSorb®), damage control surgery techniques, and targeted immunomodulation were evaluated.

Results: Cytokine storm response occurs within hours of surgical insult, with peak concentrations predating clinical deterioration markers. In severe cases, IL-6 levels reached 425.1 pg/mL (>1.200× normal), IL-10 reached 198.5 pg/mL (>1.800× normal), and IL-16 reached 623.0 pg/mL (>240× normal). Maximum cytokine storm intensity preceded peak Vasoactive-Inotropic Scores and Sequential Organ Failure Assessment scores, suggesting a critical intervention window. Damage control surgery—involving abbreviated initial operations followed by resuscitation and staged definitive repair—demonstrated reduced inflammatory burden compared to prolonged single-stage procedures. Hemoadsorption therapy showed promise in cytokine removal, though survival benefits remain inconclusive in randomized trials.

Conclusion: The early and predictable nature of surgery-induced cytokine storms presents opportunities for proactive intervention. Biomarkers such as IL-6, IL-10, and IL-16 may guide timing of immunomodulatory therapies within the critical 24-hour postoperative window. Damage control surgery philosophy aligns with this understanding by minimizing the "second hit" phenomenon—where prolonged operative stress compounds the initial inflammatory insult. Future therapeutic strategies should integrate cytokine storm biomarker monitoring with damage control principles, hemoadsorption technologies, and targeted anti-inflammatory interventions to mitigate progression from controlled inflammation to pathological sepsis-like states.

Keywords: Sepsis, sepsis-like syndrome, cytokine storm, damage control surgery

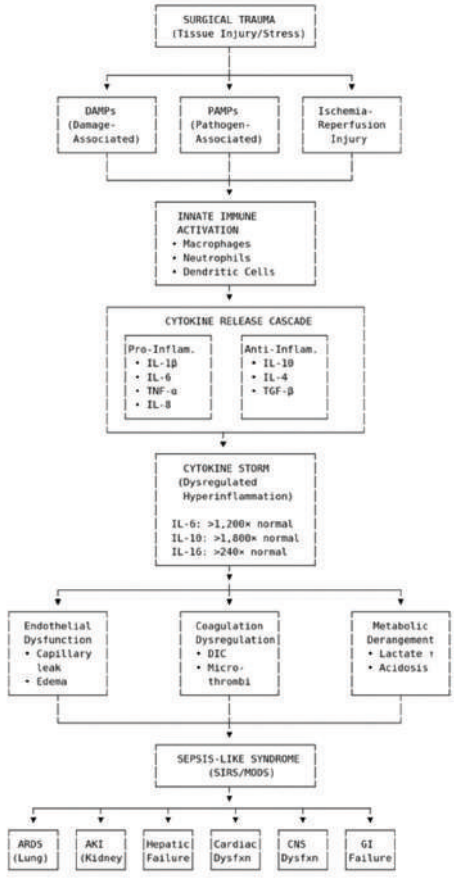

Figure 1. Etiopathogenesis of the cytokine storm.

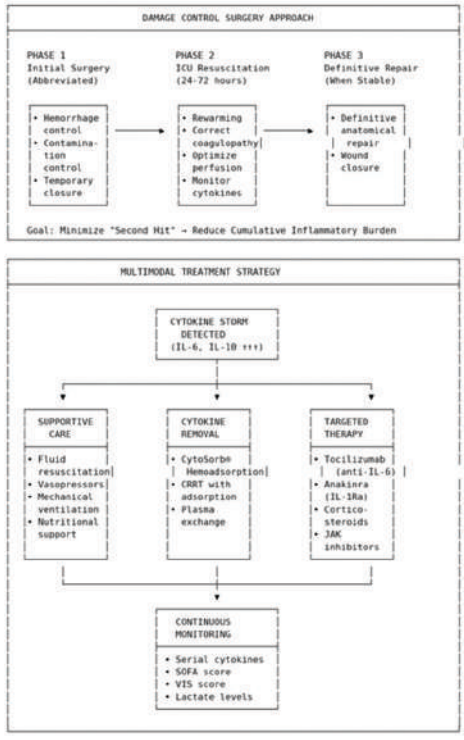

Figure 2. Treatment algorithms.

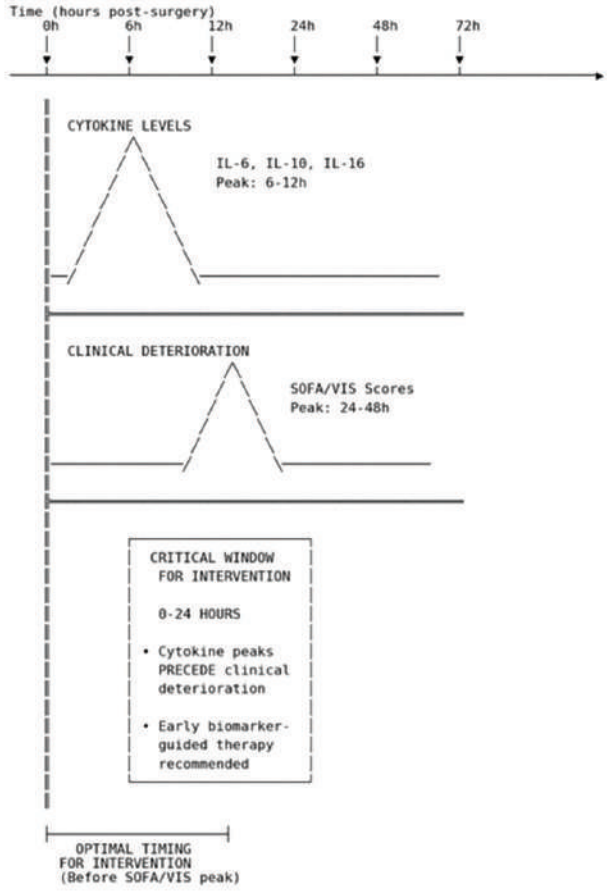

Figure 3. Cytokine dynamics.

[P-100]

Clinical management of rectal foreign bodies: A single-center experience

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Objective: Rectal foreign bodies are a rare clinical entity in general surgery but present distinctive diagnostic and therapeutic challenges. Cases associated with sexual preferences and social taboos often involve delayed presentation, difficulty obtaining a reliable medical history, and loss to follow-up, complicating clinical assessment and management. Additionally, variability in the type, size, and location of foreign bodies hinders the development of a standardized clinical approach. Although management algorithms prioritizing minimally invasive methods have been described, they do not fully address case heterogeneity, and clinical decision-making frequently relies on individual assessment. Therefore, the management of rectal foreign bodies remains a clinical problem with undefined standards. This study aims to contribute to the literature by sharing our clinical experience in managing rectal foreign bodies.

Material and Methods: Between January 2020 and January 2026, the demographic characteristics of patients treated for rectal foreign bodies, along with the diagnostic and therapeutic methods applied, were retrospectively reviewed using the hospital database.

Results: Between January 2020 and January 2026, 15 patients were treated in our clinic for rectal foreign bodies. The mean age was 41.2 years (22-66); 2 patients were female (13%) and 13 were male (87%). Upright plain abdominal radiography was performed in all patients, and abdominopelvic computed tomography was additionally obtained in 10 patients. Colon perforation with signs of peritonitis was detected in one patient, while no perforation was observed in the others. Foreign bodies were removed by digital rectal examination in 5 patients, anal examination under sedation in 1 patient, and rectosigmoidoscopy in 7 patients. In 2 patients, spontaneous passage occurred during intensive care follow-up due to concomitant drug-containing packages in the small intestine. Colon repair and colostomy were performed in the patient with perforation. Extracted foreign bodies were heterogeneous, including bottles, cucumbers, brushes, test tubes, and drug packages. Five patients were followed on an outpatient basis, nine were discharged the next day, and one on the seventh day. No mortality was observed.

Conclusion: Rectal foreign bodies, although rare, are associated with considerable uncertainty in clinical evaluation and management. In our study, most cases were safely managed with non-operative methods, while surgical intervention was required only in a limited number of complicated cases. However, delayed presentation, unreliable medical history, and case heterogeneity hinder the application of a standardized management strategy. Our single-center six-year experience supports prioritizing an individualized, stepwise, and minimally invasive approach in the management of rectal foreign bodies.

Keyword: Rectal foreign bodies

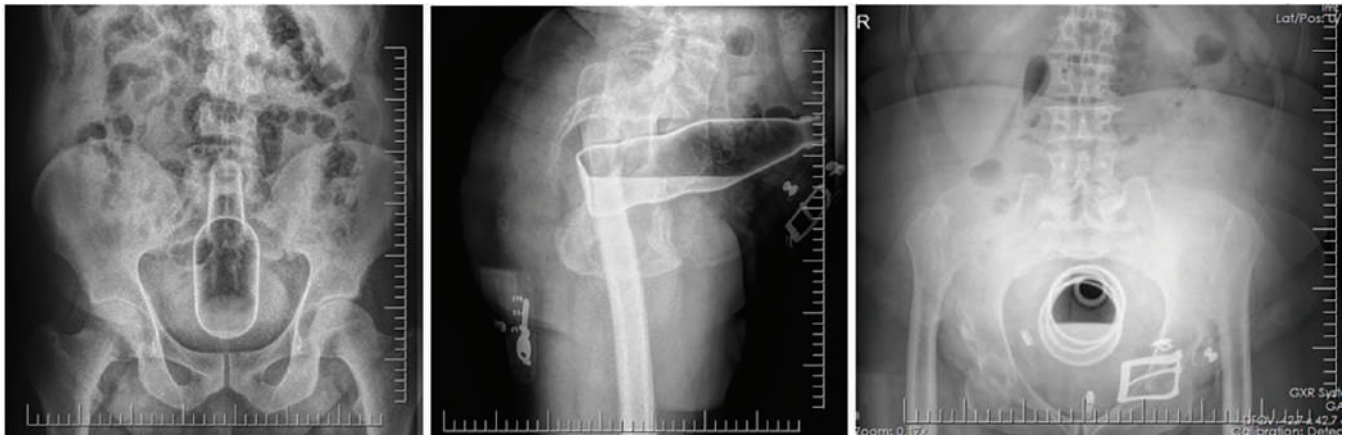

Figure 1. Foreign body on radiography.

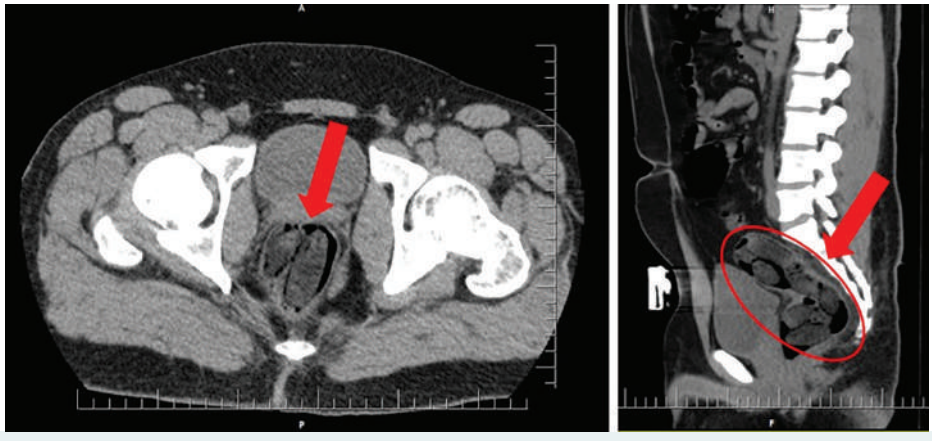

Figure 2. Abdominopelvic CT image showing drug packages in the gastrointestinal tract.

[P-101]

Evaluation of motorcycle accident cases admitted to our emergency clinic in 2025 in terms of ISS and NISS trauma scores

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Objective: Injury severity score (ISS) and new injury severity score (NISS), are anatomical scores calculated based on the abbreviated injury scale (AIS). The NISS scores multiple injuries in the same topographic region better than the ISS. The hypothesis of this study is that it does not show the same success in situations that can cause multiple orthopedic injuries, such as motorcycle accidents.

Material and Methods: In 2025, cases of motorcycle accidents brought to our hospital's emergency department were evaluated in terms of ISS and NISS scores, the clinic they were hospitalised, and need for intensive care. These scores were compared in cases admitted to the orthopedics and traumatology clinic (SPPS 27.0, Mann-Whitney U test).

Results: Of the 306 cases, 22 (7.2%) were admitted to the intensive care unit, 30 (9.8%) to the orthopedics and traumatology clinic, 13 (4.2%) to the thoracic surgery clinic, and 7 (2.3%) to other clinics. The mean ISS score was calculated as 6.57 (1-51) and the mean NISS score as 7.43 (1-51) in all cases. Both the ISS and NISS scores of the hospitalized cases were statistically significantly higher than those of the cases that did not require hospitalization (U=1776.5, p<0.001). The scores were also significantly higher in the cases admitted to the intensive care unit than in other cases (ISS U=180.5 p<0.001 and NISS U=171.5, p<0.001). However, no statistically significant difference was found between cases admitted to the orthopedics and traumatology clinic and cases admitted to other clinics (ISS U=226, p>0.05 and NISS U=230, p>0.05).

Conclusion: While ISS and NISS scores divide the body into 6 regions. ISS determines the highest score in each region and sums the squares of the top 3 regions. NISS, however, sums the squares of the top 3 pathologies regardless of topographical region. If there is multiple trauma in a single region, the ISS score may be lower than the NISS score overall. Therefore, we chose motorcycle accidents that can cause multiple fractures as our target group. Orthopedists make treatment decisions not only based on the severity of the pathology, but also considering age, the patient's general condition, the chosen treatment method, and even hospital conditions. For hospitals that want to measure themselves based on trauma scores, this situation can lead to misleading results. However, we did not obtain statistically significant results. Nevertheless, we believe that the anatomical scoring system NISS should not be used alone.better with one of the physiological trauma scores.

Keywords: Trauma scores, ISS, NISS

Table 1. Statistically results

Compared data	U	p
Hospitalisation	1776	<0.01
Need for intensive care unit	180	<0.01
Ortophedics and traumatology vs. other clinics	230	>0.05

[P-102]

The effect of nursing education on anxiety levels in patients with thoracic tube insertion

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Objective: Chest tube insertion is an invasive procedure that may increase fear, stress, and anxiety in patients. Nursing education provided before and after the procedure may improve patients' adaptation and psychological comfort. This study aimed to investigate the effect of nursing education on hospital anxiety levels in patients undergoing chest tube insertion.

Material and Methods: This study included 35 patients aged 18 years and older who were hospitalized in the Thoracic Surgery Department of Ondokuz Mayıs University Health Practice and Research Center and underwent chest tube insertion. Nursing education lasting 15-20 minutes was provided before and after the procedure. Pulse rate, respiratory rate, systolic and diastolic blood pressure, and body temperature were recorded, and the hospital anxiety assessment score (HAAS) was administered before and after the intervention. Data were analyzed using the SPSS statistical analysis program.

Results: The mean age of the patients was 57.6±16.6 years, and the mean length of hospital stay was 4.7±1.9 days. Of the patients, 40% were female and 60% were male. The mean body weight was 76.5±11.2 kg in female patients and 73.7±16.0 kg in male patients. All patients were mobilized, and 97.1% were fed with regimen 3. According to diagnoses, 65.7% of the patients had lung masses, 8.6% had pneumothorax, and 25.7% had other diagnoses (Table 1). No statistically significant differences were observed in vital signs before and after chest tube insertion ($p>0.05$). However, a statistically significant decrease in HAAS was found after nursing education ($p<0.05$) (Table 2).

Conclusion: Although chest tube insertion is an invasive procedure that increases anxiety, nursing education provided before and after the procedure significantly reduces anxiety levels without causing adverse changes in vital signs. Patient education should be considered a fundamental component of nursing care in surgical interventions.

Keywords: Thorax tube, anxiety, nursing education, nursing care

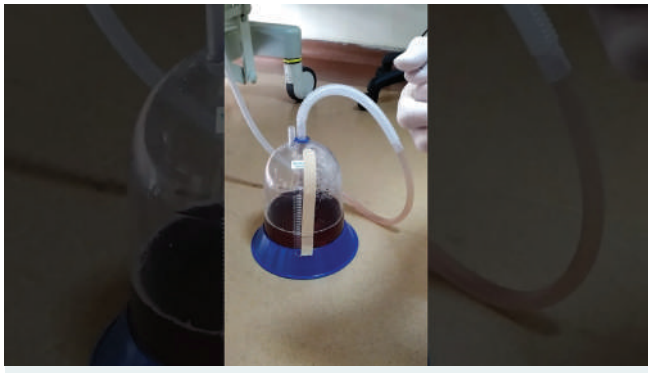

Figure 1. Thorax tube.

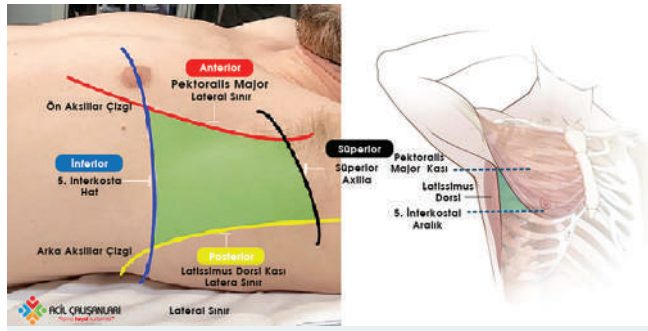

Figure 2. Insertion of a thoracic tube.

Table 1. Demographic characteristics of patients undergoing chest tube insertion

Characteristics	n=35
Age (years), mean ± SD	57.6±16.6
Gender (female/male), n (%)	14/21 (40%/60%)
Weight (kg), mean ± SD - female	76.5±11.2
Weight (kg), mean ± SD - male	73.7±16.0
Length of hospital stay (days), mean ± SD	4.7±1.9
Lung mass, n (%)	23 (65.7%)
Pneumothorax, n (%)	3 (8.6%)
Other diagnoses*, n (%)	9 (25.7%)
Mobilization, n (%)	35 (100%)
Nutrition regimen 1 (liquid), n (%)	1 (2.9%)
Nutrition regimen 3, n (%)	34 (97.1%)

*: Other diagnoses: pleural effusion, achalasia, etc., SD: Standard deviation.

Table 2. Comparison of vital signs and hospital anxiety assessment score (HAAS) before and after chest tube insertion

Parameters (n=35)	Before mean ± SD	After mean ± SD	p
Pulse rate	82.0±10.3	81.0±8.8	0.605
Systolic blood pressure	113.4±9.6	112.3±5.5	0.545
Diastolic blood pressure	69.4±5.9	70.4±4.6	0.422
Respiratory rate	22.3±0.71	22.1±0.7	0.317
Body temperature	36.3±0.28	36.2±0.3	0.188
HAAS	16.8±8.1	10.7±4.6	<0.05

SD: Standard deviation.

[P-117]

National surgical congress proceedings: Trends from 2012 to 2024. What's the next one?

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Objective: Rapid developments and changes in medicine have also led to fundamental changes in surgical disciplines. Turkish surgery is among the countries that have quickly adapted to these developments. In this study, we aimed to examine the thematic changes in the topics of papers and sessions presented at the National Surgical Congresses (UCK) between 2012 and 2024.

Material and Methods: The analysis was conducted using a qualitative comparison method based on accessible abstracts and session titles from the 18th (2012), 19th (2014), 21st (2018), 22nd (2022), and 23rd (2024) UCK, which are available on our association's website. Since the data examined represents only selected sessions and abstracts, not the entire conference content, the results should be considered a sample reflecting the general trends of the conferences. Abstract titles and main session themes were examined to determine the shift in scientific focus over the years within major surgical categories such as endocrine, gastrointestinal/colorectal, and advanced technology.

Results: Four main trends were observed: expansion of disciplinary scope: while there was a strong emphasis on endocrine surgery in 2012 and 2018, as of 2014, the congress content covered all subspecialties of general surgery, including gastrointestinal, colorectal, HPB, and bariatric surgery. Gastrointestinal/colorectal surgery, in particular, has consistently occupied a significant place on the congress agenda. The pace of technological advancement: the field of minimally invasive surgery has evolved from traditional methods in 2012 to advanced techniques such as scarless surgery (TOETVA) in 2018 and robotic surgery in 2022. In 2022, experimental approaches such as 3D bioprinting and molecular biomarkers also held an important place. New areas of expertise: the congress began to include specialized areas such as wound and burn care and adrenal surgery, and in 2024, it highlighted breast surgery, cytoreductive, and complex surgery as main topics. Focus on surgical quality and management: non-clinical but critical topics such as the philosophy of surgical safety, ethics, and the human factor, which became prominent at the 2024 congress, demonstrate the importance modern surgical practice places on holistic management and patient safety.

Conclusion: UCKs have evolved from a sub-discipline focus to a comprehensive scientific platform combining advanced technology and interdisciplinary approaches. We can anticipate that topics at the 2026 congress will include new management approaches such as long-term outcomes of robotic surgery applications and error analysis, or topics at the intersection of technology and basic sciences such as the use of artificial intelligence in gastrointestinal surgical oncology.

Keywords: National surgical congress, general surgery, surgical oncology, artificial intelligence, trend

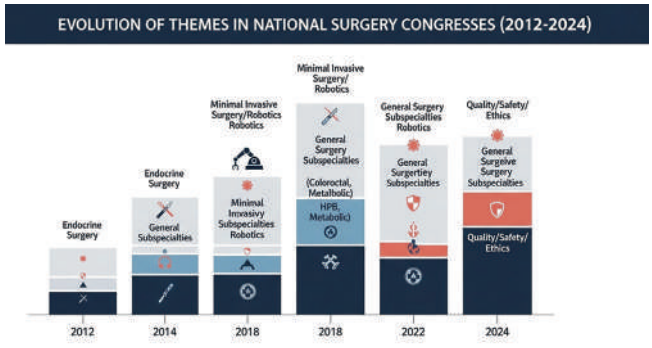

Figure 1. Congress abstract trends over the years.

Ana Konu / Tema	18. UCK 2012 (Görünür Odak)	19. UCK 2014	21. UCK 2018	22. UCK 2022	23. UCK 2024
Baskın Ana Disiplinler	Yoğun Endokrin Cerrahi (Tiroid/Paratiroid)	Çeşitlilik (Kolorektal, HPB, Fıtık, Obezite).	Yoğun Endokrin Cerrahi.	Geniş Çeşitlilik (Endokrin, HPB, Yara, Adrenal).	Kapsamlı (Tüm ana disiplinler, Meme Cerrahisi dahil).
Minimal Invaziv Cerrahi (MIC)	Video Yardımlı Tiroidektomi.	MIC Teknikleri (Rektum).	İzsiz Cerrahi (TOETVA).	Robotik Cerrahi (Adrenal).	Ana Konu (Gelişmiş teknikler ve IONM).
Obezite / Metabolik Cerrahi	Yok.	Var (DM etkileri, teknik karşılaştırmaları).	Yok.	Yok.	Ana Konu
Kolorektal Cerrahi	(Görünürde Yok)	Var (Onkolojik sınırlar, laparoskopi).	Yok.	Yok.	Ana Konu (Pelvik Cerrahi dahil).
İleri Teknoloji / Deneysel	Yok.	Deneysel (FDT).	Yok.	Yüksek Odak (3D Biyobaskılama, miRNA, Nanofiber).	Orta (Teknolojik yardımcılar, IONM).
Cerrahi Kalite / Yönetim	Yok.	Yok.	Yok.	Yok.	Ana Konu (Etik, Güvenli Cerrahi, İnsan Faktörü).
Onkoloji Desteği	Temel onkoloji (rastlantısal karsinom).	İmmünoloji (KIR) ve Onkolojik Sınırlar.	Hastalık ilişkileri (pHPT-PTC).	Moleküler biyoloji (mRNA).	Yüksek Odak (Meme Kanseri alt grupları, Sitoredüktif).

Figure 2. Congress topics.

[P-118]

One-year experience of gastric and colorectal ESD at a tertiary center: Indication diversity and early outcomes

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Objective: Endoscopic submucosal dissection (ESD) is a minimally invasive technique that enables high en-bloc and R0 resection rates for superficial gastrointestinal neoplasms. In Western series, R0 resection rates are reported at 80-91% for gastric lesions and approximately 92% for colorectal lesions. This study aimed to present the spectrum of indications, histopathology, and early clinical outcomes of gastric and colorectal ESD procedures performed over one year at a tertiary center.

Material and Methods: Patients undergoing ESD for gastric or colorectal lesions between 2025 and 2026 were retrospectively analyzed. Demographic data, lesion location, procedural details, histopathology, resection margin status, and complications were recorded. Mucosal defects were closed with endoclips or, if large, left to heal under endoscopic follow-up. Major procedural complications were noted.

Results: A total of 12 patients (7 males, 5 females; mean age 66.2 years) underwent 13 ESD procedures. Five lesions (38.5%) were gastric and eight (61.5%) colorectal. Gastric lesions were located in the antrum (n=3), antrum-corpus junction (n=1), and corpus (n=1); histopathology included GIST (low-risk, 3 cm), hyperplastic polyp with low-grade dysplasia, neuroendocrine tumor (pending), submucosal lesion (possible leiomyoma), and chronic gastritis. Colorectal lesions were located in the cecum (n=3), ascending colon (n=2), transverse colon (n=1), hepatic flexure (n=1), and rectum (n=1); histopathology included tubular adenoma, tubulovillous adenoma, intramucosal carcinoma arising in serrated adenoma, and serrated adenoma. All colorectal lesions had negative lateral and deep margins. No major complications occurred, except one cecal perforation during polyp removal, successfully managed with endoscopic clipping and conservative care. Post-procedure imaging revealed pneumoperitoneum without contrast leakage. One patient required intraperitoneal air aspiration via 16 Fr catheter due to persistent distension; the patient subsequently recovered and was discharged.

Conclusion: Our series demonstrates high R0 resection rates and low complication rates, consistent with Western literature. Notably, gastric subepithelial lesions such as GISTs were successfully enucleated via ESD. R0 resection was also achieved in technically challenging colorectal locations, including the cecum and hepatic flexure, highlighting our center's technical proficiency. These findings suggest that the ESD learning curve can be overcome early, and high success rates may be achieved with experienced endoscopists even with fewer than the previously suggested 50-100 cases. Overall, one-year experience indicates that gastric and colorectal ESD can be performed safely and effectively across a broad spectrum of indications.

Keywords: Endoscopic submucosal dissection (ESD), gastric and colorectal lesions, early outcomes

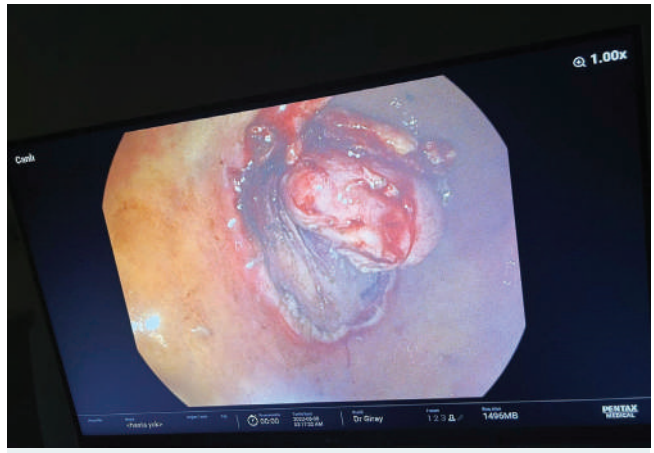

Figure 1. Enucleation was performed by endoscopic submucosal dissection at the level of the gastric incisura angularis.

Figure 2. ESD at the gastric antrum-corpus junction.

Demographic, clinical and histopathological characteristics of patients undergoing ESD

Parameter findings

Number of patients 12

Total ESD procedures 13

Gender7 Male (58.3%)/5 Female (41.7%)

Mean age 66.2 years

Lesion location stomach: 5 (38.5%)/colorectal: 8 (61.5%)

Gastric localizations antrum (n=3), antro-corporal junction (n=1), corpus (n=1)

Gastric histopathology GIST (low risk, 3 cm); hyperplastic polyp with low-grade dysplasia; neuroendocrine tumor?; submucosal lesion (leiomyoma?); chronic gastritis*

Colorectal localizations cecum (n=3), ascending colon (n=2), transverse colon (n=1), hepatic flexure (n=1), rectum (n=1)

Colorectal histopathology tubular adenoma; tubulovillous adenoma; traditional serrated adenoma with intramucosal carcinoma focus (high-grade dysplasia); serrated adenoma

Surgical margins (colorectal) negative (basal and lateral) in all lesions

Major complications none (no perforation or bleeding)

Mucosal defect management closure with endoclips or left for secondary healing in large defects.

[P-120]

Male breast cancer: A single-center retrospective descriptive study

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Objective: Male breast cancer (MBC) accounts for approximately 1% of all breast cancers. Due to its low incidence, data on the clinical, pathological, and biological characteristics of the disease are limited. Diagnosis is often made at an advanced age, and delayed presentation and lack of awareness can negatively affect the prognosis. Because of its rarity, MBC is often managed according to the treatment principles of female breast cancer. This study aimed to define the demographic, surgical, and pathological characteristics of MBC patients operated on at a single center.

Material and Methods: This retrospective and descriptive study was conducted by reviewing the files of male patients who underwent surgery for breast cancer between 2019 and 2025. Patient age, preoperative imaging findings, presence of distant metastasis, surgical method used, histopathological diagnosis, and immunohistochemical characteristics (ER, PR, HER2/CERB, Ki-67) were recorded. Data were anonymized for analysis. In statistical analysis, continuous variables were presented as mean ± standard deviation or median, and categorical variables as number and percentage (%). Since the study is descriptive, no further statistical comparisons were made.

Results: The study included 10 MBC patients. The mean age of the patients was 66.7±11 years. Preoperative evaluation revealed no distant metastases in any patient. The most frequently used surgical method was modified radical mastectomy, and sentinel lymph node biopsy was performed in selected cases. Histopathological diagnosis in all patients was invasive breast carcinoma, NST (ductal type). Immunohistochemical examination showed: ER positivity: 100%, PR positivity: 100%, HER2 (CERB) positivity: 50%, and median Ki-67 value: 15%. These findings indicate that the vast majority of patients have hormone receptor-positive biology.

Conclusion: Our study revealed that MBC is a disease diagnosed at an advanced age and has a high hormone receptor positivity rate. Our findings are consistent with EMC series reported in the literature. The detection of ER and PR positivity in all patients supports endocrine therapy as a fundamental approach in the treatment of EMC. The HER2 positivity rate of 50% suggests that targeted therapies may also play an important role in this patient group. The dominance of modified radical mastectomy in the surgical approach is related to the limited size of male breast tissue and the frequent retroareolar location of tumors. Although MBC is rare, it mostly exhibits hormone receptor-positive biological characteristics. Early diagnosis and appropriate surgery, along with a multidisciplinary approach, can improve the prognosis in these patients.

Keywords: Male breast cancer, hormone receptors, modified radical mastectomy, immunohistochemistry, retrospective study

Figure 1. Left breast malignity - preoperative.

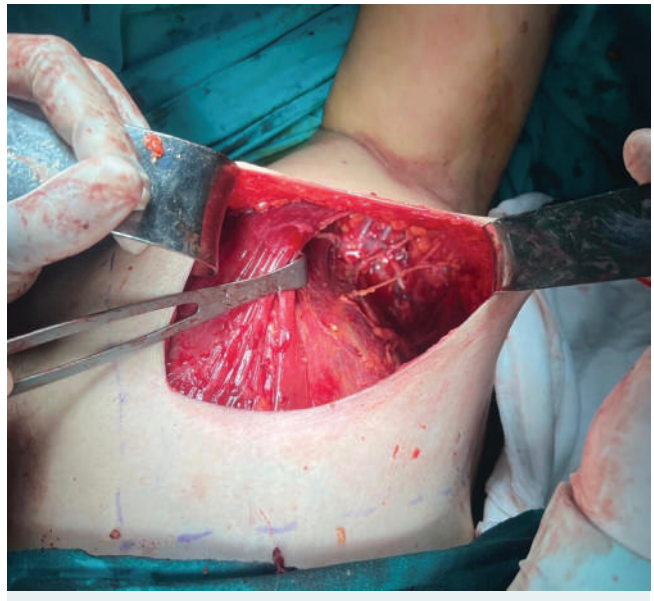

Figure 2. Left modified radical mastectomy - intraoperative.

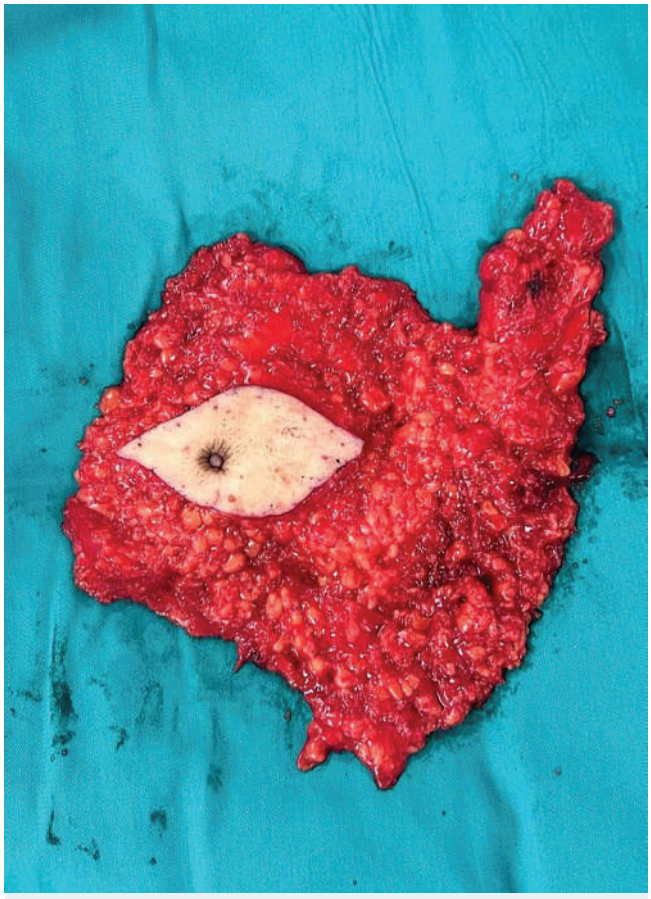

Figure 3. Left modified radical mastectomy - specimen.

Table 1. Demographic, clinical, and pathological characteristics of male breast cancer patients

Variable	Value
Number of patients	10
Sex	Male (10)
Mean age (years)	66.7 (range: 53-84 years)
Tumor location	
-Right breast	3
-Left breast	6
-Bilateral	1
Presence of distant metastasis	2
Surgical procedures	
Mastectomy	4
Modified radical mastectomy	6
Sentinel lymph node biopsy	4
Mean length of hospital stay (days)	4.1 (range: 2-7 days)
Neoadjuvant chemotherapy	1
Chemotherapy	9
Radiotherapy	3
Tumor type	
Invasive ductal carcinoma	10
Mean tumor diameter (cm)	3.2 (range: 2-6 cm)
Lymph node status	
Metastatic lymphadenopathy	5
Reactive lymphadenopathy	10
Perineural invasion	7
Estrogen receptor positivity	10
Progesterone receptor positivity	10
HER2 (c-erbB2) positivity	5
Mean Ki-67 index (%)	25.8 (range: 3-90)
ICU follow-up	0
Blood transfusion	0
Mortality	0
Mean follow-up duration (years)	3.9 (range: 2-7 years)

[P-122]

Bibliometric analysis: AI and colorectal cancer surgery (2020-2026)

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Objective: Artificial intelligence (AI) has rapidly emerged as a transformative technology in the field of colorectal cancer and surgery, offering new opportunities for early detection, diagnosis, treatment planning, and outcome prediction. As research in this interdisciplinary area accelerates, a comprehensive bibliometric analysis is essential to map the scientific landscape, identify influential authors, institutions, and journals, and highlight emerging trends and research hotspots. This study aims to systematically evaluate the global research output on AI applications in colorectal cancer and surgery, and impact of this dynamic and rapidly growing field.

Material and Methods: A bibliometric analysis was conducted using publication data exported from the Scopus database. The dataset comprised articles related to AI and colorectal cancer. Descriptive statistics were used to identify the most prolific authors, journals, and countries. Citation analysis was performed to determine the most influential articles. The top 10 authors, journals, and countries were identified based on publication counts. The most cited articles were ranked by total citation count.

Results: The most prolific authors in the field were Ichimasa, Katsuro and Kudo, Shinei, each contributing 13 publications, followed by Misawa, Masashi (10 publications), and Mori, Yuichi (8 publications). Several other authors, including Miyachi, Hideyuki and Kouyama, Yuta, also made significant contributions. The majority of articles were published in high-impact journals, with Frontiers in Oncology (12 articles) and European Journal of Surgical Oncology (10 articles) being the most frequent sources. "Artificial intelligence in colorectal cancer screening: A review" (2021), received 188 citations. Other highly cited works included "Transformer-based biomarker prediction from colonoscopy images" (2023, 170 citations) and "Artificial intelligence system to determine risk of colorectal cancer" (2021, 152 citations). China led in publication output with 171 articles, followed by the United States (157), United Kingdom (98), and Japan (90).

Conclusion: The bibliometric analysis reveals a rapidly expanding body of literature on AI in colorectal cancer and surgery, with a notable surge in publications over the past five years. This growth reflects the increasing recognition of AI's potential to enhance diagnostic accuracy, optimize surgical outcomes, and personalize patient care. Leading authors and institutions have contributed significantly to the field, and high-impact journals have provided platforms for disseminating key advancements. The shift in research focus from traditional image analysis to advanced deep learning and predictive modeling underscores the evolving landscape and the integration of AI into clinical workflows. However, challenges remain, including the need for standardized methodologies, validation in diverse populations, and addressing ethical and regulatory considerations.

Keywords: Artificial intelligence, colorectal cancer, colorectal surgery

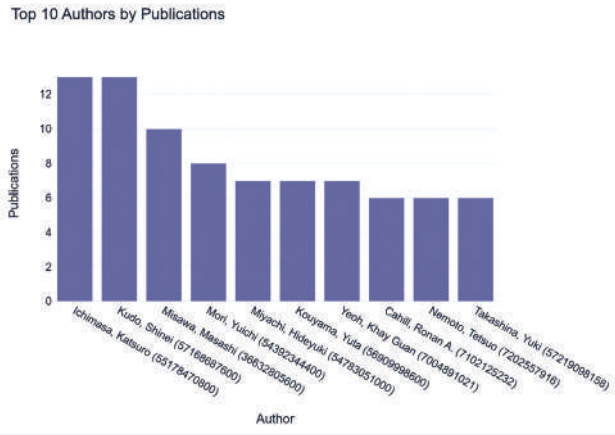

Figure 1. Top 10 authors by publication count.

Journal	Publications
Frontiers in Oncology	12
European Journal of Surgical Oncology	10
Cancers	9
Surgical Endoscopy	8
Gastrointestinal Endoscopy	7
The Lancet Gastroenterology and Hepatology	6
World Journal of Gastroenterology	6
Journal of Clinical Medicine	6
Digestive Endoscopy	6
Annals of Surgical Oncology	5

Figure 2. Top journals.

Title	Cited by	Year
Artificial intelligence in colorectal cancer screening, diagnosis and treatment. A new era	188	2021
Transformer-based biomarker prediction from colorectal cancer histology: A large-scale multicentric study	170	2023
Artificial Intelligence System to Determine Risk of T1 Colorectal Cancer Metastasis to Lymph Node	152	2021
Reducing adenoma miss rate of colonoscopy	102	2021

Figure 3. Most cited articles.

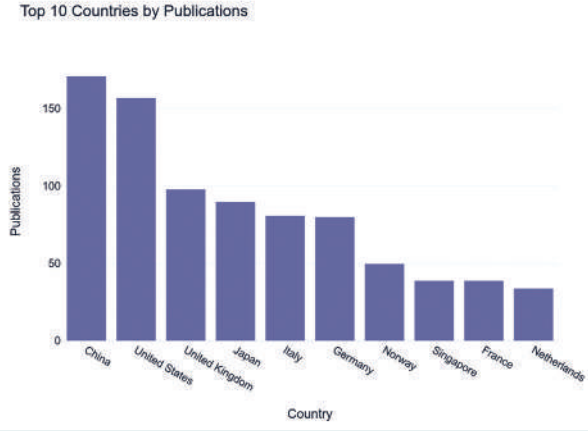

Figure 4. Top 10 countries.

[P-123]

Experience of laparoscopic colorectal surgery in a newly established general surgery clinic: Analysis of the first 26 cases

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Objective: Laparoscopic colorectal surgery (LCS) is becoming the gold standard today due to shorter hospital stays, fewer postoperative complications, faster return to daily life, and oncological results similar to conventional colorectal surgery. In this study, we aimed to present the clinical, perioperative, and short-term postoperative outcomes of LCS cases performed in our clinic, accompanied by demographic data and in light of the current literature.

Material and Methods: The data of 26 patients who underwent laparoscopic surgery for colorectal malignancy and benign diseases in our clinic were retrospectively analyzed. Patients' demographic characteristics, stages, surgical features, operation times, lengths of hospital stay, and complication rates were analyzed.

Results: The study included 15 females (57.6%) and 11 males (42.4%), with a mean age of 64.1 years. The mean body mass index of the patients was 27.11 kg/m^2. The procedures performed were laparoscopic anterior resection in 9 patients (34.6%), laparoscopic right hemicolectomy in 8 patients (30.7%), laparoscopic low anterior resection in 5 patients (19.2%), total mesorectal excision in 1 patient, conventional right hemicolectomy after laparoscopic exploration in 2 patients, and conventional abdominoperineal resection after laparoscopic exploration in 1 patient. The mean operation time was 269 minutes, and the mean hospital stay was 6.6 days. The total number of complications was 2 (7.7%), and no mortality was observed. One patient's intraoperative small bowel injury was repaired primarily, and one patient was reoperated due to a postoperative intraabdominal collection. According to the pathology data, of the 26 patients, 6 (23%) were Stage I, 6 (23%) were Stage II, 12 (46%) were Stage III, and 2 patients were evaluated as having low-grade dysplasia.

Conclusion: LCS applications performed in our clinic are safely carried out with low complication rates and short hospital stays. From the perspective of a training clinic, the contribution of these standardized techniques to resident observation and education is significant.

Keywords: Laparoscopic colorectal surgery, clinical outcomes, minimal invasive surgery

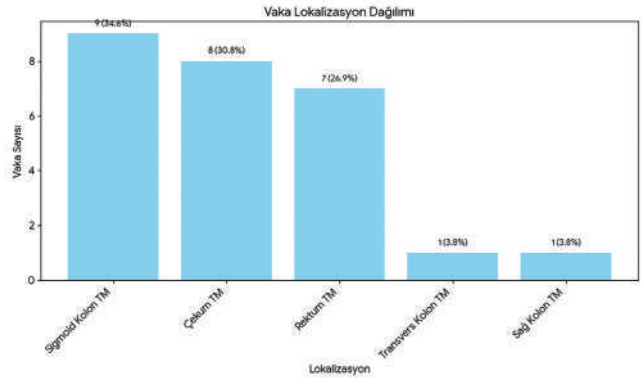

Figure 1. Distribution of case localizations.

[P-124]

Our clinical experience with wirsungojejunostomy types: A single-center experience

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Objective: Whipple procedure-related wirsungojejunostomy anastomosis leakage due to malignancy is a serious complication that prolongs hospital stay and can even significantly increase mortality. This study aimed to evaluate the development and severity of postoperative leakage according to the types of wirsungojejunostomies performed in our clinic between January 2024 and January 2026; a retrospective study was conducted

Material and Methods: Thirty patients who underwent Whipple procedure at our clinic between these dates were retrospectively reviewed. Age, gender, diagnosis, type of wirsungojejunostomy anastomosis, and postoperative amylase level, as well as drain amylase level, were recorded. The Callery fistula risk score, used to determine the risk of leakage, and the ISGPS 2016 scores, used to determine the severity of leakage, were calculated retrospectively from patient data. The development of postoperative leakage/pancreatic fistula in patients was also recorded.

Results: The mean age of the patients was 60.5 years, and 20 patients (66.6%) were male. Postoperative leakage/fistula was present in 5 patients (16.66%). Kakita, Blumgart, Blumgart+Coverage, and Peng methods were used as wirsungojejunostomy types. Leakage risk was calculated retrospectively in patients using the ISGPS 2016 score, and leakage severity was calculated using the Callery fistula score. A parallel relationship was observed between the ISGPS 2016 risk classification and Callery fistula severity; leakage development was more frequent in patients in the high-risk group. According to the Callery leakage score, it was significantly lower in the Blumgart + Coverage group.

Conclusion: Different wirsungojejunostomy techniques applied in our clinic were compared in terms of postoperative fistula risk and severity. The WJ leakage rate was 16.66%, consistent with the rates in the literature. When evaluated according to anastomosis methods, patients who underwent Blumgart+Coverage were predominantly found to have a low- and moderate-risk profile according to the ISGPS 2016 classification, and no clinically significant leakage was observed. This finding demonstrates the protective effect of supporting the anastomosis line and covering the pancreatic surface. In patients who underwent Kakita and Blumgart techniques, leakage development was mostly at Grade A-B level, and Grade C fistulas were not observed. This suggests that these techniques offer acceptable results with appropriate patient selection. However, the higher proportion of patients with a moderate-risk profile in the Blumgart technique group indicates that pancreatic tissue and duct diameter are decisive factors in this technique. In conclusion, this study emphasizes the importance of an individualized surgical strategy based on patient and pancreatic characteristics, rather than a standard approach in the selection of the WJ technique.

Keywords: Whipple, pancreaticojejunostomy, wirsungojejunostomy

Table 1. Preoperative and intraoperative findings for anastomosis types

Anastomoz Tipleri	Antrektomi	Çap (≤3)	Çap(3-6)	Çap(≥6)	Yumuşak Pankreas	Sert Pankreas	AC	Non-AC
Blumgart+Coverage (n:13)	11	4	1	8	6	7	12	1*
Kakita (n:7)	6	3	3	1	3	4	7	0
Blumgart (n:9)	9	3	2	4	3	6	7	2*
Peng (1)	1	1	0	0	1	0	0	1*

*: gastrointestinal stromal tümör, +: nöroendokrin tümör, AC: adeno CA, Non-AC: Non- Adeno CA

Table 2. Analysis of leakage risk and severity of anastomosis types according to ISGPS 2016 and Callery fistula scores

Anastamoz Çeşidi	ISGPS 2016			CALLERY		
	Düşük Risk	Orta Risk	Yüksek Risk	GRADE A	GRADE B	GRADE C
Blumgart+Coverage (n:13)	6	6	1	0	0	0
Kakita (n:7)	3	4	0	1	2	0
Blumgart (n:9)	4	5	0	2	3	0
Peng (n:1)	0	0	1	0	0	0

[P-127]

Laparoscopic repair of giant diaphragmatic hernias: Evaluating the efficacy of the spider-web-like suturing technique combined with composite mesh reinforcement

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Objective: Giant diaphragmatic hernias (GDH) are rare but clinically significant, often leading to severe respiratory and gastrointestinal complications. Surgical repair is challenging, with high recurrence rates, especially in large defects where tension-free closure is difficult. This study evaluates the effectiveness of the spider-web-like suturing technique with composite mesh reinforcement in laparoscopic GDH repair.

Material and Methods: A retrospective analysis of nine patients who underwent laparoscopic GDH repair using the spider-web-like suturing technique between May 2016 and February 2021 was conducted. Patient demographics, preoperative symptoms, intraoperative findings, surgical parameters, and postoperative outcomes were analyzed. The technique involved reducing defect size with spider-web suturing before mesh placement to enhance mechanical support and prevent recurrence (Figure 1).

Results: The mean age was 51.2 years, and the mean hernia defect size was 12.1 cm. The procedure was successfully completed laparoscopically in all cases, with a mean surgical time of 191.1 minutes and hospital stay of 4.4 days. No surgery-related mortality or major complications were observed. Minor complications included transient abdominal distension (all patients) and temporary nausea/indigestion (2 patients). The mean follow-up was 37.7 months, with 89.4% symptom resolution and 93.3% patient satisfaction. No recurrence or mesh-related complications occurred.

Conclusion: The laparoscopic spider-web-like suturing technique with composite mesh reinforcement provides an effective, durable, and minimally invasive approach for GDH repair. It offers low recurrence risk, enhanced mesh stability, and improved patient outcomes (Figure 2). While initial results are promising, further studies with larger cohorts and longer follow-up periods are needed to confirm long-term efficacy.

Keywords: Bochdalek hernia, minimally invasive surgery, mesh fixation

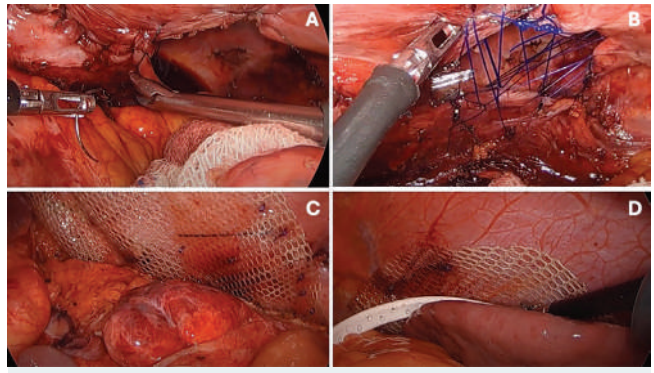

Figure 1. Stepwise repair of a giant diaphragmatic hernia using a spider-web suturing technique and composite mesh placement the giant diaphragmatic hernia was initially reduced by suturing its lateral edges to decrease the defect size. In the area where primary closure was not feasible, sutures were passed through opposing tissues in a spider-web-like fashion to create a structured closure. A composite mesh was then placed over the repaired area and secured for reinforcement. A) The defect is reduced by suturing from three different sides using V-Loc sutures. B) In the area where direct approximation is not possible, sutures are passed through opposing tissues, forming a spider-web-like structure to close the gap. C) A composite mesh is placed over the repaired area, ensuring it extends at least 2 cm beyond the defect, and is secured in place. D) The omentum and spleen are positioned over the repaired area and fixed to provide additional support and protection.

Figure 2. Comparison of preoperative abdominal computed tomography and postoperative chest X-ray images. A) In the preoperative CT scan, it is observed that the diaphragm hernia has allowed the colon, small intestine, stomach, omentum, spleen (white arrow), and kidney (black arrow) to pass into the thoracic cavity, occupying nearly the entire space. B) In the postoperative image, all abdominal organs are seen to be repositioned within the abdominal cavity, and the lung is fully expanded.

[P-128]

Topical etofenomate application in the treatment of anal fissures: Initial results

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Objective: In this study, we investigated the success rate in preventing painful defecation anxiety and improving the patient's overall comfort and relief by using an agent with analgesic, anti-edema, and anti-inflammatory effects in the treatment of anal fissures.

Material and Methods: Twenty consecutive patients were prospectively treated between September and December 2023. The indication was painful defecation and the presence of anal fissures on rectal examination. Topical etofenomat (72 mg/day, 4 times) and laxative suspension were used in cases with symptoms of chronic clinical constipation. Patients were seen 3 and 10 days after starting treatment. All were asked to answer a questionnaire from 0 to 5 (highest) indicating pain during defecation and rectal examination. The mean follow-up period was 3 months.

Results: Fourteen of the patients were women and six were men. The mean age was 34 (20-54). The pre-treatment pain score was 75% (5) in 15 patients and 25% (4) in 5 patients. Bleeding was present in 14 patients (70%), constipation in 12 patients (60%), and burning in 4 patients (20%) as accompanying symptoms. After 10 days of treatment, a significant reduction in pain score was observed in 16 patients. In 14 patients, the score was 0, meaning no pain, and in 2 patients, the score was 1, indicating regression of the pathology on physical examination. In two female patients, the pain score decreased from 4 to 3, while in the other two patients (both women), treatment was unsuccessful. In the vast majority of patients (80%), accompanying symptoms were also reduced (20%) or disappeared (60%). The only complication of treatment is perianal burning or itching (10%). One of these two patients had perianal maceration.

Conclusion: The data obtained from our study are preliminary and require further studies. On the other hand, local application of etofenomate accelerates fissure healing without any significant side effects and seems promising in the anamedical treatment of fissures.

Keywords: New supportive approaches in the medical treatment of anal fissures

[P-129]

Can bile leakage be prevented in complex and challenging biliary surgery?

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Objective: Laparoscopic cholecystectomy is one of the most commonly performed surgical procedures worldwide. However, bile leakage, stricture formation, intra-abdominal collections, cholangitis, and the need for reintervention may occur following cholecystectomy or other biliary tract surgeries. Due to its potent detergent effect on tissues, bile may cause severe inflammation, tissue destruction, and fibrosis, thereby complicating the treatment process. This issue becomes particularly critical in complex biliary cases requiring repeated interventions, where safe access to the biliary system poses a significant challenge. The concept of permanent access has traditionally been employed in situations necessitating long-term drainage and repeated interventions. This study aimed to evaluate the feasibility of a permanent access-like approach in the management of difficult biliary pathologies.

Material and Methods: One patient who developed a full-thickness common bile duct injury during cholecystectomy and two patients who developed anastomotic leakage following hepaticojejunostomy were included in the study. In all cases, the tissues were observed to be severely inflamed, edematous, and friable. Following Roux-en-Y hepaticojejunostomy, a catheter was placed across the anastomotic line and exteriorized through the abdominal wall by fixing it to the proximal (afferent) limb of the jejunal loop used for the anastomosis. In this manner, bile was diverted externally in the early postoperative period, thereby reducing pressure on the anastomotic site. During postoperative follow-up, biliary drainage was maintained via the permanent access-like route, and serial cholangiographic evaluations were performed. Technical success, complications, and clinical outcomes were retrospectively assessed.

Results: Active bile drainage through the catheter was observed in all three patients during the postoperative period, and no intra-abdominal bile leakage was detected. All patients were discharged on postoperative day 10. At three weeks, cholangiography performed via the catheter demonstrated no evidence of anastomotic leakage, and contrast passage to the distal intestine was confirmed in all cases. The catheter was subsequently clamped and removed in a controlled manner. Following catheter removal, normalization of stool color was observed in all patients. One patient developed a superficial wound infection, and one patient developed an incisional hernia. No episodes of cholangitis were observed.

Conclusion: In patients requiring long-term follow-up and repeated interventions after biliary tract surgery, permanent access is known to provide a safe and effective option that improves patient comfort. When applied in appropriately selected patients and in experienced centers, the combination of catheter placement and a permanent access approach may represent a valuable surgical option in the management of complex biliary diseases.

Keywords: Bile leakage, permanent access, hepaticojejunostomy

Figure 1. Intraoperative cholangiography.

Visualization of the bile ducts and the anastomosis line using intraoperative cholangiography.

[P-130]

Enteral and parenteral nutrition management in surgical intensive care patients: An integrative review

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Objective: Malnutrition in surgical intensive care units is a significant clinical problem that increases morbidity, mortality, and cost, as well as leading to delayed wound healing, increased risk of infection, loss of muscle strength, and prolonged hospital stay. Intensive care patients undergoing surgical procedures face significant physiological changes due to metabolic stress response. Conditions such as surgical stress, trauma, and sepsis cause rapid loss of body energy stores, negative nitrogen balance, and impaired immune function. The aim of this review is to synthesize, in light of current literature, the assessment of nutritional status in surgical and critically ill patients, the indications, contraindications, timing, and comparison of nutrition, and the importance of evidence-based nursing care in this process.

Material and Methods: This study used an integrative review method. Literature searching was conducted in the Google Scholar database using the keywords "enteral nutrition," "parenteral nutrition," "surgical patient," "intensive care," and "nursing care." Turkish studies published between 2010 and 2025, with full text available, were evaluated without any limitations regarding study type. Twelve studies were included in the review. The studies examined consisted of systematic reviews, meta-analyses, and clinical trials.

Results: The studies show that the malnutrition rate can reach up to 50% in intensive care patients undergoing surgical procedures. Therefore, nutritional support is an integral part of the treatment process. Any patient who stays in the intensive care unit for more than 48 hours should be considered at risk of malnutrition. Enteral nutrition should always be the first choice for patients with a functional gastrointestinal system; however, parenteral nutrition is life-saving when the gastrointestinal system is unusable or enteral nutrition is insufficient. Enteral nutrition preserves the mucosal integrity of the gastrointestinal system, is more physiological, reduces the risk of infection, and is less expensive than parenteral nutrition. In critically ill patients who are hemodynamically stable and have gastrointestinal function, it is recommended to start nutrition within the first 24-48 hours. Post-surgical accelerated recovery protocols also support avoiding prolonged fasting and initiating early nutrition.

Conclusion: In surgical and intensive care patients, nutritional support is a crucial part of treatment, not only to close the calorie deficit but also to manage the metabolic response and accelerate recovery. While the "use it if the gut is working" principle remains valid, parenteral support should be used when the targeted energy intake cannot be achieved. The success of nutritional management depends on early initiation, correct route selection, regular monitoring, and evidence-based nursing care.

Keywords: Enteral nutrition, parenteral nutrition, surgical patient, intensive care, nursing care

[P-131]

Temporary grafting as a barrier to protect brachial vein burn developed as a result of electrical arc burn

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Objective: In fourth-degree burns caused by high-voltage arc fires, subcutaneous tissues, muscles, and even internal organs have been observed to be affected. Vascular burns are rare complications and are difficult to detect and treat.

Material and Methods: A 46-year-old male patient was electrocuted and fell from a height after contact with a high-voltage power line. He was referred to our emergency clinic from a secondary healthcare center three hours after the trauma. The characteristics of his burns, the treatment applied, and the results were retrospectively evaluated.

Results: The patient had grade 3 and 4 burns covering most of the right upper extremity, grade 3 burns in the right axilla, and grade 3 burns covering almost the entire lateral aspect of the right thorax and abdomen. Compartment syndrome was detected in the right hand and forearm. Emergency decompression surgery was performed. Exploration was carried out to the axilla using a Lazy-S incision. Widespread necrosis was detected in all muscles of the volar surface of the forearm and debrided. An adventitial burn was observed in a 1 cm area 10 cm from the axilla in the proximal brachial vein. To prevent traumatization and injury to this area during dressing changes, the entire brachial vein was closed with a temporary split-thickness graft. In the subsequent period, after escharectomies, all burn areas were closed with partial-thickness grafts in 2 sessions starting from the 15th day. Advanced electromyographic examination of the patient showed near-complete loss of radial, ulnar, and median nerve conduction in the right arm. At six months, there were no remaining skin defects or open wounds, and although right upper extremity function had partially improved, it remained severely plegic. Venous Doppler examination of the right upper extremity revealed no pseudoaneurysm, and venous flow was normal.

Conclusion: Decompression surgery performed within the first 6 hours and by a burn center team yields the best results. In this case, we wanted to report that multiple compartments were affected, numerous muscles, tendons, and vascular structures were involved, therefore the incision (Lazy-S is preferred in our center) was kept wide, and the exposed venous structure was protected with a temporary partial-thickness skin graft. Synthetic barriers can also be used as an alternative. However, we found the skin graft suitable to allow visualization of the area where frequent debridement may be necessary. Temporary partial-thickness skin grafts can be used to protect exposed vascular structures for evaluation of necrosis and underlying tissues.

Keywords: Burn, vascular injury, graft

Figure 1. Burn areas, right upper extremity.

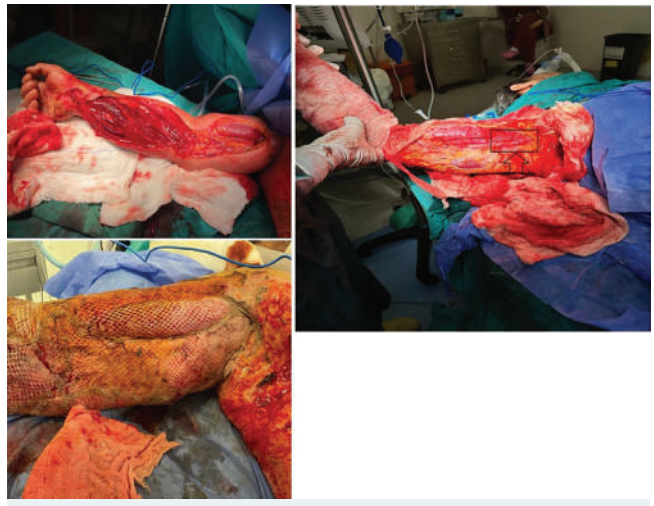

Figure 2. Before fasiatomy.

Brachial venous burn and temporary grafting.

[P-132]

Experience with 120 TAPP cases in a secondary care center

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Objective: Laparoscopic transabdominal preperitoneal (TAPP) repair is a widely accepted approach for inguinal hernia treatment. This study presents early outcomes from 120 TAPP procedures performed in a secondary care hospital.

Material and Methods: Between October 2024 and July 2025, a total of 120 TAPP cases performed by a consistent surgical team at Zonguldak Karadeniz Ereğli State Hospital were retrospectively analyzed. All patients underwent standardized procedures using polypropylene mesh, absorbable tackers for fixation, and continuous closure of the peritoneum with 3/0 V-Loc suture. Hernia defects were left open.

Results: Patients ranged from 20 to 75 years of age, with 108 males. The mean BMI was 32. Comorbidities included hypertension (40%), diabetes mellitus (26%), COPD (8%), and coronary artery disease (32%). Among the cases, 104 were primary and 16 were recurrent hernias. The average operation time was 40 minutes. One case experienced epigastric artery injury requiring drainage. Postoperatively, 2 patients developed atelectasis and 6 developed seromas, 2 of which required interventional drainage. No wound infection, mesh infection, ileus, or chronic pain was observed. VAS scores were 6 on day 1 and 2 on day 10.

Conclusion: Our experience shows that TAPP repair can be safely and effectively performed even in a secondary care hospital. Low complication rates and high patient satisfaction were achieved through consistent surgical technique and team standardization. Peritoneal closure and leaving hernia defects open were found to be safe strategies.

Keywords: Inguinal hernia, laparoscopic hernia repair, postoperative complications, secondary care center, transabdominal preperitoneal (TAPP)

Table 1. Demographic and perioperative characteristics of the patients (n=120)

Parameter	Value
Number of patients	120
Age (range)	20-75
Sex	108 male/12 female
BMI (mean)	32
HTN/DM/COPD/CAD	48/32/10/38
Primary/recurrent	104/16
Unilateral/bilateral	106/14
Mean operative time	40 dk
Periop. complication	1 epigastric artery injury
Length of hospital stay (discharge time)	100 patients: 24 h; 15 patients: 48 h; 2 patients: 72 h
Postoperative complications	2 atelectasis, 6 seroma
VAS score (POD 1/POD 10)	6/2

[P-133]

Effects of preoperative parameters and compliance with the weight loss process on post sleeve gastrectomy weight loss

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Objective: Obesity is a chronic disease that is increasingly prevalent and poses a significant risk of morbidity and mortality. Individuals with a body mass index (BMI) of 30 kg/m² or higher are classified as obese, and obesity is associated with health issues such as diabetes, cardiovascular diseases, and hypertension. Bariatric surgery is considered one of the most effective methods for achieving sustained weight loss. Sleeve gastrectomy is a commonly performed procedure that reduces stomach volume, thereby limiting food intake and providing metabolic benefits. However, surgical success is not solely dependent on the procedure itself but also on patients preoperative parameters and adherence to preoperative education. The aim of this study is to evaluate the effects of preoperative patient parameters and compliance with preoperative education on postoperative weight loss in patients undergoing sleeve gastrectomy.

Material and Methods: This retrospective study includes 113 patients who underwent sleeve gastrectomy at Ankara Bilkent City Hospital Obesity Center between December 2019 and December 2023. Inclusion criteria included patients aged 18 years and older who underwent sleeve gastrectomy and completed the follow-up process. Patients who underwent other bariatric surgical procedures or revision surgery were excluded from the study. The evaluation parameters included age, gender, preoperative and postoperative weight, BMI, waist to hip ratio, blood pressure, HbA1c, and lipid profile.

Results: The mean age of the patients was 42.22±11.55 years, with 83.2% being female and 16.8% male. Comorbid conditions such as diabetes (29.2%) and hypertension (18.6%) were identified. The average weight loss at postoperative 3 months was -28.37±12.48 kg for male patients and -22.45±8.85 kg for female patients (p=0.035). The total weight loss at postoperative 12 months was -42.32±15.81 kg for males and -35.30±12.69 kg for females (p=0.020). A moderate, positive, and statistically significant relationship was found between total and excess weight loss in the preoperative 3 months and excess weight loss at postoperative 3 and 12 months (p<0.005). The results indicate that as preoperative 3 month weight loss increases, postoperative 3 month and 12 month weight loss also increases.

Conclusion: This study demonstrates that preoperative patient parameters and compliance with preoperative education have a significant impact on postoperative weight loss in patients undergoing sleeve gastrectomy. Male patients experienced greater weight loss than females. Furthermore, adherence to preoperative education and preparation was found to support postoperative weight loss. These findings provide guidance for patient selection criteria and preoperative education processes in bariatric surgery applications.

Keywords: Obesity, sleeve gastrectomy, weight loss

Table 1. Pairwise comparison results of the time effect of total weight loss (TWL) and excess weight loss (EWL) values

	Ort±SS	Medyan (Min-Maks)	p(Zaman)	
***Toplam Kilo Kaybı (TWL)**				
Preop 3 ay	-6.48±6.54	-6.0 (-32.0- +12.0)		
Postop 3.ay	-23.44±9.75	-23.0 (-64.0 -3.0)	χ2=221.535	p<0.001
Postop 12.ay	-36.48±13.45	-35.0 (-88.0 -11.0)		
Fazla Kilo Kaybı (EWL) (%)				
Preop 3 ay	9.73±7.44	8.0 (0-32)		
Postop 3.ay	35.45±12.55	35.0 (2-68)	χ2=221.601	p<0.001
Postop 12.ay	55.12±16.10	55.0 (18-90)		

*χ^2: Friedman Testi. *Preop 3 ayda Kilo alan bireyler olduğu kilo kaybı eksi olarak gösterilmiştir.*

Table 2. The relationship between excess weight loss (EWL) preoperatively at 3 months and Excess weight loss (EWL) postoperatively at 3 and 12 months

	Fazla Kilo Kaybı (EWL) Preop 3 ay	
	r	p
Fazla Kilo Kaybı (EWL) Postop 3.ay	0.436	**<0.001**
Fazla Kilo Kaybı (EWL) Postop 12.ay	0.271	**0.004**

r:Spearman İlişki Katsayısı

[P-134]

Endoscopic submucosal dissection for gastrointestinal polypoid lesions: A single-center experience

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Objective: Endoscopic submucosal dissection (ESD) is a curative and organ-preserving treatment modality that can be applied as an alternative to surgery in superficial gastrointestinal neoplastic lesions. This study aimed to evaluate the clinical and pathological outcomes of ESD procedures performed at our center and to assess procedure-related complications.

Material and Methods: Patients who underwent ESD at the Surgical Endoscopy Unit of Marmara University Pendik Training and Research Hospital between September 2024 and January 2026 were retrospectively analyzed. A total of 20 patients were included. Lesion localization, size, en-bloc and R0 resection rates, complications, and histopathological results were evaluated. One patient whose pathology report was not yet available was excluded from the study.

Results: The mean age of the patients was 65 years. Seventeen lesions (85%) were colorectal and three (15%) were gastric in origin. Lesion size was ≤20 mm in seven patients (35%) and >20 mm in thirteen patients (65%). En-bloc resection was achieved in 16 patients (80%), and R0 resection in 18 patients (90%). Bleeding occurred in four patients (20%); three were early and one was delayed. All bleeding episodes were successfully managed with endoscopic clip application. Perforation was observed in three patients (15%). In two patients, perforation was recognized intraoperatively and closed with endoscopic clips. One of these cases involved a 3 cm sessile lesion in the sigmoid colon, in which a wall defect developed during deep dissection. In one patient, no obvious perforation was detected during the procedure; however, minimal free air was identified on postoperative CT. This patient was managed conservatively following clip application, and no emergency surgery was required. Histopathological examination revealed tubular adenoma in seven patients, tubulovillous adenoma in six, sessile serrated lesion in four, and T1 adenocarcinoma in three patients. Among the gastric lesions, one patient had a well-differentiated neuroendocrine tumor (Grade 1) located in the corpus, with lymphovascular and perineural invasion and positive deep and lateral margins. One of the two patients with non-R0 resection had invasive adenocarcinoma in the sigmoid colon (pT1, Grade 3, lymphovascular invasion positive, lateral margin positive) and underwent laparoscopic anterior resection; no residual tumor was detected in the surgical specimen. The other patient is under multidisciplinary evaluation. No recurrence was observed during early follow-up.

Conclusion: ESD performed at our center achieved high R0 resection rates, and procedure-related complications such as bleeding and perforation were largely managed endoscopically. In cases of non-curative resection, ESD played an important role in guiding further treatment decisions.

Keywords: ESD, polypoid lesions, en-bloc resection

[P-135]

Clinical value of RDW in predicting the presence of lymphoma: A retrospective study

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Objective: Lymphoma is a malignancy characterized by frequently non-specific clinical and laboratory manifestations, necessitating histopathological assessment for a definitive diagnosis. In clinical practice, there is a critical need for readily accessible parameters to predict which patients require prioritization for invasive diagnostic interventions. The objective of this study is to evaluate the clinical utility of specific hematological and biochemical parameters, derived from routine laboratory investigations, in predicting the presence of lymphoma among patients undergoing evaluation for suspected malignancy.

Material and Methods: Patients who underwent axillary lymph node sampling after being referred from the hematology clinic with suspected lymphoma between February 2024 and February 2026 were included in the study. Based on histopathological diagnosis, patients were divided into two groups: Those diagnosed with lymphoma and those who were not. Age and gender data, along with lymphocyte count, neutrophil-to-lymphocyte ratio (NLR), red cell distribution width (RDW), lactate dehydrogenase (LDH), albumin, and systemic immune-inflammation index (SII) values, were retrospectively analyzed. Data were analyzed using SPSS version 23.0. In descriptive statistics, categorical variables were presented as numbers and percentages, while continuous variables were expressed as mean ± standard deviation or median (interquartile range). Differences in categorical variables between groups were analyzed using appropriate chi-square tests, and differences in continuous variables were assessed using the Mann-Whitney U test. Statistical significance was set at $p<0.05$.

Results: A total of 27 patients were included in the study. The mean age of the patients was 54.5±18.1 years, and 51.9% were male. It was determined that 40.7% (11 patients) were diagnosed with lymphoma. No statistically significant differences were observed between the groups with and without a lymphoma diagnosis in terms of age ($p=0.394$), gender ($p=0.532$), lymphocyte count ($p=0.294$), NLR ($p=0.080$), LDH ($p=0.162$), albumin ($p=0.080$), and SII ($p=0.121$). The median RDW value was 16.20 (15.50-18.60) in the lymphoma group and 14.45 (12.70-15.93) in the non-lymphoma group. RDW values were found to be statistically significantly higher in the lymphoma group compared to the non-lymphoma group ($p=0.039$).

Conclusion: These findings suggest that routine blood parameters may guide clinicians in evaluating suspected lymphoma. Specifically, the association between RDW and lymphoma presence indicates its potential as a simple, cost-effective supportive marker in clinical decision-making. However, these results should not be used independently for diagnosis and warrant validation through larger, prospective studies.

Keywords: Lymphoma, RDW

[P-136]

Retrospective analysis of colorectal cancer surgery before, during, and after the COVID-19 pandemic (2018-2025)

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Objective: This study aimed to evaluate the impact of the COVID-19 pandemic on colorectal cancer diagnosis and surgical treatment processes by comparing emergency/elective surgery rates and disease stage at presentation across the pre-COVID, COVID, and post-COVID periods.

Material and Methods: In this retrospective single-center study, the periods were defined as follows: Pre-COVID (March 2018-February 2020), COVID (March 2020-April 2022), and post-COVID (May 2022-December 2025). Patients aged ≥18 years with histopathologically confirmed colon cancer who underwent elective or emergency surgery and whose data were accessible were included. Patients with rectal cancer were excluded. Emergency versus elective surgery rates, disease stage [early stage (Stage I-II) vs advanced stage (Stage III-IV)], and presence of metastatic disease were compared across the three periods.

Results: A total of 446 colorectal cancer cases were analyzed (pre-COVID: n=130, COVID: n=101, post-COVID: n=215). Emergency surgery rates during the pre-COVID, COVID, and post-COVID periods were 17.69% (n=23), 11.88% (n=12), and 13.49% (n=29), respectively, with no statistically significant difference between periods (p=0.38). The proportion of patients presenting with advanced-stage disease was 59.2% (n=77) in the pre-COVID period, 58.4% (n=59) during COVID, and 48.8% (n=105) in the post-COVID period, with no statistically significant difference (p=0.10). Similarly, metastatic disease rates were 11.5% (n=15), 12.9% (n=13), and 8.8% (n=19) across the respective periods, and the difference was not statistically significant (p=0.50).

Conclusion: No statistically significant differences were observed among the three periods regarding advanced-stage diagnosis, metastatic disease rates, or emergency surgical presentation in colorectal cancer patients at our center. However, compared with the pre-COVID and COVID periods, a decreasing trend in advanced-stage presentation and metastatic disease rates was observed in the post-COVID period. Multicenter studies are needed to better clarify the impact of the pandemic on colorectal cancer diagnosis and treatment processes.

Keywords: Colorectal cancer, COVID-19

[P-137]

Time-dependent effects of botulinum toxin and glyceryl trinitrate on postoperative pain after excisional hemorrhoidectomy: A systematic review and meta-analysis

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Objective: Postoperative pain following excisional hemorrhoidectomy remains a significant clinical problem, adversely affecting patient comfort, recovery, and return to daily activities. Internal anal sphincter spasm is considered a major contributing factor, along with other multifactorial mechanisms. Chemical sphincter relaxation strategies, including botulinum toxin and topical glyceryl trinitrate (GTN), have been proposed to reduce postoperative pain. However, their time-dependent efficacy has not been clearly established. This study aimed to evaluate and compare the effectiveness of botulinum toxin and GTN in postoperative pain control using a systematic review and meta-analysis.

Material and Methods: This systematic review and meta-analysis was conducted in accordance with PRISMA 2020 guidelines. PubMed was systematically searched for randomized controlled trials evaluating botulinum toxin or topical GTN for pain control after excisional hemorrhoidectomy. Studies involving stapled hemorrhoidopexy or Doppler-guided techniques were excluded. Pain outcomes were standardized to a 0-10 visual analog scale. Mean differences (MD) with 95% confidence intervals (CI) were calculated using a random-effects model for postoperative days 1, 3, and 7.

Results: Nine randomized controlled trials were included in the systematic review, and eight studies comprising 452 patients were eligible for meta-analysis. On postoperative day 1, GTN significantly reduced pain compared to controls (MD -0.72, 95% CI -1.18 to -0.26; p=0.002; I^2=48%), whereas botulinum toxin showed no significant effect (MD -0.21, 95% CI -0.58 to 0.16; p=0.26). On postoperative day 3, both GTN (MD -0.64, 95% CI -1.09 to -0.19; p=0.005; I^2=52%) and botulinum toxin (MD -0.68, 95% CI -1.12 to -0.24; p=0.003; I^2=46%) significantly reduced pain scores. On postoperative day 7, botulinum toxin demonstrated a greater and more consistent analgesic effect (MD -1.12, 95% CI -1.63 to -0.61; p<0.001; I^2=34%), while GTN was not statistically significant (MD -0.38, 95% CI -0.82 to 0.06; p=0.09). Headache was the most common adverse event with GTN, occasionally leading to discontinuation. Botulinum toxin was not associated with increased serious adverse events.

Conclusion: Chemical sphincter relaxation demonstrates time-dependent effects on postoperative pain following excisional hemorrhoidectomy. GTN provides superior pain relief in the early postoperative period, whereas botulinum toxin offers more sustained analgesia in later stages. Considering its single-dose administration and favorable safety profile, botulinum toxin may represent a more durable analgesic option. Further high-quality randomized controlled trials are required to determine optimal treatment strategies.

Keywords: Botulinum toxin, excisional hemorrhoidectomy, postoperative pain

[P-138]

Placement of markers and the impact on surgical outcomes in node-positive breast cancer patients prior to neoadjuvant therapy

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Objective: Accurate surgical management of the axilla after neoadjuvant chemotherapy (NACT) is crucial to prevent unnecessary axillary lymph node dissections (ALND). This study aimed to evaluate the impact of marker (clip) placement in biopsy-proven metastatic axillary lymph nodes prior to NACT on surgical and oncological outcomes.

Material and Methods: A total of 192 patients who underwent surgery after NACT at our tertiary breast surgery center between 2019 and 2024 were retrospectively analyzed. Patients were divided into two groups based on whether a marker was placed in the axillary lymph node. Surgical approach [sentinel lymph node biopsy (SLNB)/ALND], number of excised lymph nodes, pathological response, and surgery-related complications were compared between groups. Statistical analyses were performed using SPSS version 21.0, and p values <0.05 were considered statistically significant.

Results: Among the 192 patients, marker placement in the axillary lymph node was performed in 124 patients. In the marker group, the sensitivity (33.7%) and negative predictive value (14.7%) of SLNB were higher. In contrast, specificity was higher in the non-marker group (58.3%). No significant difference was observed between patients undergoing SLNB and ALND in terms of surgical complications such as reoperation and lymphedema. Univariate analysis identified advanced nodal stage (N2) (p=0.011) and older age (p=0.016) as factors significantly associated with the need for ALND.

Conclusion: Removal of the marker-placed lymph node during axillary evaluation after NACT improves the accuracy of axillary staging and enhances the reliability of SLNB. Marker placement is an effective method that may reduce the need for ALND in appropriately selected patients. However, the decision to avoid axillary dissection in patients with high nodal burden should be made with caution.

Keywords: Axilla, breast cancer, marker, neoadjuvant chemotherapy, sentinel lymph node

[P-139]

Immediate breast reconstruction concurrent with mastectomy: Our clinical experience

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Objective: Approximately one in eight women worldwide will be diagnosed with breast cancer during their lifetime. Preserving psychosocial well-being is particularly important for patients with a history of mastectomy due to breast cancer or an increased risk of developing breast cancer. Reconstructive options include autologous reconstruction and implant-based techniques. Although autologous reconstruction was more commonly preferred before the 2000s, implant-based reconstruction has become markedly more popular in recent years. This study aimed to report the clinical outcomes of patients who underwent immediate breast reconstruction at the time of mastectomy.

Material and Methods: Thirty-two patients who underwent immediate implant-based breast reconstruction in the subpectoral plane concurrently with mastectomy between January 2024 and January 2026 were retrospectively reviewed.

Results: The mean age of female patients was 42.8 years (range, 29-55). The mean body mass index was 19.60 kg/m^2 (range, 14.56-25.62). The mean length of hospital stay was 6.84 days. Subcutaneous mastectomy and reconstruction were performed in 32 breasts: unilateral in 29 patients (90.6%) and bilateral in 3 patients (9.4%). The mean breast specimen weight was 511.4 g. The mean implant volume was 399.1 cc (range, 250-600). No complications occurred in 22 of 32 patients. Complications were observed in 10 patients, including one patient who underwent bilateral subcutaneous mastectomy and reconstruction. Among the 10 breasts with complications, partial skin necrosis occurred in 3, bleeding in 1, wound dehiscence in 5, and pneumothorax in 1 patient. Patients with wound complications were treated with debridement and primary closure. Among molecular subtypes, the most common were luminal A (n=11) and luminal B (n=9).

Conclusion: Our single-center experience suggests that immediate subpectoral implant-based reconstruction at the time of mastectomy is a feasible option and that complications are largely manageable. Appropriate patient selection, careful assessment of mastectomy flap quality, and multidisciplinary follow-up are critical to reducing complications. Immediate reconstruction is often preferred, particularly by patients with greater cosmetic concerns. Some studies have identified immediate mastectomy plus reconstruction as a factor associated with reduced psychiatric comorbidity. Given the multitude of parameters involved—together with the cancer treatment process and patient adherence—it is evident that optimal treatment selection requires a multidimensional evaluation.

Keywords: Breast cancer, immediate, breast reconstruction

Figure 1. Postoperative 1st month.

Table 1. Patient characteristics and surgical parameters

Number of patients	**32**
Age (years)	42.8±6.4 (min-max: 29-55)
BMI (kg/m^2)	19.60±2.50 (min-max: 14.56-25.62)
Hospital stay (days)	6.84±1.71 (median 7; min-max 4-11)
Implant volume (cc)	399.1±90.4 (median 405; min-max 250-600)
Breast weight (g)	511.4±260.7 (n=18; min-max 140-1120)

[P-140]

A rare and aggressive malignancy: Clinical, surgical, and pathological analysis of our adrenocortical carcinoma cases

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Objective: Adrenocortical carcinoma (ACC) is a rare but highly aggressive endocrine malignancy characterized by a distinct biological behavior and poor prognosis. This study aimed to evaluate the demographic, clinical, surgical, and pathological characteristics, along with adjuvant therapy, recurrence, and follow-up outcomes of patients who underwent adrenalectomy and were histopathologically diagnosed with ACC in our clinic.

Material and Methods: Eleven patients who underwent adrenalectomy and were diagnosed with ACC based on pathological reports were retrospectively analyzed. Demographics, clinical presentation, hormonal functional status, radiological and surgical findings, and pathological parameters (Weiss score, Ki-67, mitosis, invasion status, and ENSAT staging) were recorded. Additionally, adjuvant mitotane therapy, recurrence, follow-up duration, and mortality data were collected. Continuous data were mean ± standard deviation or median (min-max), while categorical variables were expressed as frequencies and percentages.

Results: The study included 11 patients (mean age: 50.3 ± 13.7 years; 54.5% male). Mean BMI was 30.2 ± 8.2 kg/m^2 and ASA III rate was 54.5%. Incidentalomas were found in 63.6%. Functional tumors comprised 63.6%, with cortisol excess (Cushing's) as the primary presentation (36.4%); no virilization or feminization occurred. Hyperaldosteronism, hypokalemia, and hypertension rates were 9.1%, 9.1%, and 27.3% (Table 1A). Median operative time was 180 (95-300) minutes. Complication rate was 18.2%; none were Clavien-Dindo $\ge$III. Median hospital stay was 6 (3-12) days (Table 2B). Pathology showed capsular invasion in 54.5% and vascular invasion in 45.5%. R0 resection rate was 72.7% (Table 3B). Median tumor diameter was 90 (45-180) mm. Median Ki-67 was 25% (10-55) and mitotic activity was 16/50 HPF (5-40) (Table 3A). Per ENSAT staging, 45.5% were Stage III and 18.1% Stage IV (Table 3C). Adjuvant mitotane was given to 45.5%. Over a median 21 (3-27) month follow-up, recurrence and mortality rates were 18.2% and 9.1%.

Keywords: Adrenalectomy, adrenocortical carcinoma, ENSAT staging, mitotane, Weiss score

Table 1. Clinical presentation and hormonal characteristics of the patients (n=11)

TABLO 1A. Başvuru ve Fonksiyonel Durum

Değişken	Değer
Baskın başvuru şekli	İnsidentaloma: 7 (%63,6)
	Hormon ilişkili semptom: 3 (%27,3)
	Karın ağrısı/kitle: 1 (%9,1)
Fonksiyonel tümör	Var: 7 (%63,6)
	Yok: 4 (%36,4)
Cushing sendromu	Var: 4 (%36,4)
	Yok: 7 (%63,6)
Virilizasyon / feminizasyon	Yok: 11 (%100)
Hiperaldosteronizm	Var: 1 (%9,1)
	Yok: 10 (%90,9)
Hipertansiyon	Var: 3 (%27,3)
	Yok: 8 (%72,7)
Hipokalemi	Var: 1 (%9,1)
	Yok: 10 (%90,9)

TABLO 1B. Hormonal Laboratuvar Bulguları

Parametre	Değer
Serum kortizol (µg/dL)	16,6 ± 6,8
	Medyan: 15,4 (9,4–28,2)
ACTH (pg/mL)	17,0 ± 12,7
	Medyan: 13,6 (1,9–38,9)
DHEA-S (µg/dL)	357,4 ± 341,5
	Medyan: 224,0 (16,4–1000,0)
Aldosteron (ng/dL)	55,7 ± 35,0
	Medyan: 52,0 (13,3–112,0)

Table 2. Radiological findings and surgical characteristics (n=11)

TABLO 2A. Radyolojik Özellikler

Değişken	Değer
Patolojik tümör çapı (mm)	96,4 ± 38,7
	Medyan: 90 (45–180)

TABLO 2B. Cerrahi Özellikler ve Perioperatif Seyir

Değişken	Değer
Ameliyat süresi (dk)	182,7 ± 61,4
	Medyan: 180 (95–300)
Postoperatif komplikasyon	Var: 2 (%18,2)
	Yok: 9 (%81,8)
Clavien–Dindo sınıflaması	Grade 0: 9 (%81,8)
	Grade I–II: 2 (%18,2)
Hastanede yatış süresi (gün)	6,1 ± 2,7
	Medyan: 6 (3–12)

Table 3. Adrenokortikal carcinoma (ACC)-comparison of our series with selected literature series

ÇALIŞMA	TASARIM / MERKEZ	n	EVRE (ENSAT)	TÜMÖR BOYUTU	HORMONAL AKTİVİTE	R0 REZEKSİYON	ADJUVAN MİTOTAN	NÜKS	MORTALİTE / SAĞKALIM
Bizim serimiz (Etlik Şehir Hastanesi)	Retrospektif, tek merkez	**11**	**I–II ağırlıklı** *(serimizde erken evre baskın)*	**Medyan 90 mm**	**%63,6 fonksiyonel**	**%72,7**	**%45,5**	**%18,2**	**%9,1** *(izlem medyanı ~21 ay)*
Şişman ve ark., 2017 (Turk J Urol)	Retrospektif, tek merkez	**15**	I %20, II %6,7, III %73,3, IV %0	—	%26,7	**R0 %46,7** (R1 %26,7; R2 %13,3; Rx %13,3)	"Mitotan" %20 *(kombinasyonlarla birlikte daha yüksek)*	**Nüks %46,7**; metastaz %40	Ortalama izlem **21 ay**; ölüm **%60**
Bokal ve ark., 2025 (Slovenya, iki merkez)	Retrospektif, iki merkez	**48**	I %6, II %42, III %25, IV %27	Medyan **12 cm** (4–30)	"GC" %35; diğer %17 (toplam ~%52)	**R0 %76** *(evre I–III küratif cerrahi grubunda)*	Uygun hastalarda **%52,9** mitotan başlandı	Küratif cerrahi sonrası **relaps: 20 olgu** *(I–III relaps alt grubu)*	5 yıllık OS: **Evre I %100, II %50, III %50, IV %0**
Sakin ve ark., 2020 (Eur Arch Med Res)	Retrospektif, tek merkez	**10**	**Evre III %60, IV %40**	Ortalama **10,6±4,3 cm**	%60	Cerrahi uygulananlarda **R2 %37,5** *(3/8); R0/R1 oranı ayrıntısız sınırlı)*	**%20**	Cerrahi olanlarda **nüks %100** *(6/6)*	İzlemde ölüm **%70**
Procopio ve ark., 2025 (Updates in Surgery)	Tersiyer merkez serisi (1997–2024), evre I–III	**48**	I %12,5; II %75; III %12,5 *(IV dışlandı)*	Medyan **~92–110 mm**	—	**Tüm olgular da R0**	Adjuvan tedaviler (mitotan dâhil) gruplar arası benzer	Lokoreg. nüks: **%19 (I/II)** vs **%33,3 (III)**; uzak nüks: **%28,6 (I/II)** vs **%66,7 (III)**	5 yıllık OS yaklaşık **%69** (gruplar benzer)

[P-141]

Surgical management, treatment, and clinical outcomes in adrenal myelolipomas: A single-center experience

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Objective: Adrenal myelolipomas are rare, benign adrenal tumors that are mostly detected incidentally. Clinical uncertainty regarding the surgical approach can occur because they can reach large sizes, their imaging findings can overlap with malignant adrenal tumors, and they rarely lead to complications such as intratumoral hemorrhage. In this study, we aimed to evaluate the detailed clinical, radiological, hormonal, and surgical outcomes of patients in our clinic whose diagnosis of adrenal myelolipoma was histopathologically confirmed following adrenalectomy.

Material and Methods: Seven patients undergoing adrenalectomy with histopathologically confirmed adrenal myelolipoma were retrospectively reviewed. Clinical analysis included demographics, comorbidities, detection mode, tumor laterality/size, CT density, intratumoral hemorrhage, and hormonal status. Surgical indications, operative approach, operative time, postoperative complications, and follow-up outcomes were recorded. Data were analyzed using descriptive statistics.

Results: Mean patient age was 56.4±11.9 years, with a male predominance (71.4%). Most myelolipomas were detected incidentally (85.7%) (Table 1). Laterality was equally distributed between right and left sides (42.9% each), with one bilateral case (14.3%). Mean tumor diameter was 67.9±18.6 mm; 71.4% were giant myelolipomas (>6 cm). Mean CT density was -32.1±11.4 HU, consistent with adipose content. Intratumoral hemorrhage occurred in one patient (14.3%), necessitating surgery due to symptoms (Table 2). Hormonal evaluation revealed only one functional tumor (14.3%). Primary surgical indications were size (57.1%), symptoms (14.3%), hemorrhage (14.3%), and suspicious imaging (14.3%). Surgical approaches included laparoscopic (57.1%), open (28.6%), and robotic (14.3%) adrenalectomy. Mean operative time was 112±26 minutes. No major complications (Clavien-Dindo ≥3) occurred. Over a median follow-up of 21 months (3-39), no recurrence or mortality was recorded (Table 4).

Conclusion: Literature indicates that adrenal myelolipomas are typically non-functional, incidental benign lesions, with surgery recommended for tumors >6 cm, symptomatic cases, intratumoral hemorrhage, or malignancy suspicion. Notably, our series achieved adrenalectomy without major morbidity, recurrence, or mortality, despite a predominance of giant myelolipomas. The successful use of minimally invasive techniques confirms that laparoscopic and robotic approaches are safe and effective for large lesions in experienced centers. This study demonstrates that while tumor size is the primary determinant for surgery, symptoms, hemorrhage, and suspicious imaging findings are critical complementary indications, providing real-world guidance for clinical management (Table 5).

Keywords: Adrenal myelolipoma, adrenalectomy, giant myelolipoma, incidentaloma, minimally invasive surgery

Table 1. Demographic and clinical characteristics (n=7)

Parametre	Değer
Yaş (yıl)	56,4 ± 11,9
	Medyan: 58 (min–maks: 39–72)
Cinsiyet	Erkek: 5 (%71,4)
	Kadın: 2 (%28,6)
ASA skoru	ASA II: 4 (%57,1)
	ASA III: 3 (%42,9)
Saptanma şekli	İnsidentaloma: 6 (%85,7)
	Semptomatik: 1 (%14,3)
Fonksiyonel tümör	Var: 1 (%14,3)
Hipertansiyon	Var: 4 (%57,1)
Diyabet	Var: 1 (%14,3)
Obezite (BMI ≥30)	Var: 1 (%14,3)

Table 2. Tumor characteristics

Parametre	Değer
Tümör tarafı	Sağ: 3 (%42,9)
	Sol: 3 (%42,9)
	Bilateral: 1 (%14,3)
Tümör çapı (mm)	67,9 ± 18,6
	Medyan: 65 (min–maks: 45–102)
Dev miyelolipom (>6 cm)	Var: 5 (%71,4)
BT dansitesi (HU)	-32,1 ± 11,4
Tümör içi kanama	Var: 1 (%14,3)

Table 3. Hormonal evaluation

Parametre	Ortalama ± SS
Serum kortizol (µg/dL)	19,1 ± 4,8
ACTH (pg/mL)	64,2 ± 18,3
Aldosteron (ng/dL)	150,5 ± 42,7
DHEA-S (µg/dL)	113,6 ± 36,9
Fonksiyonel tümör	1 (%14,3)

Table 4. Surgical and postoperative outcomes

Parametre	Değer
Cerrahi yaklaşım	Açık: 2 (%28,6)
	Laparoskopik: 4 (%57,1)
	Robotik: 1 (%14,3)
Cerrahi endikasyon	Boyut: 4 (%57,1)
	Semptom: 1 (%14,3)
	Kanama: 1 (%14,3)
	Şüpheli görüntüleme: 1 (%14,3)
Ameliyat süresi (dk)	112 ± 26
Postop komplikasyon	0
Clavien–Dindo ≥3	0
Hastanede yatış (gün)	Medyan: 3 (2–6)
Nüks	0
Takip süresi (ay)	Medyan: 21 (3–39)
Takipte mortalite	0

Table 5. Surgical management of adrenal myelolipomas: comparison with recent literature

Çalışma	Tasarım / Merkez	n	Yaş (ortalama)	İnsidental saptanma	Boyut / "Giant-Dev"	Cerrahi yaklaşım	Endikasyon (özet)	Majör komplikasyon / Nüks / Mortalite
Bizim çalışmamız (Tek merkez)	Retrospektif, tek merkez	7	56,4 ± 11,9	%85,7	Ortalama 67,9 ± 18,6 mm; Dev >6 cm: %71,4; Kanama: %14,3	Lap %57,1; Robotik %14,3; Açık %28,6	Boyut %57,1; Semptom %14,3; Kanama %14,3; şüpheli görüntüleme %14,3	Majör: 0; Nüks: 0; Mortalite: 0
Paul ve ark., 2024	Tersiyer merkez kohortu (2014–2022)	15 (ameliyat: 5)	(aralık 27–70)	—	Boyut aralığı 2–15 cm; Cerrahi grup ort. 7,4 cm	—	İndetermine lezyon (n=3), ağrı+>4 cm (n=1), komşu organ bası (n=1); "boyut tek başına" değil	Tüm rezeksiyonlarda histoloji AML
Katsoulis ve ark., 2023 (JSCR)	Vaka sunumu + literatür derleme	1	—	—	"Giant/large" olgu	—	Cerrahi: semptomatik veya >5 cm ya da malignite şüphesi	Vaka bazlı
Hogea ve ark., 2024	"Giant AML" literatür derlemesi (1981–2023)	15 (>~10 cm)	Ortalama ~53 (26–72)	—	"Giant" >10 cm olgular	Değişken	Olgu bazlı	Olgu bazlı
Cochetti ve ark., 2019	Vaka sunumu (robotik)	1	—	—	Giant AML	Robotik parsiyel adrenalektomi	Cerrahi önerisi: semptomatik / hızlı büyüme / >6 cm; giant >10 cm nadir	Vaka bazlı
Bapir ve ark., 2024	Vaka sunumu (laparoskopik)	1	63	—	12×10×8 cm	Laparoskopik rezeksiyon	Dev olgu – lap uygulanabilirliği vurgusu	Vaka bazlı

[P-142]

Clinicopathological evaluation of Hürthle cell thyroid lesions: A case series

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Objective: Hürthle cell thyroid neoplasms lead to uncertainties in clinical management due to the difficulty of distinguishing adenoma from carcinoma using preoperative cytological and radiological methods. In this study, we aimed to evaluate the clinical, radiological, and pathological features of patients with Hürthle cell lesions who underwent surgical treatment in our clinic and to identify distinctive findings suggestive of carcinoma.

Material and Methods: Four patients who underwent total thyroidectomy in our clinic and whose final pathology was reported as Hürthle cell neoplasm were retrospectively reviewed. Demographic data, preoperative ultrasonography findings (TI-RADS classification), fine-needle aspiration biopsy results (Bethesda classification), surgical and pathological features, adjuvant treatment approaches, and follow-up outcomes were evaluated. Pathological examination particularly analyzed the presence of capsular invasion, vascular invasion, and extrathyroidal extension. Additional parameters such as thyroid function tests, ultrasonographic morphological features, and lymph node status were described based on clinical records.

Results: All patients included in the study were female, with a median age of 54 years (range: 47-69). Preoperative ultrasonography revealed TI-RADS category 4 nodules in all cases, with nodule sizes ranging from 8 to 56 mm. Fine-needle aspiration biopsy results ranged from Bethesda categories 2 to 6, with cytological findings overlapping between benign and malignant groups. Final pathological evaluation identified Hürthle cell carcinoma in 2 patients and Hürthle cell adenoma in 2 patients. Vascular invasion was observed in all patients with Hürthle cell carcinoma, whereas no vascular invasion, capsular invasion, or extrathyroidal extension was detected in adenoma cases. Capsular invasion and extrathyroidal extension were observed exclusively in the carcinoma group. Preoperative thyroid function tests, when available, indicated a euthyroid state in all patients. Ultrasonographic assessment showed that all nodules were solid, and no distinct morphological differences were identified between benign and malignant cases. No lymph node involvement was detected based on clinical and imaging findings. All patients in the carcinoma group received adjuvant radioactive iodine therapy. Follow-up duration ranged from 3 to 96 months, during which recurrence was observed in one carcinoma case. No mortality was observed during the study period.

Conclusion: In conclusion, this case series highlights the limited ability of preoperative ultrasonographic and cytological methods to reliably distinguish adenoma from carcinoma in Hürthle cell thyroid lesions. Our findings emphasize that postoperative pathological features, particularly vascular invasion and other invasive criteria, represent the most consistent and reliable indicators of malignancy. Despite the limited number of patients, these results support a pathology-based approach in clinical decision-making and follow-up strategies and underscore the need for careful long-term surveillance, especially in patients with Hürthle cell carcinoma.

Keywords: Case series, Hürthle cell adenoma, Hürthle cell carcinoma, Hürthle cell neoplasm, thyroid nodule

Table 1. Pathological findings

Parametre	Hürthle Karsinom (n=2)	Hürthle Adenom (n=2)
Vasküler invazyon	2/2	0/2
Kapsül invazyonu	1/2	0/2
Ekstratiroidal yayılım	1/2	0/2
Radyoaktif iyot tedavisi	2/2	0/2
Nüks	1/2	0/2
Mortalite	0	0

Table 2. Demographic and clinical characteristics

Parametre	Bulgular
Toplam hasta sayısı	4
Yaş, ortanca (aralık)	54 (47–69)
Cinsiyet	Kadın (4/4)
En büyük nodül çapı (mm)	8–56
TI-RADS	4 (4/4)
Bethesda sınıflaması	2–6
Cerrahi yöntem	Total tiroidektomi (4/4)

Table 3. Clinical, radiological, and pathological features

Olgu	Yaş	USG max çap (mm)	TI-RADS	Bethesda	Nihai patoloji	Kapsül inv.	Vasküler inv.	ETE	RAI	Takip (ay)	Nüks
Olgu 1	51	56	4	4	Hürthle karsinom	Evet	Evet	Evet	Evet	96	Evet
Olgu 2	57	56	4	6	Hürthle karsinom	Hayır	Evet	Hayır	Evet	3	Hayır
Olgu 3	47	8	4	4	Hürthle adenom	Hayır	Hayır	Hayır	Hayır	3	Hayır
Olgu 4	69	8	4	2	Hürthle adenom	Hayır	Hayır	Hayır	Hayır	36	Hayır

Table 4. Additional clinical findings during the preoperative and follow-up periods

Parametre	Bulgular
Tiroid fonksiyon durumu	Ötiroid
USG morfolojisi	Solid nodül (4/4)
Lenf nodu tutulumu	Klinik ve görüntüleme ile saptanmadı
Takip süresi (ay)	3–96
Takip yöntemi	Klinik ± görüntüleme ± Lab

Table 5. Comparison with the literature

Çalışma	Yıl	Çalışma Tipi	Hasta Sayısı	Ayırt Edici Bulgular	Preoperatif Ayırım	Klinik Mesaj
Bizim çalışmamız	2025	Olgu serisi	4	**Karsinomlarda vasküler invazyonun tutarlı varlığı**, adenomlarda invazyon yokluğu	Sınırlı	Patolojik invazyon, karsinom lehine en belirgin ayırt edici bulgudur
Haugen ve ark. (ATA)	2015 (güncel rehber)	Klinik rehber	—	Patolojik invazyon risk sınıflamasında temel belirleyici	Sınırlı	Tedavi ve takip kararları patoloji temelli olmalıdır
NCCN Tiroid Kanseri Rehberi	2023–2024	Klinik rehber	—	Vasküler ve kapsüler invazyon yüksek risk kriteridir	Sınırlı	Hürthle karsinom agresif biyoloji gösterebilir
Zhang ve ark.	2020	Retrospektif seri	>100	Vasküler invazyon ve ETE kötü prognostik faktörler	Yetersiz	Sitoloji malignite ayrımında sınırlıdır
Trimboli ve ark.	2021	Sistematik derleme	—	Sitoloji ve USG malignileyi güvenilir ayıramaz	Yetersiz	Cerrahi sonrası patoloji esastır
Pitoia ve ark.	2022	Klinik derleme	—	Hürthle karsinomda geç nüks riski	—	Uzun dönem takip gereklidir

[P-143]

Parathyroid surgery: A single-center, single-surgeon experience (53 cases)

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Objective: Parathyroid surgery is the definitive treatment for primary hyperparathyroidism and is increasingly performed in general surgical practice. Primary hyperparathyroidism is one of the most common causes of hypercalcemia, particularly affecting elderly patients and women. With appropriate patient selection and a standardized surgical approach, high success rates with low complication risk can be achieved. This study aimed to present the demographic characteristics, preoperative imaging findings, pathological diagnoses, and early postoperative clinical and biochemical outcomes of patients who underwent parathyroid excision at our center.

Material and Methods: A retrospective analysis was conducted of 53 patients who underwent parathyroid surgery at a single center by a single surgeon. Demographic data, comorbidities, preoperative biochemical parameters [serum calcium and parathyroid hormone (PTH) levels], preoperative imaging results (ultrasonography and/or scintigraphy), pathological diagnoses, early postoperative laboratory findings, complications, reoperation rates, and length of hospital stay were evaluated. Intraoperative intact PTH monitoring could not be performed due to technical limitations, and frozen section examination was not routinely used. The study was designed as a descriptive analysis.

Results: Of the patients, 77.4% (n=41) were female and 22.6% (n=12) were male. Most patients were elderly, and a considerable proportion had at least one comorbidity. The mean preoperative serum calcium and PTH levels were 11.1 mg/dL and 273.6 pg/mL, respectively. Preoperative imaging successfully localized the parathyroid lesion in 90.6% of patients (n=48). Pathological examination revealed parathyroid adenoma in 92.5% (n=49) and parathyroid carcinoma in 7.5% (n=4). Single-gland excision was performed in 81.1% of cases (n=43), while multigland excision was required in 18.9% (n=10). Despite the absence of intraoperative PTH monitoring and routine frozen section analysis, significant biochemical improvement was observed. On postoperative day one, mean serum calcium and PTH levels decreased to 8.9 mg/dL and 38.0 pg/mL, corresponding to reductions of approximately 20% and 85%, respectively. Most patients experienced no postoperative complications, and hospital stay was generally limited to one day.

Conclusion: Parathyroid surgery at our center achieved high rates of successful preoperative localization, marked early postoperative biochemical improvement, and low complication rates. Even without intraoperative intact PTH monitoring and routine frozen section examination, effective and predictable outcomes were obtained with careful surgical exploration and appropriate patient selection.

Keywords: Parathyroid surgery, parathyroid hormone, serum calcium

[P-144]

Outcomes of percutaneous cholecystostomy in high-risk patients with acute cholecystitis: A single-center experience

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Objective: Emergency surgery in high-risk patients with acute cholecystitis is associated with substantial morbidity and mortality. In this patient population, percutaneous cholecystostomy (PC) has been proposed as an alternative or bridge-to-surgery treatment option. This study aimed to evaluate the clinical outcomes of PC in high-risk patients with acute cholecystitis.

Material and Methods: In this retrospective study, 53 patients with acute cholecystitis who underwent PC at our institution were analyzed. Demographic characteristics, diagnoses, Tokyo severity grades, ASA scores, Charlson comorbidity index (CCI), indications for cholecystostomy, need for intensive care, length of hospital stay, 30-day mortality, recurrent cholecystitis episodes, and rates of elective cholecystectomy were recorded.

Results: The mean age of the 53 patients was 75.2±11.8 years, and 64.2% were male. Regarding diagnosis, 83.0% had acute cholecystitis and 17.0% had perforated cholecystitis. According to the Tokyo classification, 77.4% of patients were classified as grade III. In terms of surgical risk, 71.7% were ASA III and 28.3% were ASA IV. The mean CCI was 5.9±2.1. The most common indication for PC was high surgical risk (67.9%), followed by sepsis (20.8%) and need for intensive care (11.3%). Overall, 41.5% of patients required intensive care unit follow-up. The median length of hospital stay was 12 days (IQR: 7-18). The 30-day mortality rate was 7.5%. During follow-up, 83.0% of patients did not experience recurrent cholecystitis. Only 18.9% of patients subsequently underwent elective cholecystectomy.

Conclusion: PC is an effective and safe treatment option in high-risk patients with acute cholecystitis, with relatively low 30-day mortality rates. Particularly in elderly patients with significant comorbidities, this approach may serve as an alternative to emergency surgery and often remains the definitive treatment in a substantial proportion of patients.

Keywords: Acute cholecystitis, percutaneous cholecystostomy, mortality

[P-145]

Pancreatic osteoclast-like giant cell undifferentiated carcinoma: A rare case treated with surgical resection

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Objective: Undifferentiated pancreatic carcinoma with osteoclast-like giant cells (UC-OGC) is an extremely rare histological subtype among pancreatic malignancies, accounting for less than 1% of all pancreatic tumors. This study aimed to present a case of UC-OGC treated surgically.

Material and Methods: Patient data were retrospectively obtained from the database of Gaziantep University Hospital.

Results: A 72-year-old male patient presented to the emergency department with abdominal pain. Ultrasound revealed a suspicious lesion in the pancreas, and the patient underwent further investigation. A mass was detected in the pancreatic corpus during the evaluation for pancreatic cancer. Dynamic contrast-enhanced upper abdomen CT scan revealed a heterogeneous hypodense mass measuring approximately 48×45×40 mm in the pancreatic corpus, extending superoposteriorly and containing cystic-necrotic areas. There was approximately 5 mm dilation in the tail section of the pancreatic duct. The lesion was in close proximity to the celiac trunk and its branches, as well as the portal and splenic veins, and its borders with the right diaphragmatic crus could not be clearly distinguished. A PET-CT scan performed for staging purposes revealed a hypermetabolic lesion measuring 4.72×3.60 cm in the pancreatic corpus with an SUV_{max} of 14.75 and a centrally hypometabolic (consistent with necrosis). Additionally, a suspicious soft tissue lesion measuring 1.3 cm with low FDG uptake was observed. Tru-cut biopsy results revealed findings consistent with an UC-OGC; carcinosarcoma could not be definitively ruled out. The patient underwent neoadjuvant chemotherapy. A PET-CT scan performed after treatment showed a slight increase in the size of the lesion and metabolic stability (5.37×4.29 cm, SUV_{max} 15.2). Surgical treatment was then planned, and the patient underwent distal pancreatectomy and splenectomy. No complications developed in the postoperative period, and the patient was discharged without any problems.

Conclusion: UC-OGC is a rare pancreatic malignancy and differs from classic pancreatic ductal adenocarcinoma in terms of clinical and histopathological features. Radiologically, it is usually seen as large masses with a necrotic and heterogeneous structure. The effectiveness of chemotherapy is limited, and a better prognosis is reported in cases where surgical resection is feasible. UC-OGC is rare but should be considered in the differential diagnosis. Preoperative biopsy may be helpful in the diagnostic process, and surgical resection is the primary treatment option in suitable patients.

Keywords: Osteoclast-like giant cells, distal pancreatectomy, splenectomy

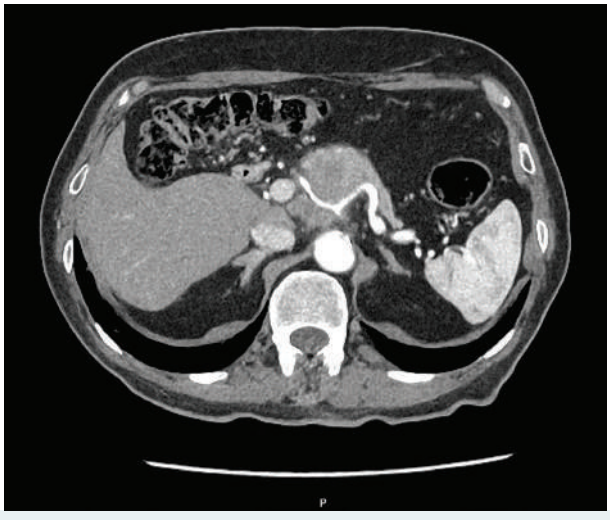

Figure 1. CT scan image of the tumor in the pancreas.

[P-146]

Evaluation of clinical features, diagnosis, treatment, and surgical outcomes in cases of hydatid cysts with atypical localization: A retrospective study

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Objective: This study aimed to evaluate the clinical features, diagnostic challenges, and surgical outcomes of hydatid cysts with atypical localization based on a single-center retrospective case series.

Material and Methods: This was a retrospective study of patients who underwent surgery for pathologically confirmed hydatid cysts in locations outside the liver, spleen, and pancreas between 2014 and 2024. Postoperative recurrence, intraoperative and postoperative complications, and the need for reoperation were evaluated. All patients were assessed with ultrasonography and/or computed tomography according to standard diagnostic protocols for hydatid disease, and albendazole was used as adjuvant therapy regardless of cyst localization.

Results: Ten patients (mean age 44.5±17.7 years; 8 females, 2 males) were included. Cysts were localized in musculoskeletal tissues (n=5, 50%), retroperitoneum (n=3, 30%), adrenal gland (n=1, 10%), and adnexal region (n=1, 10%). Total cyst excision was performed in eight patients (80%), while cystotomy and drainage were required in two patients (20%). Postoperative recurrence was observed in two patients (20%), one following excision of a gluteal cyst and one after retroperitoneal cyst drainage; both patients underwent reoperation. No intraoperative or postoperative complications and no mortality were observed during the follow-up period.

Conclusion: This case series demonstrates that hydatid cysts with atypical localization present with diverse anatomical involvement and may be associated with a risk of postoperative recurrence, particularly in non-radical surgical procedures. Careful preoperative evaluation and complete surgical excision, when feasible, may reduce the need for reoperation in these patients.

Keywords: Hydatid cyst, atypical localization, diagnosis and surgery

[P-147]

Classic inflammatory findings may be absent in perforated appendicitis: A diagnostic pitfall

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Objective: Perforated appendicitis is a common surgical cause of acute abdominal pain, and its diagnosis often requires the combined evaluation of clinical findings, laboratory tests, and imaging results. Although inflammatory markers such as leukocytosis and C-reactive protein (CRP) are frequently used as supportive tools, they are not always reliable predictors. Ultrasonography, particularly in the early stages, may fail to detect perforation and yield false-negative results. Recent studies suggest that perforated appendicitis without accompanying classical inflammatory findings may complicate the diagnostic process and increase the risk of delayed treatment. This study aims to evaluate the diagnostic pitfalls of perforated appendicitis cases in which classical inflammatory findings are absent.

Material and Methods: This retrospective study reviewed patients who underwent surgery for acute appendicitis at Medicana Ataşehir Hospital between May 2021 and August 2025. The diagnosis of perforated appendicitis was confirmed based on intraoperative findings and pathological reports. Among patients with perforation, those without fever and leukocytosis were identified. Demographic characteristics, symptom duration, laboratory parameters (CRP, white blood cell count, and neutrophil-to-lymphocyte ratio), and ultrasonography findings were evaluated. Perforated appendicitis cases with and without classical inflammatory findings were compared.

Results: A total of 286 patients operated on for acute appendicitis were evaluated. Among them, 32 patients were confirmed to have perforated appendicitis based on surgical and pathological findings. In 8 patients (25%), neither fever nor leukocytosis was present. In this subgroup, the median CRP level was 4.9 mg/dL, and the median symptom duration was 72 hours. Ultrasonography failed to detect perforation in 5 patients (62.5%). A summary of the findings and the diagnostic process is presented in Figure 1.

Conclusion: Perforated appendicitis without accompanying classical inflammatory findings such as fever and leukocytosis represents a significant diagnostic pitfall in clinical practice. Our findings demonstrate that normal body temperature and white blood cell counts do not reliably exclude perforated appendicitis. In patients with prolonged symptom duration and subtle inflammatory markers, clinical suspicion should be maintained even when imaging findings are unremarkable, and a comprehensive diagnostic approach is essential. Among 286 patients operated on for acute appendicitis, 32 cases were confirmed as perforated appendicitis based on intraoperative and pathological findings. In 8 patients (25%), neither fever nor leukocytosis was present. In this subgroup lacking classical inflammatory findings, ultrasonography failed to detect perforation in 62.5% (5/8) of cases. The median CRP level was 4.9 mg/dL, and the median symptom duration was 72 hours. This schematic highlights that normal body temperature and white blood cell counts do not reliably exclude perforated appendicitis.

Keywords: Perforated appendicitis, diagnostic pitfall, normal inflammatory markers, ultrasonography, C-reactive protein

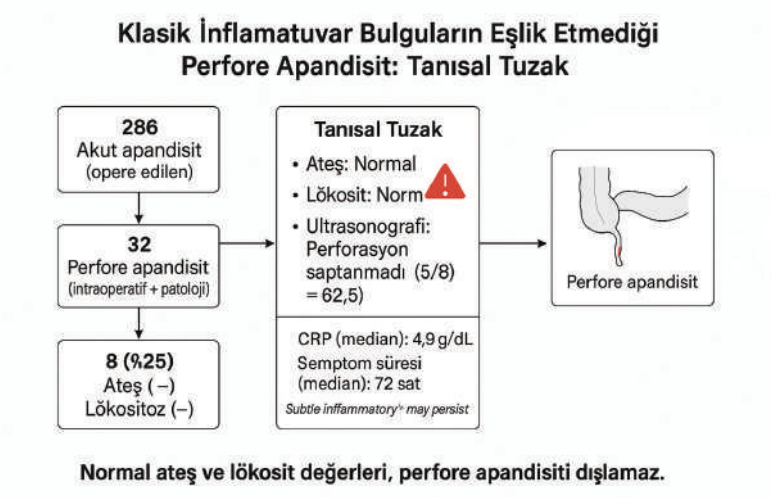

Figure 1. Schematic illustration of the diagnostic pathway in perforated appendicitis cases without classical inflammatory findings.

[P-148]

Gastrointestinal introduction of drug-filled plastic capsules: A single-center experience and clinical management in light of literature recommendations

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Objective: Gastrointestinal introduction of drug-filled plastic capsules is a high-risk clinical scenario due to potential complications such as obstruction, perforation, and rupture-related toxicity. Current recommendations generally support close observation and conservative elimination in patients without toxicity or complications, while advocating surgical management when symptoms or suspected complications are present. In the setting of gastric retention, the optimal timing of intervention remains patient-specific and debated. Here, we present the diagnostic workup and treatment outcomes of patients managed at a single center.

Material and Methods: Seven consecutive patients brought to the hospital under law-enforcement supervision with multiple drug-filled capsules identified within the gastrointestinal tract were retrospectively reviewed. Recorded variables included demographics, diagnostic modality, the method used to confirm complete capsule clearance from the gastrointestinal tract, number of capsules, signs of toxicity, laxative use, time to passage, duration of in-hospital observation, management strategy, and complications.

Results: The median age of the seven patients was 39 years (27-48), and six were male. The number of capsules ranged from 7 to 93. Diagnosis was established by computed tomography (CT) in all patients. Clearance was confirmed by CT in four patients and by colonoscopy in two patients. No patient developed clinical signs of toxicity. Six patients were managed conservatively, and all patients in the conservative group received laxatives. In this group, capsule passage occurred within 1-2 days. One patient underwent surgical treatment due to marked gastric retention on presentation accompanied by abdominal pain; 52 capsules were removed via gastrotomy. The median duration of in-hospital observation was 2 days (range 1-5). No complications were observed in any patient. In the patient operated on due to abdominal pain with marked gastric retention on CT, a total of 52 capsules were extracted via gastrotomy.

Conclusion: When this series is interpreted alongside the literature, management appears to be best guided by risk stratification. Close observation and conservative treatment should be prioritized in patients without toxicity or acute abdominal findings. Surgical treatment should be considered in the presence of toxicity, marked gastric retention, obstruction, or perforation.

Keywords: Body packing, conservative management, emergency surgery

Figure 1. Appearance of capsules within the gastrointestinal tract on CT.

Figure 2. Capsules removed via gastrotomy.

[P-149]

Clinical, laboratory, and imaging characteristics of negative and uncomplicated cases in acute appendicitis: Single-center real-life data

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Objective: Acute appendicitis is one of the most common causes of acute abdomen requiring emergency surgical intervention. Variability in clinical presentation and the limitations of imaging modalities may complicate the differentiation of negative and uncomplicated appendicitis in daily practice, potentially leading to increased rates of negative appendectomy and unnecessary surgical interventions. A better understanding of the clinical, laboratory, and imaging characteristics of negative and uncomplicated appendicitis may improve diagnostic accuracy and help reduce unnecessary surgeries. This study aimed to compare the clinical, laboratory, and imaging findings of patients with negative and uncomplicated appendicitis.

Material and Methods: This single-center retrospective study included patients who underwent surgery with a diagnosis of acute appendicitis. Patients with pathological findings consistent with negative appendicitis (normal appendix or reactive/lymphoid hyperplasia) and uncomplicated appendicitis were included. Patients with complicated appendicitis and those with incomplete data were excluded from the analysis. Demographic characteristics, preoperative laboratory parameters (white blood cell count, C-reactive protein, albumin levels, and neutrophil-to-lymphocyte ratio), and imaging findings obtained by ultrasonography and computed tomography were evaluated. Group comparisons were performed using appropriate statistical tests, and a p-value of <0.05 was considered statistically significant.

Results: A total of 82 patients were included in the study, of whom 13 had negative appendicitis and 69 had uncomplicated appendicitis. The proportion of normal or equivocal findings on computed tomography was significantly higher in the negative appendicitis group compared with the uncomplicated group (33.3% vs. 7.5%; $p=0.034$). Although white blood cell count, C-reactive protein levels, and neutrophil-to-lymphocyte ratio tended to be lower in patients with negative appendicitis, these differences did not reach statistical significance ($p>0.05$ for all). No significant difference was observed in albumin levels between the groups.

Conclusion: Computed tomography findings are more frequently reported as normal or equivocal in patients with negative appendicitis, indicating persistent diagnostic uncertainty in this subgroup. While clinical and laboratory parameters alone may not be sufficiently discriminative, careful interpretation of imaging findings may help reduce negative appendectomy rates. These results support the importance of a multidisciplinary diagnostic approach in patients with suspected acute appendicitis.

Keywords: Acute appendicitis, negative appendectomy, imaging modalities

[P-150]

Traumatic diaphragmatic injuries: Diagnosis, surgical approach, and retrospective analysis of clinical outcomes

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Objective: Traumatic diaphragmatic injuries (TDI), although uncommon, are clinically significant due to diagnostic challenges and the high rate of associated thoracoabdominal injuries. This study aimed to retrospectively evaluate the demographic characteristics, mechanisms of trauma, diagnostic processes, associated injuries, surgical management, and clinical outcomes of patients operated for TDI at the General Surgery Department of University of Health Sciences Türkiye, Ankara Etlik City Hospital between November 2022 and December 2025.

Material and Methods: This single-center retrospective case series included patients operated for TDI during the study period. Data were obtained from electronic medical records. Demographics, trauma mechanism and type, time to admission, time to diagnosis and delayed diagnosis (>24 hours), imaging modalities and CT findings, associated injuries, side of injury and defect size, surgical timing, approach and repair technique, and clinical outcomes were recorded. Continuous variables were presented as median (IQR), and categorical variables as number and percentage.

Results: Twenty-one patients were analyzed. The median age was 29 years (IQR: 23-42), and 95.2% were male. Penetrating trauma accounted for 76.2% of cases, most commonly stab wounds (52.4%), while 23.8% resulted from blunt trauma. Injuries involved the left hemidiaphragm in 81.0% and the right in 19.0%. Most patients (95.2%) presented in the acute phase; the median time from trauma to diagnosis was 3 hours (IQR: 2-6), with delayed diagnosis in 14.3%. CT identified diaphragmatic injury in 42.9% of patients, whereas 19.0% were missed on initial imaging. Associated injuries were present in 90.5%, predominantly thoracic (81.0%) and abdominal (76.2%). Solid organ injury occurred in 42.9%, hollow viscus injury in 28.6%, and abdominal organ herniation in 28.6%. All patients underwent emergency surgery. Laparotomy was the most common approach (81.0%), and primary suture repair was performed in all cases. The median defect size was 4 cm (IQR: 2-7), and median operative time was 90 minutes (IQR: 90-120). All patients required ICU admission; median ICU stay was 7 days (IQR: 2-8), and median hospital stay was 14 days (IQR: 7-18). No reoperations or mortality were observed. Median follow-up was 4 months (IQR: 1-11).

Conclusion: TDI represents a critical trauma entity characterized by diagnostic difficulty and a high incidence of associated injuries. Despite widespread CT use, a subset of injuries was missed on initial imaging, underscoring the importance of clinical suspicion. Systematic evaluation for diaphragmatic injury is essential, particularly in penetrating thoracoabdominal trauma.

Keywords: Traumatic diaphragm injury, penetrating trauma, emergency surgical repair

Table 1. Demographic, trauma, application characteristics, and imaging

Parameter	Value
Age, y	29 (23-42)
Male sex	20 (95.2)
Female sex	1 (4.8)
Mechanism-penetrating	16 (76.2)
Mechanism-blunt	5 (23.8)
Injury type-stab wound	11 (52.4)
Injury type-traffic accident	5 (23.8)
Injury type-firearm injury	5 (23.8)
Side-left	17 (81.0)
Side-right	4 (19.0)
Presentation-acute	20 (95.2)
Presentation-delayed	1 (4.8)
Time from trauma to diagnosis, h	3 (2-6)
Glasgow coma scale score	15 (14-15)
Systolic blood pressure, mmHg*	105 (90-119)
Shock index (HR/SBP)*	1.00 (0.90-1.22)
Intubation requirement	3 (14.3)
Comorbidity	3 (14.3)
Delayed diagnosis (>24 h)-yes	3 (14.3)
Delayed diagnosis (>24 h)-no	18 (85.7)
Imaging modality-CT + US (FAST)	20 (95.2)
Imaging modality-US (FAST) only	1 (4.8)
Diagnosed by CT	9 (42.9)
Not diagnosed by CT	12 (57.1)
CT finding-collar sign	2 (9.5)
CT finding-herniation	1 (4.8)
CT finding-unspecified (code 0)	18 (85.7)
Missed on initial CT	4 (19.0)
Associated injury-yes	19 (90.5)
Thoracic injury-yes	17 (81.0)
Abdominal injury-yes	16 (76.2)
Solid organ injury-yes	9 (42.9)
Hollow viscus injury-yes	6 (28.6)
Abdominal organ herniation-yes	6 (28.6)

Table 2. Surgical characteristics and clinical outcomes

Parameter	Value
Surgical timing-emergency	21 (100)
Surgical approach-laparotomy	17 (81.0)
Surgical approach-laparoscopy	1 (4.8)
Surgical approach-thoracotomy	1 (4.8)
Repair method-primary suture	21 (100)
Diaphragmatic defect size, cm (maximum)	4 (2-7)
Defect area, cm^{2*}	16 (4-24)
Operative time, min	90 (90-120)
ICU admission	21 (100)
ICU length of stay, days	7 (2-8)
Hospital length of stay, days	14 (7-18)
Reoperation	0
30-day mortality	0
Overall mortality	0
Follow-up duration, months	4 (1-11)

Figure 1. Posttraumatic diaphragma hernia.

Diaphragmatic laceration and hiatal hernia following a vehicle traffic accident.

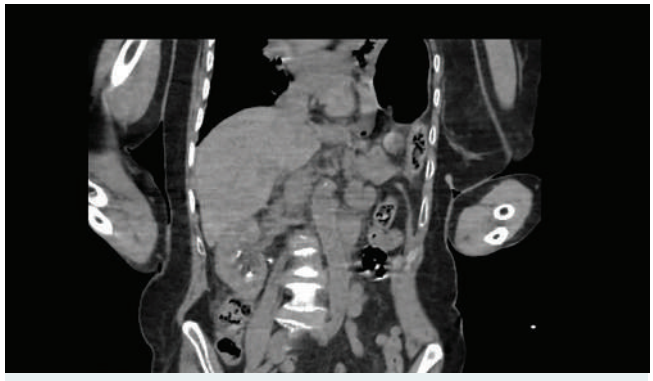

Figure 2. Posttraumatic diaphragma hernia.

Diaphragmatic laceration and hiatal hernia following a vehicle traffic accident.

[P-151]

Pneumatosis intestinalis: A mysterious radiological finding or an early harbinger of surgical necessity? Our experience with 28 cases

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Objective: Pneumatosis intestinalis (PI) is a radiological finding defined by the presence of gas within the bowel wall. It may appear in a linear or cystic pattern within the submucosal or subserosal layers of the intestine. PI is not pathognomonic for a single disease entity and may be encountered in a wide clinical spectrum ranging from benign, self-limiting conditions to life-threatening acute mesenteric ischemia requiring emergency surgical intervention.The aim of this study was to retrospectively evaluate the role of this clinical-radiological marker, whose pathogenesis is not yet fully understood, in predicting the need for surgical intervention.

Material and Methods: Patients in whom PI was detected on radiological imaging at Necmettin Erbakan University Faculty of Medicine Hospital over the last five years were retrospectively reviewed. Patients younger than 18 years of age and those who were not evaluated by a general surgery specialist were excluded from the analysis. Demographic data, presenting symptoms, laboratory parameters (lactate, CRP, WBC), computed tomography findings, and surgical outcomes were analyzed.

Results: A total of 28 patients diagnosed with PI were included in the study. The mean age was 60.8±18.4 years (range, 23-92), with a median age of 58.5 years. Regarding sex distribution, PI was observed in both genders without a marked predominance, demonstrating a heterogeneous distribution. Among the 28 patients, 13 (46.4%) were managed conservatively with medical treatment, whereas 13 patients (46.4%) underwent surgical intervention. However, two additional patients for whom surgical intervention was indicated could not undergo surgery: one patient died before the operation due to hemodynamic instability, and another patient refused surgical treatment. Therefore, while surgical indication was established in 15 patients, 13 were ultimately operated on indications for surgery. The main reasons for surgical decision-making were: • Mesenteric ischemia • Bowel necrosis • Perforation • Internal herniation • Progresive mechanical ileus. Surgical decisions were primarily based on clinical findings consistent with an acute abdomen and radiological suspicion of bowel ischemia. Patients with surgical indication demonstrated significantly higher leukocyte levels. CRP levels also tended to be higher in this group, whereas lactate levels showed a similar distribution between groups.

Conclusion: PI alone is not an absolute indication for surgery; however, in our series, it was associated with a substantial rate of significant surgical pathology. When evaluated together with clinical and laboratory parameters, PI may serve as an early warning sign of serious conditions such as bowel ischemia and perforation. Therefore, careful clinical assessment and timely surgical decision-making are of critical importance in patients diagnosed with PI.

Keyword: Pneumatosis intestinalis

Table 1. Comparison of surgical indications and laboratory parameters between surgically treated and primarily medically managed patients

Parameter	Surgical indication (n=15)	Primary medical management (n=13)
WBC (×10³/µL)	17.3	11.3
CRP (mg/L)	197.8	149.6
Lactate (mmol/L)	4.62	4.43

[P-152]

Rare complication of pleural drainage catheter: Iatrogenic splenic vein cannulation and management

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Objective: While subdiaphragmatic organ injuries during pleural effusion drainage have been described in the literature, direct cannulation of a vascular structure by a pleural catheter (pleurocan) is extremely rare. This report discusses the surgical management of a case in which a catheter, placed for pleural effusion, traversed the splenic parenchyma and was malpositioned directly into the splenic vein.

Material and Methods: A 69-year-old female patient, hospitalized in the oncology department for chemotherapy due to metastatic ovarian cancer, was consulted following pleurocan catheterization for pleural effusion. The consultation was prompted by the drainage of approximately 1000 cc of hemorrhagic fluid, accompanied by acute hypotension (90/50 mmHg) and tachycardia (130 bpm). Laboratory findings revealed a hemoglobin level of 8.2 g/dL. A non-contrast chest CT, performed to check the catheter position, demonstrated that the drainage catheter had advanced into the abdomen through the left 9th-10th intercostal space, traversed the entire splenic parenchyma, and extended to the level of the splenic hilum. Due to hemodynamic instability and potential vascular injury, the patient was taken for emergency surgery.

Results: During exploration, no hemorrhagic fluid was detected within the abdominal cavity. It was observed that the catheter had passed through the diaphragm, entered the spleen via the lateral-posterior aspect, emerged from the splenic hilum medially, and advanced into the splenic vein. The spleen was mobilized by sharp dissection from its surrounding ligaments. The splenic artery and vein were skeletonized. The artery was ligated and divided. The catheter was palpated within the vein; it was then removed in a controlled manner, followed by the ligation and division of the vein. Subsequently, the spleen was removed from the abdomen. The diaphragm was repaired primarily, and a new pleural drainage catheter was inserted. The patient, who experienced no postoperative complications, was transferred back to the oncology department on the 5th day.

Conclusion: This case highlights that pleural interventions, though rare, can lead to life-threatening complications such as major vascular cannulation following parenchymal passage. Rapid imaging and timely surgical intervention are essential to reducing mortality and morbidity.

Keywords: Iatrogenic complication, pleural drainage catheter, splenectomy

Figure 1. Macroscopic view of the splenectomy specimen and catheter malposition.

Figure 2. Perioperative view of splenic vein cannulation.

[P-153]

Nursing care for the use of abdominal binder after major abdominal surgery and abdominal hernia surgery

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Objective: Approximately 400 abdominal hernia surgeries are performed annually in the General Surgery-3 unit of University of Health Sciences Türkiye, Başakşehir Çam and Sakura City Hospital, where we are employed. Nursing care provided to these patients during the preoperative and postoperative periods primarily encompasses the use of surgical abdominal binders, respiratory exercises, early mobilization, nutritional management, wound care, and discharge education. Within the scope of binder use, nurses conduct comprehensive physical and psychosocial assessments, provide patient education and practical support, and take an active role in ensuring appropriate application while preventing potential complications. The aim of this study is to present our clinical experience regarding nursing care in patients using abdominal binders following surgery.

Material and Methods: Abdominal binders are initiated within the first 24 hours postoperatively, in conjunction with the mobilization process. The duration of use generally ranges between 2-6 weeks, depending on the type of surgery performed. In this context, the patient's height, weight, waist circumference, and, if present, the presence and location of a stoma should be carefully assessed. By comprehensively evaluating these characteristics, nurses facilitate the selection of the appropriate binder. During the first postoperative mobilization, the binder is applied while the patient is in a supine position or slightly turned to the right or left lateral position, ensuring full support of the abdominal region. While fastening the binder straps, nurses pay particular attention to maintaining adequate respiratory function, avoiding excessive compression of the body, preventing impairment of regional blood circulation, and ensuring that existing drains are not compromised.

Results: Patients are instructed to wear the surgical binder during each mobilization period for 2-6 weeks, depending on the type of surgery, and to loosen or remove the straps when resting in the supine position after mobilization. Furthermore, in accordance with the physician's recommendations, patients are advised not to wear the binder while bathing and during wound care following discharge.

Conclusion: Incorrect use of abdominal binders may lead to skin irritation, pressure injuries, and impairments in circulation and respiratory function. In conclusion, in surgeries requiring abdominal incisions, the use of an abdominal binder in accordance with physician recommendations necessitates comprehensive nursing roles, including patient assessment, implementation support, complication prevention, and management. The effective execution of these roles based on scientific principles and collaboration with patients and their families throughout the process contributes significantly to the improvement of postoperative care quality.

Keywords: Abdominal surgery, binder, nursing care

[P-154]

Successful management of congenital transmezocolic internal hernia in adult patients with second-look surgery

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Objective: Rectovaginal fistula (RVF) is a clinical condition resulting from the formation of an abnormal tract between the rectum and the vagina, leading to serious hygiene problems, infections, and a significant loss of quality of life. RVFs secondary to pelvic radiotherapy constitute the most difficult subgroup to treat due to poor vascularization and fibrosis. The success rate of primary surgical repair in these cases is low. Fecal diversion is often preferred as the first-line approach. However, spontaneous closure after diversion is rare. This report presents a case of radiation-related RVF that completely closed after fecal diversion and mucosal support therapy.

Material and Methods: The clinical findings, imaging methods, surgical approach, and follow-up results of a 59-year-old female patient with a history of neoadjuvant chemoradiotherapy were retrospectively evaluated.

Results: The patient presented approximately one year after radiotherapy with complaints of fecal leakage from the vagina and foul-smelling discharge. Imaging revealed a RVF extending from the anterior rectal wall to the vagina. Colonoscopy confirmed a large fistula 15 cm proximal to the anal verge. Primary repair was considered high-risk due to the previously irradiated area, fistula width, and suspicion of widespread disease, so fecal diversion was planned. During laparotomy, colon mobilization was not possible due to a "frozen pelvis" appearance, so a loop ileostomy was performed. The vaginal leakage completely resolved in the postoperative period. Omental biopsies were reported as benign. Long-term mesalazine and sucralfate enema therapy was administered to support the radiation-damaged mucosa. The sixth-month follow-up colonoscopy showed complete closure of the fistula and epithelialization. The ileostomy was closed at eight months. No fistula recurrence or additional complications were detected during the 24-month follow-up.

Conclusion: In the treatment of radiation-induced RVF, fecal diversion, when used in conjunction with mucosal support therapy in appropriate patients, may allow for permanent fistula closure. This case demonstrates that conservative approaches may be an alternative to surgical reconstruction in selected cases.

Keywords: Rectovaginal fistula, radiation damage, fecal diversion, ileostomy, mucosal support therapy

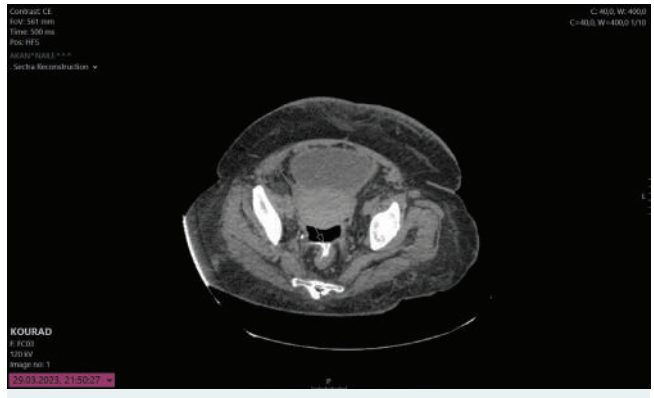

Figure 1a. Contrast-enhanced abdominal CT scan showing a rectovaginal fistula.

In rectal contrast-enhanced CT, a tract extending from the anterior rectal wall towards the cervix/vaginal apex, through which contrast material passes into the vagina.

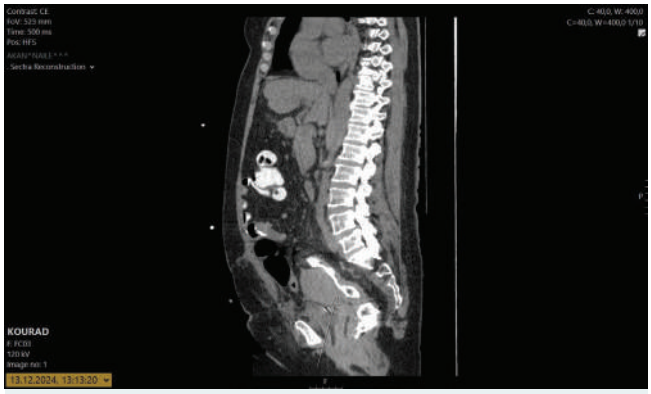

Figure 2a. Contrast-enhanced abdominal CT scan showing a rectovaginal fistula.

In rectal contrast-enhanced CT, a tract extending from the anterior rectal wall towards the cervix/vaginal apex, through which contrast material passes into the vagina.

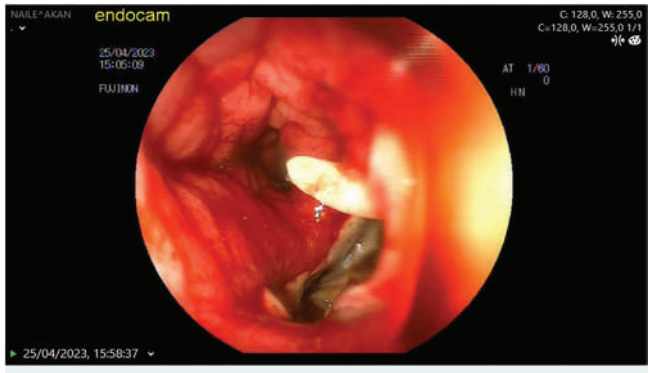

Figure 3a. Colonoscopy image of rectovaginal fistula.

Colonoscopy revealed a rectovaginal fistula located approximately 15 cm proximal to the anal verge and approximately 5 cm in width.

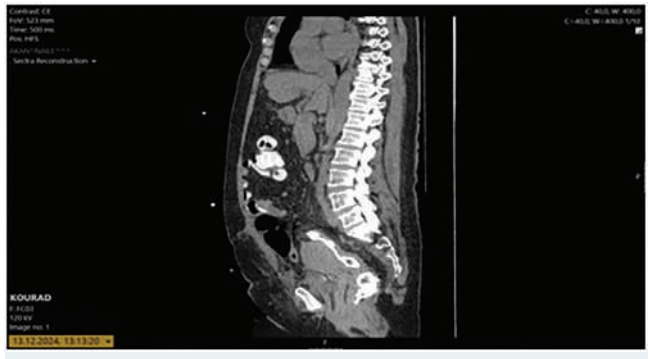

Figure 4a. Image of a healed rectovaginal fistula with contrast-enhanced abdominal CT scan.

Image showing absence of contrast passage into the vagina via contrast-enhanced lower abdominal CT scan.

Figure 5a. Colonoscopy image of healed rectovaginal.

The colonoscopy image shows that the rectovaginal fistula is completely epithelialized and closed.

[P-187]

Colonoscopy findings in diverticular disease: Are polyps and colorectal malignancy actually increasing?

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Objective: Diverticular disease is a common clinical condition in the colonoscopy patient population. The relationship between diverticular disease and colonic polyps and colorectal malignancy remains unclear. In particular, data on the relationship between the location of the diverticulum in the colon, the clinical stage of the disease, and the prevalence of polyps and malignancy are limited. This study aimed to evaluate the age and gender distribution, colonic location, polyp prevalence, Hinchey classification, and colorectal malignancy frequency in patients diagnosed with diverticular disease.

Material and Methods: This retrospective study included 79 patients of whom 48 underwent by colonoscopy. Patients' age and gender information, diverticulum location (right colon, left colon, total colon), Hinchey classification, presence of polyps detected by colonoscopy, and malignancy status were recorded. The presence of polyps was assessed as a binary variable (present/absent). Missing data were coded as NA and excluded from the relevant subgroup analyses. The Hinchey classification was evaluated only in patients diagnosed with acute diverticulitis. Patients with colorectal malignancy were excluded from the polyp prevalence analysis. Continuous variables were presented as median (minimum-maximum), and categorical variables were presented as number and percentage. The chi-square test was used to compare categorical variables.

Results: Of the patients included in the study, 49 (62.0%) were female and 30 (38.0%) were male. The median age was 58 years (range 32-92). In terms of colonic location, left-sided colon involvement was observed in the vast majority of cases. Colonic polyps were detected in 9 (18.8%) of the 48 patients with available polyp data. No statistically significant relationship was found between the presence of polyps and gender or colonic location ($p>0.05$). The majority of patients were in the Hinchey 1A-1B group, while Hinchey ≥2 cases were rare. No significant relationship was found between complicated diverticulitis and the presence of polyps. Colorectal malignancy was rarely detected in patients who underwent colonoscopy.

Conclusion: The prevalence of colonic polyps in patients with diverticular disease is similar to that in the general population, and cases are predominantly localized in the left colon. The presence of complicated diverticulitis does not pose an additional risk for polyp development. Colorectal malignancy was observed at a low rate in patients with diverticulitis who underwent colonoscopy. These findings suggest that diverticular disease and the development of colonic polyps and colorectal malignancy may be largely independent processes.

Keywords: Diverticulitis, polyps, malignancy

[P-188]

Frequency of neoplastic lesions in appendectomy specimens: A single-center experience with 749 cases

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Objective: Acute appendicitis is one of the most common indications for emergency surgical intervention, with a reported lifetime incidence of approximately 7-8%. In patients presenting with typical clinical symptoms, the diagnosis is generally established using imaging modalities, followed by appendectomy. However, histopathological examination of appendectomy specimens is of great importance not only for identifying inflammatory conditions but also for detecting rare yet clinically significant neoplastic lesions.

Material and Methods: In this study, pathology reports of 749 patients who underwent surgery for acute appendicitis at the Department of General Surgery, Ondokuz Mayıs University Faculty of Medicine, between January 2017 and January 2026 were retrospectively reviewed. Histopathological findings were categorized, and the frequency of neoplastic lesions was evaluated.

Results: Among the 749 cases, the most common histopathological diagnosis was acute appendicitis, observed in 477 patients (63.68%). This was followed by necrotizing appendicitis in 174 cases (23.63%), lymphoid hyperplasia in 32 cases (4.27%), and perforated appendicitis in 16 cases (2.13%).Neoplastic lesions were identified in 12 cases (1.6%). The distribution of these lesions was as follows: low-grade mucinous neoplasm (6 cases), high-grade mucinous neoplasm (1 case), adenocarcinoma (2 cases), tubulovillous adenoma (1 case), and grade 2 neuroendocrine tumor (2 cases). Non-neoplastic pathologies accounted for 98.4% of all cases.The most frequently detected pathology in appendectomy specimens was acute appendicitis, which is consistent with the rates of 60-70% reported in the literature. Complicated forms such as necrotizing and perforated appendicitis together constituted approximately 25-30% of cases. Although appendiceal neoplasms are rare, they are clinically significant. Mucinous neoplasms and neuroendocrine tumors often mimic the clinical presentation of acute appendicitis in the preoperative period. The neoplasm rate of 1.6% observed in our study is consistent with the range of 0.5-2% reported in the literature.

Conclusion: Although acute appendicitis remains the most common diagnosis in appendectomy specimens, neoplastic lesions are detected at a non-negligible rate. These findings support the clinical necessity of routine histopathological examination of all appendectomy specimens, as early diagnosis contributes to appropriate treatment and follow-up planning.

Keywords: Appendectomy, appendicitis, neoplasia

[P-189]

What has changed in the surgical management of T1a papillary thyroid carcinoma over the last 10 years?

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Objective: Papillary thyroid carcinoma (PTC) is the most common differentiated thyroid cancer. Its incidence has steadily increased over the past 50 years, and approximately half of surgically treated cases are tumors ≤1 cm (T1a, micro-PTC). Although lymph node metastasis is present at diagnosis in 9-42% of these tumors, prognosis is generally excellent. Management options for T1a tumors range from active surveillance to total thyroidectomy and therapeutic neck dissection. We aimed to evaluate whether there has been a change in the surgical management of T1a tumors in our clinic over the past decade.

Material and Methods: We retrospectively reviewed patients who underwent surgery for PTC with T1a (<1 cm) tumors between January 2016 and December 2025. Patients with lymph node metastasis underwent therapeutic central and/or lateral neck dissection. Patients were divided into two groups: 2016-2020 (group 1) and 2021-2025 (group 2). Surgical extent was compared between the two periods.

Results: A total of 178 patients (147 females, 31 males) were included: 52 in group 1 and 126 in group 2. Initial surgery in group 1 vs. group 2 was lobectomy in 21 (40.4%) vs. 76 (60.3%), total thyroidectomy in 25 (48.1%) vs. 46 (36.5%), and total thyroidectomy with central ± lateral neck dissection in 6 (11.5%) vs. 4 (3.2%), respectively (p=0.0142). Completion thyroidectomy after lobectomy was performed in 6 (11.1%) and 5 (4.1%) patients in groups 1 and 2, respectively (p=0.0803). After completion procedures, final surgical distribution was lobectomy in 17 (32.7%) vs. 72 (57.1%), total thyroidectomy in 28 (53.8%) vs. 50 (39.7%), and total thyroidectomy with central ± lateral neck dissection in 6 (11.5%) vs. 4 (3.2%) (p=0.0046).

Conclusion: A significant shift in the surgical management of T1aN0M0 tumors has occurred over the last decade. During the first 5-year period, total thyroidectomy (± neck dissection) was the most common procedure, accounting for nearly 60% of cases. In the second period, approximately 60% of patients underwent lobectomy, making it the preferred initial surgical approach. The rate of neck dissection for lymph node metastasis decreased from 10% to 3%, likely reflecting a move away from prophylactic dissection and an increase in incidentally detected small tumors.

Keywords: Papillary thyroid carcinoma, T1a tumor, lobectomy

[P-191]

Invasive lobular breast cancer progressing to aggressive metaplastic carcinoma

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Objective: Breast cancer is a malignancy exhibiting heterogeneous biological characteristics, with treatment response and prognosis varying significantly according to histopathological subtypes. Metaplastic breast carcinoma (MBC) is a rare subtype, accounting for less than 1% of all breast cancers, which is usually aggressive, triple-negative, and resistant to chemotherapy. The sequential development of different histopathological breast cancer types in the same patient is quite rare and complicates clinical management. This case presents aggressive MBC developing after a history of invasive lobular breast cancer.

Material and Methods: The clinical course, imaging findings, surgical interventions, and histopathological results of a 44-year-old female patient who developed different breast cancer subtypes at different times were retrospectively evaluated.

Results: The patient was initially operated on due to a mass developing in the left breast. Pathological evaluation revealed HER2-positive invasive breast carcinoma, and adjuvant chemotherapy, trastuzumab, and radiotherapy were administered. During follow-up, a rapidly growing mass in the right breast was surgically removed, and invasive lobular carcinoma was diagnosed. Adjuvant chemotherapy was initiated. However, eight months after right mastectomy, while adjuvant treatment was ongoing, a rapidly progressing mass invading the pectoral muscle developed at the mastectomy site. No distant metastases were detected on imaging. Following a multidisciplinary team decision, the lesion was en bloc excised along with the pectoral muscle segment. Pathological examination revealed findings consistent with MBC with a triple-negative phenotype, containing widespread squamous differentiation, and the surgical margins were negative.

Conclusion: Although MBC is rare, it exhibits aggressive biological behavior and chemoresistant properties. This case highlights the possibility of biological transformation in breast cancer and the necessity for re-biopsy and multidisciplinary evaluation in cases of recurrence or progression. An aggressive surgical approach in the absence of distant metastasis may offer an important treatment option for local control.

Keywords: Metaplastic breast carcinoma, invasive lobular carcinoma, breast cancer, triple-negative phenotype, local recurrence

[P-194]

Reasons for conversion from breast-conserving surgery decision to primary mastectomy in multidisciplinary tumor boards: Pandemic impact and temporal trends

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Objective: Reasons for conversion from breast-conserving surgery decision to primary mastectomy in multidisciplinary tumor boards: pandemic impact and temporal trends.

Material and Methods: In this single-center retrospective analysis, cases initially recommended for BCS by the MTB but who subsequently underwent primary mastectomy were evaluated annually. The "pandemic impact" period was defined as 2021-2022, and the "post-pandemic" period as 2023-2025. Reasons for conversion were categorized as physician-based (extra-board re-evaluation: concerns regarding negative surgical margins, cosmetic considerations) and patient-based [preference for mastectomy following counseling: perceived higher efficacy of mastectomy, difficulty accessing radiotherapy (RT), fear of RT/hospital contact, and the desire to minimize hospital visits by opting for a single-session procedure]. Ethical committee exemption was obtained for the study.

Results: Between 2021 and 2025, a total of 369 BCS decisions were made, and primary mastectomy was performed in 77 cases (20.9%). While the annual number of BCS decisions increased from 62 to 84 (a 35.5% increase), the conversion rate from BCS to mastectomy was 37.1% (23/62) in 2021, 25.0% (17/68) in 2022, 22.7% (17/75) in 2023, 12.5% (10/80) in 2024, and 11.9% (10/84) in 2025. The conversion rate was significantly higher during the pandemic impact period (30.8%, 40/130) compared to the post-pandemic period (15.5%, 37/239) ($p<0.001$). Throughout the entire study period, 33.8% (26/77) of conversions were physician-based, while 66.2% (51/77) were patient-based. The most common physician-based reason was concern regarding negative surgical margins (19/26), followed by cosmetic reasons (7/26). In the pandemic impact period, fear of RT/hospital contact and RT access difficulties were the predominant patient-based factors; in the post-pandemic period, although the overall conversion rate decreased, patient-related factors remained the primary driver.

Conclusion: The conversion rate from a BCS recommendation to primary mastectomy was found to be significantly higher during the pandemic impact period. In the post-pandemic era, while BCS decisions increased, the conversion rate markedly decreased. We conclude that the standardization of patient counseling and implementation of measures to facilitate access to radiotherapy may further reduce the conversion rates from BCS to mastectomy in the future.

Keywords: Breast cancer, BCS, mastectomy

[P-195]

Multidisciplinary team (MDT)-tumor board practices and the need for digital solutions in Türkiye

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Objective: The annual number of newly diagnosed cancer cases in Türkiye is reported to be approximately 240.000 (Turkish Statistical Institute), and these cases,together with other complex clinical conditions,are evaluated within multidisciplinary team meeting (MDT/tumor boards); however, MDT/tumor board practices vary across institutions, and the need for digitalization in terms of recording,data management, and sustainability is increasing. Systematic evaluation of MDT practices in Türkiye remains limited.

Material and Methods: This cross-sectional survey study included 167 physicians representing 26 medical specialties and 23 different tumor board types from 30 cities across Türkiye. Participants were digitally administered a 42-item online questionnaire (Google Forms) covering MDT experience, tumor board workflow, recording-consent-data security practices, and attitudes toward digital MDT solutions.

Results: Of the 167 participating physicians, 63.47% were male and 36.53% female, with 68.26% aged 31-50 years. Overall, 69.46% had ≥5 years of post-specialty experience, and 83.24% worked in tertiary care institutions. Regarding MDT experience, 66.02% reported ≥4 years and 33.53% ≥10 years. According to participant reports, 82.63% of MDT meetings are still conducted face to face, and 46.10% of decisions are recorded on paper forms. Presentation materials and patient files are commonly stored on personal computers (31.70%), messaging platforms (24.00%), and email attachments (21.60%), with 63.47% reporting file loss or version confusion. The proportion reporting that no specific patient consent is obtained for MDT discussions was 73.65%, while 71.26% indicated the absence of a written procedure for communicating decisions to patients. Only 22.75% considered MDT processes to be fully compliant with "KVKK/GDPR". Additionally, 44.31% reported frequent impact on personal time, and 32.93% on working hours. Despite this, MDT participation was not institutionally documented in 47.31% of cases; 94.01% reported no financial benefit, and 80.24% rated academic prestige/publication contribution as none or rare. Artificial intelligence was not used in MDT processes by 89.20% of participants. The main barriers to digitalization were lack of technical infrastructure (67.10%), insufficient digital tool usage habits (61.10%), and institutional integration challenges (52.70%). The most prioritized features of a digital MDT system were single-panel access to all patient data (77.80%), automated and standardized decision recording (73.70%), PACS integration (71.30%), and "HBYS/e-Nabız" integration (59.90%). A total of 84.40% agreed that digital MDTs would improve standardization, accessibility, and institutional sustainability, and 78.40% believed they would contribute to the national healthcare system. Digital solutions for MDT preparation and implementation (Table 1) and the anticipated innovations and benefits of a digital MDT software (Table 2) were rated as highly important and beneficial. Finally, 92.80% stated they would use a digital MDT system (definitely 53.30%, if needed 39.50%), and 74.85% were willing to participate voluntarily in pilot, testing,or design phases.

Conclusion: This study demonstrates that MDT practices in Türkiye are widespread but require further development in terms of standardization, data security, and recording systems; however, there is strong acceptance and high willingness to participate in digital, integrated, and artificial intelligence-supported MDT solutions. The findings indicate that digital MDT solutions hold significant transformative potential.

Keywords: Multidisciplinary tumor boards, multidisciplinary team meeting, digital health, artificial intelligence, data security

Table 1. Perceived importance of MDT session, preparation, and patient communication processes

Durum	1=hiç önemli değil	2=az önemli	3=orta düzeyde önemli	4=önemli	5=çok önemli
Uzaktan erişim ile konsültan katılımı	9 (5.39%)	22 (13.17%)	43 (25.75%)	49 (29.34%)	44 (26.35%)
Konsey kararlarının dijital ortamda kayıt imkanı	1 (0.60%)	3 (1.80%)	30 (17.96%)	44 (26.35%)	89 (53.29%)
Kurumsal standart sunum formatı bulunması	2 (1.20%)	2 (1.20%)	36 (21.56%)	46 (27.54%)	81 (48.50%)
Sunum dosyalarına toplantı öncesi online erişim	1 (0.60%)	6 (3.59%)	24 (14.37%)	50 (29.94%)	86 (51.50%)
Hastalardan özel yazılı/dijital onam alınması	22 (13.17%)	28 (16.77%)	48 (28.74%)	37 (22.16%)	32 (19.16%)
Konsey kararlarının hastaya yazılı/dijital iletilmesi	7 (4.19%)	11 (6.59%)	34 (20.36%)	54 (32.34%)	61 (36.53%)
KVKK/GDPR'ye tam uyumlu veri işleme ve paylaşım	6 (3.59%)	8 (4.79%)	34 (20.36%)	54 (32.34%)	65 (38.92%)
Durum	**1=hiç önemli değil**	**2=az önemli**	**3=orta düzeyde önemli**	**4=önemli**	**5=çok önemli**
Ortalama kazanım yüzdeleri	**4.11%**	**6.84%**	**21.30%**	**28.57%**	**39.18%**

Table 2. Evaluation of innovations and benefits of the digital MDT software

Yenilik/kazanım	1=kesinlikle faydasız	2=faydasız	3=kararsız/ kısmen faydalı	4=faydalı	5=çok faydalı
Sabit dijital mimari ve geliştirilebilir format	5 (2.99%)	10 (5.99%)	46 (27.54%)	62 (37.13%)	44 (26.35%)
Konsey süresi verimliliği ve zaman tasarrufu	3 (1.80%)	13 (7.78%)	39 (23.35%)	60 (35.93%)	52 (31.14%)
Konsey hazırlık süreçlerini hızlandırması ve hataları azaltması	2 (1.20%)	11 (6.59%)	27 (16.17%)	78 (46.71%)	49 (29.34%)
Hasta verilerinin güvenli dijital saklanması ve arşiv kayıplarının önlenmesi	3 (1.80%)	12 (7.19%)	25 (14.97%)	63 (37.72%)	64 (38.32%)
Konsey katılım bilgilerinin kişisel ve akademik olarak belgelenebilmesi	1 (0.60%)	9 (5.39%)	28 (16.77%)	60 (35.93%)	69 (41.32%)
Etik onam, dijital belge/sonuç iletimi ve siber güvenlik	5 (2.99%)	17 (10.18%)	36 (21.56%)	57 (34.13%)	52 (31.14%)
Klinik araştırma için veri entegrasyonu ve etik onamlı katılım	6 (3.59%)	14 (8.38%)	33 (19.76%)	60 (35.93%)	54 (32.34%)
Dijital davet ve planlama ile toplantı organizasyonu	5 (2.99%)	14 (8.38%)	30 (17.96%)	62 (37.13%)	56 (33.53%)
Yapay zeka destekli klinik önerilerin artması	4 (2.40%)	20 (11.98%)	42 (25.15%)	54 (32.34%)	47 (28.14%)
Konsey geçmişinin arşivlenebilir, indekslenebilir ve erişilebilir olması	3 (1.80%)	8 (4.79%)	26 (15.57%)	59 (35.33%)	71 (42.51%)
Katılımın kurumsal ve akademik olarak belgelendirilmesi	4 (2.40%)	10 (5.99%)	29 (17.37%)	53 (31.74%)	71 (42.51%)
MDT katılımı olmayan kurumlara ve hastalara erişim imkanı	8 (4.79%)	13 (7.78%)	35 (20.96%)	55 (32.93%)	56 (33.53%)
Tanı-tedavi-maliyet etkinlik analiz imkânı	6 (3.59%)	10 (5.99%)	44 (26.35%)	54 (32.34%)	53 (31.74%)
Yenilik/kazanım	**1=kesinlikle faydasız**	**2=faydasız**	**3=kararsız/ kısmen faydalı**	**4=faydalı**	**5=çok faydalı**
Ortalama kazanım yüzdeleri	**2.53%**	**7.41%**	**20.27%**	**35.77%**	**33.99%**

[P-196]

Evolution of educational resources: A comparative analysis of laparoscopic cholecystectomy videos over two decades

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Objective: Laparoscopic cholecystectomy (LAP chole) is one of the most commonly performed surgeries worldwide. With the rise of online platforms like YouTube and WebSurg, surgical videos have become popular educational tools. However, the quality of these videos varies, raising concerns about their reliability. This study evaluates the changes in the quality of laparoscopic cholecystectomy videos over two decades and compares the educational value of YouTube and WebSurg videos.

Material and Methods: Twenty-four videos were analyzed and divided into four groups: older YouTube, older WebSurg, newer YouTube, and newer WebSurg. Six videos from each group were selected based on relevance and popularity. Three independent surgeons assessed them using standardized scoring systems, including the JAMA benchmark score, global quality score (GQS), LAP-VEGaS, and a new LAP chole-specific score (SS). Video characteristics such as duration, uploader type, and viewer engagement were also considered. Statistical comparisons were made between the groups.

Results: The analysis showed that although newer videos were longer, the difference was not statistically significant (p=0.74). Newer videos had significantly better image quality (p<0.001). WebSurg videos consistently outperformed YouTube videos across all evaluation criteria (Table 1). WebSurg scored higher in the JAMA benchmark (2.62 vs. 1.66), GQS (3.58 vs. 2.63), LAP-VEGaS (13.7 vs. 6.58), and LAP chole-SS (4.08 vs. 2.33) (Table 2).

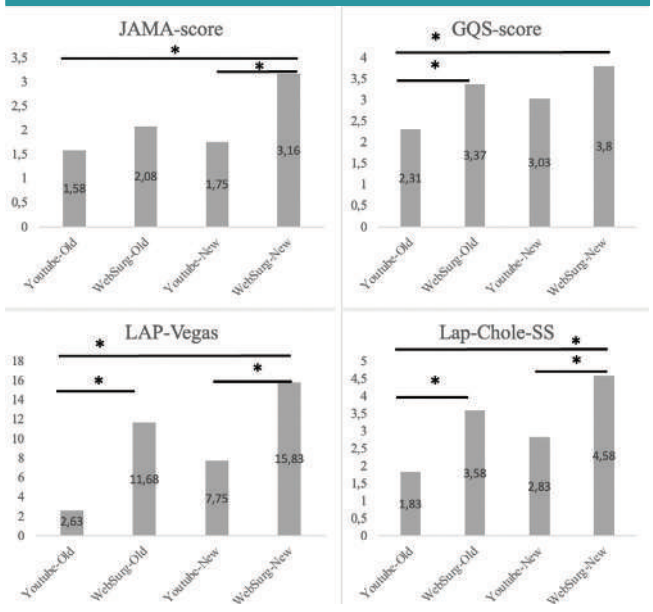
Conclusion: In conclusion, WebSurg provides higher-quality, peer-reviewed content, making it more reliable for surgical education, while YouTube offers accessibility but often lacks educational rigor.

Keywords: Cholecystectomy, education, laparoscopic surgery, youtube, video

Table 1.

		YouTube videos (n=12)	WebSurg videos (n=12)	sig.
Duration		485	546	.877
		(107-978)	(282-1130)	
Views		52k	6.8k	.050
		(1.1k-550k)	(0.6k-23k)	
Source				<.001
Physician Commercial		9 3	12 0	
Country				<.001
India USA France		8 4 0	0 0 12	
Image quality				<.001
Poor Moderate Good		5 1 6	0 0 12	
Background sound				<.001
Music Narration Silent		6 5 1	0 11 1	
JAMA benchmark		1.66	2.62	.965
GQS		2.63	3.58	.005
LAP-VEGaS		6.58	13.7	.493
LAP chole-SS		2.33	4.08	.047

Table 2.



[P-197]

Upper and lower gastrointestinal endoscopy: Indications and findings according to age groups in a tertiary center

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Objective: Upper and lower gastrointestinal endoscopy are essential diagnostic tools for evaluating gastrointestinal symptoms. Endoscopic indications and findings may vary according to age, influencing diagnostic yield and clinical decision-making. This study aimed to evaluate age-related differences in indications and findings of both upper and lower gastrointestinal endoscopy and to explore whether clinically relevant findings increase before the current colorectal cancer screening age.

Material and Methods: A retrospective analysis was conducted on patients who underwent upper and/or lower gastrointestinal endoscopy between 2025 and 2026 in a tertiary care center. Patients were stratified into age groups (<40, 40-49, 50-59, and ≥60 years). Demographic characteristics, indications for endoscopy, and endoscopic findings were recorded. Upper and lower gastrointestinal endoscopy results were analyzed separately and comparatively according to age groups using descriptive and comparative statistical methods.

Results: A total of 325 endoscopic procedures were included, comprising 167 upper and 156 lower gastrointestinal endoscopies. Dyspeptic symptoms were the most common indications for upper gastrointestinal endoscopy across all age groups. Antral gastritis was the most frequent upper endoscopic finding. Lower gastrointestinal endoscopy was most commonly performed for rectal bleeding, altered bowel habits, anemia, and abdominal pain. Normal or near-normal findings were more frequent in younger patients, whereas pathological findings increased with age, particularly in patients aged 50 years and older. Although colorectal cancer screening is generally recommended from the age of 50, analysis of patients aged 40-49 years did not reveal a statistically significant increase in pathological endoscopic findings compared with other age groups (p=0.66), indicating no clear evidence to support lowering the screening age to 40 in this cohort.

Conclusion: Endoscopic findings demonstrate a progressive age-related increase rather than a sharp rise in the 40-49 age group. While pathological findings become more prevalent after the age of 50, the current data do not support lowering the colorectal cancer screening age to 40. An age-based and indication-driven approach to gastrointestinal endoscopy remains essential for optimizing diagnostic yield.

Keywords: Gastrointestinal endoscopy, age groups, colorectal cancer screening, screening age

[P-198]

The role of nurses in preventing post-liver transplantation complications

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Objective: Liver transplantation is a life-saving treatment for end-stage liver disease. However, early postoperative complications such as infection, acute rejection, bleeding, vascular thrombosis, and biliary complications remain major causes of morbidity and mortality. Nurses play a pivotal role in the early detection, monitoring, and prevention of these complications.

Material and Methods: This study was designed as an evidence-based literature review. Recent national and international studies were analyzed to identify common postoperative complications and related nursing interventions. Key nursing responsibilities, including hemodynamic monitoring, infection control practices, immunosuppressive therapy management, fluid and electrolyte balance assessment, early mobilization, and patient education, were systematically evaluated.

Results: Findings indicate that structured and protocol-driven nursing care significantly reduces preventable postoperative complications. Continuous monitoring of vital signs and laboratory parameters enables early detection of acute rejection and graft dysfunction. Strict adherence to aseptic techniques lowers infection rates, while comprehensive patient education enhances medication adherence and long-term graft survival.

Conclusion: Nurses play a critical role in preventing early complications after liver transplantation. The integration of standardized nursing protocols into postoperative care pathways improves patient safety, reduces complication rates, and enhances overall transplant outcomes.

Keywords: Liver transplantation, nursing care, postoperative complications

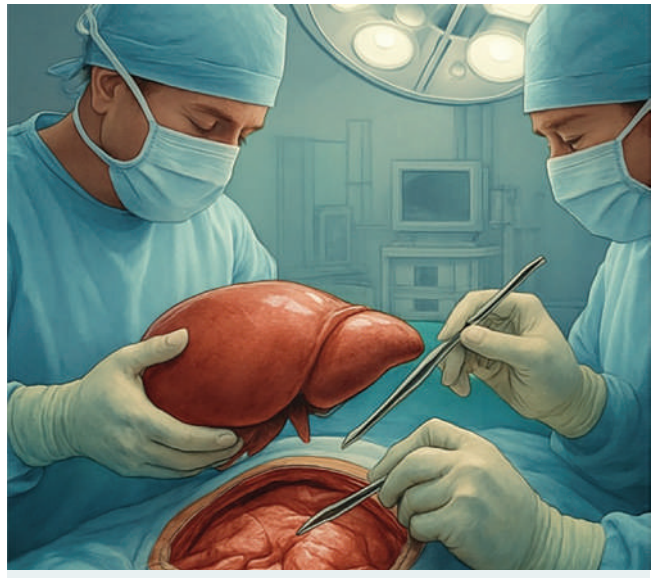

Figure 1. Liver transplantation.

A glimpse of surgeons performing liver transplantation.

[P-201]

The role of four-dimensional computed tomography in preoperative localization in primary hyperparathyroidism

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Objective: Accurate preoperative localization is of critical importance in the surgical management of primary hyperparathyroidism (PHPT). Ultrasonography (USG) and sestamibi scintigraphy are first-line imaging modalities. However, in cases where first-line imaging is negative or discordant, four-dimensional computed tomography (4D-CT) has gained increasing importance. In this study, the concordance between imaging modalities and surgical findings was analyzed in PHPT patients who underwent 4D-CT and subsequent surgery.

Material and Methods: Demographic and clinical characteristics of 23 patients diagnosed with PHPT were retrospectively recorded. Patients included in the study had a diagnosis of PHPT, had not undergone prior surgery, had non-localizing findings on first-line imaging or discordance between imaging modalities, and underwent 4D-CT imaging preoperatively. Surgical findings were accepted as the gold standard, and the localization success and complete concordance rates of the imaging methods were evaluated accordingly. Intraoperative rapid parathyroid hormone (PTH) measurement and nerve monitoring were utilized in all cases. Focused parathyroidectomy or four-gland exploration was performed depending on the case.

Results: Of the patients (19 females, 4 males), the mean age was 46.8±14.5 years. The mean preoperative serum calcium level was 10.81±0.83 mg/dL, and the mean PTH level was 279.4±437.1 pg/mL. All patients underwent preoperative USG, scintigraphy, and 4D-CT imaging. According to surgical findings, the most common adenoma location was the right inferior gland (39.1%). The localization success rate of USG was 87% (20/23), with a complete localization accuracy of 78.3% (18/23). 4D-CT achieved localization in 65.2% (15/23) of cases, with a complete surgical concordance rate of 39.1% (9/23). Scintigraphy achieved localization in 30.4% (7/23) of cases, with a complete concordance rate of 17.4% (4/23). In cases with marked discordance between USG and scintigraphy, 4D-CT provided additional anatomical information in some patients and contributed to surgical planning, particularly in ectopically located glands. However, 4D-CT did not demonstrate sufficient concordance with surgical findings in all discordant cases. Among the imaging modalities, USG showed the highest concordance with surgical findings.

Conclusion: Although the overall success rate of 4D-CT was low in our study, it appears to serve a complementary role, particularly in selected patients with negative or discordant conventional imaging findings. According to the literature, we attribute our relatively low imaging success rate with 4D-CT to the learning curve associated with this technique. Despite inadequate imaging results, pathological foci were identified and successfully excised in 21 patients. These findings support the importance of a stepwise imaging approach in the management of PHPT.

Keywords: Hyperparathyroidism, 4D-CT, ultrasonography, scintigraphy

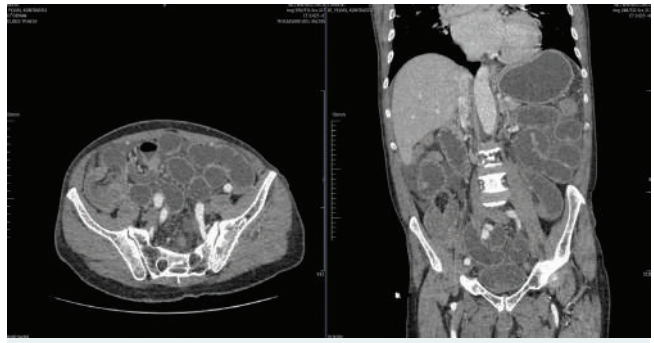

Figure 1. İleoçekal invajinasyon.

Sağ alt kadranda ileoçkal invajinasyon ve dilate ince barsak anslarının aksiyel ve coronal BT görüntüsü.

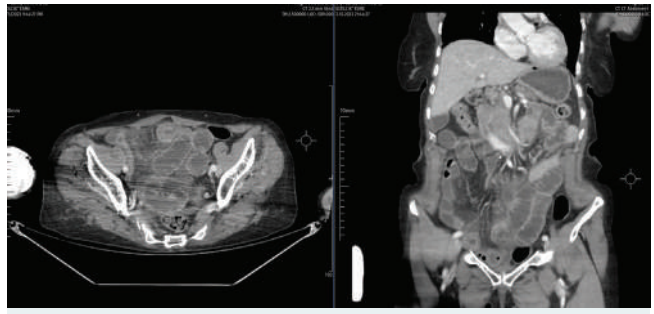

Figure 2. Sağ alt kadranda ileo-ileal invajinasyona ait hedef tahtası bulgusu.

[P-205]

"Diagnosis, surgical approach, and clinical outcomes in adult intussusception: A single-center experience"

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Objective: Adult intussusception is a challenging clinical entity in terms of diagnosis and management due to its rarity, high rate of malignancy in the etiology, and variable clinical course. In this study, the demographic characteristics, clinical and radiological findings, surgical approaches, and clinical outcomes of adult patients with intussusception presenting to the emergency department were evaluated.

Material and Methods: Thirty-eight adult patients diagnosed with intussusception after presenting to the Emergency Department at the General Surgery Department, University of Health Sciences Türkiye, Ankara Etlik City Hospital were retrospectively reviewed. Demographic data, duration of symptoms, clinical and radiological findings, surgical decision-making processes, pathological diagnoses, and postoperative outcomes were analyzed.

Results: Median age was 50 years (IQR: 31.5-57.8), and 55.3% were male. The most common presenting symptom was abdominal pain (94.7%), followed by nausea-vomiting (71.1%) and obstipation (50.0%). Fever (15.8%) and hypotension (10.5%) were noted, while a palpable abdominal mass on physical examination was recorded in 5.3% of patients. Computed tomography (CT) was used for diagnostic evaluation in all patients, and a preoperative diagnosis of intussusception was achieved in 97.4% of cases. The most frequently identified type of intussusception was enteroenteric (83.8%). CT findings included the target/donut sign in 97.4%, an invaginated segment longer than 3 cm in 81.6%, obstruction in 51.4%, and free fluid in 39.5% of patients. Diagnostic delay (>48 hours) was present in 52.6% of cases. The median time from symptom onset to diagnosis was 59 hours (IQR: 12-81). Of the 38 patients, 27 (71.1%) underwent surgical intervention, the vast majority under emergency conditions (96.3%). The most common surgical indications were bowel obstruction (37.0%), acute abdomen/peritonitis (25.9%), signs of ischemia (18.5%), and suspicion of malignancy (18.5%). Bowel resection was performed in 55.6% (15/27) of surgically treated patients. Among those who underwent resection, 93.3% received segmental small bowel resection and 6.7% underwent right hemicolectomy. The stoma formation rate was 3.7%. Pathological examination of resected specimens revealed malignancy in 33.3% (5/15) of cases. In the postoperative period, at least one complication occurred in 18.5% of patients. The most common complications were surgical site infection (7.4%) and sepsis (7.4%). No anastomotic leakage was observed. A total of 40.7% of patients required intensive care unit follow-up, with a median ICU stay of 0 days (IQR: 0-1). The 30-day mortality rate was 2.6%, and overall mortality was 7.4%. The median follow-up duration was 12 months (IQR: 7.5-20.5).

Conclusion: The literature indicates that adult intussusception is often detected electively or incidentally. In our study, the fact that all cases presented through the emergency department reflects a distinct patient population with a more severe clinical course. The malignancy rate of 33.3% in surgically treated and resected cases is consistent with the literature and underscores that the possibility of malignancy must be carefully considered in clinical decision-making for emergent adult intussusception. The central role of CT in diagnosis was confirmed, as CT was used in all patients with a preoperative diagnostic rate of 97.4%. Radiological parameters such as the target/donut sign, invaginated segment length, and findings of obstruction or ischemia significantly guided surgical decision-making. In conclusion, adult intussusception presenting to the emergency department is associated with a high need for surgery and a substantial malignancy risk, requiring integrated clinical, radiological, and pathological evaluation for timely surgical management.

Keywords: Adult intussusception, bowel resection, computed tomography (CT), emergency surgery, malignancy

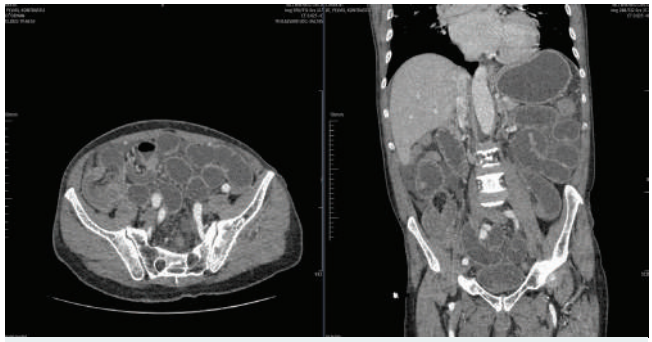

Figure 1. Ileocecal intussusception.

Axial and coronal CT images demonstrating ileocecal intussusception in the right lower quadrant with dilated small bowel loops.

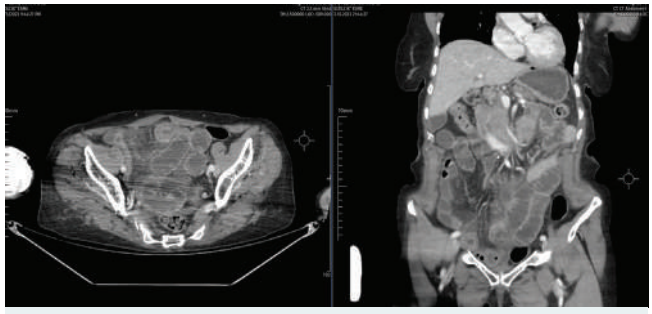

Figure 2. Ileoileal intussusception.

Target sign of ileoileal intussusception in the right lower quadrant.

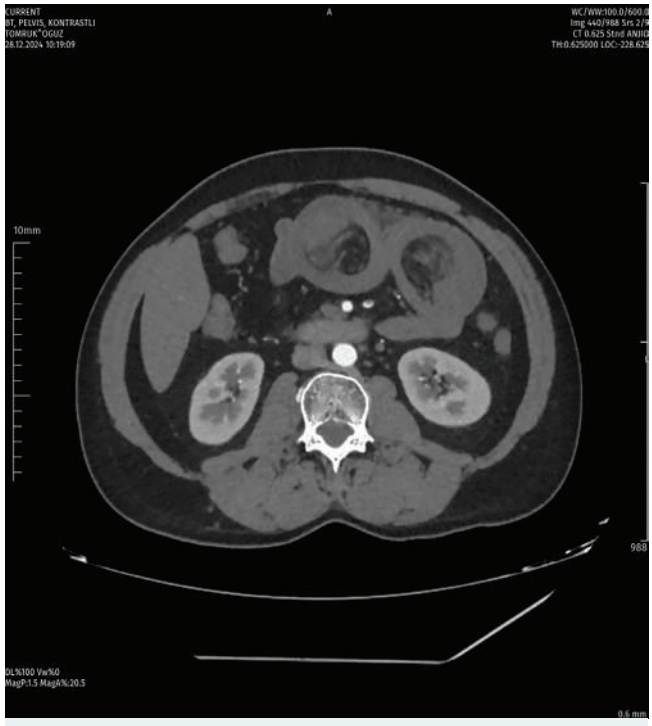

Figure 3. Jejunojejunnal intussusception.

Axial CT image demonstrating small bowel intussusception involving the mesentery.

Figure 4. Intraoperative findings.
Reduction of intussusception using laparoscopic and open surgical techniques.

Table 1. Demographic characteristics and presenting findings (n=38)

Variable	Value
Age (years), median (IQR)	50 (31.5-57.8)
Age (years), mean ± SD	46.9±18.6
Sex	
Male	21 (55.3%)
Female	17 (44.7%)
Body mass index (kg/m^2), median (IQR	22.8 (19.8-27.9)
ASA score	
ASA I	9 (23.7%)
ASA II	16 (42.1%)
ASA III	8 (21.1%)
ASA IV	5 (13.1%)
Presence of comorbidity	
Absent	18 (47.4%)
Present	20 (52.6%)
Mode of presentation	
Emergency	38 (100%)
Symptom duration (days), median (IQR)	3.0 (2.0-7.0)

Table 2. Clinical symptoms and laboratory findings

Variable	Value
Abdominal pain	36 (94.7%)
Nausea/vomiting	27 (71.1%)
Absence of flatus-stool passage	19 (50.0%)
Lower gastrointestinal bleeding	7 (18.4%)
Palpable mass	2 (5.3%)
Fever (>38 °C)	6 (15.8%)
Hypotension (SBP <90 mmHg)	4 (10.5%)
WBC (10^3/µL), median (IQR)	11.6 (9.1-16.8)
Hemoglobin (g/dL), median (IQR)	12.6 (10.9-14.4)
CRP (mg/L), median (IQR)	42.0 (15.0-132.0)
Lactate (mmol/L), median (IQR)	2.1 (1.4-3.6)

Table 3. Imaging findings and diagnostic characteristics

Variable	Value
Imaging modality used	
CT	19 (50.0%)
Ultrasonography	0 (0.0%)
CT+ultrasonography	19 (50.0%)
Diagnosis of intussusception by CT	37 (97.4%)
Type of intussusception	
Enteroenteric	31 (83.8%)
Ileocecal	6 (16.2%)
Ileocolic	0 (0.0%)
Colocolic	0 (0.0%)
Suspicion of malignancy on CT	7 (19.4%)
Bowel obstruction	19 (51.4%)
Signs of bowel ischemia	6 (16.2%)
Free fluid	15 (39.5%)
Clear visualization of lead point on CT	4 (10.5%)
Target/donut sign	37 (97.4%)
Segment length >3 cm	31 (81.6%)
Preoperative diagnosis established	37 (97.4%)
Time from symptom onset to diagnosis (hours), median (IQR	59 (12-81)
Diagnostic delay (>48 hours)	20 (52.6%)

Table 4. Surgical and pathological findings	
Variable	**Value**
Patients who underwent surgery	27 (71.1%)
Timing of surgery	
Emergency	26 (96.3%)
Semi-elective	1 (3.7%)
Indication for surgery	
Bowel obstruction	10 (37.0%)
Acute abdomen/peritonitis	7 (25.9%)
Signs of ischemia	5 (18.5%)
Suspicion of malignancy	5 (18.5%)
Patients in whom reduction was attempted	4 (14.8%)
Successful reduction	4/4 (100%) (among attempted)
Bowel resection	15 (55.6%)
Type of resection (patients with resection, n=15)	
Segmental small bowel resection	14 (93.3%)
Right hemicolectomy	1 (6.7%)
Anastomosis performed	15 (55.6%)
Stoma creation	1 (3.7%)
Operative time (min), median (IQR)	60 (45-85)
Pathological findings (patients with resection, n=15)	
Benign	10 (66.7%)
Malignant	5 (33.3%)

Table 5. Postoperative complications and outcomes (patients who underwent surgery, n=27)	
Postoperative complication (at least one)	**5 (18.5%)**
Anastomotic leakage	0 (0.0%)
Postoperative ileus	1 (3.7%)
Surgical site infection	2 (7.4%)
Sepsis	2 (7.4%)
Clavien-Dindo grade ≥3	2 (7.4%)
Intensive care unit admission	11 (40.7%)
ICU stay (days), median (IQR)	0 (0-1)
Length of hospital stay (days), median (IQR	6 (3-8.5)
30-day mortality	0 (0.0%)
Overall mortality	2 (7.4%)
Recurrence	0 (0.0%)
Follow-up duration (months), median (IQR)	12 (7.5-20.5)

Erişkin invajinasyonunda güncel literatür ile çalışmamızın karşılaştırılması

Çalışma	Tasarım / Dönem	N	Hasta profili	Yaş	BT/CT kullanımı	Preop tanı	Cerrahi oranı	Malignite oranı	Öne çıkan mesaj
Bizim çalışmamız (Etlik Şehir Hastanesi, acil başvurulu erişkin invajinasyon)	Retrospektif, tek merkez	38	Tümü acil başvuru	Medyan 50 (IQR 31,5–57,8)	**%100 (BT tek başına veya BT+USG)**	**BT ile preoperatif tanı %97,4 (acil popülasyon)**	**%71,1 (27/38)**	**Rezeksiyon yapılanlarda %33,3 (5/15)**	Acil popülasyonda yüksek cerrahi yükü; BT tanıda çok güçlü; malignite riski klinik kararın merkezinde
Chand ve ark., 2024	Sistematik derleme (59 makale)	1902 / 1920 invajinasyon	Karma (erişkin)	Ort. 52,1±15,0	BT primer yöntem %88,5	Preop tanı %98,3	Çoğunluk cerrahi	NR	Redüksiyon çok nadir; cerrahide onkolojik prensip vurgusu
Heersche ve ark., 2025	Sistematik derleme	2402 invajinasyon	Karma (erişkin)	NR	NR	NR	Operatif %65	Lokalizasyona göre %9–68	Lokalizasyona göre malignite riski keskin biçimde değişiyor
Su ve ark., 2020	Retrospektif, tek merkez	150	Karma (erişkin)	Ort. 54,5	BT %92	NR	%92,7	%36,7 (cerrahi hastalarda)	Büyük seri; cerrahi ve tümör ilişkisi yüksek
Revista Gastroenterología de México, 2022	Retrospektif, tek merkez	28	Karma (erişkin)	Medyan 46	NR	NR	25/28	%32,1	Morbidite ve mortalite vurgusu

Figure 5. Comparison of our study with the current literature on adult intussusception.

[P-206]

Global research trends in robotic versus laparoscopic low anterior resection for rectal cancer: A bibliometric analysis

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Objective: Low anterior resection (LAR) is a cornerstone procedure in rectal cancer surgery, with minimally invasive techniques increasingly replacing open approaches. While laparoscopic LAR has demonstrated favorable perioperative and oncological outcomes, technical limitations in challenging pelvic anatomy have encouraged the adoption of robotic platforms. With the maturation and wider availability of robotic technology, comparative studies between robotic and laparoscopic LAR have increased. However, beyond clinical outcome comparisons, the global research structure and collaborative patterns of this literature have not been systematically evaluated. This study aimed to perform a bibliometric analysis of publications comparing robotic and laparoscopic low anterior resection, focusing on temporal trends, core journals, and leading contributors.

Material and Methods: This bibliometric analysis evaluated PubMed-indexed literature comparing robotic and laparoscopic low anterior resection for rectal cancer. A systematic search of titles and abstracts was conducted using the terms "low anterior resection" OR "LAR" AND "robotic" AND "laparoscopic," without restrictions on publication year, article type, or language. Publications published between 2006 and 2026 were included and exported in MEDLINE format. Analyses were performed using the Bibliometrix package and Biblioshiny interface. Evaluated indicators included annual scientific production, life cycle analysis, core journals identified by Bradford's law, corresponding author countries, and collaboration patterns based on co-authorship and geographic networks.

Results: A total of 198 publications across 77 journals were included, authored by 1,248 unique researchers. All publications were multi-authored, with a mean of 7.7 authors per document, indicating a highly collaborative research environment. Scientific production remained limited until 2012, followed by steady growth after 2013 and a marked increase from 2020 onward. Life cycle analysis demonstrated that the field has entered a maturity phase, reaching approximately 75% of its projected saturation level. Journal analysis revealed a concentrated dissemination pattern, with a small group of core journals accounting for a disproportionate share of publications. Japan was identified as the leading contributing country, followed by South Korea, China, and the United States, with predominantly regional research networks. Thematic assessment indicated a shift from feasibility-oriented laparoscopic studies toward robotic-focused and outcome-driven research. Annual number of publications comparing robotic and laparoscopic low anterior resection for rectal cancer between 2006 and 2026. Scientific output remained limited until 2012, followed by a steady increase after 2013 and a marked surge from 2020 onward. Life cycle analysis of publications comparing robotic and laparoscopic low anterior resection. The model demonstrates that the research field has reached approximately 75% of its projected saturation level, indicating a maturity phase of scientific production. Leading journals publishing studies on robotic versus laparoscopic low anterior resection, demonstrating a concentrated dissemination pattern in a limited number of core surgical journals.

Conclusion: This bibliometric analysis demonstrates that research comparing robotic and laparoscopic low anterior resection has evolved into a mature and expanding field. Although bibliometric data cannot establish clinical superiority, observed research trends suggest that robotic platforms are increasingly perceived as potential solutions to the limitations of conventional laparoscopy in complex pelvic surgery. These findings support the need for future multicenter and cost-effectiveness-focused studies to define the role of robotic technology in routine rectal cancer practice.

Keywords: Bibliometric analysis, laparoscopic surgery, low anterior resection, rectal cancer, robotic surgery

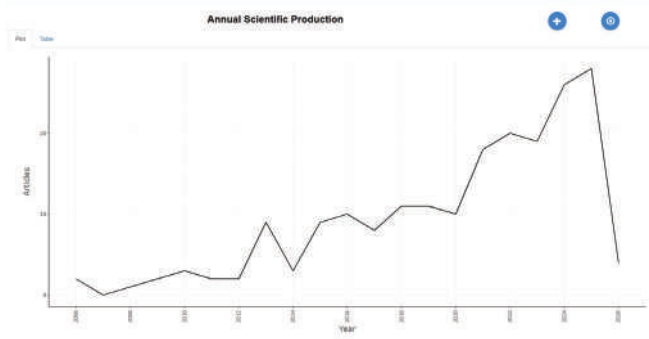

Figure 1. Annual scientific production.

Figure 2. Life cycle of scientific production.

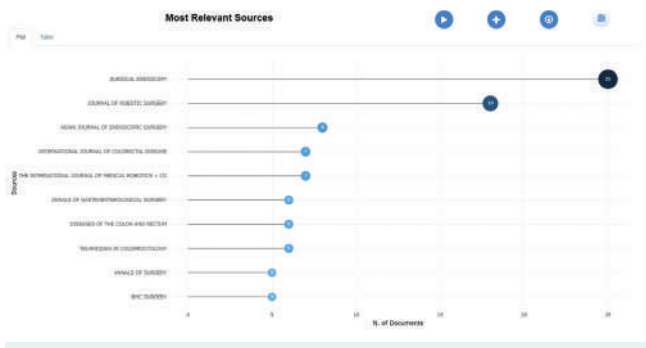

Figure 3. Most relevant sources.

[P-207]

Can axillary positivity be predicted by hemogram parameters in breast cancer patients with axillary positivity at the time of diagnosis?

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Objective: This study aimed to evaluate the predictive value of hemogram parameters for axillary metastasis in patients diagnosed with breast cancer who had synchronous axillary lymph node metastasis at the time of diagnosis.

Material and Methods: This retrospective study was conducted among patients diagnosed with breast cancer who presented to the breast/endocrine surgery outpatient clinic of University of Health Sciences Türkiye, Prof. Dr. Cemil Taşcıoğlu City Hospital between June 2023 and May 2025. Patients were divided into two groups according to axillary lymph node (ALN) status at diagnosis as ALN-negative and ALN-positive. Hemogram parameters at initial presentation were evaluated, and lymphocyte, neutrophil, and platelet counts were recorded. Based on these values, the neutrophil-to-lymphocyte ratio (NLR), platelet-to-lymphocyte ratio (PLR), and lymphocyte-to-monocyte ratio (LMR) were calculated.

Results: Of the 203 patients included in the study, 101 were ALN-positive and 102 were ALN-negative. Lymphocyte counts were significantly higher in ALN-positive patients ($p<0.001$), whereas no significant differences were observed in monocyte, platelet, or neutrophil counts. Similarly, NLR, PLR, and LMR values were found to be statistically significant ($p<0.001$). Ultrasonography, mammography, and magnetic resonance imaging (MRI) showed a strong positive association with ALN positivity ($p<0.05$), while no association was found between tumor type and axillary positivity ($p=0.805$). ALN biopsy results were also found to be significantly higher in identifying ALN positivity ($p<0.001$).

Conclusion: We concluded that hemogram parameters may be effective in predicting axillary lymph node positivity in breast cancer patients, particularly in situations where radiological methods and biopsy procedures are not accessible.

Keywords: Lymphocyte-to-monocyte ratio (LMR), breast cancer, metastatic axillary lymph node, neutrophil-to-lymphocyte ratio (NLR), platelet-to-lymphocyte ratio (PLR)

[P-209]

Quality and safety of AI-generated patient education in general surgery: A pilot study

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Objective: Artificial intelligence (AI)-generated patient education materials are increasingly used to support perioperative counseling in general surgery. However, concerns remain regarding the accuracy, safety, readability, and clinical appropriateness of AI-generated information. This pilot study aimed to evaluate the quality, safety, and readability of AI-generated patient education content for common general surgical conditions.

Material and Methods: In this cross-sectional pilot study, patient education texts were generated using a large language model for 10 common general surgery topics, including appendicitis, cholelithiasis, hernia, colorectal cancer, and postoperative care. Three general surgery specialists independently evaluated the materials using validated assessment tools, including DISCERN, global quality score (GQS), and a safety checklist focusing on misinformation and missing critical warnings. Readability was assessed using flesch reading ease and grade-level metrics. Inter-rater reliability was analyzed using intraclass correlation coefficients (ICC).

Results: A total of 50 AI-generated education texts were evaluated. The mean DISCERN score was 61.4 ± 8.2, indicating moderate-to-high quality, while the mean GQS was 3.8 ± 0.7. Safety assessment identified minor omissions in 18% of materials, primarily related to complication warnings and red-flag symptoms, whereas critical misinformation was rare (4%). Readability analysis showed that most texts were written at a grade level above recommended patient education standards (mean grade level: 10.6 ± 1.3). Inter-rater agreement was good to excellent ($ICC=0.82$).

Conclusion: AI-generated patient education materials in general surgery demonstrate acceptable overall quality and safety but frequently exceed recommended readability levels and may omit key safety information. Human supervision remains essential before clinical implementation. Larger studies are needed to establish standardized frameworks for AI-assisted patient education

Keywords: Artificial intelligence, patient education, DISCERN

[P-210]

Our clinical experience with laparoscopic splenectomy

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Objective: Laparoscopic splenectomy is considered the gold standard for elective splenectomy in benign hematological diseases, as it provides less postoperative pain, shorter hospital stay, and faster recovery compared with open surgery. This study aimed to evaluate the outcomes of laparoscopic splenectomy performed at our clinic.

Material and Methods: Forty-four patients who underwent laparoscopic splenectomy for benign hematological diseases between 2015 and 2022 were retrospectively analyzed. Demographic characteristics, indications for splenectomy, length of hospital stay, conversion to open surgery, transfusion requirements, and postoperative complications were evaluated.

Results: The patients' ages ranged from 19 to 87 years; 26 were female and 18 were male. Immune thrombocytopenic purpura was the most common indication (79.5%). Conversion to open surgery occurred in one patient. The median length of hospital stay was 4 days. No significant associations were found between age, sex, spleen size, preoperative platelet count, or hematological diagnosis and complication rate, mortality, length of hospital stay, or conversion rate. However, complication rates were significantly higher in patients requiring perioperative transfusion ($p<0.05$). Low preoperative hemoglobin levels and high preoperative leukocyte counts were also significantly associated with increased complication rates ($p<0.05$).

Conclusion: Laparoscopic splenectomy is a safe and effective procedure for benign hematological diseases. Careful assessment of preoperative hematological parameters is essential to reduce postoperative complications.

Keywords: Immune thrombocytopenic purpura, laparoscopic splenectomy

[P-211]

The organ-preserving role of endoluminal surgical techniques in large colorectal polyps: Initial experience of our center

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Objective: With the implementation of advanced endoluminal techniques such as endoscopic mucosal resection (EMR) and hybrid EMR/endoscopic submucosal dissection (ESD), large colorectal polyps and superficially spreading lesions that were previously considered unresectable can now be removed without the need for organ resection. This approach reduces the rate of colorectal resections performed for benign lesions and prevents the morbidity and mortality associated with major colorectal surgery. In this study, we aimed to present our initial experience with EMR and hybrid EMR/ESD procedures performed at our center.

Material and Methods: Patients who underwent endoluminal surgical techniques at our center between 2024 and 2025 were included in the study. Demographic, clinical, endoscopic, pathological, and follow-up data were retrospectively evaluated.

Results: A total of nine patients were included. The median age was 63 years (range: 51-77), and six patients (66.7%) were male. The median lesion size was 26 mm (range: 17-37), with five lesions located in the rectum. According to the Paris classification, seven lesions were type 0-IIa, one was type 1sp, and one was type 1p. Based on the Kudo pit pattern classification, five lesions were type 3 and four were type 4. En bloc resection was achieved in five patients, while piecemeal resection was performed in four patients. Post-polypectomy bleeding occurred in only one patient and was successfully managed with endoscopic clipping. No perforation was observed. Histopathological examination revealed tubulovillous adenoma in seven patients and villous adenoma in two patients. High-grade dysplasia was identified in three patients (33.3%); all three lesions were resected en bloc with negative surgical margins. During a median follow-up of 17 months (range: 13-21), no recurrence was detected.

Conclusion: Endoluminal surgical techniques enhance organ-preserving management in colorectal polyps and superficially spreading lesions. Their wider adoption, given the low complication rates, may reduce the need for colorectal resections performed for benign disease.

Keywords: Endoscopic mucosal resection, endoscopic submucosal dissection

[P-212]

1331 iatrogenic perforation in consecutive colonoscopies: A single-center experience of five cases

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Objective: Colonoscopy is a widely used and generally considered safe procedure for the diagnosis and treatment of colorectal diseases. However, perforation is one of the rare but potentially serious complications. This study aimed to evaluate the incidence of iatrogenic perforations and the results of surgical management in 1331 consecutive colonoscopy procedures performed at our center.

Material and Methods: 1331 colonoscopies performed during the specified period were retrospectively reviewed. Five patients who developed perforation after the procedure were included in the study. Patients were evaluated in terms of demographic characteristics, accompanying comorbidities, perforation localization, time of diagnosis (during the procedure or in the postoperative period), surgical approach applied, need for intensive care, length of hospital stay, and 30-day mortality.

Results: Perforation occurred in five patients out of a total of 1331 colonoscopy procedures, and the perforation rate was calculated as 0.37%. The average age of the patients was approximately 68 years, and the majority of cases were in the elderly age group. Most perforations were found in the distal colon, particularly in the rectosigmoid region; one case involved a perforation at the level of the splenic flexure. The diagnosis was made during the procedure in some patients, while in others it was diagnosed based on acute abdominal symptoms that developed after the procedure. All patients were treated surgically. Primary repair was preferred in hemodynamically stable cases with limited intra-abdominal contamination. Laparoscopic approach was safely applied in appropriate cases. A temporary stoma was required in one patient with a more clinically complicated course. No mortality was observed during the 30-day follow-up period.

Conclusion: Although rare, colonoscopic perforation is a potentially serious complication. The perforation rate in our series was consistent with the literature. Successful clinical outcomes were achieved with early diagnosis and timely surgical intervention. When appropriate patient selection is made, primary repair stands out as a safe and effective treatment option, especially for perforations located in the distal colon.

Keywords: Colonoscopy, iatrogenic perforation

Hasta No / Patient No	Yaş / Age	Cinsiyet / Gender	Lokalizasyon / Localisation	Perforasyon Boyutu / Perforation size	Fekal Kontaminasyon / Fecal contamination	Peritonit / Peritonitis
1	60	E / M	SİGMOİD KOLON / SIGMOID COLON	2 CM	1	1
2	67	K / F	REKTUM / RECTUM	3 CM	0	1
3	71	E / M	SPLENİK FLEKSURA / SPLENİC FLEXURE	1,5 CM	1	1
4	72	E / M	SİGMOİD KOLON / SIGMOID COLON	2 CM	0	0
5	63	K / F	SİGMOİD KOLON / SIGMOID COLON	2 CM	0	0

Hasta No / Patient No	Cerrahi Tip / Surgery Type	Postoperatif Komplikasyon ClavienDindo / Postoperative Complication ClavienDindo	Reoperasyon / Reoperation	Yoğun Bakım Yatışı / ICU Admission	Hastanede Kalış gün / Days spent in the hospital	30 Gün İçerisinde Mortalite / Mortality in 30 Days
1	1	1	0	1	7	0
2	2	2	1	1	13	0
3	2	1	0	1	9	0
4	2	1	0	0	7	0
5	2	1	0	1	7	0

Figure 1. Findings of iatrogenic perforation on colonoscopy.

Fecal contamination: 1 = Present, 0 = Absent; Peritonitis: 1 = Present, 0 = Absent; Surgical approach: 1 = Laparoscopic, 0 = Open; Reoperation: 1 = Yes, 0 = No; ICU admission: 1 = Yes, 0 = No; 30-day mortality: 1 = Yes, 0 = No.

[P-213]

Laparoscopic repair of iatrogenic colon perforations occurring during colonoscopy

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Objective: Colonoscopy is a diagnostic procedure commonly performed for suspected colonic pathologies. The incidence of iatrogenic perforation during colonoscopy ranges between 0.03% and 0.8%. In this study, we aimed to present the management of patients who developed perforation during colonoscopy.

Material and Methods: Iatrogenic perforation occurred in three patients during colonoscopy procedures. The mean age of the patients was 57.6 years; two were male and one was female. None of the patients had a history of previous abdominal surgery. Colonoscopy was performed in one patient due to abdominal pain and constipation, while in the other two patients it was performed for diagnostic purposes following a positive fecal occult blood test. The perforations were detected intraoperatively by direct visualization of intraperitoneal perforation, and the patients were taken for emergency surgery. Laparoscopic exploration revealed no intra-abdominal contamination. Perforation sites were located in the sigmoid colon in two patients and at the rectosigmoid junction in one patient. The perforation size ranged between 2 and 3 cm. Primary repair was performed laparoscopically using 3/0 Vicryl sutures. A pelvic drain was placed, and the procedure was concluded. During follow-up, no anastomotic leakage was observed. A liquid diet was initiated on postoperative day 3, and all patients were discharged uneventfully on postoperative day 5.

Results: Iatrogenic colon perforations occurring during colonoscopy may present as an acute abdomen requiring emergency surgery if not recognized promptly. However, early detection during the procedure allows timely intervention. Depending on the size of the perforation, surgical repair, resection, or ostomy creation may be preferred based on the patient's comorbidities and the degree of contamination.

Conclusion: In our case series, early-detected perforations were successfully managed with laparoscopic intervention. In similarly presenting cases, laparoscopic management should be considered as the first-line approach.

Keywords: Colonoscopy, laparoscopic repair, perforation

[P-214]

Is surgery always necessary in adult intussusception?

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Objective: Adult intussusception is a rare clinical entity that differs from pediatric cases due to the higher likelihood of underlying pathological causes. Although surgery has traditionally been recommended in adult patients, the widespread use of advanced imaging techniques has led to increased detection of transient and self-limiting small bowel intussusceptions. This has raised questions regarding the necessity of routine surgical intervention. The aim of this study was to evaluate the need for surgery in adult intussusception based on localization and to assess the risk of malignancy, particularly in colonic cases.

Material and Methods: Adult patients who were hospitalized after being diagnosed with intussusception on imaging studies following emergency department or outpatient clinic admission over the past 10 years were retrospectively reviewed. In patients with multiple admissions, the admission requiring surgery was included; if none required surgery, the admission with the most complete data was selected. Patients were compared according to operative and non-operative management. Intussusceptions were classified as small bowel or colonic. Histopathological findings were evaluated in surgically treated patients.

Results: A total of 90 patients were included in the study. Surgical treatment was performed in 38 patients (42%), while 52 patients (58%) were managed non-operatively. The rate of surgical intervention was significantly higher in colonic intussusceptions compared to small bowel intussusceptions (64% vs. 32%, p=0.028). Colonic intussusceptions were associated with a 3.7-fold increased risk of requiring surgery (OR: 3.7, 95% CI: 1.1-12.4). Malignant pathology was identified in 1 patient (2.6%) who underwent surgery, and malignancy was observed exclusively in the colonic intussusception group.

Conclusion: Surgical management of adult intussusception should not be routine for all patients but rather individualized according to the location of the intussusception. While a substantial proportion of small bowel intussusceptions can be safely managed conservatively, the potential presence of underlying malignancy in colonic intussusceptions should always be considered, favoring a surgical approach.

Keywords: Adult intussusception, colonic intussusception, surgical management, malignancy

[P-215]

Bibliometric analysis of the sacral neuromodulation literature in pelvic floor disorders

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[2]*Etimesgut State Hospital, Ankara*

Objective: This study aimed to bibliometrically evaluate the scientific output, historical evolution, thematic trends, and global research dynamics of sacral nerve stimulation (SNS) and sacral neuromodulation in the context of pelvic floor disorders and pelvic floor dysfunction.

Material and Methods: This bibliometric study included publications indexed in PubMed between 2001 and 2026. The search strategy combined "sacral nerve stimulation" or "sacral neuromodulation" with "pelvic floor disorders" or "pelvic floor dysfunction." Retrieved records were analyzed for annual scientific output, author and institutional contributions, country-level productivity, journal distribution, keyword frequencies, trending topics, and patterns according to Lotka's and Bradford's laws. Analyses were performed using the bibliometrix package.

Results: A total of 56 publications were identified across 42 journals, with contributions from 257 authors. The literature was predominantly multi-authored, with a mean of 4.95 authors per document; the international collaboration rate was 10.71% (single-author publications: n=4). Annual output was low and irregular between 2001 and 2010, followed by a marked increase after 2015, with a clear concentration during 2018-2025. Country-level productivity was mainly driven by the United States, Chile, China, Norway, Portugal and France, reflecting a progressive global dissemination of the field. At the institutional level, pelvic floor innovation centers and university hospitals predominated, with core production concentrated in a limited number of centers. Journal distribution conformed to Bradford's law, clustering in journals focused on colorectal surgery, urogynecology, gastroenterology, and neuromodulation. Keyword and trend analyses identified humans, female, electric stimulation therapy/methods, and treatment outcome as dominant terms, with a temporal shift from technique-oriented themes toward clinical outcomes and quality-of-life-focused research; author productivity followed Lotka's law.

Conclusion: This bibliometric analysis indicates that sacral nerve stimulation and sacral neuromodulation have become an increasingly studied and maturing research area in pelvic floor disorders. The literature remains concentrated in specific countries and high-volume centers, yet recent years show broader global expansion with growing contributions from diverse regions. The predominantly multi-author and interdisciplinary structure suggests a clinically driven, collaboration-based research ecosystem. The original contribution of this study is its holistic characterization of scientific production in this field—not only quantitatively, but also through thematic trajectories, journal dynamics, and temporal shifts in research focus. The observed transition from technique- and pathophysiology-oriented approaches toward treatment outcomes and quality-of-life–centered evaluations clearly reflects ongoing clinical integration. By clarifying the structure and developmental pathways of the literature, this work provides a practical framework for researchers, clinicians, and policymakers and serves as a strategic reference for planning future multicenter, prospective, and standardized studies.

Keywords: Pelvic floor disorders, publication dynamics, sacral neuromodulation

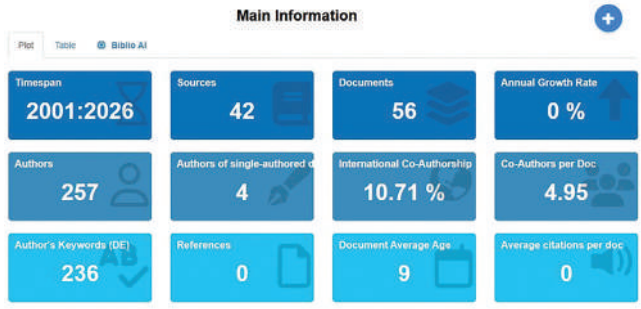

Figure 1. Main bibliometric characteristics of the sacral nerve stimulation and sacral neuromodulation literature (2001-2026).

Figure 2. Word cloud analysis of author keywords in the sacral nerve stimulation and sacral neuromodulation literature.

[P-216]

Rectal cancer patients: The effect of distal resection margin on local recurrence and survival

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Objective: To evaluate the impact of distal circumferential surgical margin (distal resection margin; DRM) length on local recurrence and survival in patients undergoing curative resection for rectal cancer, and to provide clinical data to inform ongoing debates on the optimal distal margin.

Material and Methods: This retrospective cohort study included 186 patients who underwent surgery with curative intent for rectal cancer at Mersin University Faculty of Medicine, Department of General Surgery, between 2010 and January 2025. Patients were stratified into three groups according to the distal margin length reported in the pathology report: ≤1 cm (n=43), 1-2 cm (n=51), and >2 cm (n=92). Clinical, intraoperative, pathological, and postoperative variables were recorded. Survival analyses were performed using the Kaplan-Meier method, and groups were compared with the log-rank test. Factors associated with mortality and recurrence were assessed using univariable and multivariable Cox regression analyses.

Results: The mean age was 63.72±9.63 years and 57.0% of patients were male. The overall local recurrence rate was 6.5% (n=12). There were no statistically significant differences among DRM groups in 60-month overall survival (OS) or disease-free survival (DFS) (all p>0.05); 60-month DFS rates were 81.3% in the ≤1 cm group, 80.4% in the 1-2 cm group, and 81.5% in the >2 cm group. Anal verge distance and stoma formation rates differed significantly between groups, whereas no meaningful differences were observed in other demographic, clinical, or pathological variables. In mortality analyses, postoperative complications and lymphovascular invasion increased the risk of mortality; perineural invasion was associated with mortality in univariable analysis.

Conclusion: In this cohort, distal resection margin length (≤1 cm, 1-2 cm, >2 cm) did not significantly affect local recurrence or 60-month survival outcomes. These findings suggest that, particularly when oncologic resection quality is ensured (R0/CRM-negative resection and appropriate surgical technique), individualized decision-making based on tumor biology and clinical context may be more rational than a single rigid distal margin threshold.

Keywords: Rectal cancer, distal resection margin, local recurrence, survival

[P-217]

Truths and falsehoods in transanal excision decisions

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Objective: The widespread adoption of screening programs has led to a significant increase in the early diagnosis of rectal cancer. In addition, staging tools and treatment modalities for rectal cancer have greatly advanced. Consequently, there is growing interest in multimodal organ-preserving strategies, including the use of local excision and chemoradiotherapy in patients with early rectal cancer. In our study, we aimed to evaluate the correct and incorrect decisions regarding local excision in patients who underwent transanal resection (TAR).

Material and Methods: Patients who underwent transanal resection for a mass in the distal rectum between November 2023 and August 2024 were included in the study. The patients' demographic data, such as age, gender, height, and weight, comorbidities, preoperative radiological and endoscopic images, and pathology results were recorded. Patient positions, duration, complications, pathology results, and follow-up data during surgery were recorded.

Results: Three patients were included in the study. Two patients were male and one was female. The mean age was 61.3 years. Two patients were ASA 3 and one was ASA 2. The patients' BMIs were 29.1, 27.9, and 25.2, respectively. The follow-up periods of the patients were 21, 35, and 30 months. The distances of the lesions from the dentate line were 1 cm, 2 cm, and 3 cm. The sizes were 5x6 cm for the small lesion and 4x3 cm for the other lesion. The CEA values of the patients were 1.7, 20.1, and 8. The biopsy results of 2 patients were reported as tubulovillous adenoma, and the biopsy of 1 patient was reported as intramucosal carcinoma. Preoperative endosonography did not reveal muscularis propria invasion in 2 patients, and there was suspicion of muscularis propria invasion in 1 patient. CT and MR imaging were performed for this patient. LAP was not detected on CT imaging. The patients' surgery durations were 70, 50, and 120 minutes. Postoperative pathology results: Adenocarcinoma (biopsy result: Tubulovillous adenoma) was detected in 1 patient, and adenocarcinoma invading the muscularis propria (biopsy result: Intramucosal carcinoma) was detected in 1 patient. Low anterior resection was performed on this patient. No malignancy was detected in the surgical pathology specimen. The other two patients underwent colonoscopic follow-up.

Conclusion: When deciding on local excision for rectal masses, radiological and endoscopic examinations and pathology specimens should be evaluated by experienced multidisciplinary teams. Correct decisions based on preoperative data can protect patients from unnecessary surgery, while incorrect assessments negatively affect patients' definitive surgical processes after local excision.

Keywords: Transanal excision, early rectal cancer

Table 1.

Patient no	**1**	**2**	**3**
Age	58	65	61
Gender	M	F	M
Asa	2	3	3
BMI	29.1	27.9	25.2
Additional disease	DM	DM, HT	Tuberculosis history
Previous surgery	Subtotal gastrectomy (due to perforation), appendectomy	Thyroidectomy, appendectomy	None
Pre-operative colonoscopy	Above the dentate line by 2 cm (5*6 cm)	Above the dentate line by 3 cm (4*3 cm)	Dentate line'in 1cm by (5*6 cm)
Pre-operative biopsy	Tubulovillous adenoma with mild dysplasia	Tubulovillous adenoma with foci of intramucosal adenocarcinoma	Tubulovillous adenoma
Pre-operative cea	1.7	20	1.18
EUS	None	Polypoid mass in the rectum (suspected invasion of the musculatura propria?)	Muscle-invasive mass, perirectal, 3 cm or smaller, 3 pieces, lap
CT	Polypoid mass measuring 26*22 mm in the distal rectum in the sol lateral position	Suspected asymmetric wall thickening in the rectum	No pathology in the report
MR	Increased wall thickness in a 4 cm segment at the distal rectum level	No pathology in the report	An asymmetric, mass-like lesion reaching 10 mm at its thickest point in the distal third of the rectum, protruding into the lumen in places
PET	None	Post op: In a case followed up with a diagnosis of rectal cancer, an increase in diffuse FDG uptake was observed in a 3 cm segment of the proximal rectum (residual ?).	10*8 cm FDG uptake in the rectum
Position	Jackknife	Right decubitus	Jackknife
Suture	4/0 PDS	3/0 V-Loc	3/0 V-Loc
Duration	90 minutes	120 minutes	100 minutes
Surgical pathology	Tubulovillous adenoma with focal intramucosal adenocarcinoma focus. surgical margin at the base is clear, high-grade dysplasia at the surgical margin on the left side	Well-differentiated adenocarcinoma developed on a tubulovillous adenoma base. The tumor has invaded the muscularis propria	Tubulovillous adenoma (right lateral surgical margin with low-grade dysplasia)
Hospitalization period	6 days	6 Days	6 days
2. Surgery	None	Lap. Low anterior resection + loop ileostomy No malignancy detected in the pathology.	None
Follow-up period	21 months	35 months	30 months

[P-218]

Magnetic compression therapy for a patient with colorectal anastomotic stricture

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Objective: We aimed to present the outcomes of a patient who developed colorectal anastomotic stricture following colorectal surgery and was treated using magnetic compression therapy.

Material and Methods: A 70-year-old male patient presented with difficulty in gas and stool passage and abdominal distension. He had a history of Hartmann's procedure performed approximately two years earlier for rectosigmoid adenocarcinoma causing intestinal obstruction. Synchronous liver metastases had also been detected, and the patient was under medical oncology treatment. His colostomy had been closed approximately nine months prior, and three months after closure, an anastomotic stricture was identified. Despite one endoscopic stent placement and five balloon dilatation procedures, the stricture could not be resolved. Rectoscopic examination revealed a tight stricture approximately 10 cm from the anal verge, preventing passage of the colonoscope. The patient underwent surgery, during which a loop ileostomy was created. Under colonoscopic guidance, magnets were placed across the anastomotic stricture. At three-week follow-up rectoscopy, restoration of luminal patency was observed, and the magnets were removed. The patient was discharged with a plan for subsequent ileostomy closure.

Results: The patient underwent surgery, during which a loop ileostomy was created. Under colonoscopic guidance, magnets were placed across the anastomotic stricture. At three-week follow-up rectoscopy, restoration of luminal patency was observed, and the magnets were removed. The patient was discharged with a plan for subsequent ileostomy closure.

Conclusion: Magnetic compression therapy may be successfully applied in selected cases of colorectal anastomotic stricture.

Keywords: Anastomotic stricture, colorectal cancer, magnetic treatment

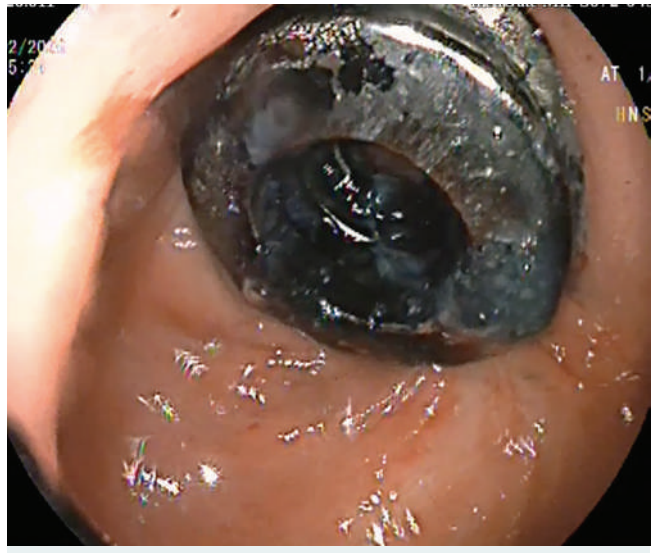

Figure 1. View of magnets placed in the anastomotic stricture from the rectum.

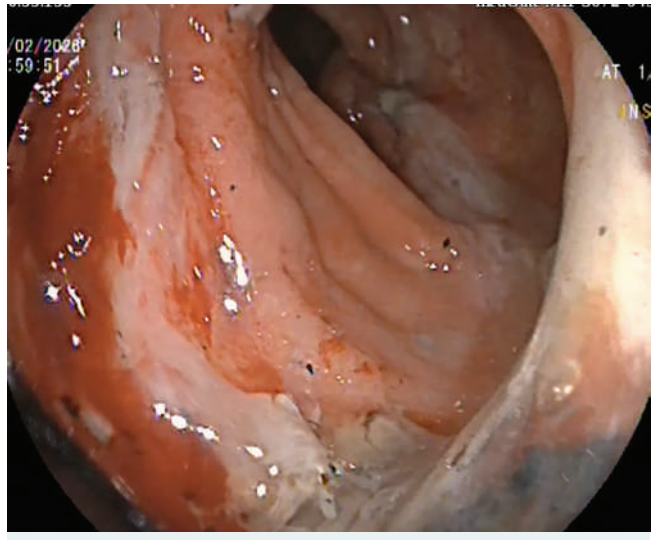

Figure 2. Appearance of the anastomosis after magnetic therapy.

[P-219]

The relationship between tumor regression and clinicopathological parameters in breast cancers treated with neoadjuvant systemic therapy

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Objective: Neoadjuvant systemic therapy is accepted as the standard approach in locally advanced breast cancers and in tumors that are sensitive to targeted therapies according to their biological subtype. However, the response to treatment varies depending on the biological characteristics of the tumor. In this study, we aimed to evaluate the relationship between tumor regression and clinicopathological parameters in breast cancer patients who received neoadjuvant systemic therapy.

Material and Methods: A total of 35 breast cancer patients who underwent surgery following neoadjuvant systemic therapy at our institution were retrospectively evaluated. Tumor regression after neoadjuvant therapy was analyzed according to the Miller-Payne classification. Patients were divided into two groups based on treatment response: Miller-Payne grades 1-3 were defined as poor response, and grades 4-5 as good response. Histopathological type, tumor grade, ER, PR, HER2 status, Ki-67 proliferation index, luminal subtype, clinical T stage, lymph node status, perineural invasion, and lymphovascular invasion parameters obtained from biopsy and resection specimens were evaluated. Categorical variables were analyzed using the chi-square test, and continuous variables were analyzed using the Mann-Whitney U test. ROC analysis was performed for Ki-67 to determine the optimal cut-off value.

Results: A significant association was found between tumor grade, luminal subtype, histopathological type, and response to neoadjuvant systemic therapy ($p=0.047$, $p<0.001$, and $p<0.001$, respectively). ER positivity was observed in 71% of patients, PR positivity in 45%, and HER2 positivity in 37%, and all were significantly associated with a good response to neoadjuvant systemic therapy ($p=0.006$, $p<0.001$, and $p=0.002$, respectively). The Ki-67 value (cut-off 35%) demonstrated an AUC of 0.70 in ROC analysis for predicting response to neoadjuvant therapy, and the optimal cut-off value was determined as 35%. At this threshold, sensitivity was 58.8% and specificity was 88.9%. No significant association was found between tumor regression and clinical T stage, MRI tumor size, age, or lymphovascular invasion.

Results: Tumor response to neoadjuvant systemic therapy is closely associated with the biological characteristics of the tumor. In particular, hormone receptor status, HER2 expression, proliferation index, and luminal subtype are key determinants in predicting tumor regression. The impact of anatomical staging parameters on treatment response appears to be limited. These findings support the importance of biology-driven approaches in the planning of neoadjuvant therapy.

Keywords: Neoadjuvant systemic therapy, breast cancer, tumor regression

[P-220]

Clinicopathological characteristics and recurrence analysis in male breast cancer: A single-center experience

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Objective: Male breast cancer is a rare malignancy accounting for approximately 1% of all breast cancers; therefore, available data remain limited. Although it shares biological similarities with female breast cancer, diagnosis is often established at a more advanced stage, and prognostic factors are not clearly defined. Tumor size, lymph node involvement, histological grade, and immunohistochemical markers are considered important determinants of prognosis. However, data regarding predictors of recurrence in male breast cancer are insufficient. This study aimed to evaluate our institutional experience and investigate the association between clinicopathological characteristics and recurrence.

Material and Methods: This retrospective study included patients who underwent surgery for histopathologically confirmed male breast cancer between 2023 and 2025 at Ankara Bilkent City Hospital. Demographic data, comorbidities, preoperative tumor markers, surgical procedure, tumor size, lymph node status, lymphovascular and perineural invasion, and immunohistochemical parameters (ER, PR, HER2, Ki-67) were recorded. Tumors were staged according to the AJCC 8th edition. The Nottingham prognostic index (NPI) was calculated. Patients were followed for disease-free survival (DFS) and categorized as disease-free or recurrence/metastasis/death. Statistical analyses were performed using appropriate parametric or non-parametric tests and the chi-square test, with $p<0.05$ considered significant.

Results: A total of 20 male breast cancer patients were evaluated. The mean age was 60.7 ± 15 years, and the mean tumor size was 2.6 ± 1.1 cm. Sixty percent were T2 stage, and nodal positivity was observed in 60%. The mean number of lymph nodes removed was 13.7 ± 4.8, while the median number of metastatic nodes was 1 (0-17). All tumors were invasive ductal carcinoma, and 60% were grade 2. Lymphovascular invasion was present in 85% and perineural invasion in 50%. Modified radical mastectomy was performed in 75%. Estrogen receptor positivity was frequent, whereas HER2 positivity was 25%. The mean Ki-67 index was approximately 30%. Most patients were classified as intermediate risk according to the Nottingham Prognostic Index. Mean disease-free survival was 14 months (6-36), and recurrence/metastasis/death occurred in 20%. Although tumor size and metastatic lymph node number were higher in recurrent cases, differences were not statistically significant ($p>0.05$).

Conclusion: Male breast cancer predominantly presents as hormone receptor-positive disease with an intermediate prognostic profile. None of the evaluated clinicopathological parameters significantly predicted recurrence. However, increased tumor size and nodal burden may be associated with recurrence. Larger multicenter studies are needed to clarify prognostic factors.

Keywords: Male breast cancer, recurrence, prognostic factors

Table 1. Demographic, clinicopathological characteristics and follow-up outcomes of male breast cancer patients	
Age (years)	60.75±15.08
Sex	
Male	20 (100%)
BMI (kg/m²)	26.9 (23.5-37.8)
Family history of breast cancer	
Present	4 (20%)
Absent	16 (80%)
Smoking	
Present	12 (60%)
Absent	8 (40%)
Alcohol use	
Present	2 (10%)
Absent	18 (90%)
Charlson comorbidity index (CCI)	2 (0-8)
Length of hospital stay (days)	7.15±2.34
Tumor location	
Left retroareolar	12 (60%)
Right retroareolar	6 (30%)
Right upper inner quadrant	2 (10%)
Neoadjuvant chemotherapy	
Present	4 (20%)
Absent	16 (80%)
Preoperative CEA (ng/mL)	1.2 (0.5-3.1)
Preoperative CA 15.3 (U/mL)	12.7 (2.5-28.9)
Surgical procedure	
Modified radical mastectomy	15 (75%)
Mastectomy + SLNB	5 (25%)
Histopathologic diagnosis	
Invasive ductal carcinoma	20 (100%)
Presence of DCIS component	
Present	13 (65%)
Absent	7 (35%)
Estrogen receptor (ER)	
>90%	11 (55%)
80-90%	8 (40%)
50-60%	1 (5%)
Progesterone receptor (PR)	
>90%	5 (25%)
80-90%	3 (15%)
70-80%	3 (15%)
60-70%	3 (15%)
20-30%	5 (25%)
1%	1 (5%)
CerB2	
Score 0	6 (30%)
Score 1	4 (20%)
Score 2	8 (40%)
Score 3	2 (10%)
HER2	
Positive (+)	5 (25%)
Negative (-)	15 (75%)

Table 1. Continued	
Ki-67 proliferation	
40-50%	5 (25%)
30-40%	3 (15%)
20-30%	7 (35%)
10-20%	3 (15%)
3-5%	2 (10%)
TNM**	
T1	6 (30%)
T2	12 (60%)
T3	2 (10%)
N0	8 (40%)
N1	4 (20%)
N2	4 (20%)
N3	4 (20%)
M0	19 (95%)
M1	1 (5%)
Perineural invasion	
Present	10 (50%)
Absent	10 (50%)
Lymphovascular invasion	
Present	17 (85%)
Absent	3 (15%)
Modified bloom-richardson grade	
Grade 1	4 (20%)
Grade 2	12 (60%)
Grade 3	4 (20%)
Total number of lymph nodes removed	13.75±4.89
Number of metastatic lymph nodes	1 (0-17)
Maximum tumor diameter (cm)	2.61±1.17
Nottingham prognostic index (NPI)	
Grup 1	1 (5%)
Grup 2	2 (10%)
Grup 3	13 (65%)
Grup 4	4 (20%)
Adjuvant radiotherapy (RT)	
Present	18 (90%)
Absent	2 (10%)
Adjuvant chemotherapy (CT)	
Present	14 (70%)
Absent	6 (30%)
Adjuvant targeted therapy	
Present	13 (65%)
Absent	7 (35%)
Adjuvant hormone therapy	
Present	18 (90%)
Absent	2 (10%)
Disease-free survival (months)	14 (6-36)
Follow-up status	
Disease-free	16 (80%)
Recurrence/metastasis/death	4 (20%)

** AJCC 8th edition, BMI: Body mass index, CEA: Carcinoembryonic antigen, SLNB: Sentinel lymph node Biopsy, DCIS: Ductal carcinoma *in situ*, HER2: Human epidermal growth factor receptor 2.

Table 2. Parameters associated with recurrence/metastasis/death				
Variable		**Disease-free**	**Recurrence/metastasis/death**	**p-value**
Age (years)		62.06±15.26	55.5±15.15	*0.522
BMI (kg/m²)		27.350 (23.5-37.2)	26.55 (24.5-37.8)	**0.813
Total number of lymph nodes removed		13.5±4.96	14.75±5.18	*0.866
Number of metastatic lymph nodes		1 (0-12)	7 (0-17)	**0.557
Preoperative CEA (ng/mL)		1.3 (0.6-3.1)	1.2 (0.5-1.4)	**0.448
Preoperative CA 15.3 (U/mL)		14.1 (2.5-27.2)	9.1 (7.5-28.9)	**0.345
Tumor size (cm)		2.34±0.85	3.67±1.79	**0.155
Family history of breast cancer	Present	3 (75%)	1 (25%)	***0.624
	Absent	13 (81.3%)	3 (18.7%)	
Smoking	Present	8 (66.7%)	4 (33.3%)	***0.117
	Absent	8 (100%)	0 (0%)	
Alcohol use	Present	2 (100%)	0 (0%)	***0.632
	Absent	14 (77.8%)	4 (22.2%)	
Presence of DCIS component	Present	10 (76.9%)	3 (23.1%)	***0.561
	Absent	6 (85.7%)	1 (14.3%)	
Perineural invasion	Present	8 (80%)	2 (20%)	***0.709
	Absent	8 (80%)	2 (20%)	
Lymphovascular invasion	Present	14 (82.4%)	3 (17.6%)	***0.509
	Absent	2 (66.7%)	1 (33.3%)	
HER2 status	Positive	5 (100%)	0 (0%)	***0.282
	Negative	11 (73.3%)	4 (26.7%)	
Estrogen receptor (ER)	≥90%	9 (81.8%)	2 (18.2%)	***0.625
	<90%	7 (77.8%)	2 (22.2%)	
Progesterone receptor (PR)	≥80%	6 (75%)	2 (25%)	***0.535
	<80%	10 (83.3%)	2 (16.7%)	
Ki-67	≥30%	6 (75%)	2 (25%)	***0.535
	<30%	10 (83.3%)	2 (16.7%)	
Modified bloom-richardson grade	Grade 1, 2	13 (81.3%)	3 (18.7%)	***0.624
	Grade 3	3 (75%)	1 (25%)	
Nottingham prognostic index (NPI)	Group 1, 2	2 (66.7%)	1 (33.3%)	***0.509
	Group 3, 4	14 (82.4%)	3 (17.6%)	

*t-test, **Mann-Whitney U test, ***Chi-square test, DCIS: Ductal carcinoma *in situ*.

[P-221]

Insulinoma: Clinicopathological characteristics and surgical management -a case series-

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Objective: This study aims to evaluate the clinical and pathological characteristics of patients treated for insulinoma and discuss the surgical outcomes in light of the current literature.

Material and Methods: We retrospectively reviewed six insulinoma patients operated on between 2023 and 2025. Demographic, clinical, surgical, and histopathological data were extracted from institutional databases. Long-term outcomes and symptom resolution were assessed via telephone follow-up.

Results: The mean age of the patients was 52,17±15,63 years, with an equal gender distribution (3 females, 3 males). The mean body mass index (BMI) was 26.38±1.46 kg/m². All patients presented with syncope as the primary reason for emergency admission, and whipple's triad (WT) was observed in all cases. The mean blood glucose level at admission was 31.83±10.42, and all six patients exhibited elevated C-peptide levels. The Prolonged Fasting test was positive in four patients. Preoperative localization was achieved in all cases via imaging. Surgical intervention consisted of laparotomy in five patients and a laparoscopic approach in one. In all laparotomy cases, intraoperative ultrasound (IOUS) was utilized for definitive lesion localization. The primary factor influencing operative time was the duration of intraoperative localization. While the lesion was identified through direct surgical exploration in three patients, IOUS was required for localization in the remaining three. The mean tumor size was 17.5±7.37 mm. Surgical procedures included distal pancreatectomy for distal lesions (n=1), Whipple procedure (pancreaticoduodenectomy) for a lesion in the pancreatic head adjacent to the wirsung duct (n=1), and enucleation for the remaining four cases. The patient who underwent the Whipple procedure required a 131-day hospitalization due to postoperative complications, whereas the mean hospital stay for other patients was 5 days. Histopathological analysis revealed WHO NET grade 1 in three patients, grade 2 in two, and grade 3 in one. The Ki-67 proliferation index was below 5% in five patients, while it was 20% in the patient who underwent distal pancreatectomy. During the follow-up period (23.17±11.57 months), all patients achieved complete symptomatic relief with no evidence of recurrence.

Conclusion: Surgical resection is definitive, though intraoperative localization remains challenging. We emphasize the necessity of intraoperative ultrasonography (IOUS). Despite high morbidity reported in the literature—such as citing a 53% fistula and 7% hemorrhage rate for proximal lesions—our series remained recurrence-free. One patient required re-intervention for a post- Whipple fistula. Persistent hypoglycemia post-resection should prompt investigation for multiple adenomas or MEN syndromes. High Ki-67 indices and poor differentiation necessitate rigorous long-term surveillance.

Keywords: Insulinoma, surgical treatment

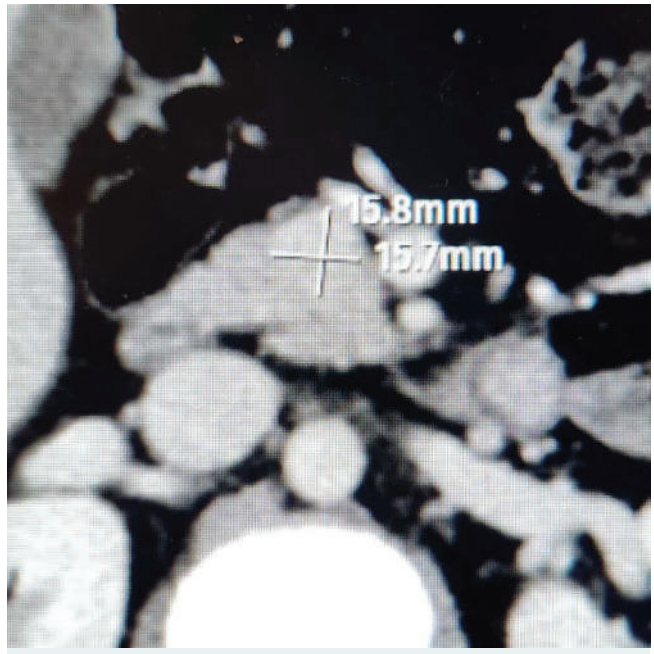

Figure 1. Preoperative radiological (CT) evaluation of the case.

Figure 2. Macroscopic evaluation of the lesion excised following enucleation.

Table 1. Demographic and laboratory characteristics (n=6)

	Hasta 1	Hasta 2	Hasta 3	Hasta 4	Hasta 5	Hasta 6
Yaş (yıl)	33	67	55	41	73	44
Cinsiyet	Kadın	Erkek	Erkek	Kadın	Kadın	Erkek
VKİ (kg/m²)	26.00	27.10	28.40	26.30	24.00	26.50
ASA	2	3	2	3	3	2
Glukoz (mg/dL)	22	23	32	25	45	44
İnsülin (µIU/mL)	120.00	7.81	28.30	34.30	20.70	6.74
C-peptid (ng/mL)	4.36	2.10	4.30	6.39	3.30	1.56

Table 2. Surgical and pathological findings (n=6)

	Hasta 1	Hasta 2	Hasta 3	Hasta 4	Hasta 5	Hasta 6
Adenom boyutu (mm)	30	12	11	20	20	12
Adenom yerleşim yeri	Kuyruk	Korpus	Baş	Korpus	Baş	Korpus
Cerrahi yaklaşımı ve tipi	Laparoskopi, Distal pankreatektomi	Laparotomi, Enükleasyon	Laparotomi, Whipple	Laparotomi, Enükleasyon	Laparotomi, Enükleasyon	Laparotomi, Enükleasyon
WHO NET Grade	G3	G1	G2	G1	G1	G2
Ki-67 (%)	20.00	2.00	3.20	2.00	2.00	5.00

Table 3. Comparative literature review and current series results

Çalışma	n	Cerrahi yaklaşım / dağılım	Adenom yerleşimi / boyutu	Komplikasyonlar (özet)	Sonuç (kür / nüks)
Li ve ark. 2025	76	LAP/LaP(*) ? Enükleasyon 50 Whipple 7 Subtotal pankreatektomi 19	Baş 37 Korpus/Kuyruk 39 Adenom boyutu 1.6±0.6 cm	Pankreatik fistül 41 Pankreatit ? Kanama 6 Nüks 0 Mortalite 1	Takip süresi 68 ay Nüks 0
Iglesias ve ark. 2015	29	LAP/LaP 2/25 Enükleasyon 18 Whipple 0 Subtotal pankreatektomi 9	Baş 11 Korpus 13 Kuyruk 4 Ektopik yerleşim 1 Adenom boyutu 1.7±0.7 cm	Pankreatik fistül 4 Pankreatit ? Kanama ? Nüks 0 Mortalite 0	Takip süresi 53 ay Nüks 0 Cerrahi ile kür %88.9
Ülkü ve ark. 2018	13	LAP/LaP 0/13 Enükleasyon 11 Whipple 0 Subtotal pankreatektomi 2	Baş 5 Korpus 6 Kuyruk 2 Adenom boyutu 1.85 cm	Pankreatik fistül 3 Pankreatit 1 Kanama 1 Nüks 0 Mortalite 0	Takip süresi 63.6 ay Nüks 0
Ritter ve ark. 2025	8	LAP/LaP 6/2 Enükleasyon 2 Whipple 0 Subtotal pankreatektomi 6	Baş 2 Korpus/Kuyruk 6 Adenom boyutu 1.7±1.3 cm	Pankreatik fistül 0 Pankreatit ? Kanama ? Nüks 0 Mortalite 1	Takip süresi 15.5 ay Nüks 0
Sayın ve ark. 2025 (Sunulan seri)	6	LAP/LaP 1/5 Enükleasyon 4 Whipple 1 Subtotal pankreatektomi 1	Baş Korpus Kuyruk Adenom boyutu 1.7±0.7 mm	Pankreatik fistül 1 Pankreatit 0 Kanama 0 Nüks 0 Mortalite 0	Takip süresi 23.1 ay Nüks 0

(*)LAP/LaP: Laparoskopi/Laparotomi

Table 4.

	Mean	Min.	Max.
Age	52.6	20	80
BMI	21.6	14	31

[P-222]

Surgical approach to chronic pancreatitis cases: Analysis of a single-center study

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Objective: Chronic pancreatitis is a clinical condition characterized by severe pain, with its etiology primarily categorized into biliary and non-biliary causes. This study aims to evaluate patients diagnosed with chronic pancreatitis who underwent surgical intervention at our center, comparing surgical approaches in relation to postoperative hospital stay, complication rates, and postoperative pathological findings.

Material and Material: Patients operated on between June 2020 and December 2025 were retrospectively analyzed. Surgical methods were classified into the frey procedure, laparoscopic frey procedure, laparoscopic beger procedure, classic Whipple procedure, pylorus-preserving Whipple (PPPD), and robotic puestow procedure. Data regarding etiology, body mass index (BMI), ASA score, age, gender, length of hospital stay, postoperative complications, and surgical indications were recorded to evaluate the clinical impact of surgical treatment.

Results: Eighteen patients were included in the study. Six patients had a confirmed preoperative diagnosis of chronic pancreatitis, with biliary and non-biliary etiologies equally represented. The remaining 12 patients underwent a Whipple procedure due to an inability to exclude malignancy in the presence of distal common bile duct stricture (n=3), pancreatic head cysts (n=2), and pancreatic head masses (n=7). Patient histories revealed recurrent attacks of abdominal pain. Regarding etiology, 6 of the patients who underwent the Whipple procedure presented with biliary pathology. Surgical techniques included classic Whipple in 9 (50%) patients, PPPD in 3 (16.6%), laparoscopic beger in 1 (5.5%), laparoscopic frey in 2 (11.1%), frey in 2 (11.1%), and robotic puestow in 1 (5.5%). The mean age was 52, mean BMI was 21.6, mean hospital stay was 16 days, median ASA score was 2, and the mean preoperative attack frequency was 5. The postoperative complication rate was 33.3% (n=6), with pancreatic fistula being the most common cause. The median number of attacks was 2 in the complication group and 5 in the non-complication group. Notably, the final pathology for all 12 patients who underwent radical resection due to suspected malignancy was consistent with chronic pancreatitis. Pain recurrence was observed in one patient operated on for non-biliary chronic pancreatitis.

Conclusion: While drainage methods suffice, Whipple remains necessary if malignancy is suspected. Preoperative attack frequency predicts complications, requiring meticulous patient and technique selection to optimize clinical outcomes

Keywords: Chronic pancreatitis, surgery

Table 1. Values

	Mean value	Min	Max
Age	52.6	20	82
BMI	21.6	14	31
Length of stay	16.1 days	6	42
ASA score	2.4	2	3
Number of attacks	4.8	2	15

[P-223]

Surgical treatment outcomes and prognostic factors in non-colorectal non-endocrine liver metastases: A single-center experience

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Objective: Liver metastases resulting from malignancies other than colorectal and endocrine tumors (non-colorectal non-endocrine liver metastases; NCNELM) are characterized by heterogeneous biological behavior and generally poor prognosis. However, in cases with appropriate patient selection, surgical resection remains one of the most important curative treatment options capable of providing long-term survival. This retrospective study aimed to analyze the demographic, clinicopathological, and operative characteristics of patients with NCNELM who underwent surgery, and to evaluate perioperative outcomes and survival data in conjunction with the existing literature.

Material and Methods: Patients who underwent liver resection in a separate session from the primary tumor surgery between June 1, 2020, and October 31, 2025, at our clinic due to NCNELM were retrospectively analyzed. The demographic data, comorbidities, operative findings, primary tumor and metastasis characteristics, postoperative clinical course, and histopathological results of the patients were evaluated.

Results: The median age of the 18 patients was 53.5 years (range 31-74), and 13 (72.2%) were female. Ten patients (55.6%) had at least one comorbidity. The distribution of primary tumors was as follows: Breast (n=7, 38.9%), lung (n=3, 16.7%), sarcoma (n=2, 11.1%), stomach (n=2, 11.1%), pancreas (n=1, 5.6%), small intestine (n=1, 5.6%), ovary (n=1, 5.6%), and ocular origin (n=1, 5.6%). Surgical procedures performed included segmentectomy in 12 patients (66.7%) and bisegmentectomy in 6 patients (33.3%). The R0 resection rate was 83.3% (n=15). Postoperatively, one patient (5.6%) developed an intra-abdominal abscess, and two patients (11.1%) developed wound infections. No mortality was observed within 90 days postoperatively.

Conclusion: Surgical resection stands out as a safe and feasible treatment option in patients with non-colorectal non-endocrine liver metastases who are appropriately selected. The high rate of R0 resection achieved in our series, together with low morbidity rates and the absence of 90-day mortality, supports the perioperative safety and reliability of the surgical approach. Despite the heterogeneous tumor biology, these results suggest that surgery may provide a potential survival benefit in selected patients. Therefore, an aggressive surgical approach should be considered for appropriate candidates with NCNELM following multidisciplinary evaluation.

Keywords: Liver resection, non-colorectal liver metastases, non-endocrine liver metastases

[P-224]

Epidemiological distribution and clinical correlations of pathological findings in cholecystectomy specimens: A single-center experience with 509 patients

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Objective: Cholecystectomy is one of the most frequently performed operations in general surgery. The aim of this study is to determine the distribution of gallbladder pathology results in patients who underwent cholecystectomy and to evaluate its relationship with clinical parameters.

Material and Methods: A retrospective analysis was conducted on 509 consecutive cholecystectomy patients who underwent surgery at the general surgery clinic of University of Health Sciences Türkiye, İstanbul Haseki Training and Research Hospital, between 2020 and 2025. Demographic data, type of surgery (laparoscopic/open), operation time, length of hospital stay, and postoperative complications were recorded. Histopathological results were classified as chronic cholecystitis, acute cholecystitis, cholesterolosis, adenomyomatosis, polyp, dysplasia, and incidental malignancy. Categorical variables were analyzed using the chi-square test, and continuous variables were analyzed using the Mann-Whitney U or Kruskal-Wallis test.

Results: The study included 509 patients who underwent cholecystectomy. Of these patients, 327 (64.2%) were women and 182 (35.8%) were men, with a median age of 50 years (IQR: 40-60). The most frequently detected pathology was chronic cholecystitis (87.8%) in 447 patients, followed by acute cholecystitis (3.7%), adenomyomatosis (2.8%), and cholesterol polyp (2.4%). Dysplasia was observed in 14 patients (2.8%) in the study group. The incidence of incidental gallbladder malignancy was 0.8%. Among non-malignant causes, the longest operation time was 112 minutes (IQR: 61-149) in the acute cholecystitis group, and the length of hospital stay was statistically longer than in the other groups, similar to the acute pancreatitis group ($p<0.05$). No association was found between the presence of malignancy and dysplasia and continuous variables ($p<0.05$). Patients with malignancy were older, but no statistically significant difference was found ($p=0.606$).

Conclusion: The vast majority of cholecystectomy specimens consist of benign inflammatory pathologies. However, the occurrence of incidental malignancy, albeit at a low rate, highlights the importance of routine histopathological evaluation of all specimens.

Keywords: Cholecystectomy, gallbladder neoplasms, incidental findings

[P-225]

Complementary surgery in incidental gallbladder cancers: A single-center experience from 2018-2025

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Objective: Gallbladder cancer (GBC), although rare, is clinically significant due to its aggressive course and frequent late diagnosis. Most cases are incidentally detected after cholecystectomy performed with a preliminary diagnosis of benign disease. Complementary surgery is recommended in stages T1b and above due to the risk of residual disease and regional lymph node metastasis. This study evaluated incidental GBC cases detected in cholecystectomy specimens after 2018 and the pathological results of the complementary surgeries performed.

Material and Methods: Cholecystectomies performed in our center between 2018 and 2025 were retrospectively reviewed. A total of 8.886 cholecystectomies were performed during this period [8.162 laparoscopic (91.9%)], 724 open [(8.1%)]. Cases with malignancy were identified by reviewing pathology records. Tumors were staged according to the AJCC 8th edition TNM classification. The primary surgical type, T stage, complementary surgical content (liver bed/segment IVb-V resection and regional lymph node dissection), and complementary pathology findings were analyzed.

Results: Between 2018 and 2025, gallbladder malignancy was detected in 9 patients (incidence ≈0.10%). 5 of the patients were female (55.6%), and 4 were male (44.4%). The mean age was 68.7±8.0, and the median age was 70 (57-80). The majority of cases were T2 or higher stage (T1b: 1; T2/T2a: 7; T3: 1). All 8 patients with information on complementary surgery underwent liver bed/segment resection along with regional lymph node dissection. Metastatic lymph nodes were detected in 3 of the patients who underwent lymph node dissection (37.5%); One patient had N2 disease (≥4 metastatic nodes). Complementary pathology samples revealed residual tumor or microscopic malignant involvement in 3 patients (37.5%).

Conclusion: Incidental gallbladder cancer (GBC) is rare but clinically significant. The rates of lymph node metastasis and residual disease detected during complementary surgery in T2 and higher cases strongly support the critical oncological importance of liver bed resection and regional lymph node dissection.

Keywords: Cholecystectomy, complementary surgery, gallbladder cancer, incidental carcinoma

Table 1. Demographic and clinical characteristics (2018-2025, n=9)

Feature	Value
Number of patients	9
Age (mean ± SD)	68.7±8.0
Median age (min-max)	70 (57-80)
Female, n (%)	5 (55.6%)
Male, n (%)	4 (44.4%)

Table 2. Pathological and complementary surgical findings

Feature	Value
T1b	1
T2/T2a	7
T3	1
Complementary surgery performed	8
Liver bed/segment resection	8
Lymph node dissection performed	8
Lymph node metastasis	3 (37.5%)
N2 disease	1
Residual tumor detection	3 (37.5%)

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Clinical characteristics, diagnostic process, and treatment outcomes of bezoar ileus cases: A single-center retrospective analysis

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Objective: Although rare, bezoar ileus represents an important cause of acute abdomen and mechanical intestinal obstruction. This study aimed to retrospectively evaluate the demographic characteristics, clinical findings, diagnostic methods, treatment approaches, and clinical outcomes of patients diagnosed with bezoar ileus and managed at the Department of General Surgery, University of Health Sciences Türkiye, Ankara Etlik City Hospital.

Material and Methods: Patients who presented to the emergency department between October 2022 and November 2025 and were followed, treated, or surgically managed with a diagnosis of bezoar ileus were retrospectively analyzed. Demographic data, comorbidities, clinical symptoms, laboratory findings, imaging modalities, bezoar characteristics, applied treatment modalities, and postoperative outcomes were recorded. Continuous variables were presented as median (IQR) and mean ± standard deviation, whereas categorical variables were expressed as number and percentage.

Results: A total of 22 patients were included in the study. The median age was 60 years (48.2-68.5), and 59.1% were female. All patients were admitted. The most common presenting symptoms were abdominal pain (90.9%), nausea/vomiting (90.9%), and abdominal distension (81.8%). The median symptom duration was 3.5 days (2.0-5.0). Computed tomography was the most frequently used imaging modality, and a preoperative diagnosis of bezoar was established in 68.2% of patients, while 27.3% were initially diagnosed with non-bezoar-related causes. The majority of bezoars were phytobezoars (86.4%), and the common location was the ileum (72.7%). Conservative treatment was attempted in 45.5% of patients; however, 81.8% ultimately required emergency surgery. Open surgery was performed in all surgically treated patients, with enterotomy and bezoar extraction being the most commonly applied procedure (77.8%). Bowel resection was required in 18.2% of patients. The postoperative complication rate was 27.3%, with postoperative ileus being the most frequent complication. No mortality was observed, and the recurrence rate during follow-up was 9.1%.

Conclusion: Our series demonstrates that bezoar ileus represents an important cause of mechanical intestinal obstruction, particularly in elderly patients with a high comorbidity burden. Despite widespread use of computed tomography, preoperative diagnosis was achieved in only two-thirds of patients, and misdiagnosis persisted, consistent with the existing literature. Although conservative and endoscopic approaches showed limited effectiveness, the majority of patients required emergency surgery. Enterotomy with bezoar extraction was the most commonly performed and effective surgical method, whereas the need for bowel resection remained limited. The absence of mortality and acceptable complication rates support the safety of early and timely surgical intervention. Therefore, appropriate clinical suspicion, effective imaging, and prompt surgical decision-making are critical to reducing morbidity and preventing recurrence.

Keywords: Bezoar ileus, emergency surgery, enterotomy, mechanical intestinal obstruction, phytobezoar

Table 1. Demographic characteristics, clinical findings

TABLO 1. Demografik Özellikler ve Komorbiditeler (n=22)

PARAMETRE	AÇIKLAMA / DEĞER
Yaş (yıl)	60.0 (48.2–68.5) | 57.1 ± 16.0
Cinsiyet	Kadın: 13 (%59.1) – Erkek: 9 (%40.9)
Vücut kitle indeksi (kg/m²)	30.0 (27.2–34.0) | 30.6 ± 5.0
ASA skoru	3.0 (2.0–3.0) | 2.5 ± 0.9
Charlson komorbidite indeksi	2.0 (0.2–3.8) | 2.5 ± 2.3
Ek hastalık varlığı	Var: 10 (%45.5) – Yok: 12 (%54.5)
Önceki GİS cerrahisi öyküsü	Var: 11 (%50.0) – Yok: 11 (%50.0)
Gastrektomi öyküsü	Var: 4 (%18.2) – Yok: 18 (%81.8)
Bariatrik cerrahi öyküsü	Var: 2 (%9.1) – Yok: 20 (%90.9)
Diyabet	Var: 7 (%31.8) – Yok: 15 (%68.2)
Hipotiroidi	Var: 2 (%9.1) – Yok: 20 (%90.9)
Psikiyatrik hastalık öyküsü	Var: 3 (%13.6) – Yok: 19 (%86.4)
Trikotillomani öyküsü	Var: 1 (%4.5) – Yok: 21 (%95.5)
Liften zengin diyet öyküsü	Var: 13 (%59.1) – Yok: 9 (%40.9)

TABLE 1. Demographic Characteristics and Comorbidities (n=22)

PARAMETER	DESCRIPTION / VALUE
Age (years)	60.0 (48.2–68.5) | 57.1 ± 16.0
Sex	Female: 13 (59.1%) – Male: 9 (40.9%)
Body mass index (kg/m²)	30.0 (27.2–34.0) | 30.6 ± 5.0
ASA score	3.0 (2.0–3.0) | 2.5 ± 0.9
Charlson comorbidity index	2.0 (0.2–3.8) | 2.5 ± 2.3
Presence of comorbidity	Yes: 10 (45.5%) – No: 12 (54.5%)
History of previous GI surgery	Yes: 11 (50.0%) – No: 11 (50.0%)
History of gastrectomy	Yes: 4 (18.2%) – No: 18 (81.8%)
History of bariatric surgery	Yes: 2 (9.1%) – No: 20 (90.9%)
Diabetes mellitus	Yes: 7 (31.8%) – No: 15 (68.2%)
Hypothyroidism	Yes: 2 (9.1%) – No: 20 (90.9%)
History of psychiatric disease	Yes: 3 (13.6%) – No: 19 (86.4%)
History of trichotillomania	Yes: 1 (4.5%) – No: 21 (95.5%)
High fiber diet history	Yes: 13 (59.1%) – No: 9 (40.9%)

TABLO 2. Klinik Bulgular, Laboratuvar ve Bezoar Özellikleri

PARAMETRE	AÇIKLAMA / DEĞER
Başvuru şekli	Acil: 22 (%100)
Semptom süresi (gün)	3.5 (2.0–5.0) | 4.6 ± 4.6
Karın ağrısı	Var: 20 (%90.9)
Bulantı / kusma	Var: 20 (%90.9)
Karın distansiyonu	Var: 18 (%81.8)
Gaz–gaita çıkışı yok	Var: 17 (%77.3)
Ateş (>38 °C)	Var: 3 (%13.6)
WBC (10³/μL)	11.0 (7.2–15.8) | 12.2 ± 5.7
CRP (mg/L)	19.5 (4.2–44.8) | 69.9 ± 112.6
Laktat (mmol/L)	1.5 (1.0–2.0) | 1.7 ± 0.8
Serum albümin (g/dL)	3.5 (3.1–4.0) | 3.6 ± 0.7
Malnütrisyon (Alb <3.5 g/dL)	Var: 9 (%40.9)
Görüntüleme yöntemi	BT: 21 (%95.5) – BT+USG: 1 (%4.5)
BT'de bezoar tanısı	Var: 15 (%68.2)
Bezoar tipi	Fitobezoar: 19 (%86.4) – Trikobezoar: 3 (%13.6)
Bezoar lokalizasyonu	İleum: 16 (%72.7) – Jejunum: 4 (%18.2) – Mide/Duodenum: 2 (%9.1)
Bezoar çapı (mm)	40 (30–40) | 39.5 ± 10.2
Multipl bezoar	Var: 5 (%22.7)
Eşlik eden gastrik bezoar	Var: 1 (%4.5)
Preoperatif bezoar tanısı	Var: 15 (%68.2)
Yanlış ön tanı ile izlem	Var: 6 (%27.3)

TABLE 2. Clinical Findings, Laboratory Results, and Bezoar Characteristics

PARAMETER	DESCRIPTION / VALUE
Admission type	Emergency: 22 (100%)
Symptom duration (days)	3.5 (2.0–5.0) | 4.6 ± 4.6
Abdominal pain	Present: 20 (90.9%)
Nausea / vomiting	Present: 20 (90.9%)
Abdominal distension	Present: 18 (81.8%)
Absence of flatus/stool	Present: 17 (77.3%)
Fever (>38 °C)	Present: 3 (13.6%)
WBC (10³/μL)	11.0 (7.2–15.8) | 12.2 ± 5.7
CRP (mg/L)	19.5 (4.2–44.8) | 69.9 ± 112.6
Lactate (mmol/L)	1.5 (1.0–2.0) | 1.7 ± 0.8
Serum albumin (g/dL)	3.5 (3.1–4.0) | 3.6 ± 0.7
Malnutrition (Alb <3.5 g/dL)	Present: 9 (40.9%)
Imaging modality	CT: 21 (95.5%) – CT+US: 1 (4.5%)
Bezoar diagnosis on CT	Present: 15 (68.2%)
Bezoar type	Phytobezoar: 19 (86.4%) – Trichobezoar: 3 (13.6%)
Bezoar location	Ileum: 16 (72.7%) – Jejunum: 4 (18.2%) – Stomach/Duodenum: 2 (9.1%)
Bezoar diameter (mm)	40 (30–40) | 39.5 ± 10.2
Multiple bezoars	Present: 5 (22.7%)
Concomitant gastric bezoar	Present: 1 (4.5%)
Preoperative bezoar diagnosis	Present: 15 (68.2%)
Follow-up with misdiagnosis	Present: 6 (27.3%)

Table 2. Treatment methods and literature comparison

TABLO 3. Tedavi Yöntemleri ve Klinik Sonuçlar

PARAMETRE	AÇIKLAMA / DEĞER
Konservatif tedavi denendi	Var: 10 (%45.5)
Enzimatik tedavi	Var: 4 (%18.2)
Endoskopik tedavi denendi	Var: 2 (%9.1)
Endoskopik tedavi başarılı	0
Acil cerrahi gereksinimi	Var: 18 (%81.8)
Cerrahi uygulandı	Var: 18 (%81.8)
Cerrahi endikasyon	İleus: %100
Cerrahi yaklaşım	Açık: 18 (%100)
Cerrahi prosedür	Enterotomi + bezoar çıkarılması: 14 (%77.8) – Rezeksiyon: 4 (%22.2)
Ameliyat süresi (dk)	65 (60–97.5) | 81.1 ± 37.0
Barsak rezeksiyonu	Var: 4 (%18.2)
Postop komplikasyon	Var: 6 (%27.3)
Postop ileus	Var: 4 (%18.2)
Cerrahi alan enfeksiyonu	Var: 2 (%9.1)
Sepsis	Var: 1 (%4.5)
Clavien–Dindo ≥ III	Var: 1 (%4.5)
Yoğun bakım yatışı	Var: 15 (%68.2)
Yoğun bakım süresi (gün)	3 (1–4) | 3.7 ± 4.0
Hastanede yatış süresi (gün)	7 (5.2–10.5) | 9.4 ± 7.4
Mortalite	Yok
Nüks (takipte)	Var: 2 (%9.1)
Takip süresi (ay)	10 (4–12) | 11.5 ± 12.5

TABLO 4. Literatür Karşılaştırma Tablosu

Parametre	Bizim Çalışma (Etlik Şehir Hast., 2022–2025)	Gök 2019	Tang 2019	Tihan 2016	Yakan 2010	Erzurumlu 2005
Örneklem (n)	22	25	36 (operatif vaka)	17	14	34
Yaş	Medyan 60	Medyan 60	—	Ortalama 56.8±17.0	—	—
Kadın (%)	59.1	52	—	35.3	—	—
BT yapılma (%)	95.5	—	—	88.2	(rutin değil)	—
BT de bezoar tanısı (%)	68.2	—	75	80 (BT çekilenlerde)	Preop tanı çok düşük: %7 (13/14 intraop)	—
Preop tanı güçlüğü / intraop tanı	Yanlış ön tanı 27.3	—	"Non-diagnostic CT" risk faktörü	İntraop kesin tanı 29.5	İntraop tanı %93	—
Cerrahi gereksinimi (%)	81.8	80	%100 (çalışma tasarımı: operatif)	(çoğu cerrahi) enterotomi baskın	Neredeyse tümü acil cerrahi	—
Cerrahi yöntemi (özet)	Enterotomi 77.8 (cerrahlar içinde), rezeksiyon 22.2	Cerrahi %80, komplikasyonlar raporlu	Milking fragmentasyon 55.6, enterotomi rezeksiyon 44.4	Enterotomi 64.7, nadiren laparoskopi+milking	Terminal ileum %64, jejunum %36 yerleşim	—
Postop komplikasyon (%)	27.3	3 olgu komplikasyon	Enterotomi rezeksiyonda morbidite 43.8 (milking %7)	Yüzeyel CAE %5.9 (1 olgu)	—	29.4
Mortalite (%)	0	4	—	—	—	11.5
Yatış süresi	Medyan 7 gün	Medyan 7 gün	—	Medyan 4 gün	—	—

TABLE 3. Treatment Modalities and Clinical Outcomes

PARAMETER	DESCRIPTION / VALUE
Conservative treatment attempted	Yes: 10 (45.5%)
Enzymatic therapy	Yes: 4 (18.2%)
Endoscopic treatment attempted	Yes: 2 (9.1%)
Successful endoscopic treatment	0
Emergency surgery requirement	Yes: 18 (81.8%)
Surgical intervention performed	Yes: 18 (81.8%)
Surgical indication	Ileus: 100%
Surgical approach	Open: 18 (100%)
Surgical procedure	Enterotomy + bezoar removal: 14 (77.8%) – Resection: 4 (22.2%)
Operation time (min)	65 (60–97.5) | 81.1 ± 37.0
Bowel resection	Yes: 4 (18.2%)
Postoperative complication	Yes: 6 (27.3%)
Postoperative ileus	Yes: 4 (18.2%)
Surgical site infection	Yes: 2 (9.1%)
Sepsis	Yes: 1 (4.5%)
Clavien–Dindo ≥ III	Yes: 1 (4.5%)
ICU admission	Yes: 15 (68.2%)
ICU stay (days)	3 (1–4) | 3.7 ± 4.0
Length of hospital stay (days)	7 (5.2–10.5) | 9.4 ± 7.4
Mortality	None
Recurrence (during follow-up)	Yes: 2 (9.1%)
Follow-up duration (months)	10 (4–12) | 11.5 ± 12.5

TABLE 4. Literature Comparison Table

Parameter	Our Study (Etlik City Hosp., 2022–2025)	Gök 2019	Tang 2019	Tihan 2016	Yakan 2010	Erzurumlu 2005
Sample size (n)	22	25	36 (operative cases)	17	14	34
Age	Median 60	Median 60	—	Mean 56.8±17.0	—	—
Female (%)	59.1	52	—	35.3	—	—
CT performed (%)	95.5	—	—	88.2 (not routine)	—	—
Bezoar diagnosis by CT (%)	68.2	—	75	80 (among CT cases)	Preop diagnosis very low: 7%	—
Preop diagnostic difficulty / intraop diagnosis	Misdiagnosis 27.3%	—	"Non-diagnostic CT" risk factor	Intraop definitive diagnosis 29.5%	Intraop diagnosis 93%	—
Surgical requirement (%)	81.8	80	100	Mostly surgical	Almost all emergency surgery	—

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Clinical outcomes of a case series of heller myotomy and Dor fundoplycation for achalasia

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Objective: Achalasia is a rare primary esophageal motility disorder affecting 1.6 people per 100,000 annually, characterized by progressive dysphagia, regurgitation, and nocturnal aspiration. If left untreated, patients eventually become unable to maintain oral feeding, leading to significant nutritional deficiencies and weight loss. The physical discomfort and social eating restrictions caused by chronic symptoms significantly reduce the patients' health-related quality of life.

Material and Methods: This case series includes five patients admitted and treated at a tertiary teaching hospital between 2018 and 2025. All patients underwent diagnostic evaluation with preoperative contrast esophageal radiography, esophagogastroscopy, and esophageal manometry. Three patients had previously undergone unsuccessful endoscopic balloon dilation at other centers. All patients underwent laparoscopic Heller myotomy and partial anterior (Dor) fundoplication to prevent reflux. The patients' clinical outcomes were evaluated preoperatively and postoperatively using the Eckardt score (range 0-12).

Results: The study included five patients with an average age of 46 (29-56). All procedures were successfully completed laparoscopically. During myotomy, an undesirable disruption of mucosal integrity (mucosal opening) was detected in two patients, but these were immediately noticed and corrected with primary repair during surgery. In the postoperative period, all patients showed uneventful recovery, with no signs of leakage or infection. Patients were discharged on the 3rd or 4th day postoperatively without any delay caused by intraoperative repairs. The mean follow-up period was 77 months (33-95 months), and in the last clinical evaluation in January 2026, it was determined that all five patients had completely resolved their dysphagia and reflux symptoms and achieved clinical improvement (Eckardt score <1).

Conclusion: Laparoscopic myotomy and Dor fundoplication provide safe, permanent, and effective long-term relief for achalasia despite failed endoscopic treatments.

Keywords: Achalasia, heller myotomy, Dor fundoplication, Eckardt score

Table 1. Patient characteristics and clinical outcomes

Case	Age, gender	Type	Pre ECK score	Post ECK, score	LOS	Follow-up (mo)
1	56	I	7	0	4	95
2	45	II	8	1	3	80
3	29	II	9	1	3	77
4	53	II	6	0	3	49
5	34	II	8	1	3	33

[P-228]

Clinicopathological features of patients diagnosed with gastrointestinal stromal tumor (GIST): A single-center experience

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Objective: Gastrointestinal stromal tumors (GISTs) are the most common mesenchymal tumors of the gastrointestinal tract and exhibit heterogeneous clinical and histopathological characteristics. This study aimed to evaluate the demographic, clinical, and pathological features of patients diagnosed with GIST between 2015 and 2025 at our center, and to analyze recurrence rates and synchronous/metachronous tumor associations.

Material and Methods: A total of 83 patients diagnosed histopathologically with GIST between 2015 and 2025 were retrospectively analyzed. Demographic data, tumor localization, histological and immunohistochemical features, surgical approaches, and adjuvant treatment information were obtained from medical records.

Results: The mean age was 60.7 years; 48 patients (57.8%) were male and 35 (42.2%) were female. The most common presenting symptoms were abdominal pain (n=26) and gastrointestinal bleeding (n=16). Tumors were most frequently located in the stomach (47%), followed by the small intestine (26.5%) and other sites (14.5%). Recurrence developed in 10 patients (12%), with 50% of recurrences involving the liver. Open resection was performed in 65 patients, while 18 underwent laparoscopic surgery. The recurrence rate was 5.6% in the laparoscopic group and 13.8% in the open surgery group. Absence of mitosis was observed in 42.9% of recurrent cases and in 28.6% of non-recurrent cases. Metachronous tumors were detected in 12 patients (14.5%). Synchronous malignancies were identified in 11 cases (13.3%). In these patients, the Ki-67 proliferation index was lower compared to the primary pathology, and 7 cases were reported as micro-GIST.

Conclusion: GISTs are most commonly located in the stomach, and our findings are consistent with the literature regarding demographic and clinical distribution. The considerable rate of liver recurrence and concomitant malignancies highlights the importance of long-term multidisciplinary follow-up in these patients.

Keywords: Gastrointestinal stromal tumor (GIST), recurrence, synchronous malignancy

[P-229]

Current approach to post-resuscitation care after cardiac arrest in the surgical critical care unit: Fever control instead of therapeutic hypothermia

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Objective: Targeted temperature management has long been considered one of the main components of post-resuscitation care in order to reduce hypoxic-ischemic brain injury after cardiac arrest. Previous international guidelines recommended therapeutic hypothermia (32-34 °C) as a standard approach in comatose patients who achieved return of spontaneous circulation (ROSC). However, large randomized controlled trials published in recent years and updated guidelines have questioned the clinical benefit of routine hypothermic cooling and have brought active prevention of fever to the forefront. The aim of this report is to evaluate, in light of the 2025 European Resuscitation Council (ERC) and European Society of Intensive Care Medicine (ESICM) guidelines, why fever control has become a higher priority than therapeutic hypothermia in post-resuscitation care after cardiac arrest.

Material and Methods: This study was conducted based on randomized controlled trials, systematic reviews, and meta-analyses published after 2021, with particular emphasis on the 2025 ERC-ESICM Post-Resuscitation Care Guidelines. Therapeutic hypothermia, controlled normothermia, and active fever prevention strategies were comparatively analyzed in terms of mortality, neurological outcomes, and treatment-related complications.

Results: Current evidence indicates that deep therapeutic hypothermia (32-34 °C) does not provide a significant advantage over normothermia with active fever control in terms of survival or favorable neurological outcome. In contrast, aggressive cooling strategies have been reported to increase the incidence of complications such as arrhythmias, electrolyte disturbances, infections, and coagulopathy. In accordance with these findings, the 2025 ERC guidelines no longer recommend therapeutic hypothermia as a routine and mandatory intervention in comatose patients after ROSC; instead, continuous temperature monitoring and active prevention of fever are defined as the primary goals. The target temperature for fever control is generally specified as ≤37.5-37.7 °C, and this strategy is recommended to be maintained for 36-72 hours. Selection of lower target temperatures is left to individual clinical assessment in specific patient subgroups.

Conclusion: The current approach to post-resuscitation care after cardiac arrest has shifted away from routine therapeutic hypothermia toward effective and continuous control of fever. This approach reflects an important change that enhances patient safety, reduces the risk of complications, and supports evidence-based individualized critical care management. In surgical critical care units, in cases of cardiac arrest occurring in the postoperative period or due to surgical conditions such as trauma, sepsis, and massive hemorrhage, post-resuscitation temperature management should be regarded as a critical component of care that directly affects clinical outcomes.

Keywords: Cardiac arrest, fever, post-resuscitation care, surgical critical care, therapeutic hypothermia

[P-230]

Laparoscopy in emergency general surgery: Balancing benefit and risk from hernia to trauma and emergency colorectal surgery (a synthesis of six systematic reviews)

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Objective: Although minimally invasive, laparoscopy in emergency general surgery remains debated due to sepsis, hostile anatomy, hemodynamic instability, and the need for conversion. We synthesized short-term outcomes of laparoscopy versus open surgery across major emergency indications using existing systematic reviews/meta-analyses.

Material and Methods: Systematic reviews/meta-analyses comparing laparoscopic and open approaches in adult emergency general surgery were collated across six domains: Emergency inguinal hernia repair, emergency femoral hernia management (minimally invasive strategies), laparoscopic peritoneal lavage (LPL) versus resection for complicated perforated diverticulitis, laparoscopic versus open surgery after stenting for obstructive colorectal cancer, laparoscopy versus laparotomy in abdominal trauma, and laparoscopy versus open surgery in emergency colorectal procedures. Primary outcomes were mortality, morbidity, and length of stay (LOS). Secondary outcomes included surgical site infection (SSI)/wound complications, pulmonary complications, ileus, reintervention, and conversion. Findings were narratively synthesized by direction of effect and reported p-values.

Results: In emergency inguinal hernia repair (13 studies; 38,659 patients), laparoscopy reduced LOS (MD -2.96 days; p=0.0074) and lowered wound infection (p<0.0001), with a 2.78% conversion rate. Evidence for emergency femoral hernia was limited and largely non-comparative; nevertheless, minimally invasive approaches—particularly TAPP—were highlighted for evaluating hernia content and potentially avoiding non-therapeutic laparotomy. For complicated perforated diverticulitis, LPL decreased mortality and permanent stoma rates (p<0.001) but increased sepsis (p=0.03), intra-abdominal abscess (p<0.001), and recurrence (p<0.001). After stenting for obstructive colorectal cancer (12 cohorts; 933 patients), laparoscopy reduced overall complications (p<0.0001), LOS (p=0.001), and SSI (p=0.04), at the expense of longer operative time (p=0.03), while 30-day mortality was similar (p=0.95). In abdominal trauma, missed injury and mortality were comparable (p=0.90 and p=0.09), whereas wound infection was lower with laparoscopy (p=0.002). In emergency colorectal surgery (29 studies; 63,727 patients), laparoscopy was associated with lower mortality and morbidity (both p<0.001), and reduced ileus (p=0.009) and pulmonary complications (p<0.001).

Conclusion: Across meta-analytic evidence, laparoscopy appears to be a safe alternative in selected emergency patients managed by experienced teams, with particularly favorable short-term outcomes in emergency colorectal and hernia surgery. In contrast, in complicated peritonitis (as exemplified by LPL), the increased risk of abscess/recurrence underscores the importance of careful selection, robust source control, and a low threshold for conversion.

Keywords: Emergency surgery, laparoscopy, trauma

[P-231]

Surgical and clinical outcomes of kidney transplantation according to renal artery number

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Objective: Kidney transplantation is the most effective treatment for end-stage renal disease. The presence of multiple renal arteries in donor kidneys has traditionally been considered a controversial issue due to the increased complexity of vascular anastomosis. This study aimed to evaluate the surgical and early-to-midterm clinical outcomes of kidney transplants performed at our center according to the number of renal arteries.

Material and Methods: Patients who underwent kidney transplantation at our center between 2021 and 2025 were retrospectively analyzed. Recipients were divided into two groups based on graft renal artery number: Single-artery and multiple-artery (≥2 arteries) grafts. Demographic data, donor type, perioperative findings, vascular and urological complications, and follow-up serum creatinine levels were analyzed. Data were evaluated using descriptive statistical methods.

Results: A total of 200 kidney transplants were evaluated. Single renal artery was present in 142 patients (71.0%), while 58 patients (29.0%) had multiple renal arteries. Among the multiple-artery grafts, 49 had two arteries, 8 had three arteries, and 1 had four arteries. The incidence of vascular complications in multiple-artery grafts did not show a significant increase compared with single-artery grafts. During follow-up, serum creatinine levels remained within acceptable ranges in both groups.

Conclusion: This study demonstrates that the presence of multiple renal arteries in kidney transplantation does not constitute a disadvantage in terms of surgical or early-to-midterm clinical outcomes. With appropriate vascular reconstruction techniques in experienced centers, kidneys with multiple arteries—including selected cases with four arteries—can be safely transplanted, achieving functional outcomes comparable to those of single-artery grafts.

Keywords: Kidney transplants, multiple renal arteries

[P-232]

Exposure to electrocautery smoke in operating rooms and nurse awareness: An observational poster study

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Objective: Surgical smoke generated during the use of electrocautery constitutes a significant occupational risk for healthcare professionals working in operating rooms. Inhalation of surgical smoke has been associated with respiratory tract irritation, headaches, and potential long-term health problems.

Material and Methods: This study was designed as an observational study based on clinical practices in operating rooms. In surgeries where electrocautery was used, the occurrence of surgical smoke, the use of smoke evacuation systems, and the types of masks preferred were evaluated. In addition, operating room nurses' awareness of the possible health effects of electrocautery smoke was assessed through clinical observations.

Results: Observations revealed that surgical smoke occurred in the majority of procedures involving electrocautery. It was noted that smoke evacuation systems were not actively used in every case and that standard surgical masks were predominantly preferred. Nurses' awareness regarding the long-term health effects of electrocautery smoke was found to be insufficient.

Conclusion: Electrocautery smoke represents an important source of occupational exposure for operating room nurses. Therefore, effective use of smoke evacuation systems and the planning of awareness-enhancing educational programs for nurses are necessary.

Keywords: Operating room nursing, surgical smoke, occupational safety, nurse health, electrocautery smoke

Figure 1. Exposure to electrocautery smoke in operating rooms and nurse awareness: An observational poster study.

• Observation of surgical smoke generated during electrocautery use • Operating room nurse exposed to electrocautery smoke • Dispersion of surgical smoke within the operating room environment • Use of a smoke evacuation system to reduce exposure to surgical smoke • Use of standard surgical masks during procedures involving electrocautery.

[P-233]

Information continuity in the operating room: The impact of communication channels on workflow

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Objective: Operating rooms are high-risk environments where multidisciplinary teams work simultaneously, and the continuity of information flow directly impacts patient safety and workflow. The objective of this study is to evaluate the impact of communication channels used in the operating room on information continuity and their relationship with the workflow.

Material and Methods: This study is a descriptive and observational evaluation conducted in the operating room of a large-scale hospital. Communication methods used among nurses, surgeons, and anesthesia teams during surgical processes were examined; specifically, information transfer processes during shift handovers, emergency cases, and peak working hours were observed. No patient data were used in the study, and it did not require ethics committee approval.

Results: The evaluation revealed that communication breakdowns increased in cases where information transfer was person-dependent and relied solely on verbal communication. The absence of a standardized information transfer process, particularly during shift handovers, led to workflow disruptions, prolonged surgical preparation times, and increased stress levels within the team. Conversely, it was observed that structured and documented communication channels supported information continuity.

Conclusion: Ensuring information continuity in the operating room is of critical importance for the sustainability of safe surgical practices. Standardizing communication channels and developing specific information transfer models for shift processes can positively influence workflow and enhance team performance. This study highlights areas for communication-based improvements in perioperative nursing.

Keywords: Perioperative nursing, communication, information continuity, shift, workflow

[P-258]

A retrospective evaluation of surgical site infection in patients undergoing colostomy closure

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Objective: Colostomy closure is a commonly performed procedure in gastrointestinal surgery; however, surgical site infections remain one of the most frequent postoperative complications. These infections may lead to prolonged hospital stay, additional treatment requirements, and increased postoperative morbidity. The aim of this study was to retrospectively evaluate surgical site infections following colostomy closure and to identify associated risk factors.

Material and Methods: This retrospective study reviewed medical records of patients who underwent colostomy closure at the University of Health Sciences Türkiye, Ankara Etlik City Hospital, Department of General Surgery between 2023 and 2025. Patients aged ≥18 years, with at least 30 days of postoperative follow-up and documented surgical site infection status were included. Patients with incomplete records, additional surgeries, or immunosuppression were excluded. Demographic data, comorbidities, surgical details, and postoperative outcomes were collected. Patients with and without surgical site infections were compared. Continuous variables were analyzed using Independent t-test or Mann-Whitney U test, and categorical variables using chi-square or Fisher's exact test. Statistical significance was set at $p<0.05$.

Results: In this study of 80 patients, the overall incidence of surgical site infection (SSI) was 23.7%. Univariate analyses identified smoking history ($p=0.004$), emergency surgery ($p=0.002$), and longer operative time ($p=0.005$) as significant factors associated with increased SSI risk. Additionally, a strong association was observed between skin closure method and infection development ($p<0.001$). Multivariate analysis demonstrated that operative time (OR: 1.066; $p=0.012$) and skin closure method (OR: 19.911; $p=0.002$) were independent risk factors for the development of SSI.

Conclusion: Surgical site infection after colostomy closure remains a common complication. Primary skin closure and prolonged operative time are key independent risk factors. Awareness of these factors may guide surgical planning and perioperative management to reduce SSI incidence and improve postoperative outcomes.

Keywords: Colostomy closure, surgical site infection, risk factors, surgical complications

Table 1. Demographic and clinical findings			
	There is a wound infection (n=19)	**No wound infection (n=61)**	**p**
Age	64.7±13.6	62.9±15.7	0.651
Gender			
Male	12 (63.2%)	34 (55.7%)	0.568
Female	7 (36.58%)	27 (44.3%)	
Smoking	17 (89.5%)	32 (52.5%)	0.004
Additional medical history	12 (63.2%)	35 (57.4%)	0.655
Diabetes	10 (52.6%)	22 (36.1%)	0.198
Hypertension	4 (21.1%)	10 (6.4%)	0.641
History of immunosuppression	0 (0.0%)	5 (8.2%)	0.332
Chronic renal failure	0 (0.0%)	2 (3.3%)	0.579
Indications for colostomy Malignancy Diverticulitis Gunshot injury Stab wound Fournier	 6 (31.6%) 7 (36.8%) 3 (15.8%) 0 (0.0%) 3 (11.8%)	 14 (23.0%) 15 (24.6%) 11 (18.0%) 8 (13.1%) 8 (21.3%)	0.448
Complication of colostomy care	4 (21.1%)	11 (18.0%)	0.501
Colostomy closure time (months)	8.6±3.9	8.4±4.6	0.852
Emergency	14 (73.7%)	60 (98.4%)	0.002
Operation time (minutes)	67.1±16.1	57.6±11.1	0.005
Hospital stay duration (days)	5.3±1.8	4.5±2.3	0.153
Multi-organ injury	3 (15.8%)	19 (31.1%)	0.190
Postoperative ICU requirement	3 (15.8%)	7 (11.5%)	0.620
Type of surgery Laparoscopic Open Surgery	 5 (26.3%) 14 (73.7%)	 25 (41.0%) 36 (59.0%)	0.249
Intraabdominal contamination	11 (57.9%)	31 (50.8%)	0.590
Type of colostomy Hartman Loop colostomy	 8 (42.1%) 11 (57.9%)	 22 (36.1%) 39 (63.9%)	0.635
Skin closure method Primary closure Secondary healing	 16 (84.2%) 3 (15.8%)	 20 (32.8%) 41 (67.2%)	<0.001
Type of anastomosis Stapled Hand-sewn	 12 (63.2%) 7 (36.8%)	 42 (68.9%) 19 (31.1%)	0.644

[P-259]

Surgical management and pathological reclassification of non-parasitic cystic lesions of the liver: A single-center experience (2019-2025)

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Objective: Non-parasitic cystic lesions of the liver are pathologies that require careful surveillance and appropriate management due to their potential risk of malignancy. In this context, the data of patients who were operated on with a preliminary diagnosis of biliary cystadenoma at our institution were retrospectively analyzed.

Material and Methods: The surgical approaches performed between 2019 and 2025 and postoperative complications were evaluated. In addition, the pathological specimens of cases diagnosed with biliary cystadenoma were re-examined to confirm and clarify the diagnoses of mucinous cystic neoplasm (MCN) and biliary intraductal papillary neoplasm (IPNB)

Results: A total of 12 patients were operated on between 2019 and 2025. Nine patients (75%) were female and three (25%) were male, with a mean age of 53.5 years (range, 36-78 years). Regarding lesion localization, four patients had right lobe involvement and eight had left lobe involvement. Ten patients were primary cases, whereas two underwent surgery for recurrence. In terms of surgical approach, robotic surgery was performed in one patient, laparoscopic surgery in six patients, and open surgery in five patients. Final pathological evaluation revealed mucinous cystic neoplasm (MCN) in eight patients, intraductal papillary neoplasm of the bile duct (IPNB) in two patients, and simple cyst in two patients. One patient developed a postoperative intra-abdominal collection, which was successfully managed with percutaneous intervention. The mean follow-up duration was 57 months.

Conclusion: Non-parasitic cystic lesions of the liver should be carefully evaluated due to their potential for malignancy. A multidisciplinary approach is essential in the diagnostic and therapeutic process. With appropriate patient selection, minimally invasive surgical techniques can be applied safely and effectively.

Keywords: MKN, IPNB, non-parasitic

[P-262]

The need for formal recognition of endocrine surgery as a subspecialty of general surgery in Türkiye

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Objective: General surgery has evolved over time into a discipline composed of focused areas of expertise. While structured fellowship programs and "focused practice" designations have been developed in the United States (USA), only surgical oncology, intensive care, and gastrointestinal surgery are currently recognized as formal subspecialties in Türkiye. Endocrine surgery, despite its high technical complexity and steadily increasing case volume, is not included among the general surgery subspecialty programs in Türkiye.

Material and Methods: The subspecialty system in Türkiye was compared with the training model defined by the American Medical Association FREIDA database (2024) and the American Board of Surgery. The number of accredited programs, training structure, and officially recognized fellowship areas were reviewed, with particular focus on endocrine surgery.

Results: In the USA, general surgery training is conducted as a five-year residency in 368 accredited programs, followed by structured fellowship programs in multiple focused fields. These include complex general surgical oncology, hepatopancreatobiliary surgery, colorectal surgery, minimally invasive surgery, pediatric surgery, vascular surgery, transplant surgery, surgical critical care, breast surgery, burn surgery, and hand surgery. Endocrine surgery is practiced as an independent field in high-volume centers, encompassing thyroid, parathyroid, adrenal, and neuroendocrine diseases. Surgeons who have received subspecialty training in this field have been shown to have lower complication rates and better functional outcomes. Endocrine surgery is an advanced field requiring detailed anatomical knowledge, nerve preservation, hormonal physiology, and the integration of oncologic principles. A strong association between high case volume and improved surgical outcomes has been demonstrated, supporting the value of focused training. However, there is currently no standardized subspecialty training program in endocrine surgery in Türkiye.

Conclusion: Formal recognition of endocrine surgery as a subspecialty of general surgery in Türkiye would provide standardization in training and enhance patient safety.

Keywords: Endocrine surgery, focused practice, general surgery, subspecialty training

Table 1. Comparison of general surgery subspecialty/fellowship structures in Türkiye and the USA

Yapılanmasının Karşılaştırılması

Özellik	Türkiye	ABD
Genel cerrahi eğitim süresi	5 yıl	5 yıl
Resmî yan dal sayısı	3	>10
Tanınan alanlar	Cerrahi Onkoloji, Cerrahi Yoğun Bakım, Gastrointestinal Cerrahi	Surgical Oncology, HPB, Colorectal, MIS, Transplant, Vascular, Breast, Endocrine, vb.
Endokrin cerrahisi	Tanınmıyor	Bağımsız fellowship
Eğitim modeli	Merkezden merkeze değişken	Standart, akredite
Vaka hacmi şartı	Yok	Var
Komplikasyon oranları	Heterojen	Daha düşük (yüksek hacimli merkezler)
Hasta güvenliği	Standart dışı	Yüksek

[P-264]

Integration of robotic colorectal surgery into clinical practice: First year experience and early clinical outcomes

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Objective: Robotic surgery (da Vinci Surgical System) offers advanced visualization and instrumentation advantages in colorectal resections. However, data regarding the early phase of integration of a robotic platform into an established surgical practice remain limited in the literature. This study aimed to evaluate the safety and early clinical outcomes of a robotic colorectal surgery program initiated at our center between December 2024 and December 2025.

Material and Methods: A total of 48 patients who underwent robotic colorectal surgery between December 2024 and December 2025 were retrospectively analyzed. Demographic characteristics, ASA score, type of operation, operative time, estimated blood loss, conversion rate (to open surgery), postoperative complications, and length of hospital stay were recorded. Major complications were defined as Clavien-Dindo grade ≥III. Continuous variables were analyzed using appropriate parametric or non-parametric tests, and categorical variables were compared using the chi-square test. A p-value <0.05 was considered statistically significant. All procedures were performed by the same experienced surgical team following standardized surgical principles.

Results: Among the 48 patients included in the study, 56.3% were male, and the median age was 61.5 years (range, 38-81). ASA ≥3 was present in 20.8% of patients. The most frequently performed procedures were anterior resection (n=20, 41.7%) and right hemicolectomy (n=16, 33.3%). The mean operative time was 213 minutes, and the median estimated blood loss was 120 mL. Conversion to open surgery occurred in 5 patients (10.4%). The overall complication rate was 18.8%, and the major complication rate was 6.2%. The anastomotic leak rate was 4.2%, and no mortality was observed. The median length of hospital stay was 7 days (range, 4-14). All oncologic resections achieved negative surgical margins (R0). Comparison between the early (first 24 cases) and late (last 24 cases) periods demonstrated a statistically significant reduction in operative time, blood loss, overall complication rate, and length of hospital stay (p<0.05).

Conclusion: The integration of robotic colorectal surgery into a tertiary referral center appears to be safe, with low mortality, acceptable complication rates, and conversion rates consistent with the literature during the first year of implementation. The observed improvements in clinical parameters suggest a structured learning curve. Although the retrospective design and limited sample size restrict generalizability, these findings support that robotic colorectal surgery can be effectively and sustainably integrated into clinical practice in the presence of an experienced surgical team and appropriate institutional organization.

Table 1. Learning curve analysis according to clinical parameters

Parameter	All cases	First 24 cases	Last 24 cases	p
Operative time, min (mean)	213.2	232.6	193.8	**<0.001**[a]
Blood loss, mL (median)	120.5	155.5	100.5	**<0.001**[b]
Length of hospital stay, days (median)	7.0	9.5	5.0	**<0.001**[b]
Conversion, n (%)	10.4	12.5	8.3	1.000[c]
Complications, n (%)	18.8	33.3	4.2	**0.023**[c]
Anastomotic leakage, n (%)	4.2	8.3	0.0	0.489[c]

[a]Student's t test, [b]Mann-Whitney U, [c]Fisher's exact test.

[P-272]

Patients after cardiopulmonary resuscitation should be evaluated for organ donation: CPR is not a contraindication to organ transplantation!

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Objective: A substantial proportion of patients who achieve return of spontaneous circulation after cardiac arrest die due to irreversible hypoxic brain injury or progressive multiple organ failure. It was a widespread belief that patients who had undergone cardiopulmonary resuscitation (CPR) would not be suitable for organ donation. However, the 2025 Post-Resuscitation Care Guidelines of the European Resuscitation Council and the European Society of Intensive Care Medicine have stated that this belief is incorrect and recommend that patients after cardiac arrest should be evaluated for their potential as organ donors.

Material and Methods: In this study, recommendations regarding organ donation after cardiac arrest were reviewed on the basis of the 2025 Post-Resuscitation Care Guidelines of the European Resuscitation Council and the European Society of Intensive Care Medicine.

Results: The guideline clearly states that all patients who achieve return of spontaneous circulation after cardiopulmonary resuscitation should be assessed for organ donation. Numerous observational studies have shown that there is no significant difference in graft function or recipient survival between organs obtained from resuscitated donors and those obtained from non-resuscitated donors. This finding applies to all major solid organs, including the heart, lungs, liver, kidneys, pancreas, and small intestine.

Conclusion: The main barrier to organ donation after cardiac arrest is not a lack of medical evidence, but the insufficiently systematic evaluation of potential donors. The guideline defines organ donation as an integral component of post-cardiac arrest care. The fact that cardiopulmonary resuscitation has been performed is not, by itself, a determinant of donor suitability. Surgeons and intensivists working in surgical critical care units play an important role in the early identification of potential donors and timely notification of transplantation teams. Organ donation after cardiac arrest is an evidence-based practice that remains underutilized. The 2025 European Resuscitation Council and European Society of Intensive Care Medicine Post-Resuscitation Care Guidelines recommend that every patient who dies after successful cardiopulmonary resuscitation should be evaluated for organ donation. Evaluation of patients after CPR in surgical critical care units will increase the number of potential donors.

Keywords: Brain death, cardiac arrest, cardiopulmonary resuscitation, organ donation, surgical critical care unit

[P-273]

Multimodal risk assessment of thyroid malignancy in nodules with indeterminate cytology: Six years of research analysis

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Objective: Thyroid nodules are a common clinical finding, with prevalence rates ranging from 19% to 68% in the general population, largely due to the widespread use of high-resolution ultrasonography (US). While the vast majority of these nodules are benign, a significant proportion necessitate further evaluation to rule out malignancy. To evaluate the clinical, ultrasonographic, and elastographic parameters for risk stratification of malignancy in thyroid nodules with indeterminate cytology according to The Bethesda System for Reporting Thyroid Cytology (TBSRTC).

Material and Methods: This retrospective, single-center study analyzed 838 thyroid nodules from 716 consecutive patients for six years. The diagnostic performance of nodule size, Doppler US features, American Thyroid Association (ATA) risk of malignancy (ROM) guidelines, and Tsukuba elasticity scores (TES) via strain elastography (SE) was assessed. A multinomial logistic regression analysis was employed to compare indeterminate cytology (categories III, IV, and V) with benign cytology (category II) to identify independent predictors of malignancy.

Results: Nodules with ambiguous cytology exhibited larger mean diameters compared to benign nodules (20.83±9.89 mm vs. 18.65±9.08 mm; $p<0.05$), and significant associations were found between categories III, IV, and V and increased peripheral/central vascularization, high-risk ATA ROM classifications, and high TES (4 and 5). Histopathological malignancy rates were higher in the ambiguous groups ($p<0.05$); however, patient age and nodule localization did not show significant predictive value.

Conclusion: The integrated assessment of nodule size, Doppler vascularity, ATA risk stratification, and SE significantly enhances the predictive accuracy for malignancy in nodules with indeterminate cytology. Eventually, these multiparametric indices may provide essential guidance for optimizing surgical indications and clinical management in cases of diagnostic uncertainty.

Keywords: Thyroid gland, cytology, risk

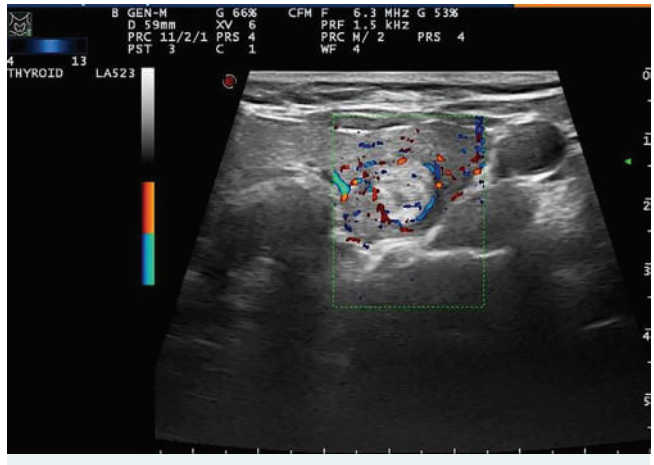

Figure 1. A Doppler US of an isoechoic nodule in the inferoposterior region of the left lobe of the thyroid gland with peripheric vascularization, possessing category II, TBSRTC, cytology.

TBSRTC: The Bethesda System for Reporting Thyroid Cytology, TES: Tsukuba elasticity score, OR: Odds ratio, CI: Confidence interval.

[P-275]

Results and patient satisfaction of inguinal hernia repair in a teaching hospital

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Objective: Inguinal hernia is one of the most common diseases in general surgery practice, affecting 2-4% of the population and with a lifetime risk of approximately 30% in men. Due to its high prevalence and the applicability of different surgical techniques (open and laparoscopic), not only recurrence and chronic pain but also long-term quality of life and patient satisfaction are important in evaluating the success of these elective procedures.

Material and Methods: Adult mesh inguinal hernia repairs (Lichtenstein, TEP, TAPP) performed at our tertiary training hospital between January 2020 and December 2023 were retrospectively analyzed. Patients were divided into four groups according to surgical technique (open/laparoscopic) and side (unilateral/bilateral). Postoperative outcomes (recurrence, chronic pain, quality of life) were compared. Statistical analyses were performed using R software.

Results: A total of 153 patients (mean age 55±14) were divided into four groups: Laparoscopic bilateral (LB, n=58), Open bilateral (AB, n=42), open unilateral (AU, n=33), and laparoscopic unilateral (LU, n=20). Follow-up was achieved in 139 patients (91%), while 9% were not followed up. The overall recurrence rate in the entire cohort was 10% (n=14), and the rate of chronic pain was 6% (n=8). Recurrence rates were 0% in the AB group, 15% in the AU group, 12% in the LB group, and 15% in the LU group. There was no statistically significant difference in recurrence rates between the surgical techniques (p=0.117). Similarly, there was no significant difference in the incidence of chronic pain (p=0.38). There were also no significant differences between the groups in terms of patient satisfaction and quality of life (p=0.12).

Conclusion: Inguinal hernia repairs performed at a tertiary teaching hospital resulted in good postoperative quality of life and similar recurrence and morbidity rates among the techniques. High patient satisfaction was noteworthy in open bilateral repair. The relatively high recurrence rates observed in the laparoscopic group require evaluation in larger series.

Keywords: Inguinal hernia, teaching hospital, recurrence

Table 1. Clinical outcomes and patient satisfaction by surgical technique

Group	N.	Reached	Recurrence	Chronic pain	Satisfaction	Quality of life
Open bilateral	37	37 (100%)	0 (0%)	1 (3%)	35 (95%)	9.3
Open unilateral	33	33 (100%)	5 (15%)	2 (6%)	26 (79%)	9.0
Laparoscopic bilateral	63	49 (78%)	6 (12%)	2 (4%)	44 (90%)	8.7
Laparoscopic unilateral	20	20 (100%)	3 (15%)	3 (15%)	18 (90%)	9.4
Total cohort	153	139 (91%)	14 (10%)	8 (6%)	123 (89%)	9
p-value*	-	-	0.12	0.4	0.21	-

[P-276]

Early mortality rate in laparoscopic sleeve gastrectomies: A single center review, this time we'll point the finger at ourselves

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Objective: The increasing rate of worldwide obesity is considered one of the most challenging contemporary threats to public health. Over 50% of bariatric surgeries performed are laparoscopic sleeve gastrectomy (LSG) at worldwide. The remaining 30% are gastric bypass and metabolic surgeries. Laparoscopic sleeve gastrectomy remaining most chosen technique in bariatric surgical treatment because of cost effectivity rate, technical simplicity and remaining digestive system. According to IFSO data, the mortality rate after LGS varies between 0.18% and 0.27% depending on age, gender, and comorbidities.

Material and Methods: In our study, we examined the total number of laparoscopic sleeve gastrectomies performed at the Clinic of General Surgery, İzmir Bozyaka Training and Research Hospital, University of Health Sciences Türkiye.

Results: Our study revealed that a total of 680 patients performed laparoscopic sleeve gastrectomy. %88 of the patients were female and %12 were male. The age distribution of the cases ranged from 18 to 71. The average hospital recovery period for patients after surgery was 4 days. The postoperative mortality rate of our patients was 0.7% (5 patients). The cause of death in these patients was gastrointestinal perforation in 3 patients and sudden cardiac death in 2 patients.

Conclusion: The number of sleeve gastrectomy operations is directly proportional to the obesity rate in the population. While the postoperative mortality rate is 0.7% in our clinic, this rate may vary in more experienced centers. Patients existing comorbidities and age distribution affect postoperative mortality and morbidity rates. There is a need for multicenter studies on this subject in our country.

Keywords: Gastrointestinal perforation, Health Sciences University, laparoscopic sleeve gastrectomy, mortalty rate

[P-280]

A portal vein branch identified in the gallbladder bed during laparoscopic cholecystectomy: A rare and high-risk case report

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Objective: Portal vein anatomy and its variations are of clinical importance in hepatobiliary surgery. Although these variations are most commonly considered during hepatic resections and major liver surgeries, they may rarely pose a risk of serious vascular injury during laparoscopic cholecystectomy as well. In particular, portal vein branches coursing within the gallbladder bed may lead to difficult-to-control and potentially life-threatening hemorrhage if unrecognized. In this report, we present a case of a portal vein branch that was identified intraoperatively during laparoscopic cholecystectomy and required a modification of the surgical approach.

Results: A 52-year-old male patient presented to our outpatient clinic with complaints of biliary colic. Preoperative ultrasonography and computed tomography revealed a 9-mm gallstone. No variations related to portal vein anatomy were reported on preoperative imaging. An elective laparoscopic cholecystectomy was planned for the patient. Following standard trocar placement, adhesions between the gallbladder and the omentum were separated using sharp and blunt dissection. The cystic duct and cystic artery were carefully dissected, clipped, and divided. During dissection of the gallbladder from the liver bed, a vascular structure consistent with a portal vein branch, approximately 1 cm in diameter and 2 cm in length, was identified within the gallbladder bed, following an atypical anatomical course. Given the location and diameter of the identified vascular structure, it was considered that standard electrocautery dissection could result in severe and difficult-to-control hemorrhage. At this stage, the surgical strategy was revised intraoperatively; dissection was continued carefully and in a controlled manner without the use of energy devices, with preservation of the vascular structure. The portal vein branch was successfully preserved without injury, and the gallbladder was completely separated from the liver bed (Figure 1). No intraoperative bleeding was observed, and no additional surgical intervention was required. The gallbladder was removed in an endobag and sent for pathological examination. No postoperative complications such as bleeding or bile leakage were observed. The patient was discharged on postoperative day 1. No complications were noted during a six-month follow-up period.

Conclusion: This case demonstrates that portal vein variations may pose a risk of serious vascular injury not only during major hepatic surgeries but also during commonly performed procedures such as laparoscopic cholecystectomy. When unexpected vascular structures are encountered in the gallbladder bed, intraoperative awareness and appropriate modification of the dissection strategy are crucial for preventing major hemorrhage and ensuring safe surgery.

Keywords: Portal vein variation, laparoscopic cholecystectomy, gallbladder bed, vascular injury

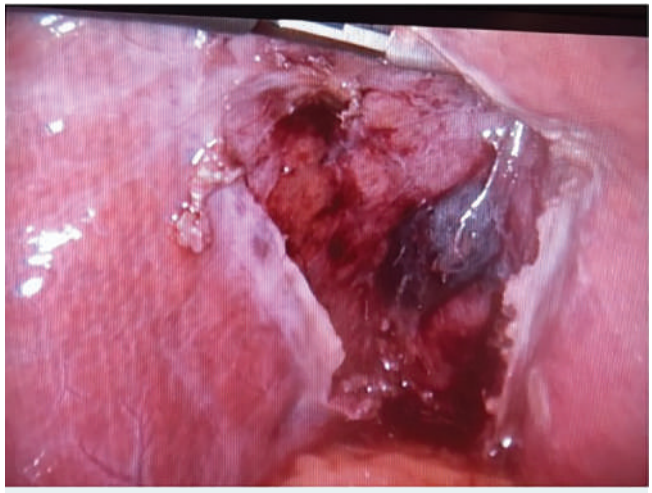

Figure 1. Intraoperative view of a portal vein branch approximately 1 cm in diameter coursing within the gallbladder bed.

[P-281]

Laparoscopic surgical approach in acute cholecystitis: A single-center retrospective study

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Objective: Acute cholecystitis is an acute inflammatory disease of the gallbladder, most commonly caused by gallstones. It occupies an important place among the causes of acute abdomen, and if not treated surgically in time, morbidity may increase. Nowadays, laparoscopic cholecystectomy has become the standard treatment approach for patients diagnosed early due to its feasibility in the early period, shorter hospital stay, and lower complication rates. This study aimed to evaluate demographic data, comorbidities, intraoperative findings, and postoperative outcomes in patients who underwent laparoscopic cholecystectomy for acute cholecystitis.

Material and Methods: Between February 2024 and January 2026, a total of 47 patients who underwent laparoscopic cholecystectomy with a diagnosis of acute cholecystitis in the Department of General Surgery, Bakırçay University Çiğli Training and Research Hospital, were retrospectively analyzed. The following data were recorded: age, sex, body mass index (BMI), comorbidities, previous surgical history, Parkland score, time from symptom onset to surgery, Tokyo classification of acute cholecystitis, intensive care unit (ICU) stay, development of complications, and postoperative length of hospital stay.

Results: Of the patients, 26 (55.3%) were female and 21 (44.7%) were male. The mean age was 60.8±15.4 years, and the mean BMI was 28.7±4.8 kg/m². The most common comorbidities were hypertension (40.4%), diabetes mellitus (23.4%), and cardiac disease (19.1%). Previous abdominal surgery was present in 46.8% of patients. Based on the Tokyo Classification, 18 patients were Grade 1 and 29 were Grade 2. The Parkland score was 2 in 3 patients, 3 in 19 patients, 4 in 10 patients, and 5 in 15 patients. The mean time from the onset of symptoms to surgery was 3.3 days. Postoperative respiratory complications occurred in only one patient (2.1%), and no surgical complications were observed. The mean postoperative hospital stay was 3.0±1.5 days.

Conclusion: Laparoscopic cholecystectomy in acute cholecystitis is a safe surgical method when appropriate patient selection is made, offering a low complication rate and shorter hospital stay. Although advanced age, high BMI, and comorbidities may increase surgical difficulty, they do not significantly raise complication rates.

Keywords: Acute cholecystitis, laparoscopic cholecystectomy, Parkland classification

[P-282]

Postoperative recurrence in intra-abdominal and retroperitoneal sarcomatosis: A ten-year retrospective analysis of 82 cases

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Objective: Intra-abdominal and retroperitoneal soft tissue sarcomas are rare tumors characterized by aggressive biological behavior and high rates of local recurrence, necessitating close postoperative surveillance. The development of sarcomatosis represents an advanced stage of disease; however, data addressing long-term recurrence patterns and the impact of prior surgical interventions in this patient population remain limited. The aim of this study was to comprehensively evaluate histopathological subtype distribution, postoperative recurrence timing, and the effect of previous surgical history in patients undergoing surgery for intra-abdominal and retroperitoneal sarcomatosis.

Material and Methods: A total of 82 patients who underwent surgery for intra-abdominal and retroperitoneal sarcomatosis over a 10-year period were retrospectively analyzed. Histopathological diagnoses, history of previous sarcoma-related surgery at other institutions, postoperative recurrence, and time to recurrence were evaluated. Patients presenting with sarcomatosis as recurrence or disease progression following prior surgery were analyzed as a distinct subgroup.

Results: The histopathological distribution of the 82 patients was heterogeneous and consistent with the existing literature. The most common diagnosis was liposarcoma, observed in 41 patients (50.0%), followed by leiomyosarcoma in 18 patients (22.0%) and undifferentiated pleomorphic sarcoma in 11 patients (13.4%). Less frequent subtypes included solitary fibrous tumor in 5 patients (6.1%), malignant peripheral nerve sheath tumor in 4 patients (4.9%), and other high-grade sarcoma subtypes in 3 patients (3.6%). Postoperative recurrences occurred predominantly during the early and intermediate follow-up periods. The median time to recurrence was 16 months (IQR: 9-32 months). Overall, 62% of recurrences developed within the first 24 months, and 85% occurred within the first 60 months. Patients with a history of prior surgery at other institutions had a shorter median time to recurrence (12 months) compared with those whose primary surgery was performed at our center (22 months), indicating a significant impact of previous surgical interventions on recurrence patterns.

Conclusion: This study represents one of the largest single-center series detailing postoperative recurrence timing and histopathological distribution in patients with intra-abdominal and retroperitoneal sarcomatosis. The demonstrated association between prior surgical history and earlier recurrence constitutes a key original contribution of this analysis. Our findings underscore the importance of initial sarcoma surgery being planned and performed in experienced, high-volume centers using a multidisciplinary approach, as well as the need for intensive, long-term follow-up strategies focused on the early postoperative period in this high-risk patient population.

Keywords: Intra-abdominal sarcoma, retroperitoneal sarcoma, postoperative recurrence

[P-283]

The experience of four young general surgeons (experience <5 years) in colorectal malignancy surgery at the newly opened University of Health Sciences Türkiye, Antalya City Hospital: Is comprehensive and high-quality colorectal surgery possible with standard core training?

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Objective: Colorectal cancer surgery is most often performed in high-volume tertiary centers by subspecialist surgeons. In addition to technical success, adherence to oncological surgical principles is of paramount importance. The aim of this study was to evaluate the experience of four young general surgeons, all graduates of the same training center and trained under the same core curriculum, who are currently working at the newly established University of Health Sciences Türkiye, Antalya City Hospital, and to assess the impact of standardized training on clinical practice in terms of surgical approach diversity and pathological quality criteria.

Material and Methods: This retrospective descriptive study included patients who underwent surgery for colorectal malignancy between March 2024 and December 2025 at the newly established tertiary-care University of Health Sciences Türkiye, Antalya City Hospital, University of Health Sciences Türkiye. Demographic data, emergency versus elective surgical status, surgical approach, and pathological outcomes were analyzed. All procedures were performed by four general surgeons who shared the same education.

Results: A total of 101 patients were included in the study. The mean age was 66.3±15.25 years (range: 31-91 years). Of the patients, 60.4% were male and 39.6% were female. Fifty-nine surgeries (57.8%) were performed electively, 42 (41.2%) were performed under emergency conditions. Tumor localization was as follows: right colon in 24 patients (23.7%), left colon in 8 (8%), transverse colon in 2 (2%), sigmoid colon in 17 (16.8%), and rectum in 50 patients (49.5%). Regarding surgical approach, 54 patients (52.9%) underwent open surgery, 22 (21.6%) laparoscopic surgery, and 26 (25.5%) robotic surgery. The overall rate of minimally invasive surgery was 47.1%. No positive surgical margins were detected pathologically. In 14 patients (13.8%), the number of harvested lymph nodes was fewer than 12, whereas adequate lymph node dissection with complete mesocolic excision was achieved in 86.2% of patients. These findings were consistent with the existing literature. Postoperatively, 8 patients (7.9%) died in the intensive care unit due to non-surgical causes; all patients had undergone emergency surgery. Three patients (3%) died due to postoperative surgical complications. These mortality rates were consistent with those reported in the literature.

Conclusion: Young general surgeons trained through a standardized and robust core curriculum are capable of performing colorectal cancer surgery in city hospital settings not only with technical proficiency but also in accordance with oncological principles and pathological quality standards. However, as not all residency training centers provide education at the same standard, the continuation of post-graduate training and the active involvement of the Turkish Surgical Association and the Turkish Society of Colorectal Surgery remain crucial.

Keywords: Colorectal cancer, core curriculum training, oncological surgical quality

[P-284]

Evaluation of colonoscopic polypectomy outcomes: University of Health Sciences Türkiye, Bağcılar Training and Research Hospital experience

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Objective: Polyps are defined as abnormal mucosal growths protruding into the lumen of the colon and rectum. Colonoscopy is considered the gold standard for both diagnosis and treatment of colorectal polyps. In addition, colonoscopic polypectomy is a fundamental method for preventing the development of colorectal cancer. We aimed to evaluate the endoscopic and histopathological characteristics of patients who underwent colonoscopic polypectomy.

Material and Methods: Between 2018 and 2024, a total of 10,927 lower gastrointestinal endoscopic examinations were performed in the endoscopy unit of the general surgery department. Among these, 2,364 patients (21.6%) who underwent colonoscopic polypectomy and 3,291 polyps were retrospectively analyzed. Demographic characteristics, polyp localization, number, size, histopathological type, degree of dysplasia, and malignancy rates were recorded.

Results: The male-to-female ratio was 1,488/876 and the median age was 58 years (range: 16-92). Polyps were detected in 3.291 locations during 2.364 procedures (cecum 177, ascending colon 370, transverse colon 385, descending colon 482, sigmoid colon 1.052, rectum 735). The sigmoid colon was the most frequent location. Polyps were found in a single location in 774 cases and in multiple locations in 1,590 cases. The median polyp size was 5 mm (range: 1-45). Histopathological evaluation revealed benign lesions in 1.370 polyps (41.7%), premalignant lesions in 1.745 polyps (53%), and malignant lesions in 176 polyps (5.3%). Dysplasia was low-grade in 316 polyps (9.5%) and high-grade in 340 polyps (10.3%). Malignant lesions were detected in 111 of 2.183 polyps (5.1%) in 1.488 male patients and in 65 of 1.108 polyps (5.9%) in 876 female patients.

Conclusion: Colonoscopic polypectomy, when performed in experienced centers, is a safe and effective method with a low complication risk for both the diagnosis and treatment of colorectal cancer. Given the high frequency of premalignant lesions, particularly in the sigmoid colon and rectum, rectosigmoidoscopic examination may be appropriate in screening programs. Larger studies are needed to better define the prevalence and prognosis of premalignant lesions.

Keywords: Polypectomy, colonoscopy, colorectal cancer

[P-285]

Impact of emergency and elective surgery on short-term clinical outcomes in right colon cancer: A single-center experience (2023-2026)

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Objective: In this study, we aimed to evaluate the impact of emergency surgery on short-term clinical outcomes in patients undergoing surgical resection for right colon cancer and to compare these outcomes with those of elective surgery.

Material and Methods: In this retrospective single-center study, 102 patients who underwent surgery for right colon cancer between 2023- 2026, were included. Patients were divided into two groups according to emergency (n=32) and elective surgery (n=70). The primary endpoint was defined as major morbidity (Clavien-Dindo ≥3). Secondary endpoints included 30-day mortality, anastomotic leakage, intensive care unit (ICU) requirement, and length of hospital stay. Continuous variables were expressed as median and analyzed using the Mann-Whitney U test, while categorical variables were analyzed using Fisher's exact test or the chi-square test.

Results: The groups were similar in terms of age (p=0.759).The rate of ASA ≥III was significantly higher in the emergency group (65.4% vs. 41.4%, p=0.042). No significant difference was detected between the groups regarding the Charlson comorbidity index (p=0.691). In the emergency group, preoperative CRP levels were significantly higher (44.05 vs. 6.15 mg/L, p<0.001), while albumin levels were significantly lower (3.46 vs. 4.18 g/dL, p=0.001). Regarding the surgical approach, 84.4% of patients in the emergency group underwent open surgery, whereas minimally invasive techniques were preferred in 77.1% of the elective group. The conversion rate was 60% in the emergency group and 11.1% in the elective group. Operative time was significantly longer in the elective group (197.5 vs. 150 minutes, p<0.001). Pathological staging showed a significant difference in T stage distribution between the groups (p<0.001); the T4 rate was 50% in the emergency group compared with 12.9% in the elective group. Although the N2 rate was higher in the emergency group (34.4% vs. 17.1%, p=0.074). There was no significant difference in the total number of retrieved lymph nodes between the groups [22 (16.8-34.2) in the emergency group vs. 20 (17.0-25.0) in the elective group, p=0.178]. The rate of major morbidity was significantly higher in the emergency group (21.9% vs. 1.4% ,p=0.001). Thirty-day mortality was also higher in the emergency group (18.8% vs. 2.9%,p=0.011). Anastomotic leakage was observed only in the emergency group (12.5% vs. 0%, p=0.008). Length of stay was significantly longer in the emergency group (8 vs. 6 days, p=0.041).

Conclusion: Emergency surgery in right colon cancer is associated with advanced T stage, higher rates of open surgery and conversion, and significantly increased major morbidity and mortality. Although the oncological quality of surgery is comparable, emergency presentation significantly worsens short-term clinical outcomes due to loss of physiological reserve and greater disease burden.

clinical outcomes.

Keywords: Elective surgery, emergency surgery, right colon cancer

Table 1. Demographic characteristics, operative features, and pathological findings

Variable	Emergency (n=32)	Elective (n=70)	p
Age, median (IQR)	68 (60-77)	68.5 (62-77)	0.759
ASA ≥III	17 (65.4%)	29 (41.4%)	0.042
CCI, median (IQR)	5 (4-7.25)	5 (4-6)	0.691
Open surgery	27 (84.4%)	16 (22.9%)	<0.001
Minimally invasive surgery	5 (15.6%)	54 (77.1%)	<0.001
Conversion*	3/5 (60.0%)	6/54 (11.1%)	-
Operative time (min), median (IQR)	150 (132.5-176.2)	197.5 (166.2-248.8)	<0.001
T stage distribution (overall)	-	-	<0.001
T4	16 (50.0%)	9 (12.9%)	<0.001
N2	11 (34.4%)	12 (17.1%)	0.074
Total lymph nodes, median (IQR)	22 (16.8-34.2)	20 (17.0-25.0)	0.178
≥12 lymph nodes retrieved	29 (90.6%)	64 (91.4%)	1.000

Table 2. Clinical outcomes

Variables			
30-day mortality	6 (18.8%)	2 (2.9%)	0.011
Anastomotic leakage	4 (12.5%)	0	0.008
ICU requirement	10 (31.2%)	21 (30.0%)	1.000
Length of hospital stay (days), median (IQR)	8 (6-12.75)	6 (6-7)	0.041

[P-286]

Reduction of biopsy requirement with magnetic resonance imaging in breast cancer: A five-year clinical experience in high-risk women

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Objective: In women with familial risk of breast cancer, mammography and ultrasound (US) can yield indeterminate findings that prompt biopsy. Breast magnetic resonance imaging (MRI) may better characterize lesions, reduce avoidable procedures, and reveal malignancies occult on conventional imaging. To compare biopsy recommendations generated by mammography/US with those after breast MRI and to summarize a five-year single-center experience.

Material and Methods: We retrospectively reviewed 99 women with a positive family history who underwent breast MRI between January 2020 and January 2025 at a tertiary center. Familial risk was defined as breast cancer in a first-degree relative (mother and/or sister) and/or a second-degree maternal relative (maternal aunt). Imaging assessments from mammography and/or US were compared with subsequent MRI interpretations. A biopsy recommendation was considered indicated when the index lesion was categorized as BI-RADS 4-5 on the reporting modality (mammography, US, or MRI). The primary outcome was the change in biopsy recommendation after MRI (withdrawal or new indication). Secondary outcomes were pathology results and short-term safety of deferring biopsy.

Results: Overall, biopsy was recommended in 26/99 patients (26.3%). Sixteen patients had BI-RADS 4 findings on mammography and/or US prompting biopsy. After MRI, 10/16 (62.5%) were downgraded to BI-RADS 2-3 and biopsy was withdrawn; no malignancy was observed during a minimum 12-month follow-up using clinical assessment plus interval imaging (US and/or mammography). The remaining 6/16 (37.5%) continued to meet BI-RADS 4-5 criteria and underwent biopsy; all pathology results were benign. Among patients without a biopsy indication on mammography/US, MRI alone prompted biopsy in 10/99 (10.1%). Seven underwent biopsy: 5 benign and 2 malignant. Biopsy was not performed in 3 patients and follow-up data were unavailable; these cases were treated as missing and excluded from outcome assessment.

Conclusion: In women with familial risk, adding breast MRI to mammography and US reduced biopsy recommendations by downgrading many BI-RADS 4 findings with reassuring follow-up, while also detecting malignancy in a subset not identified by conventional imaging. MRI appears to be a useful problem-solving adjunct within guideline-based screening pathways for this population.

Keywords: Magnetic resonance imaging (MRI), mammography, breast ultrasound (US), familial risk, BI-RADS

[P-287]

Is non-surgical treatment of breast cancer possible

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Objective: Breast cancer, once considered untreatable, has evolved into an era where the necessity of surgery is being questioned. Thanks to molecular advancements, cancer subtypes can be defined on a receptor basis, allowing for the development of disease-specific, targeted treatment strategies. With increased experience and advancements in imaging technologies, early diagnosis rates are rising. In light of these developments, the opportunity has arisen to answer the question: Is non-surgical breast cancer treatment possible?

Material and Methods: Studies published in the PubMed database between 2017-2025, which reported the accuracy of pathologic response via minimal invasive biopsy prior to surgery after neoadjuvant therapy, were screened. Keywords used included "Neoadjuvant therapy", "pathologic complete response", "vacuum-assisted biopsy", "core needle biopsy", and "surgery omission". Prospective, retrospective comparative, feasibility, and accuracy studies were included, while case reports and studies with insufficient methodology were excluded. Literature findings were synthesized to evaluate the efficacy of biopsy-based surgery omission strategies.

Results: Breast cancer is classified into four subtypes: Luminal A, Luminal B, HER2+, and Triple Negative, which show significant differences in treatment response and prognosis. Current neoadjuvant chemotherapy and radiotherapy applications have increased clinical complete remission rates, reaching up to 60% specifically in HER2+ and triple-negative patients. However, reliably ruling out residual tumor after neoadjuvant therapy remains challenging; while the sensitivity and specificity of imaging methods vary (Table 1), some studies have shown that results can be improved with artificial intelligence. Regarding axillary management, the AMAROS trial (2001-2010, n=4806) compared 1425 cN+ patients and found 5-year axillary recurrence rates of 0.43% in the axillary lymph node dissection (ALND) group and 1.19% in the radiotherapy (RT) group. Disease-free survival was 86.9% and 82.7%, respectively, while overall survival was 81.4% and 84.6%. In detecting breast pathologic complete response (pCR), the false-negative rate of invasive biopsies ranges from 0% to 49% depending on factors such as needle size and technique (VAB, CNB). A review of studies over the years indicates that pCR rates are progressing positively (Table 2).

Conclusion: Avoidance of surgery cannot yet enter routine practice; prospective studies should be awaited. The crucial point is to prove the accuracy of pathologic complete response via non-surgical methods. Current methods lack sufficient sensitivity and specificity to select patients with pathologic complete response. While moving away from breast cancer surgeries is an inevitable trend, higher quality clinical studies are required. Treatment algorithms will be reshaped in the future with the results of AI and multi-center studies.

Keywords: Non-operative management of breast cancer

Table 1. Sensitivity and specificity of imaging methods

	Sensitivity (%)	Specificity (%)
Mammography (3)	81	48
Diffusion-weighted MRI (4)	93	82
USG (5)	90	80
PET-CT (6)	84	71

Table 2. Pathologic complete response (pCR) rates by subtype

	Multi-center	TR (7)
Luminal A	10-15%	8.7%
Luminal B	15-30%	10.8%
Luminal B HER2 +	30-55%	42.4%
HER2+ HR-	50%+	54.5%
Triple negative	30-60%	46.7%

[P-288]

Bilateral breast cancer: A single-center experience

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Objective: Bilateral breast cancer is a rare disease entity that presents diagnostic and therapeutic challenges due to its clinical and pathological heterogeneity. Tumors may develop in both breasts either synchronously or at different time points, necessitating individualized surgical approaches and adjuvant treatment planning. The aim of this study was to evaluate the clinicopathological characteristics and treatment approaches of patients diagnosed with bilateral breast cancer.

Material and Methods: In this retrospective study, patients diagnosed with metachronous bilateral breast cancer at our center between 2021 and 2026 were analyzed. Demographic characteristics, tumor localization, histological and molecular subtypes, surgical procedures, and adjuvant treatments were evaluated using patient medical records and electronic databases.

Results: A total of 21 patients were included in the study. The median age of the patients was 47 years (range: 39-78). The mean follow-up period was 29.4 months (range: 2.1-61.2). Histopathological evaluation revealed mixed invasive lobular and invasive ductal carcinoma in 2 patients (9.5%), while invasive ductal carcinoma was present in 19 patients (90.5%). Bilateral luminal-type tumors were observed in 16 patients (76.2%), whereas 5 patients (23.8%) had luminal-type breast cancer in one breast and hormone receptor-positive, HER2-positive breast cancer in the contralateral breast. Breast-conserving surgery was performed in 10 patients (47.6%), while mastectomy was performed in 11 patients (52.4%). Pathological staging revealed advanced-stage disease in both tumors in 1 patient (4.8%), whereas all remaining patients were diagnosed at an early stage. In 3 patients (14.3%), the second tumor was identified as carcinoma *in situ*. During the follow-up period, no local recurrence or distant metastasis was observed.

Conclusion: In this single-center experience, the prognosis of patients with metachronous bilateral breast cancer was found to be comparable to that of patients with unilateral breast cancer. Although the literature reports a higher incidence of invasive lobular carcinoma in bilateral breast cancer, invasive lobular carcinoma was observed only in patients with mixed histopathological subtype in our series. Despite the relatively short follow-up period, favorable clinical outcomes were observed, likely attributable to the fact that the majority of patients were diagnosed at an early stage. Accordingly, breast-conserving surgery was feasible in nearly half of the patients. These findings suggest that appropriate patient selection and individualized treatment strategies may play a decisive role in the prognosis of metachronous bilateral breast cancer.

Keywords: Bilateral breast cancer, metachronous breast cancer, breast-conserving surgery

[P-289]

Imaging-guided localization of non-palpable early-stage breast cancer and its surgical and oncological outcomes: A single-center registry study

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Objective: With the widespread use of screening programs and neoadjuvant therapies, non-palpable breast cancers are encountered more frequently in clinical practice. In these patients, preoperative localization is of great importance in terms of achieving complete tumor excision, reducing the need for re-surgery, and preserving cosmetic results.

Material and Methods: This retrospective registry analysis included 67 patients with non-palpable breast cancer at Tis-T1N0M0 stage who underwent breast-conserving surgery with image-guided localization between 2015 and 2024. Complete data on surgical outcomes were available for 50 patients. Demographic characteristics, tumor characteristics, and oncological outcomes were evaluated using descriptive statistical methods.

Results: The mean age of the patients was 55.2±10.1 years. The mean diameter of the largest tumor was 13.9±4.5 mm, consistent with early-stage disease. Three patients (6%) required re-excision after the first surgery. A second re-excision was performed in two patients (4%). During follow-up, local recurrence was observed in one patient (2%), regional recurrence in one patient (2%), and systemic recurrence in two patients (4%). Disease-related mortality occurred in one patient (2%).

Conclusion: In non-palpable early-stage breast cancer, imaging-guided localization appears to be a safe and effective approach with low re-excision rates and favorable oncological outcomes. Larger multicenter studies are needed to evaluate the impact of different localization techniques on long-term outcomes.

Keywords: Non-palpabl, wire guided

[P-290]

Is the stage at diagnosis advanced in patients under 40 years of age with breast cancer?: A single-center experience

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Objective: Breast cancer occurring at a young age represents a distinct clinical subgroup due to its more aggressive biological characteristics and exclusion from routine screening programs. This study aimed to evaluate the clinical stage distribution at diagnosis in patients under 40 years of age with breast cancer and to compare the proportion of advanced-stage disease (Stage III-IV) with population-based literature data.

Material and Methods: In this single-center retrospective study, 62 patients under the age of 40 diagnosed with invasive breast cancer and evaluated at the multidisciplinary breast tumor board in 2025 were analyzed. Clinical stages were reclassified according to the AJCC 8th edition, and Stage III-IV disease was defined as "advanced stage." The observed proportion of advanced-stage disease was compared with rates reported in national and international population-based studies using a one-sample proportion test.

Results: Among the 62 patients, 11 (17.7%; 95% CI: 10.2-29.0%) were diagnosed with advanced-stage disease. The rate of metastatic disease at presentation was 4.8%. The observed advanced-stage proportion did not differ significantly from the approximately 15-20% rates reported in the Turkish National Breast Cancer Registry Program and SEER data (p=0.64).

Conclusion: In this single-center young-age cohort, the proportion of advanced-stage disease was comparable to population-based data. Despite the well-documented increased biological aggressiveness of breast cancer in younger patients, the stage distribution did not demonstrate a marked deviation from that of the general population. Larger, multicenter studies are warranted.

Keywords: Breast cancer, early-onset, staging

[P-291]

Clinical characteristics and surgical outcomes of hypercalcemic patients aged 65 years and older with primary hyperparathyroidism

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Objective: Primary hyperparathyroidism represents the leading cause of hypercalcemia. Although hypercalcemia is frequently asymptomatic across age groups, elders tend to present with atypical and non-specific manifestations, which may contribute to delayed diagnosis. This study aimed to characterize the clinical presentation and therapeutic outcomes of patients aged ≥65 years with hypercalcemia and to evaluate the necessity and effectiveness of surgical management in this population.

Material and Methods: Patients diagnosed with hyperparathyroidism, either referred from internal medicine/endocrinology clinic or consult to general surgery clinic between September 2022-2025 were retrospectively evaluated. Demographics, laboratory data, imaging modalities, and treatments were systematically reviewed. All patients underwent neck ultrasonography and parathyroid scintigraphy; 4D computed tomography (4D-CT) was employed when initial imaging failed to localize a parathyroid lesion.

Results: Among 165 patients diagnosed with hyperparathyroidism and hypercalcemia, 22 (13.3%) were ≥65 years of age. The cohort consisted of 15 women (68.1%) and 7 men (31.8%), with a mean age of 70.5 years; while female patients demonstrated a slightly higher mean age (71.5 years). Hypercalcemia was incidentally detected in laboratory tests in 7 patients (31.8%). Musculoskeletal complaints were reported by 8 patients (36.3%), whereas hypertension and cognitive dysfunction each constituted the presenting symptom in 3 patients (13.6%). One patient (4.5%) was diagnosed with nephrolithiasis. All patients with confirmed biochemical hyperparathyroidism underwent minimally invasive parathyroidectomy. In 8 cases, the addition of 4D-CT facilitated precise localization and optimized the surgical approach. A double adenoma was identified in one patient via 4D-CT. A 53-year-old male patient with primary hyperparathyroidism in whom a parathyroid adenoma could not be identified by ultrasonography or scintigraphic imaging; however, the lesion was successfully diagnosed and localized using four-dimensional computed tomography (4D CT).

Conclusion: Primary hyperparathyroidism in elderly patients most commonly arises from parathyroid adenoma, lesser hyperplasia, or, least frequently, parathyroid carcinoma. Given the potential multisystem involvement of hypercalcemia in this age group, timely intervention is imperative. Surgical treatment should be prioritized in patients who do not respond adequately to medical therapy. Considering the higher prevalence of comorbid conditions in the elderly, accurate preoperative localization is crucial to minimize operative time and reduce perioperative morbidity. Focused minimally invasive parathyroidectomy represents an optimal first-line strategy, offering shorter operative duration and lower complication rates.

Keywords: Hypercalcemia, primary hyperparathyroidism, diagnosis, imaging, treatment

Table 1.

	Female	Male
Sex	15 (68.1%)	7 (31.8%)
Mean age at the time of diagnosis	71.5	70.5

Table 2.

Symptoms	
Incidentally detected	7
Musculuskeletal complaints	8
Hypertension	3
Cognitive dysfunction	3
Nephrolithiasis	1

Figure 1. 4D CT at primary hyperparathyroidism.

[P-292]

Evaluation of clinical, pathological, and genetic findings in medullary thyroid carcinoma: A single-center experience

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Objective: Medullary thyroid carcinoma (MTC) holds a distinctive position among thyroid malignancies due to its aggressive biological behavior, potential for early lymph node metastasis, monitorability via biochemical markers, and strong association with familial/genetic syndromes. The extent of surgical treatment, neck dissection strategies, and the genetic evaluation process are fundamental factors directly impacting prognosis. This study aims to provide a detailed evaluation of the demographic, clinical, genetic, surgical, and pathological characteristics of MTC patients surgically treated at University of Health Sciences Türkiye, Ankara Etlik City Hospital, Department of General Surgery; to present short-term follow-up outcomes, and to emphasize the role of institutional experience in MTC management.

Material and Methods: In this retrospective observational study, seven patients operated on with a diagnosis of MTC were analyzed. Parameters including age, sex, ASA score, familial MTC/MEN history, presence of MEN syndrome, RET mutation status, preoperative calcitonin and CEA levels, surgical procedures performed, pathological findings, and follow-up data were recorded. Continuous variables were presented as mean ± standard deviation or median (minimum–maximum), and categorical variables were expressed as frequencies and percentages.

Results: All patients were female, with a mean age of 40.4±6.9 years. Most patients were ASA II (71.4%). A family history of MTC/MEN was present in 28.6%, and RET mutation was positive in 28.6%. One patient (14.3%) had MEN 2A syndrome (Table 1). Preoperative biochemical assessment revealed a median calcitonin level of 585 pg/mL (120-2000 pg/mL) and a median CEA level of 18 ng/mL (4-65 ng/mL). All patients underwent total thyroidectomy and central neck dissection; 42.9% required lateral neck dissection (Table 2). Mean tumor diameter was 2.1±0.7 cm. Multicentricity and extrathyroidal extension rates were both 28.6%. Lymph node metastasis was identified in 42.9% of cases. Over a median follow-up of 17 months (4-41 months), no recurrence or mortality was observed (Table 3).

Conclusion: Despite its low incidence, MTC is a malignancy that requires high clinical vigilance during surgical planning and follow-up. Given the high rates of lymph node metastasis and recurrence risk reported in the literature, the complete implementation of standard surgical approaches and multidisciplinary evaluation in our series resulted in zero short-term recurrence and mortality. Our findings support that early diagnosis, genetic screening, and appropriate neck dissection strategies are decisive factors for prognosis, underscoring the importance of institutional experience and structured surgical approaches in this rare tumor group (Table 4).

Keywords: Medullary thyroid carcinoma, MEN syndromes, neck dissection, RET mutation, total thyroidectomy

Table 1. Demographic, clinical, and genetic characteristics (n=7)

Parametre	Değer
Yaş (ortalama ± SS), yıl	40,4 ± 6,9
Yaş (medyan, min–maks), yıl	40 (30–49)
Cinsiyet – Kadın, n (%)	7 (100)
ASA I, n (%)	1 (14,3)
ASA II, n (%)	5 (71,4)
ASA III, n (%)	1 (14,3)
Ailede MTC/MEN öyküsü – Var, n (%)	2 (28,6)
MEN sendromu – MEN2A, n (%)	1 (14,3)
MEN sendromu – MEN2B, n (%)	0 (0)
MEN sendromu – Yok, n (%)	6 (85,7)
RET mutasyonu – Var, n (%)	2 (28,6)

Table 2. Preoperative biochemical and surgical characteristics

Parametre	Değer
Preoperatif kalsitonin (pg/mL), medyan (min–maks)*	967 (87,4–16825)
Preoperatif CEA (ng/mL), medyan (min–maks)	19,6 (4,9–126)
Cerrahi tipi – TT + Santral LN, n (%)	3 (42,9)
Cerrahi tipi – TT + Santral + Lateral LN, n (%)	4 (57,1)
Lateral boyun diseksiyonu – Evet, n (%)	4 (57,1)

Table 3. Pathological findings and follow-up outcomes

Parametre	Değer
Primer tümör çapı (cm), ortalama ± SS	2,61 ± 1,95
Multifokalite – Var, n (%)	3 (42,9)
Ekstratiroidal yayılım – Var, n (%)	1 (14,3)
Lenf nodu metastazı – Var, n (%)	3 (42,9)
Takip süresi (ay), medyan (min–maks)	15 (4–41)
Nüks, n (%)	0 (0)
Takipte mortalite, n (%)	0 (0)

Table 4. Comparison of clinical and pathological findings in MTC with literature

Parametre	Bizim Çalışmamız (Etlik Şehir Hastanesi)	Machens & Dralle(World J Surg)	Wells ve ark.(ATA Guidelines)	Elisei ve ark.(J Clin Endocrinol Metab)
Hasta sayısı (n)	7	>1000	Çok merkezli	638
Ortalama yaş (yıl)	40,4	45–50	40–55	47
Kadın oranı (%)	100	~55–60	~50	56
Ailesel MTK / MEN (%)	28,6	20–25	20–30	24
RET mutasyonu (%)	28,6	25–30	25–35	27
MEN 2A (%)	14,3	10–15	10–20	12
Preop kalsitonin (pg/mL)	967 (medyan)	Değişken	Prognostik belirteç	Yüksek düzey LN ile ilişkili
Lateral LN diseksiyonu (%)	57,1	40–60	Risk bazlı önerilir	~50
Lenf nodu metastazı (%)	42,9	40–70	Sık	45–60
Ekstratiroidal yayılım (%)	14,3	10–30	Prognozu etkiler	20
Nüks (%)	0	10–20	Uzun dönemde artar	15–25
Takipte mortalite (%)	0	5–10	Evreye bağlı	8–12

[P-293]

Our results of parathyroid surgery: A single-center experience (2020-2025)

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Objective: Hyperparathyroidism is characterized by elevated parathyroid hormone (PTH) levels and impaired calcium metabolism. The most common etiological factor is parathyroid adenoma, while parathyroid hyperplasia and, rarely, parathyroid carcinoma may also be responsible. Surgical treatment provides definitive management in appropriate patients. Preoperative imaging plays a critical role in localizing pathological glands and improving surgical success.

Material and Methods: A total of 265 patients who underwent surgery for hyperparathyroidism, hypercalcemia, or parathyroid adenoma at University of Health Sciences Türkiye, Kartal Dr. Lütfi Kırdar City Hospital between January 2020 and June 2025 were retrospectively analyzed. Demographic characteristics, imaging modalities, surgical techniques, preoperative and postoperative PTH and calcium levels, and pathological findings were evaluated. Ultrasonography and scintigraphy were used for preoperative localization in all patients.

Results: Of the patients, 75 (28.3%) were male and 190 (71.7%) were female, with a mean age of 46 years. Chronic kidney disease was present in 71 patients, and 14 patients had a history of renal transplantation. The mean preoperative PTH level decreased from 623 pg/mL to 68.7 pg/mL postoperatively. Mean serum calcium levels decreased from 10.88 mg/dL preoperatively to 8.78 mg/dL postoperatively. The most common localization was the left inferior parathyroid gland, and the mean lesion size was 1.93 cm. Subtotal (3.5-gland) parathyroidectomy with autotransplantation was performed in 38 patients. Pathological examination revealed parathyroid adenoma in 190 patients, parathyroid hyperplasia in 58 patients, and normal parathyroid tissue/thymus in 17 patients. Parathyroid carcinoma was detected in three patients, and parathyromatosis in one patient.

Conclusion: Parathyroid surgery is a safe and effective treatment for hyperparathyroidism. The combined use of ultrasonography and scintigraphy provides accurate preoperative localization. In our series, parathyroid adenoma was the most common pathology, and significant reductions in PTH and calcium levels were observed after surgery. Our findings support the effectiveness of surgical management in hyperparathyroidism.

Keywords: Hyperparathyroidism, parathyroid adenoma, parathyroidectomy

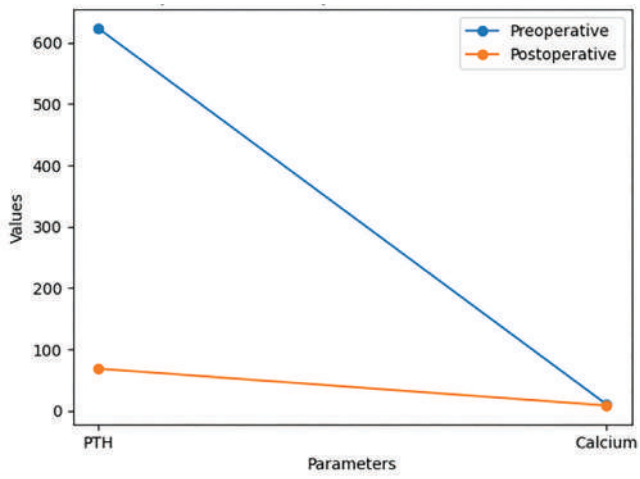

Figure 1. Preoperative vs. postoperative biochemical values.

Table 1. Surgical and pathological findings

Variable	Value
Most common gland localization	Left inferior
Mean lesion size (cm)	1.93
Subtotal parathyroidectomy + autotransplantation, n	38
Parathyroid adenoma, n	190
Parathyroid hiperplasia, n	58
Normal parathyroid tissue/thymus, n	17
Parathyroid carcinoma, n	3
Parathyromatosis, n	1

[P-294]

Clinical significance of prognostic nutritional and inflammatory indices in patients undergoing the Whipple procedure: Analysis of PNI, AGR, and CAR

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Objective: The aim of this study was to evaluate the relationship between inflammation- and nutrition-based indices, including the prognostic nutritional index (PNI), albumin-globulin ratio (AGR), and C-reactive protein-albumin ratio (CAR), and the clinical and pathological characteristics of patients undergoing pancreaticoduodenectomy (Whipple procedure).

Material and Methods: This retrospective study included 89 patients who underwent the Whipple procedure at the Department of General Surgery, Mersin University Faculty of Medicine, within the last five years. Demographic data, pathological diagnoses, tumor stages, and preoperative laboratory parameters were recorded. PNI was calculated using the formula 10× albumin (g/dL) + 0.005× total lymphocyte count; AGR as albumin/(total protein-albumin); and CAR as CRP/albumin. Patients with available pathological stage information were considered to have adenocarcinoma. The associations between these indices and age groups, pathological diagnosis, and tumor stage were analyzed.

Results: The mean age of the patients was 62.9±11.9 years. Seventy patients (78.7%) were diagnosed with adenocarcinoma. Patients with adenocarcinoma had lower PNI values and higher CAR values compared to patients with other pathologies. In patients aged ≥70 years, PNI and AGR values were markedly lower, while CAR values were significantly higher.As pathological stage advanced, PNI values decreased and CAR values increased. Although AGR values were similar between adenocarcinoma and non-adenocarcinoma groups, a decreasing trend was observed in the elderly population. Low PNI and high CAR values were more pronounced in patients with advanced-stage disease, suggesting that increasing inflammatory burden adversely affects nutritional and immune status.

Conclusion: PNI, AGR, and CAR values were found to be associated with clinical and pathological characteristics in patients undergoing the Whipple procedure. Low PNI and high CAR, in particular, appear to be important indicators reflecting advanced disease burden and increased systemic inflammation. AGR may serve as a supportive parameter reflecting the patient's overall inflammatory and nutritional status rather than tumor biology. Incorporation of these indices into preoperative assessment may contribute to improved risk stratification and surgical management.

Keywords: Whipple procedure, PNI, CAR, AGR, pancreatic cancer, prognostic indices

Table 1. PNI, CAR, and AGR values according to pathological stage

Pathological stage	Number of patients (n)	PNI (mean ± SD)	CAR (mean ± SD)	AGR (mean ± SD)
Stage 1a	11	31.9±4.8	33.3±28.1	1.25±0.36
Stage 1b	13	33.0±5.1	24.7±23.0	1.29±0.47
Stage 2a	3	25.0±2.8	35.5±24.3	0.97±0.32
Stage 2b	26	33.4±5.5	23.3±19.7	1.36±0.38
Stage 3	13	35.8±7.5	24.2±22.0	1.22±0.42

PNI: Prognostic nutritional index, CAR: C-reactive protein-albumin ratio, AGR: Albumin-globulin ratio, SD: Standard deviation.

[P-295]

Clinicopathological features and surgical outcomes of incidental and non-incidental gallbladder adenocarcinoma: A retrospective study

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Objective: Gallbladder adenocarcinoma (GBC) is a rare malignancy with aggressive biological behavior and poor prognosis. Due to the absence of disease-specific clinical symptoms and the limited diagnostic sensitivity of radiological imaging, a substantial proportion of cases are diagnosed incidentally during histopathological examination of cholecystectomy specimens. Early diagnosis remains challenging, and surgical resection is the only potentially curative treatment option. This study aimed to evaluate the clinicopathological characteristics, diagnostic findings, and surgical management of patients with GBC, with particular emphasis on differences between incidental and non-incidental cases.

Material and Methods: This retrospective study included 48 patients diagnosed with GBC between 2015 and 2025 in Ankara Bilkent City Hospital. Patients were classified according to the mode of diagnosis as incidental GBC (n=28) and non-incidental GBC (n=20). Demographic data, clinical presentation, radiological findings, operative procedures, tumor localization, and pathological staging were recorded. Tumor staging was assessed according to the AJCC 8th edition. Comparative analyses were performed to identify differences in disease presentation and tumor stage between the two groups.

Results: The study cohort consisted of 32 women (66.7%) and 16 men (33.3%), with a mean age of 65.9 years. More than half of the patients were older than 65 years at diagnosis. Most patients presented with non-specific symptoms, and gallstones were present in 40 cases. Cholecystectomy alone was oncologically sufficient in 12 patients (25%), whereas additional hepatic resection was required in 25 patients (52.1%). Tumors were most frequently located in the fundus (27.1%), while multifocal or diffuse involvement was observed in 22.9% of patients. In the incidental GBC group, 81.4% of patients had early-stage tumors (T1-T2). In contrast, 85% of patients in the non-incidental GBC group, including inoperable cases, had advanced-stage disease (T3-T4).

Conclusion: GBC is frequently diagnosed incidentally due to the lack of specific clinical and radiological findings. Non-incidental cases are more commonly associated with advanced tumor stage and multifocal involvement. Careful preoperative evaluation is therefore essential for optimal surgical planning. Adequate surgical resection remains the only potentially curative treatment for GBC.

[P-296]

Comparison of the peritoneal cancer index, the morphological stage of the tumor, and cytology results detected by staging laparoscopy in gastric cancer, with the results after neoadjuvant chemotherapy and postoperative pathology results: A single-center experience with 89 patients

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Objective: Staging laparoscopy performed before neoadjuvant chemotherapy (CT) in gastric cancer;plays an important role in assessing peritoneal spread of the tumor, determining whether the tumor is T4, whether it has invaded the serosa, and enabling cytology work, thereby facilitating the detection of free tumor cells. This helps guide initial treatment and provides insight into the course of the disease. So, how much and how do these data change in patients after CT? Our study aimed to compare the PCI score determined before neoadjuvant CT, the morphological status of the tumor, and cytological data with the findings and pathologies after surgery following CT.

Material and Methods: Patients diagnosed with gastric adenocarcinoma at our center who require neoadjuvant CT are routinely evaluated with staging laparoscopy. In our study, patients scheduled for neoadjuvant CT and undergoing staging laparoscopy between January 1, 2022, and January 1, 2026, were retrospectively evaluated. During pre-CT laparoscopy, the PCI score was calculated, serosal invasion of the tumor was assessed, and peritoneal lavage cytology was obtained. Following neoadjuvant CT, patients were re-evaluated during surgery or repeat laparoscopy, and findings before and after CT were analyzed comparatively.

Results: In the pre-CT assessment, cytology positivity was detected in a certain proportion of patients, along with serosalinvasion and varying levels of PCI scores. In the evaluation performed after neoadjuvant CT, cytology negativity, regression of serosalinvasion, and changes in PCI scores were observed in a group of patients. However, it was noted that peritoneal disease persisted in another groupof patients. Overall, variable responses in peritoneal tumor burden were observed after CT. In conclusion, neoadjuvant CT may improve the response rate to subsequent treatment in patients with peritoneal metastasis.

Conclusion: Laparoscopic staging is becoming increasingly important in the management of patients diagnosed with gastric cancer. Peritoneal cytology after neoadjuvant CT may reveal changes in tumor serosal invasion and PCI scores. Our study specifically seeks to answer the question of what should be expected from neoadjuvant therapy at which point and in which patient group. The question of what these changes in PCI, cytology, and serosal invasion following neoadjuvant therapy correspond to in the final surgical pathology of patients remains relevant and requires further detailed evaluation.

Keywords: Stomach cancer, neoadjuvant chemotherapy, staging laparoscopy

[P-297]

Early feeding management after surgery and the role of the nurse: An integrative review

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Objective: Surgical interventions lead to a distinct metabolic stress response characterized by hypermetabolism and increased protein breakdown in the organism. Malnutrition that may develop during this physiological process is associated with clinically important outcomes such as delayed wound healing, increased risk of infection, and prolonged length of hospital stay in surgical patients. Enhanced recovery after surgery (ERAS) protocols developed in recent years recommend the initiation of early feeding within the first 24 hours after surgery in order to reduce the aforementioned adverse effects.

Material and Methods: In this review, it is aimed to present current evidence regarding post-operative early feeding practices, ESPEN (European Society for Clinical Nutrition and Metabolism) guidelines, and nursing interventions. Accordingly, the study was planned and conducted using the integrative review method. The literature search was performed in PubMed, ScienceDirect, and Google Scholar databases using the keywords “early feeding”, “nursing care”, “malnutrition”, “ERAS”, and “surgical”. No restriction was made in terms of study type; a total of 26 studies published between 2015-2025, with full text access, in English and Turkish were included in the review. The examined publications consist of systematic reviews, multicenter randomized controlled trials, observational data analyses, and meta-analyses.

Results: In the vast majority of the studies examined, it has been reported that post-operative early oral or enteral feeding is safe and does not increase the risk of anastomotic leakage. Furthermore, it is stated that early feeding ensures the onset of bowel motility (gas and stool passage) in an earlier period. Studies show that early feeding practices significantly reduce the length of hospital stay and health care costs; moreover, they provide positive effects on immune functions. Nurses have basic responsibilities within the multidisciplinary health team such as assessing nutritional risk with screening tools like NRS-2002, monitoring gastrointestinal tolerance (nausea, vomiting), maintaining enteral feeding tube care, and implementing interventions to prevent aspiration. However, in some studies, it is emphasized that nurses still maintain traditional long-term fasting approaches and that the need for education regarding current evidence-based protocols continues.

Conclusion: Early feeding in the post-operative period is an effective care approach supported by strong scientific evidence that reduces morbidity and improves patient outcomes. Increasing nurses’ knowledge and awareness levels regarding early feeding will play an important role in enhancing the quality of care by contributing to the effective transfer of evidence-based protocols into clinical practice.

Keywords: Early feeding, ERAS, nursing care

[P-298]

The effect of early enteral nutrition on clinical outcomes in surgical intensive care patients: An integrative review

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Objective: In surgical intensive care units (SICUs), inadequate nutritional support is associated with increased morbidity, prolonged hospitalization, infectious complications, and impaired wound healing. Early enteral nutrition (EEN), initiated within the first 24-48 hours of intensive care admission, has been recommended to preserve gut integrity, modulate immune response, and improve clinical outcomes. Despite growing evidence supporting early enteral feeding in critically ill patients, the effects of EEN specifically in surgical intensive care populations remain inconsistent across studies. This integrative review aimed to evaluate the effects of EEN on clinical outcomes in surgical intensive care patients.

Material and Methods: An integrative review methodology was used. A comprehensive literature search was conducted in PubMed, ScienceDirect, CINAHL, and Google Scholar databases using the keywords "EEN," "SICU", "critically ill patients," and "clinical outcomes." Studies published between 2005 and 2025, available in full text, and written in English or Turkish were included without restriction on study design. A total of 10 studies meeting the inclusion criteria were analyzed, including systematic reviews, meta-analyses, and clinical studies focusing on surgical intensive care populations.

Results: The reviewed studies demonstrated that EEN in surgical intensive care patients was associated with reduced infectious complications, shorter intensive care unit and hospital length of stay, and improved nutritional adequacy. Several studies reported a decrease in postoperative pulmonary complications and mortality rates among patients receiving EEN compared to delayed feeding. Additionally, EEN was shown to be well tolerated, with no significant increase in gastrointestinal intolerance or aspiration risk when appropriate patient selection and monitoring were applied. Most studies emphasized the importance of standardized feeding protocols and multidisciplinary collaboration to optimize

Conclusion: This integrative review indicates that EEN positively affects clinical outcomes in surgical intensive care patients. Initiating enteral feeding within the early phase of intensive care may reduce complications and support recovery. Nurse-led nutritional assessment and protocol-driven enteral feeding practices play a critical role in the successful implementation of EEN. Further randomized controlled studies focusing specifically on surgical intensive care populations are needed to strengthen the existing evidence.

Keywords: Early enteral nutrition, surgical intensive care unit, critically ill patients, clinical outcomes, nursing care

[P-299]

"More than a superficial finding? The relationship between seat belt injury and severe intra-abdominal trauma"

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Objective: Seat belt injury is an important clinical finding that may be associated with serious intra-abdominal injuries following blunt abdominal trauma. The aim of this study was to evaluate the clinical, radiological, and surgical characteristics of patients with seat belt injury and to assess the clinical course in this patient group.

Material and Methods: This study was conducted through a retrospective review of patients followed with a diagnosis of seat belt injury at the University of Health Sciences Türkiye, Ankara Etlik City Hospital General Surgery Clinic. Demographic data, clinical and laboratory findings at presentation, imaging results, need for surgical intervention, and clinical outcomes were evaluated based on patient medical records. The study was descriptive in nature, and no statistical comparisons were performed.

Results: A total of two patients with seat belt injury were included in the study. The median age was 71 years (IQR:68-74), and the sex distribution was equal; all patients were passengers in the vehicle. Although they were hemodynamically stable at presentation, admission lactate levels were markedly elevated (median 8.25 mmol/L; IQR:7.98-8.53), and free intraperitoneal fluid was detected in all cases. Imaging findings supported suspicion of intra-abdominal injury, with mesenteric injury and bowel wall thickening identified in half of the cases. Organ injury was present in all patients. Based on this clinical and radiological picture, all patients underwent surgical intervention, with the time to operation ranging from 4 to 6 hours; the amount of intra-abdominal bleeding was recorded as 500-600 cc. In the postoperative period, major complications developed in all cases, all required intensive care, and a fatal outcome was observed; the median length of hospital stay was 2.5 days (IQR: 2.25-2.75).

Conclusion: The literature reports that seat belt injury is a high-risk clinical marker, particularly for mesenteric and bowel injuries, and may be associated with increased morbidity and mortality due to delayed diagnosis even in hemodynamically stable patients. In our study, a severe clinical course was observed despite initial hemodynamic stability, accompanied by markedly elevated lactate levels, the presence of free intraperitoneal fluid on imaging, and extensive organ injuries. These findings support the notion that seat belt injury should not be regarded merely as a superficial sign of trauma, but rather as a potential harbinger of serious intra-abdominal injuries. In patients with seat belt injury, close clinical monitoring, low-threshold advanced imaging, and prompt surgical consultation are of vital importance. Our study represents a case series consistent with the literature, emphasizing seat belt injury as an indicator of severe trauma and generating hypotheses for future studies.

Keywords: Blunt abdominal trauma, intra-abdominal injury, mesenteric injury, seat belt injury, trauma surgery

Table 1. Demographic and clinical characteristics of patients with seat belt injury (n=2)

Parametre	Değer
Hasta sayısı	2
Yaş, yıl – medyan [IQR]	71,0 [68,0–74,0]
Cinsiyet	Erkek: 1 (%50) Kadın: 1 (%50)
BKİ (kg/m²) – medyan [IQR]	26,0 [25,0–27,0]
Sürücü / Yolcu durumu	Yolcu: 2 (%100)
Hemodinamik durum (stabil)	2 (%100)
Başvuru laktat düzeyi (mmol/L) – medyan [IQR]	8,25 [7,98–8,53]
Batında serbest sıvı varlığı	2 (%100)
Mezenterik yaralanma	1 (%50)
Barsak duvarında kalınlaşma	1 (%50)
Organ yaralanması	2 (%100)
İntraperitoneal kanama miktarı (cc) – medyan [IQR]	550 [525–575]
Hastanede yatış süresi (gün) – medyan [IQR]	2,5 [2,25–2,75]
Yoğun bakım ihtiyacı	2 (%100)

Table 2. Surgical findings and postoperative clinical outcomes

Parametre	Değer
Cerrahi uygulanan hasta sayısı	2 (%100)
Operasyon tipi	Tip 2: 1 (%50) Tip 3: 1 (%50)
Operasyona kadar geçen süre	4 saat, 6 saat
Majör komplikasyon gelişimi	2 (%100)
Relaparotomi gereksinimi	0
Mortalitenin varlığı	2 (%100)

Table 3. Summary of key clinical indicators associated with severe clinical course

Clinical indicator	Findings
Seatbelt finding	100%
Free fluid in the abdomen	100%
High referral lactate level (>8 mmol/L)	100%
Organ injury	100%
Need for surgery	100%
Need for intensive care	100%
Mortal clinical course	100%

[P-300]

Unexpected histopathological findings in appendectomy specimens: Analysis of Ordu University Training and Research Hospital

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Objective: Acute appendicitis (AA) is the most frequently performed emergency abdominal surgical procedure worldwide. While the primary pathogenesis involves luminal obstruction due to fecaliths or lymphoid hyperplasia, rare infectious, inflammatory, or neoplastic conditions may also lead to AA. This study aims to analyze the pathological results and unexpected findings of patients operated on with a diagnosis of AA at Ordu University Training and Research Hospital.

Material and Methods: The data of 337 patients who underwent emergency surgery for AA at Ordu University Training and Research Hospital, Department of General Surgery, between January 2020 and January 2026 were retrospectively reviewed. Patient demographics (age, gender) and histopathological reports were analyzed. Findings such as mucinous neoplasms, adenocarcinoma, parasitic infections, and endometriosis were categorized as "unexpected findings."

Results: Of the 337 patients, 218 (64.7%) were male and 119 (35.3%) were female, with a mean age of 38.8 years. Unexpected pathological results were detected in 10 patients (3%). The mean age of patients with unexpected findings (48.5 years) was significantly higher than the overall appendectomy group (p=0.012). The distribution of unexpected findings was as follows: Low-grade appendiceal mucinous neoplasia in 5 patients (1.57%), endometriosis in 2 patients (0.52%), adenocarcinoma in 1 patient (0.26%), Enterobius vermicularis in 1 patient (0.13%), and granulomatous inflammation in 1 patient (0.13%).

Conclusion: Although the most common causes of AA are lymphoid hyperplasia and fecaliths, neoplastic and non-inflammatory etiologies should be considered, especially in older patients. Routine histopathological examination of all appendectomy specimens is essential, regardless of whether they appear macroscopically normal, to ensure patients receive correct follow-up treatments such as chemotherapy or oncological surgery.

Keywords: Acute appendicitis, appendectomy, appendiceal neoplasms, histopatolological examination, unexpected pathological findings

[P-301]

Beyond acute appendicitis: Unexpected histopathological findings in appendectomy specimens- a four-year single-center experience

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Objective: Acute appendicitis is one of the most common causes of emergency abdominal surgery, and appendectomy remains the standard treatment. However, the necessity of routine histopathological examination of appendectomy specimens is still controversial. Appendices that appear macroscopically normal or simply inflamed may harbor clinically significant and unexpected pathologies that cannot be predicted preoperatively. In particular, neoplastic and premalignant lesions can only be diagnosed through histopathological evaluation, and their early detection is crucial for appropriate postoperative management and prognosis. This study aimed to evaluate the incidence, spectrum, and clinical impact of unexpected histopathological findings other than acute appendicitis in appendectomy specimens.

Material and Methods: This retrospective, single-center cohort study included adult patients (≥18 years) who underwent appendectomy for presumed acute appendicitis between January 2021 and December 2024. Patients with known malignancy, those who underwent interval appendectomy, incidental appendectomy during unrelated surgical procedures, or cases with missing histopathological data were excluded. Demographic characteristics, surgical approach, and histopathological findings were retrospectively analyzed. All pathological findings other than acute appendicitis were classified as incidental pathology.

Results: A total of 2.010 appendectomy specimens were evaluated, and incidental pathological findings other than acute appendicitis were identified in 33 cases (1.64%). The most frequent lesions were neuroendocrine neoplasms (n=12, 0.6%) and mucinous neoplasms (n=9, 0.45%). Patients with incidental pathology were significantly older and more frequently female compared with the overall cohort (p<0.05). All patients with neoplastic or premalignant lesions required additional postoperative evaluation, including imaging, colonoscopy, or oncological consultation, leading to changes in follow-up strategies.

Conclusion: Although unexpected histopathological findings in appendectomy specimens are relatively uncommon, they may have significant clinical implications. Routine histopathological examination enables early detection of lesions that cannot be identified by macroscopic assessment alone and that may directly influence postoperative management and surveillance. Therefore, routine histopathological evaluation of all appendectomy specimens should be maintained to ensure patient safety and optimal clinical outcomes.

Keywords: Acute appendicitis, appendectomy, ıncidental pathology, mucinous neoplasm, neuroendocrine neoplasm

[P-302]

General surgery consultations in a newly established city hospital: A first-year descriptive study

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Objective: Defining the consultation workload and service profile of general surgery clinics during the early period of newly established city hospitals is important for effective healthcare planning. In this study, we aimed to evaluate the distribution and characteristics of consultations requested from the General Surgery Clinic of Antalya City Hospital during its first year of operation.

Material and Methods: This descriptive study retrospectively reviewed consultations requested from the general surgery clinic between April 2024 and April 2025, following the opening of Antalya City Hospital. The source of consultations (emergency department, inpatient wards, or intensive care unit) was recorded. Consultation numbers were evaluated on a monthly basis to identify changes in workload over time.

Results: During the study period, a total of 3.674 consultations were evaluated by the general surgery clinic. Of these, 2.441 consultations (66.4%) originated from the emergency department. Monthly analysis demonstrated that the proportion of emergency department-based consultations ranged between 61% and 70% throughout the study period. While this proportion remained relatively stable, a noticeable increase in the total number of consultations was observed toward the end of 2024 and into early 2025. The majority of surgical interventions performed were appendectomy and diagnostic laparotomy related to perforation or trauma.

Conclusion: In newly established city hospitals, a substantial proportion of general surgery consultations originate from the emergency department, and the overall service workload increases significantly over time. This evaluation indicates that the interaction between the emergency department and general surgery, as well as the growing consultation burden, should be taken into account at an early stage in workforce planning, bed capacity management, and operating room organization. In addition, the allocation of an on-call general surgeon within the emergency department may also be considered.

Keywords: General surgery, consultation, emergency department, workload, retrospective descriptive study

[P-303]

A rare indication for emergency breast surgery

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Objective: Emergency breast surgery is a very rare condition in the management of breast malignancies. In this report, we present a patient who required emergency surgery due to tumor progression and bleeding despite receiving neoadjuvant chemotherapy.

Material and Methods: A 61-year-old female patient with a diagnosis of breast carcinoma, who had been receiving active chemotherapy at in a different hospital for 5 months, presented to our clinic because of an increase in tumor size and bleeding within the last week despite chemotherapy. Physical examination at admission revealed a fragile, partially ulcerated, and bleeding lesion with infectious looking surface, measuring approximately 20 cm in diameter on the anterior surface of the left breast, demonstrating an expansile growth pattern and a polypoid appearance. In addition, multiple hard, conglomerated lymph nodes fixed to the surrounding tissues were palpated in the left axillary region. Laboratory evaluation at admission revealed normocytic anemia. Positron Emission Computed tomography performed at presentation showed no evidence of distant metastasis.

Results: The patient underwent surgery the following day. Wide resection of the left breast including surrounding tissues and left axillary dissection were performed. The skin defect resulting from the resection was reconstructed using a split-thickness skin graft harvested from the anterolateral aspect of the left thigh. The postoperative course was uneventful, and the patient was discharged on postoperative day 2. Histopathological examination revealed metaplastic carcinoma; 8 cm raised from the skin and 20x8x12 cm in dimensions. The tumor consisted of 40% invasive ductal carcinoma and 60% undifferentiated pleomorphic sarcoma. Receptor status was negative for estrogen and progesterone receptors. The HER2 receptor score was +2, and fluorescence *in situ* hybridization analysis was pending. Additionally, 14 metastatic lymph nodes were identified in the axillary dissection specimen, all demonstrating extracapsular extension.

Conclusion: In this patient, due to tumor progression despite chemotherapy and uncontrollable bleeding and infection, emergency surgery was planned, and curative surgery was considered because there was no extramammarian involvement. Emergency surgical intervention in breast cancer is a rare occurrence; however, it should be considered as a treatment option in cases where chemotherapy is ineffective.

Keywords: Breast cancer, emergency surgery, pleomorphic sarcoma

Figure 1. A fragile, 20 cm diameter lesion exhibiting an expansive growth pattern and growing in a polypoid shape, originating from the anterior surface of the left breast, with areas of ulceration and bleeding.

Figure 2. The skin defect created after the resection was closed with a split-thickness skin graft taken from the anterolateral surface of the left leg.

[P-304]

The relationship between medical genetic screening and surgery in patients with familial Mediterranean fever (FMF)

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Objective: Familial Mediterranean fever (FMF) is a chronic autoinflammatory disease characterized by recurrent fever and serous inflammation attacks. FMF, recurrent fever and serositis (for example, peritonitis, pleurisy, pericarditis, synovitis) or erysipelas-like erythema attacks are characterized. Mediterranean fever (MEFV) is associated with mutations in the gene. In this study, we investigated genetic mutations in FMF patients and the effects of these mutations on BT symptoms and surgical outcomes in patients presenting to the emergency department with abdominal pain. In this way, we aimed to show that early medical genetic screening/diagnosis in FMF patients can reduce emergency hospital admissions and surgery.

Material and Methods: This study included 171 patients with MEFV gene mutations among 239 patients who presented to the medical genetics outpatient clinic of University of Health Sciences Türkiye, Bağcılar Training and Research Hospital and underwent MEFV gene mutation testing between January 1, 2021, and December 31, 2024. The genetic mutations in patients with MEFV gene mutations and the relationship between these mutations and the presentation to the emergency room, CT findings, and surgical history of patients presenting with abdominal pain were investigated.

Results: Of 240 patients examined for MEFV gene mutations, 171 patients with MEFV gene mutations were examined. A statistically significant difference was found between the number of mutations and CT findings ($p>0.05$). A statistically significant relationship was found between CT findings and surgical status ($p<0.05$). A significant relationship was found between the number of surgical cases and the number of emergency visits ($p<0.05$). The rate of ACMG class: VUS in patients with CT findings was statistically significantly higher than the rate of ACMG class: VUS in patients without CT findings ($p<0.05$).

Conclusion: The presence of CT findings plays a significant role in patients undergoing surgery. There is a correlation between emergency hospital admissions and surgically treated patients. The VUS variant is closely related to CT findings. In conclusion, our study did not find a significant difference between genetic mutations and emergency hospital admissions due to abdominal pain. However, CT findings are indicative of emergency hospital admissions due to abdominal pain in FMF patients. A statistically significant difference was found between the number of mutations and CT findings ($p<0.05$); while CT findings were more prevalent in those with a single mutation, the lower rate in those with two mutations is noteworthy. One case with four mutations had CT findings.

Keywords: Familial Mediterranean fever, genetic mutation, emergency admission

[P-305]

Clinical characteristics and treatment approaches of patients presenting to the emergency department due to rectal foreign bodies: A single-centre experience

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Objective: Patients presenting to the emergency general surgery department due to rectal foreign bodies, although rare, represent a group with important clinical decision points during diagnosis and treatment. This study aimed to descriptively evaluate the demographic, clinical, diagnostic and treatment-related characteristics of cases presenting to the General Surgery Clinic of University of Health Sciences Türkiye, Ankara Etlik City Hospital due to rectal foreign bodies.

Material and Methods: In this single-centre retrospective study, the records of patients evaluated as emergency cases due to rectal foreign bodies at the General Surgery Clinic of University of Health Sciences Türkiye, Ankara Etlik City Hospital were reviewed. Demographic data (age, sex); presentation time and symptoms; type and size of the foreign body; prior attempts at removal at home/outside the hospital; use of computed tomography (CT) and presence of perforation/free air; treatment method (manual, endoscopic or surgical); need for anaesthesia/sedation; complications; and length of hospital stay were recorded and summarised using descriptive statistics.

Results: A total of 9 patients presenting with rectal foreign bodies were included. All were male, with a mean age of 56±21.5 years (26-92). Sixty-six point seven per cent presented within 24 hours and 33.3% after more than 24 hours. The most common symptoms were pain (44.4%) and difficulty defecating (33.3%); 22.2% presented with bleeding. Foreign bodies were ≥10 cm in 77.8%. Plastic (44.4%) and glass (44.4%) were the most frequent materials; one case (11.1%) involved an organic object. Twenty-two point two per cent had a history of attempted removal at home or at an external centre prior to presentation. CT was performed in 55.6% and no perforation or free air was detected. Manual removal was performed in 33.3%, while surgery was required in 66.7%. Anaesthesia or sedation was required in 66.7%. No complications occurred. Mean hospital stay was 2.7±1.2 days (median 3 days).

Conclusion: The literature emphasises that management varies by case; foreign body size, delay in presentation and tissue injury findings are key factors determining the need for surgery and morbidity. In our study, consistent with the large size of most foreign bodies, the surgical requirement was high; however, no perforation or complications were observed. This suggests morbidity can be kept low with appropriate patient assessment and timely implementation of a stepwise treatment approach, and short hospitalisation indicates safe and effective clinical management.

Keywords: Rectal foreign body, emergency general surgery, stepwise treatment

Figure 1. ADBG.

ADBG: Standing plain abdominal X-ray demonstrating the rectal foreign body.

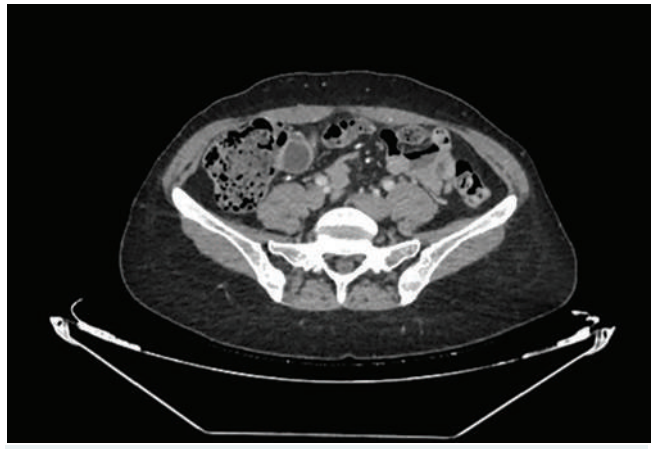

Figure 2. CT.

CT: Computed tomography.

Table 1. Descriptive characteristics of patients presenting with rectal foreign bodies (n=9)

Parameter	Value
Age (years)	56±21.5 (min-max: 26-92)
Gender	Male: 9 (100%)
Application period	≤24 hours: 6 (66.7%) >24 hours: 3 (33.3%)
Application symptom	Pain: 4 (44.4%) Bleeding: 2 (22.2%) Difficulty defecating: 3 (33.3%)
Foreign body type	Plastic: 4 (44.4%) Glass: 4 (44.4%) Vegetable/organic: 1 (11.1%)
Foreign object size	≥10 cm: 7 (77.8%) <10 cm: 2 (22.2%)
Attempted removal at home/outside the hospital	Present: 2 (22.2%) No: 7 (77.8%)
CT scan	Performed: 5 (55.6%) Not performed: 4 (44.4%)
Perforation/free air	None: 9 (100%)
Treatment method applied	Manual: 3 (33.3%) Surgical: 6 (66.7%)
Anaesthesia/sedation requirement	Yes: 6 (66.7%) No: 3 (33.3%)
Complications	None: 9 (100%)
Hospitalisation duration (days)	2.7±1.2 (median: 3)
Surgical requirement	Present: 6 (66.7%) No: 3 (33.3%)

CT: Computed tomography.

Table 2. Comparison of our study with the current literature

Study	n	Age (years)	Male (%)	Surgical intervention/ laparotomy (%)	Perforation (%)	Complications (%)	Length of stay
Our series (University of Health Sciences Türkiye, Ankara Etlik City Hospital)	9	56±21.5	100	66.7	0	0	2.7±1.2 days (median 3)
Süleyman et al., 2021 (Turk J Colorectal Dis)	12	Not reported	Not reported	16.7 laparotomy (2/12)	8.3 (1/12)	0 (no morbidity)	Not reported
Bisgin et al., 2023 (Turkish Journal of Trauma and Emergency Surgery)	2	Not reported	Not reported	19 Hartmann (4/21)	Not reported	9.5 (Clavien-Dindo III-IV)	Median 6 days (1-34)
Gemici et al., 2025 (Cumhuriyet Medical Journal)	15	Mean 33.1	100	≈40.0 laparotomy (5/15 milking + 1/15 colotomy)	Not reported	0	Not reported
Ploner et al., 2020 Systematic review + meta-analysis	54 articles	Not reported	Male/female ≈6:1	Not reported	Not reported	Total complications 30.4	Not reported

[P-306]

Necessity of imaging modalities in patients consulted for acute abdomen: A 10-year single-center experience

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Objective: This study aimed to evaluate the frequency and necessity of imaging modalities and the distribution of surgical pathologies in patients consulted from the emergency department to the general surgery clinic with a preliminary diagnosis of acute abdomen, and to emphasize the role of clinical evaluation in acute abdomen management.

Material and Methods: In this retrospective study, patients evaluated in the emergency department and consulted to the general surgery clinic with suspected acute abdomen between January 1, 2025, and December 31, 2025, were analyzed. Demographic characteristics, imaging modalities, hospitalization status, and clinical diagnoses were obtained from the hospital database. Clinical and radiological data of 2524 patients were evaluated. The results were compared with our similar study conducted at our institution 10 years earlier.

Results: The mean age was 54.9 years; 1381 patients (54.7%) were male and 1143 (45.3%) were female. CT was performed in 2296 patients (90.9%), ultrasonography in 1208 patients (47.9%), and both modalities in 980 patients (38.8%). Additionally, 1316 patients (52.1%) were evaluated directly with CT without prior ultrasonography based on clinical assessment. Advanced imaging such as MRCP was performed in 23 patients (0.9%), and repeat CT imaging during the same admission occurred in 27 patients (1.1%). Following surgical evaluation, 1948 patients (77.2%) were hospitalized. The most common diagnoses were ileus (552, 21.9%), acute appendicitis (484, 19.2%), acute cholecystitis (376, 14.9%), acute pancreatitis (208, 8.2%), incarcerated hernia (164, 6.5%), gastrointestinal perforation (48, 1.9%), and trauma (114, 4.5%; including stab wounds, firearm injuries, traffic accidents, falls, and burns). Patients not requiring admission were primarily diagnosed with non-specific abdominal pain, urinary tract infections, biliary colic, and gynecological pathologies.

Conclusion: Nearly 9 out of 10 patients underwent CT imaging, indicating extensive reliance on imaging. In surgical conditions such as incarcerated hernia and acute appendicitis, careful history and physical examination remain fundamental. Despite structural improvements in emergency services, CT utilization remains remarkably high. Similar findings to our 2017 study suggest no substantial improvement in acute abdomen evaluation. Surgical decision-making must rely primarily on clinical assessment, imaging should be selectively used, and advanced imaging before surgical evaluation should be restricted. Management of emergency departments by general surgeons should also be reconsidered.

Keywords: Acute abdomen, computed tomography, emergency department

[P-307]

Our electric arc burn cases in the last two years

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Objective: Electric arc burns are burns caused by the sudden release of energy from devices such as high-energy transformers due to faulty equipment or short circuits. Besides the blast effect of electrical energy, contact burns, flame burns due to clothing catching fire, and, worst of all, inhalation burns which involve respiratory damage, can also occur.

Material and Methods: Between January 1, 2024, and January 1, 2026, 18 cases treated at our Burn Center were evaluated in terms of age, gender, burn percentage, burn location, inhalation injury, presence of compartment syndrome, use of biodegradable temporary matrix (BTM), percentage of escharectomy and graft number, significant complications, mortality, intensive care unit stay, hospital stay, and abbreviated burn injury scale (ABSI) score.

Results: The mean age of the nineteen cases was 29.8 (16-53) and all were male. Burn percentages were 33.1% (7-75%), with head and neck burns in 11 (57.8%) cases, trunk burns in 15 (83.3%) cases, and extremity burns in 17 (94.4%) cases. Five (27.7%) cases had inhalation burns, and six (33.3%) cases had compartment syndrome. Seventeen (94.4%) cases underwent an average of 3.05 (1-8) escharectomy sessions, and 14 (77.7%) cases underwent an average of 1.8 (1-4) grafting sessions. Four (22.2%) cases required btm (body transplantation). The mean hospital stay was 30.1 (5-85) days. The need for intensive care was observed in 15 (83.3%) cases, and the average intensive care stay was calculated as 14.3 (1-67) days. Intubation was required in 7 (41.1%) cases, and these cases remained intubated for 19.2 (8-53) days. The average ABSI values were 7.1 (2-12). Mortality occurred in two (11.1%) cases.

Conclusion: Arc burns, while having effects similar to contact electrical burns, burn large surfaces due to blast effect. Inhalation burns and compartment syndrome are common, and the morbidity is quite high. Even in burn centers, these cases are complicated, with high ABSI scores and associated mortality. If possible, patients should be immediately referred after stabilization is achieved.

Table 1. Casting of electric arc burns

	Case n	Percentage %
Absi	18	7.11
Inhalation injury	5	27.7
Compartment	6	33,3
Btm	4	22,2
Intensive care	15	83.3
Intubation	6	33.3
Mortality	2	11.1

[P-353]

Early clinical experience with microwave energy ablation in simple anal fistula: A 20-patient case series

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Objective: Anal fistula treatment aims to eradicate sepsis while preserving continence. Conventional sphincter-sparing techniques often require seton placement and prolonged wound care. Microwave energy ablation (MEA) is a novel minimally invasive technique that induces controlled thermal destruction of the fistula tract. This study presents our initial clinical experience with MEA in simple anal fistulas.

Material and Methods: Twenty consecutive patients diagnosed with intersphincteric or low transsphincteric anal fistula underwent MEA. All procedures were performed under regional anesthesia in the lithotomy position. After identification of the external and internal openings, a microwave probe was introduced into the fistula tract, and circumferential thermal ablation was applied along the entire tract. The internal opening was subsequently sealed using focused microwave coagulation. No seton placement or sphincter division was performed in any patient. Patients were followed for three months, and postoperative pain (VAS), wound healing, discharge, recurrence, continence status, operative time, and hospital stay were recorded retrospectively.

Results: Twenty patients underwent MEA for a simple anal fistula. The mean operative time was approximately 5-10 minutes, and all patients were discharged after a one-day hospital stay. Postoperative pain was low and progressively decreased during follow-up (VAS 3-4 at week 1, 2-3 at month 1, and approximately 2 at month 3). Complete wound healing was achieved within 2-3 months in the majority of patients. Only one recurrence was observed during follow-up. This patient was found to have a previously unrecognized secondary fistula tract associated with abscess formation. No intraoperative or postoperative complications occurred, and no deterioration in continence was detected in any patient.

Conclusion: MEA appears to be a safe and feasible sphincter-preserving treatment for simple anal fistulas, providing minimal postoperative pain and a short operative time. Early recurrence was rare and was associated with an unrecognized secondary tract and abscess formation, highlighting the importance of careful preoperative tract evaluation.

Keywords: Anal fistula, microwave ablation, sphincter preserving treatment

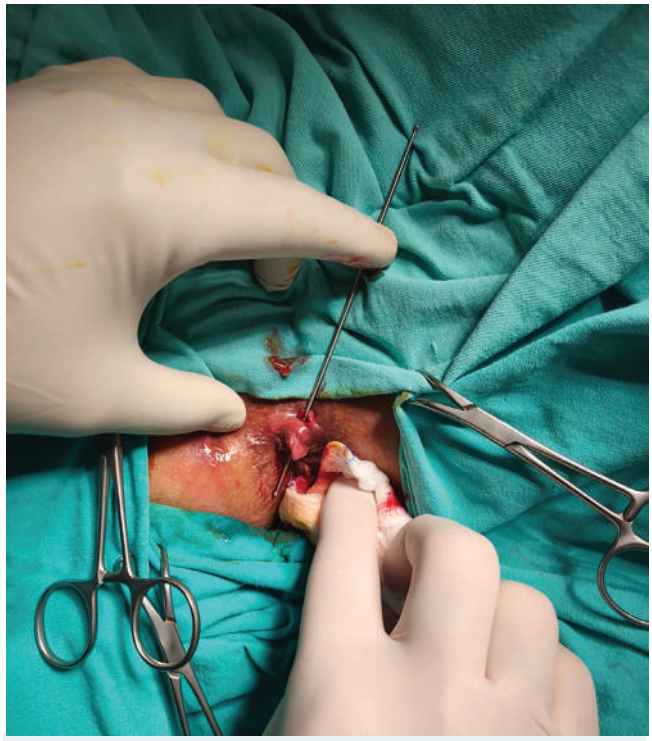

Figure 1. Recurrent case: Intraoperative identification of the primary fistula tract using a stylet probe.

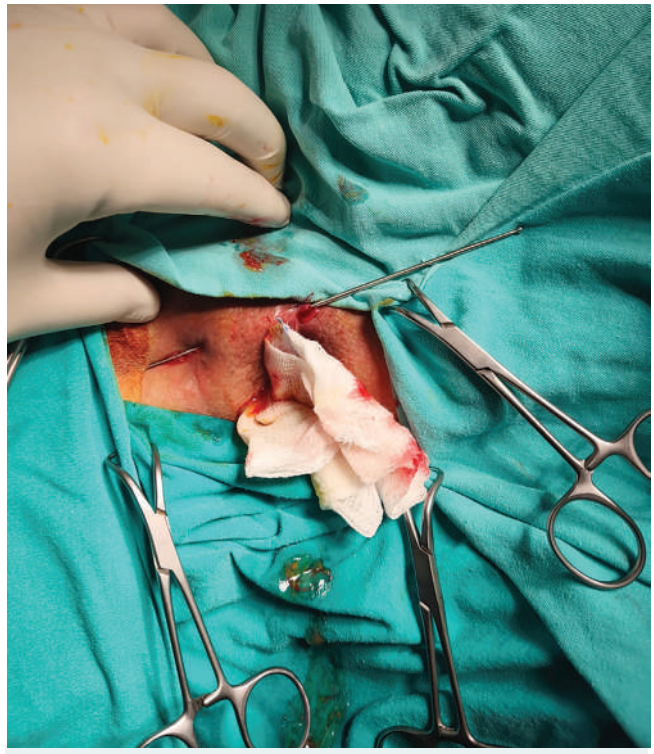

Figure 2. Recurrent case: Secondary fistula tract associated with abscess formation.

[P-354]

Factors affecting survival in metaplastic breast cancer: A single-center experience

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Objective: Metaplastic breast cancer (MBC) is a rare subtype of breast cancer characterized by the presence of both epithelial and mesenchymal components. It is known to exhibit a more aggressive clinical course and worse prognosis compared to other breast cancer subtypes. This study aimed to evaluate the clinical, pathological, and prognostic characteristics of patients with MBC who underwent surgery at our institution.

Material and Methods: Between 2017 and 2023, 31 patients diagnosed with MBC were identified. Three patients lost to follow-up were excluded, leaving 28 patients for retrospective analysis. Demographic characteristics, preoperative imaging findings, pathological data, molecular subtypes, surgical procedures, adjuvant therapies, and oncological outcomes were evaluated.

Results: All 28 patients were female, with a mean age of 55.1±16.1 years. The mean follow-up duration was 51.2±31.7 months. The tumor was located in the left breast in 17 (60.7%) patients and in the right breast in 11 (39.3%) patients. The most common tumor location was the upper outer quadrant (14 patients, 50%). At the time of diagnosis, 5 (17.9%) patients presented with ulcerated tumors. Preoperative staging revealed multicentric disease in 5 (17.9%) patients, axillary lymph node metastasis in 10 (35.7%) patients, and distant metastasis in 8 (28.6%) patients. The mean tumor size was 64.4±73.3 mm. A significant association was found between tumor size and disease-related mortality (114.2 mm vs. 64.4 mm, p=0.002). In patients with tumor diameter ≥4 cm, rates of disease progression (recurrence and metastasis) (60% vs. 23.1%) and mortality (60% vs. 7.7%) were significantly higher than in those with tumors <4 cm (p=0.048 and p=0.003, respectively). Regarding molecular subtypes, 3 (10.7%) patients were classified as Luminal, 7 (25%) patients as HER2-positive, and 18 (64.3%) patients as Triple-negative. Ki-67 proliferation index was >20% in all patients, with a mean value of 68.3±24.3%. E-cadherin expression was positive in 8 (28.6%) patients. Axillary metastatic lymph nodes were detected in 13 (46.4%) patients. No significant association was found between molecular subtypes, E-cadherin status, axillary lymph node metastasis, or Ki-67 index and disease progression or mortality. The presence of an ulcerated tumor was identified as an independent and strong poor prognostic factor for both local recurrence (80%) and mortality (100%) (p=0.002). During follow-up, disease progression occurred in 42.9%, locoregional recurrence in 35.7%, distant metastasis in 10.7%, and disease-related mortality in 35.7% of patients.

Conclusion: MBC exhibits an aggressive clinical behavior. Large tumor size and the presence of tumor ulceration are particularly associated with poor prognosis. Early diagnosis is of critical importance in improving survival outcomes in MBC patients.

Keywords: Breast cancer, metaplastic cancer, survival

[P-355]

Clinicopathological impact of MiNEN in gastric neuroendocrine neoplasms: A single-center experience

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Objective: Gastric neuroendocrine neoplasms (NENs) represent a heterogeneous group ranging from well-differentiated neuroendocrine tumors to high-grade neuroendocrine carcinomas (NECs). Tumors containing both neuroendocrine and non-neuroendocrine components are classified by the World Health Organization as mixed neuroendocrine-non-neuroendocrine neoplasms (MiNEN). MiNENs are considered to demonstrate more aggressive biological behavior compared with conventional NENs. However, comparative clinicopathological data in gastric cases remain limited. This study aimed to compare the clinicopathological characteristics of gastric NEN and MiNEN cases in our institutional series.

Material and Methods: Patients diagnosed with gastric neuroendocrine neoplasms between 2015 and 2025 were retrospectively reviewed. Pathology reports were converted into a structured dataset. Cases were classified as MiNEN when both neuroendocrine and non-neuroendocrine components were identified, and as non-MiNEN gastric NEN when only a neuroendocrine component was present. Groups were compared in terms of age, maximum tumor diameter, Ki-67 proliferation index, p53 percentage, total and metastatic lymph node counts, and recorded tumor grade. Continuous variables were expressed as median (IQR) and analyzed using non-parametric tests. Categorical variables were evaluated using chi-square or Fisher's exact tests. A p-value <0.05 was considered statistically significant.

Results: A total of 19 gastric cases were analyzed; 15 (78.9%) were non-MiNEN NEN and 4 (21.1%) were MiNEN. There was no statistically significant difference in age between groups [MiNEN: 72.5 (65.5-76.5) years vs. NEN: 63.0 (59.0-72.5) years; p=0.365]. Maximum tumor diameter was similar [MiNEN: 4.05 (2.98-6.25) cm vs. NEN: 3.05 (2.00-5.63) cm; p=0.337]. Although the Ki-67 proliferation index was higher in the MiNEN group, the difference did not reach statistical significance [60.0 (50.0-62.5) vs. 12.0 (5.0-55.0); p=0.191]. Likewise, p53 percentage was higher in MiNEN cases but without significance [40.0 (22.5-52.5) vs. 0.0 (0.0-6.2); p=0.204]. The total number of retrieved lymph nodes was comparable between groups [26.0 (18.5-36.0) vs. 24.0 (11.5-30.5); p=0.652]. However, metastatic lymph nodes were significantly higher in the MiNEN group [6.5 (4.5-10.0) vs. 0.0 (0.0-2.5); p=0.009]. Tumor grade distribution differed significantly (p=0.034); all MiNEN cases were recorded as NEC, whereas the non-MiNEN group showed a heterogeneous distribution of G1, G2, G3, and NEC cases.

Conclusion: In this single-center gastric series, MiNEN cases were associated with a significantly higher metastatic lymph node burden compared to non-MiNEN gastric NENs. Although no significant differences were observed in age, tumor size, Ki-67, or p53, the increased nodal metastasis suggests more aggressive biological behavior in MiNEN. Careful pathological evaluation for a MiNEN component is essential for accurate classification and appropriate surgical management.

Table 1. Clinicopathological distribution according to tumor grade and MiNEN status in gastric NEN

Variable	Grade 1 (n=3)	Grade 2 (n=7)	Grade 3 (n=2)	NEK (n=3)	MiNEN (n=4)	p
Age (years)	76.0 (74.0-76.0)	63.0 (52.0-66.5)	68.5 (65.8-71.2)	63.0 (59.0-64.0)	72.5 (65.5-76.5)	0.365
Sex (M/F)	0/3	6/1	0/2	2/1	4/0	0.245
Max tumor size (cm)	4.8 (2.7-7.0)	3.5 (2.0-4.0)	4.0 (3.0-5.0)	2.6 (2.4-5.9)	4.0 (3.0-6.2)	0.337
Ki-67 (%)	12.0 (6.0-36.0)	6.0 (4.0-8.5)	35.0 (35.0-35.0)	80.0 (75.0-80.0)	60.0 (50.0-62.5)	0.191
p53 (%)	0.0 (0.0-40.0)	0.0 (0.0-0.0)	2.5 (1.2-3.8)	5.0 (2.5-7.5)	40.0 (22.5-52.5)	0.204
Total LN (n)	1.0 (0,5-17.0)	19.0 (12.0-26.5)	23.0 (18.0-28.0)	25.0 (24.5-32.0)	26.0 (18.5-36.0)	0.652
Metastatic LN (n)	0.0 (0.0-0.0)	0.0 (0.0-3.5)	1.5 (0.8-2.2)	1.0 (0.5-2.0)	6.5 (4.5-10.0)	0.009

Continuous variables are presented as median (interquartile range, IQR). Categorical variables are expressed as counts. Between-group comparisons were performed using appropriate non-parametric tests for continuous variables and chi-square or Fisher's exact test for categorical variables. A p-value <0.05 was considered statistically significant. LN: Lymph node, NEC: Neuroendocrine carcinoma, MiNEN: Mixed neuroendocrine–non-neuroendocrine neoplasm.

[P-356]

Surgical management of Mirizzi syndrome type Va: A single-center experience

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Objective: Although Mirizzi syndrome is rare, the presence of a cholecystoenteric fistula in Type Va cases, along with challenging hepatocystic anatomy and an increased risk of bile duct injury, makes surgical management particularly complex. This study aimed to evaluate the diagnostic process, surgical approach, and short-term outcomes of Mirizzi Type Va cases based on our high-volume single-center experience.

Material and Methods: A total of 2,300 cholecystectomy cases performed at our center were retrospectively reviewed. Patients diagnosed with Type Va Mirizzi syndrome according to the Csendes classification were included in the study. Demographic characteristics, preoperative imaging modalities, timing of diagnosis (preoperative/intraoperative), fistula type, surgical approach, operative techniques applied, and postoperative outcomes were analyzed. Morbidity, mortality, and length of hospital stay were evaluated.

Results: Cholecystoenteric fistula consistent with Mirizzi Type Va was identified in 9 patients (0.39%). The median age was 61 years (min 39-max 75), and 55.6% of the patients were female. The cholecystoenteric fistula involved the duodenum in 6 cases and the colon in 3 cases. Diagnosis was established preoperatively in 22.2% of patients and intraoperatively in 77.8%. Surgery was initiated laparoscopically in 8 patients, with conversion required in 4 cases; primary open surgery was performed in 1 patient. Fistula repair varied according to surgeon preference, with double-layer primary repair ± omentopexy being the most commonly applied technique for duodenal fistulas (44.4%). Stapled wedge resection was performed in 2 cases (22.2%). In patients with colonic fistula, treatment consisted of right hemicolectomy (11.1%), primary repair (11.1%), and clip closure (11.1%). Postoperative morbidity developed in one patient (11.1%), presenting as biliary drainage from the surgical drain on postoperative day 1, which resolved spontaneously. One mortality related to cardiac morbidity was observed. The median length of hospital stay was 7 days.

Conclusion: Mirizzi Type Va syndrome is a condition that is most often recognized intraoperatively and requires a high level of surgical expertise for proper management. Since achieving the "critical view of safety" is frequently not feasible in these cases, early awareness and timely implementation of alternative surgical strategies are crucial to prevent bile duct injuries. Although a laparoscopic approach may be feasible in selected patients, the surgical strategy should be determined flexibly according to intraoperative findings.

[P-357]

Clinical and oncological outcomes of the standardized approach in gastrointestinal stromal tumor surgery at Cerrahpaşa Faculty of Medicine after 11 years

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Objective: Gastrointestinal stromal tumors (GISTs) are the most common mesenchymal tumors of the gastrointestinal system, exhibiting a heterogeneous spectrum of clinical behavior. Currently, surgical resection forms the basis of curative treatment, and a negative surgical margin (R0) is considered the most important prognostic factor for long-term survival. Surgical technique, patient selection, and a multidisciplinary approach directly influence oncological outcomes. In this study, the clinical and oncological outcomes of GIST cases operated on by a single surgical team over an 11-year period were analyzed to evaluate the effectiveness of a standardized surgical approach.

Material and Methods: A retrospective analysis was performed on 20 patients who underwent surgery for GIST between 2015 and 2026. All patients were operated on by the same experienced team. Demographic characteristics, tumor diameter, mitotic index, AFIP risk stratification, surgical approach, use of adjuvant therapy, length of hospital stay, and follow-up outcomes were examined.

Results: The mean age of the 20 patients was 63 years, with equal gender distribution (10/10). Tumors were located in the stomach (75%), small intestine/duodenum (20%), and rectum (5%). The mean tumor diameter was 8.4 cm (0.3-12 cm). The mean mitotic index was 7.4/5 mm^2, and the median was 2/5 mm^2 (0-98); 15% of patients had ≥6/5 mm^2 mitotic activity. One patient had a markedly high index of 98/5 mm^2. According to the AFIP classification, 35% were very low risk, 20% low risk, 40% intermediate risk, and 5% high risk. Open surgery was performed in 70% and minimally invasive surgery in 30% of patients. R0 resection was achieved in all cases, with no intraoperative tumor rupture. The median hospital stay was 4 days (3-9), shorter after minimally invasive procedures. Two high-risk patients (10%) received adjuvant imatinib. One (8 cm, 6/5 mm^2, multifocal duodenal tumor, NF-1 and T-ALL history) had no recurrence. The other (AFIP 6A; 8 cm ileal tumor, 98/5 mm^2, lymph node metastasis) developed distant metastases 28 months postoperatively (5%). No recurrence occurred in the low or intermediate risk groups, and no GIST-related mortality was observed.

Conclusion: A standardized surgical approach performed by a single surgical team can achieve a high R0 resection rate and low morbidity in GIST cases. The absence of recurrence in low and moderate-risk groups supports surgical efficacy, while the development of metastasis in high-risk cases highlights the prognostic value of the risk stratification. Minimally invasive surgery can be safely applied in selected cases.

Keywords: Gastrointestinal stromal tumor, oncological outcomes, surgical resection

Table 1. Demographic, tumor and surgical characteristics (n=18)

Parameter	Value
Number of patience	20
Age (mean)	63
Gender (F/M)	10/10
Median follow-up time	24 month
Stomach	15 (75%)
Small intestine/duodenum	4 (20%)
Rectum	1 (5%)
Mean tumor diameter	8.4 cm (0.3-12 cm)
Mitotic index (mean)	7.4/5 mm
≥6 mitoses	3 patient (%15)
Histological type	
Spindle	14 (70%)
Epithelioid	3 (15%)
Mixed	3 (15%)
AFIP risk group	
Very low	7
Low	4
Medium	8
High	1
Surgical approach	
Open	14 (70%)
Minimally invasive	6 (30%)

AFIP: Armed Forces Institute of Pathology.

[P-358]

Artificial intelligence in emergency surgery: Current applications, ethical debates, and future perspectives

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Objective: Artificial intelligence (AI) has initiated a significant transformation in emergency surgical practice, driven by increasing patient volume, complex decision-making processes, and limited healthcare resources. AI-assisted systems have the potential to improve clinical decision-making by supporting diagnosis, treatment planning, education, and healthcare management. This article reviews the current applications of AI in emergency surgery, its ethical implications, role in surgical education, and future perspectives based on recent literature.

Material and Methods: AI is increasingly used in emergency surgery for diagnostic support, prediction of mortality and complications, and optimization of resource allocation. Particularly in trauma and intensive care surgery, real-time analysis of bedside clinical data enables accurate prediction of patient outcomes. AI-based tools such as POTTER and the Trauma Outcome Predictor have demonstrated high accuracy in predicting postoperative mortality and complications.

Results: AI shows potential in guiding complex decisions in emergency surgery, including situations involving treatment futility. However, its integration into clinical decision-making raises ethical concerns regarding

autonomy, accountability, and fairness in healthcare delivery. The extent to which AI should influence or replace human judgment remains controversial. Consequently, the implementation of human-supervised AI systems and the establishment of clear ethical frameworks are essential to maintain balanced and just clinical practice. AI-supported surgical simulation platforms offer personalized feedback and objective assessment of technical skills. Integration of AI algorithms into virtual reality, augmented reality, and mixed reality environments has been shown to shorten learning curves and improve preclinical competency evaluation. Additionally, these technologies facilitate individualized assessment in remote surgical education. In common emergency surgical conditions such as acute appendicitis, AI algorithms demonstrate promising diagnostic performance. Machine learning models including random forest, support vector machines, and decision trees can analyze clinical and imaging data to distinguish complicated from uncomplicated cases with high accuracy. This capability may support surgical decision-making in diagnostically ambiguous patients and reduce unnecessary surgical interventions.

Conclusion: The full potential of AI in emergency surgery has yet to be realized. Enhanced clinical integration, standardized ethical guidelines, and widespread adoption in surgical education are necessary to maximize its impact on patient safety and surgical outcomes. Future research supported by real-world data and strengthened multidisciplinary collaboration will be critical to ensuring a sustainable and effective transformation.

Keywords: Emergency surgery, artificial intelligence, clinical decision support systems, surgical

[P-359]

An innovative approach to pressure ulcer management in intensive care patients: Ultrasonic debridement

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Objective: Pressure ulcers are a serious health problem with incidence rates ranging from 1.4% to 36.4%, particularly in intensive care unit patients, due to immobilization, sedation, tissue perfusion disorders, and malnutrition. Stage III and IV ulcers represent deep tissue loss extending to the fascia, muscle, and bone. Surgical debridement may not always be feasible in these patients due to coagulopathy or hemodynamic instability. Ultrasonic debridement offers a minimally invasive alternative for preserving healthy tissue, minimizing bleeding, and managing pain in this patient group.

Material and Methods: Patients with stage 3 and 4 pressure ulcers admitted to level 2 and 3 intensive care units between January 2025 and July 2025 were prospectively evaluated. Patients were divided into two groups: 1) patients who underwent ultrasonic debridement (Figures 1 and 2); 2) patients who underwent surgical debridement. These patients were evaluated in terms of age, gender, debridement effectiveness, and post-debridement bleeding.

Results: A total of 60 patients were included in the study. The median age was 68.8 (range 40-94 years). There were 17 female and 13 male patients who underwent ultrasonic debridement, while 13 female and 17 male patients underwent surgical debridement. In terms of debridement effectiveness between the two groups, debridement was not effective in 5 patients who underwent ultrasonic debridement. Debridement effectiveness was high in all patients who underwent surgical debridement. No significant difference in debridement efficacy was observed between the two groups. Bleeding was observed in 1 patient undergoing ultrasonic debridement. Bleeding was observed in 19 patients undergoing surgical debridement. In terms of bleeding ($p<0.001$), ultrasonic debridement was found to be safer.

Conclusion: Ultrasonic debridement is an alternative debridement method for the treatment of pressure ulcers in intensive care patients due to the mobility of the device, its applicability at the patient's bedside, its improvement of patient comfort in pain management, and its effective removal of necrotic tissue. In addition, it has a low risk of bleeding due to its preservation of living tissue. Despite its high cost, it is an effective debridement method.

Keywords: Pressure ulcer, surgical debridement, ultrasonic debridement, intensive care

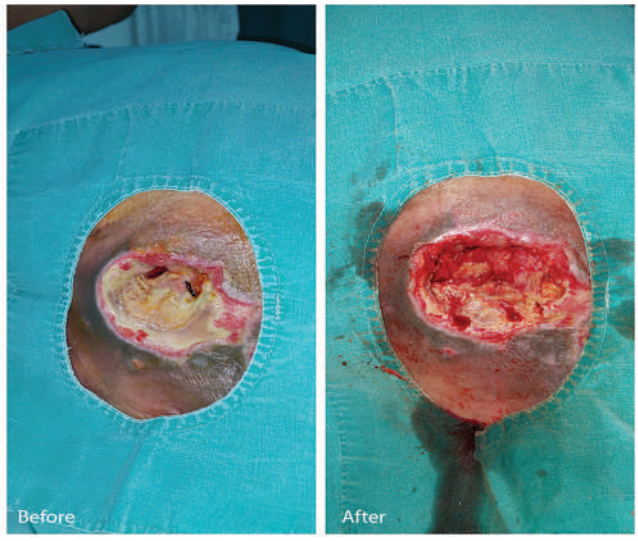

Figure 1. Before and after ultrasonic debridement in the sacrum region.

Figure 2. Before and after ultrasonic debridement in the trochanteric region.

[P-361]

Revision bariatric surgeries after sleeve gastrectomy: Indications and early clinical and metabolic outcomes

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Objective: Sleeve gastrectomy is one of the most commonly performed bariatric surgical procedures for the treatment of morbid obesity. Despite its effectiveness in achieving significant weight loss and metabolic improvement, some patients may experience insufficient weight loss, weight regain, or inadequate metabolic response, necessitating additional surgical interventions. Consequently, revision surgery has become an important option in obesity management. The indications for revision surgery, selection of the appropriate surgical technique, and the clinical and metabolic outcomes of these procedures play a critical role in patient management. However, data regarding early outcomes of revision surgeries following sleeve gastrectomy remain limited. This study aims to evaluate the indications and early clinical and metabolic outcomes of patients undergoing revision surgery after sleeve gastrectomy.

Material and Methods: This retrospective study included patients who underwent revision surgery following sleeve gastrectomy. Data regarding patient age, primary surgical procedure, type of revision surgery, pre- and post-revision body weight and body mass index (BMI) values, and metabolic parameters (HbA1c and lipid profile) were recorded. Continuous variables were presented as mean ± standard deviation. Clinical and metabolic parameters before and after revision surgery were compared.

Results: A total of 8 patients were included in the study. The mean age of the patients was 38.4±5.4 years. All patients had previously undergone sleeve gastrectomy as the primary procedure. The main indications for revision surgery were insufficient weight loss and inadequate metabolic response. Revision procedures included gastric bypass and re-sleeve surgery. The mean pre-revision body weight was 113.1±16.9 kg and the mean BMI was 41.2±5.8 kg/m^2. Post-revision follow-up revealed a mean body weight of 99.4±15.2 kg and a mean BMI of 36.3±5.3 kg/m^2. The average decrease in BMI after revision surgery was 4.9 kg/m^2. Evaluation of metabolic parameters showed an improvement trend in HbA1c levels after revision surgery. In the lipid profile analysis, decreases in triglyceride and LDL levels were observed.

Conclusion: Revision bariatric surgeries performed due to insufficient weight loss or inadequate metabolic response after sleeve gastrectomy may provide significant early weight loss and improvement in metabolic parameters. With appropriate patient selection, revision surgery represents an effective option in the treatment of obesity. However, larger patient series and long-term follow-up results are required to confirm these findings.

Keywords: Sleeve gastrectomy, revision bariatric surgery, insufficient weight loss, metabolic response, bariatric surgery

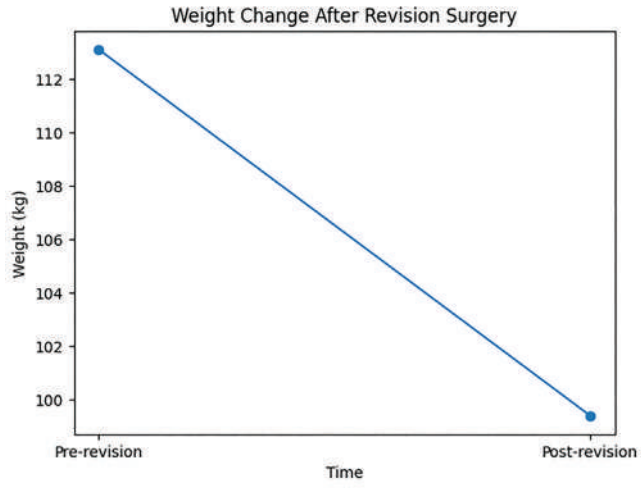

Figure 1. Change in body weight after revision surgery.

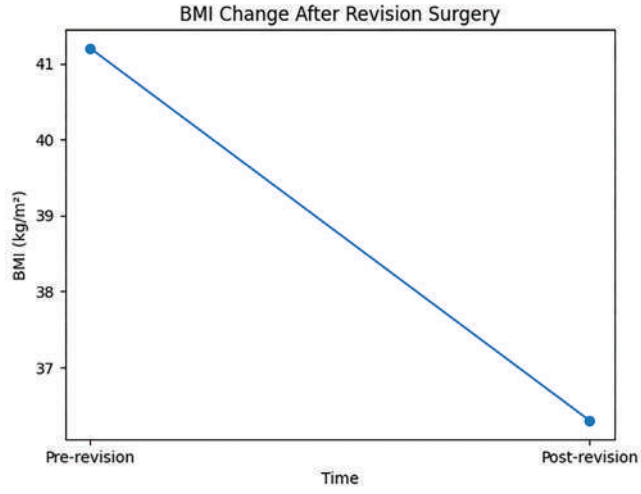

Figure 2. Change in body mass index (BMI) after revision surgery.

[P-362]

Change in ferritin levels at the 6th month after sleeve gastrectomy: A single-center analysis

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Objective: Laparoscopic sleeve gastrectomy is one of the most frequently performed bariatric surgical methods in the treatment of morbid obesity. Although it is a restrictive method, it can lead to a number of nutritional deficiencies in the early postoperative period. Serum ferritin levels are an important parameter reflecting the body's iron stores. Decreases in serum ferritin levels usually occur before the development of anemia. In this study, we aimed to evaluate the changes in serum ferritin levels before and at 6 months postoperatively in patients who underwent laparoscopic sleeve gastrectomy.

Material and Methods: Forty-eight patients (26 men, 22 women) who underwent Laparoscopic Sleeve Gastrectomy at our center between January 2025 and 2026 and had their serum ferritin levels measured preoperatively and at 6 months postoperatively were included in the study. All patients received a standard postoperative nutritional protocol and routine multivitamin (Argivit®) supplementation. Paired t-test and Wilcoxon test were used for statistical analysis. A p-value <0.05 was considered statistically significant.

Results: The mean preoperative serum ferritin levels were 90.2±88.8 ng/mL, and the mean postoperative 6-month level was 87.1±91.6 ng/mL. The median values were 64.5 and 60.5 ng/mL, respectively. The mean difference was not statistically significant (paired t-test p=0.73; Wilcoxon p=0.33). In patient-specific evaluation, serum ferritin levels fell below 30 ng/mL in 31% of cases and below 15 ng/mL in 17%. In some patients, a decrease in serum ferritin levels was detected even though serum hemoglobin levels did not reach the anemia threshold.

Conclusion: Even in the early period following laparoscopic sleeve gastrectomy, a decrease in serum iron stores can be observed. Although the average change was not statistically significant, approximately one-third of patients experienced insufficient serum iron stores. These findings indicate the existence of a clinically significant subgroup, even without statistical significance. The fact that serum ferritin levels precede the decrease in hemoglobin levels suggests that monitoring serum hemoglobin alone may be insufficient. Therefore, serum ferritin levels should be included as a routine monitoring parameter in patients who have undergone laparoscopic sleeve gastrectomy, and replacement planning should be done early when deemed necessary.

Keywords: Ferritin, nutritional deficiency, sleeve gastrectomy

[P-363]

Complication rate and management after sleeve gastrectomy surgery: A single center study

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Objective: Obesity is a modern public health problem affecting all segments of society. The obesity rate among the adult population in our country is 34%. In addition to medical treatments against obesity, surgical treatments are also used today. More than 50% of bariatric surgeries are laparoscopic sleeve gastrectomy (LSG). Surgical treatment maintains its popularity due to its low risk of complications and rapid results. LSG remains the most frequently performed independent bariatric operation because it both preserves the integrity of the digestive tract and is technically easier to perform compared to other operations. According to IFSO data, the postoperative complication rate after LSG is 2.12%.

Material and Methods: In our study, we examined laparoscopic sleeve gastrectomies performed at the General Surgery Clinic of İzmir Bozyaka Training and Research Hospital.

Results: Our study revealed that a total of 680 patients underwent LSG. 88% of the patients were female and 12% were male. The age range of the patients was 18-71 years. The average hospital stay after surgery was 4 days. The postoperative complication rate was 0.7% (5 patients). In our patients, intra-abdominal abscess formation due to leakage from the stapler line was observed after surgery. In these patients, external drainage catheter placement was performed by interventional radiology in the postoperative period. at the same time, stent placement was performed via gastroscopy to preserve the anastomosis line. During follow-up, intra abdominal abscess formation regressed in our patients, and they recovered their health.

Conclusion: Sleeve gastrectomy surgery is a solution that individuals around the world are turning to in the fight against obesity. Like any surgical procedure, sleeve gastrectomy carries various risks of complications. These complications can lead to life-threatening outcomes. Patients should be properly and comprehensively informed before the operation. While the postoperative complication rate is 0.7% in our clinic, this rate may vary in experienced centers. There is a need for multi center studies on this subject in our country.

Keywords: İzmir Bozyaka Training and Research Hospital, laparoscopic sleeve gastrectomy, obesity

[P-366]

Which technique should be preferred in concomitant elective laparoscopic cholecystectomy and inguinal hernia repair? A case series of 18 patients with a review of the literature

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Objective: Simultaneous elective laparoscopic cholecystectomy (LC) and inguinal hernia repair are considered advantageous approaches regarding patient comfort, anesthesia exposure, and cost-effectiveness. However, there is no clear consensus in the literature regarding the ideal technique selection and the risk of infection, particularly due to mesh use. This study aims to evaluate clinical outcomes of simultaneous LC and inguinal hernia repair to aid technique selection.

Material and Methods: Eigh-teen patients who underwent simultaneous LC and inguinal hernia repair under elective conditions at a single center between January 2021 and December 2025 were analyzed retrospectively. Demographics, comorbidities, hernia type, surgical technique, operative time, postoperative length of stay, and follow-up results were analyzed. The choice of surgical technique was determined based on patient characteristics and surgeon experience.

Results: Median age was 53 (26-75); 4 (22.2%) patients were female and 14 (77.8%) male. Bilateral inguinal hernias were present in two patients (11.1%); one underwent TAPP and the other TEP. In unilateral hernia cases (n=16), the most preferred technique was TAPP (56.3%), followed by TEP (25.0%) and open anterior repair (18.7%). The median operative time was 115 minutes, and the median postoperative stay was 1 day. No mesh infection or major complications were observed during follow-up. Seroma developed in two patients (11.1%) (one bilateral TEP, one unilateral TAPP). Scrotal pain was observed in three patients (16.7%) within the first 30 days, all in the TAPP group. No hernia recurrence was detected. One patient (5.6%) had an unexpected visit due to a hematoma at the LC trocar site; readmission was not required. This study demonstrates that simultaneous LC and inguinal hernia repair under elective conditions is a safe and feasible approach. Consistent with the literature, no increase in mesh infection risk was observed. While international guidelines report no significant superiority between TAPP and TEP regarding long-term results, they suggest selecting the technique based on surgeon experience and patient characteristics. In the presence of simultaneous LC, the TAPP technique may offer practical ease due to port compatibility and intra-abdominal evaluation. Short hospital stays and the absence of serious complications support the benefits of the minimally invasive approach. However, the small sample size and retrospective design are the study's main limitations.

Conclusion: Simultaneous elective LC and inguinal hernia repair is a safe approach. Regarding ideal technique selection, an individualized approach based on patient characteristics and surgeon experience should take precedence over the absolute superiority of a single method. Larger, prospective, and comparative studies are needed.

Keywords: Elective laparoscopic cholecystectomy, inguinal hernia, open anterior repair, TAPP, TEP

[P-367]

Re-operation due to postoperative deep neck hematoma after thyroidectomy: A single-center experience

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Objective: Postoperative deep neck hematoma after thyroidectomy is a rare but potentially life-threatening complication due to airway compression, laryngeal spasm, and edema, which may lead to acute airway obstruction. Early diagnosis and urgent surgical intervention are therefore critical. This issue has also been widely discussed in the context of the safety of thyroidectomy as a day-case procedure. We aimed to evaluate the clinical features, timing, and management outcomes of patients who required re-operation for postoperative neck hematoma and to present our single-center experience.

Material and Methods: Patients who underwent total thyroidectomy or lobectomy between 2020 and 2025 at the General Surgery Department of University of Health Sciences Türkiye, Şişli Hamidiye Etfal Training and Research Hospital were retrospectively reviewed. Those who developed postoperative neck hematoma requiring re-operation were included. Intraoperative nerve monitoring was used in all thyroidectomy procedures. Data regarding timing of hematoma, bleeding source, emergency management, and clinical outcomes were analyzed.

Results: A total of 1.115 patients underwent surgery (total thyroidectomy n=554; lobectomy n=561). Postoperative neck hematoma occurred in 7 patients (0.6%). Patients were aged 33-71 years; 6 were female and 1 male. Preoperative diagnoses were nodular goiter (n=3), Graves' disease (n=3), and primary hyperparathyroidism (n=1). Three patients underwent total thyroidectomy, three lobectomy, and one lobectomy with bilateral exploration. The time from initial surgery to re-operation ranged from 25 to 445 minutes. All patients were taken urgently to the operating room. The most common bleeding source was the left superior thyroid artery (n=4); one case originated from the Berry ligament and one from the left middle thyroid vein. All bleeding points were controlled with 3/0 silk sutures. Drains were present in five patients after the initial surgery and were reinserted after re-exploration. Three patients required intensive care monitoring. Hospital stay ranged from 1 to 4 days. Postoperative vocal cord examination revealed bilaterally mobile cords in all patients, and no mortality occurred.

Conclusion: Although postoperative deep neck hematoma after thyroidectomy is rare, it is a critical condition requiring urgent surgical intervention when it occurs. Hematomas generally develop in the early postoperative period; therefore, close monitoring of patients within the first 8 hours (480 minutes) is essential for early diagnosis. We believe that re-exploration of the thyroid bed with intraoperative nerve monitoring may be protective against vocal cord paralysis .O ur findings suggest that early recognition and prompt surgical intervention are crucial for airway safety and for reducing patient morbidity and mortality.

Keywords: Thyroidectomy, deep neck hematoma, intraoperative nerve monitoring

[P-370]

Regional distribution of public interest in robotic surgery in Türkiye: A comparative google trends analysis with other surgical techniques

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Objective: Robotic surgery has gained increasing visibility among minimally invasive surgical techniques, accompanied by growing public awareness. However, how public interest in robotic surgery is regionally distributed compared with other surgical techniques remains unclear. Online health-related search behavior may serve as an indirect indicator of public interest. Google Trends provides a suitable platform for comparative and region-based analyses. This study aimed to evaluate the regional distribution of public interest in robotic surgery in Türkiye, in comparison with laparoscopic and open surgery.

Material and Methods: Google Trends data were retrieved for Türkiye for the period 2007-2026 using the search terms "robotic surgery," "laparoscopic surgery," and "open surgery". Province-level data were analyzed to identify regions with the highest relative interest for each surgical technique. All values were interpreted as normalized relative interest scores ranging from 0 to 100, and regional patterns of robotic surgery interest were compared with those of other surgical techniques.

Results: High relative interest in robotic surgery was observed in non-metropolitan provinces such as Artvin (100), Karabük (92), and Düzce (92). Among metropolitan cities, İzmir (85), İstanbul (78), and Ankara (78) also demonstrated high relative interest in robotic surgery. Interest in laparoscopic surgery was most prominent in provinces such as Isparta (100), Yozgat (75), and Bolu (75), whereas interest in open surgery was concentrated in a limited number of provinces, particularly Kars (100) and Denizli (53) (Table 1). When these distributions are considered, interest in laparoscopic surgery appears to be more geographically balanced across the country, while interest in robotic surgery (blue shades) shows marked clustering in specific provinces (Figure 1). The province-level distribution of interest in robotic surgery was more heterogeneous compared with other surgical techniques.

Conclusion: Google Trends data indicate that public interest in robotic surgery in Türkiye varies markedly across regions. The presence of high interest in robotic surgery in non-metropolitan provinces, compared with other surgical techniques, suggests that public expectations and awareness may develop independently of local service availability. These findings highlight the importance of region-specific patient education and health communication strategies regarding surgical technologies.

Keywords: Robotic surgery, public interest, regional differences, surgical techniques

Table 1. Province-level distribution of public interest in robotic surgery compared with other surgical techniques (Google Trends, 2007-2026)

Surgical technique	Province	Relative interest score (0-100)
Robotic surgery	Artvin	100
Robotic surgery	Karabük	92
Robotic surgery	Düzce	92
Robotic surgery	Edirne	85
Robotic surgery	İzmir	85
Laparoscopic surgery	Isparta	100
Laparoscopic surgery	Yozgat	75
Laparoscopic surgery	Bolu	75
Laparoscopic surgery	Bursa	62
Laparoscopic surgery	Ankara	62
Open surgery	Kars	100
Open surgery	Denizli	53
Open surgery	Giresun	38
Open surgery	Zonguldak	30
Open surgery	Isparta	30

This table presents the province-level distribution of public interest in robotic, laparoscopic, and open surgery in Türkiye based on Google Trends data from 2007 to 2026. Values represent normalized relative interest scores ranging from 0 to 100 for each surgical technique. The table highlights regional differences in public interest in robotic surgery compared with other surgical approaches.

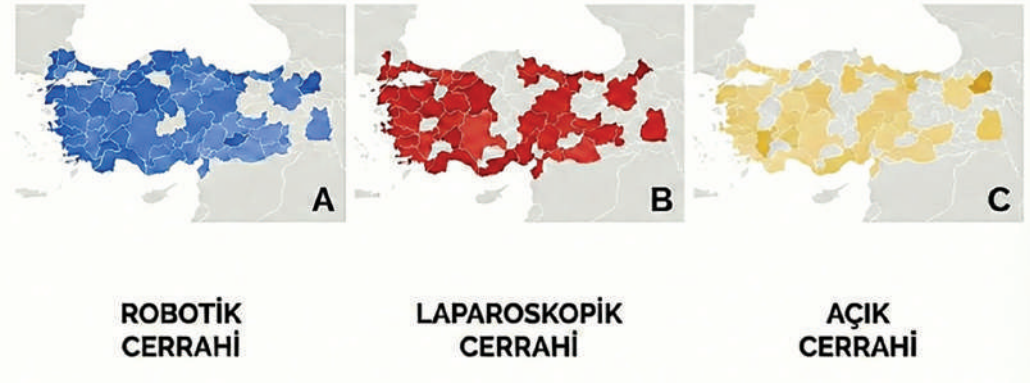

Figure 1. Province-level distribution of public interest in robotic, laparoscopic, and open surgery in Türkiye.

Province-level distribution of public interest in robotic (A), laparoscopic (B), and open surgery (C) in Türkiye based on Google Trends data from 2007 to 2026. Values represent normalized relative interest scores ranging from 0 to 100 for each search term. The maps illustrate distinct regional patterns and heterogeneity in public interest across different surgical techniques.

[P-371]

How should resection be performed in synchronous colon tumors

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Objective: There is no consensus on the surgical management of synchronous colon carcinomas. As the extent of resection increases, rates of morbidity and mortality also rise. This study is aiming to define appropriate resection limits in emergency and elective settings.

Material and Methods: Patients who underwent emergency or elective surgery for synchronous colorectal carcinoma at the Department of General Surgery, University of Health Sciences Türkiye, Gaziosmanpaşa Training and Research Hospital between 2023 and 2026 were retrospectively analyzed.

Results: A total of nine patients were included, eight operated electively and one emergently. The male-to-female ratio was 4:5, and the mean age was 69.8 years (range 57-77). Mean preoperative carcinoembryonic antigen level was 25.1 ng/mL (0.5-54.1), and mean CA 19-9 level was 36.9 U/mL (1.2-74.9). Six patients underwent open surgery and three laparoscopic surgery. Subtotal colectomy was performed in seven patients, and extended left hemicolectomy with endoscopic submucosal dissection (ESD) in two patients. The emergency case underwent a Hartmann procedure due to perforation of the tumor, and following detection of an additional transverse colon tumor during pre colostomy reversal colonoscopy, completion to subtotal colectomy was performed. One patient had three synchronous malignant tumors in the colon, and another had two synchronous colonic malignancies along with another primary malignancy in the lower pole of the right kidney, for which subtotal colectomy and partial nephrectomy were performed in the same session. Four patients had multiple polypoid lesions in addition to malignant foci detected on colonoscopy. No distant metastases were identified. There was no early postoperative (<30 days) mortality. Loss of MLH1, MLH2, MSH6, or PMS2 expression was not observed in any patient except two.

Conclusion: In patients diagnosed with synchronous colon tumors, subtotal colectomy or extended hemicolectomy encompassing tumor-bearing segments alongside appropriate lymph node dissection are both surgical procedures that can be safely chosen. Colon-preserving resection may be achieved in selected patients with polypoid malignant tumors excised within safe margins using endoscopic techniques such as ESD.

Keywords: Syncronous colon carcinomas, subtotal colectomy, left extended hemicolectomy, wide of resection

[P-372]

Nipple-sparing mastectomy and implant reconstruction in breast cancer: Our one-year experience in a single center

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Objective: Breast cancer is the most common malignancy in women, and surgical treatment continues to play a fundamental role in the local control of the disease. Surgical approaches aim not only for good oncological outcomes but also to improve quality of life and cosmetic results. In this respect, breast tissue reconstruction (MBC) and implant-based reconstruction have become increasingly preferred approaches in the appropriate patient group. MBC offers aesthetic advantages by allowing the preservation of the breast skin and, in appropriate cases, the nipple-areola complex, and also improves psychosocial well-being when combined with implant-based reconstruction. However, the feasibility of this surgical approach requires careful evaluation of many factors such as tumor size, tumor-to-breast ratio, multifocality, axillary status, and histopathological features. This study aims to present the results of patients diagnosed with breast cancer and treated with MBC and implant reconstruction in our clinic.

Material and Methods: This retrospective, single-center study included 17 patients diagnosed with breast cancer and undergoing MBCM and implant-based reconstruction between January 2025 and January 2026. Demographic characteristics, tumor characteristics, molecular subtypes, neoadjuvant therapy (NAT) status, surgical indications, axillary surgical approach, pathological staging, length of hospital stay, and early (≤30 days) surgical complications were analyzed. Statistical evaluation was performed using descriptive methods.

Results: The mean age of the patients was 44.8 years. The most frequent histological type was ductal carcinoma (70.6%), and the most common molecular subtype was luminal A (41.2%). The most frequent surgical indication was the presence of a widespread *in situ* component (41.2%). NAT was performed in 35.3% of the patients. In all cases, reconstruction was performed with a subpectoral implant after MBKM. The overall early complication rate was 29.4%, and the major complication rate was 11.8%.

Conclusion: Nipple-sparing mastectomy and implant-based reconstruction, when performed with appropriate patient selection and a multidisciplinary approach, is a safe and effective method in breast cancer surgery that offers acceptable early surgical outcomes.

Keywords: Breast cancer, nipple-sparing mastectomy, implant-based reconstruction, neoadjuvant therapy, surgical complications

Table 1. Demographic, clinical, and pathological characteristics of patients (n=17)

Feature	Value
Mean age (years)	44.8
Age distribution	36-66
Median age (years)	45
Breast involvement, side, n (%)	
• Left	10 (58.8%)
• Right	7 (41.2%)
Molecular subtype, n (%)	
• Luminal A	7 (41.2%)
• Luminal B	5 (29.4%)
• HER2 rich	4 (23.5%)
• Triple negative	2 (11.8%)
Mean tumor size (mm)	29.6
Tumor size distribution (mm)	6-80
Mean Ki-67 index (%)	21.2
Ki-67 distribution (%)	5-50

Table 2. Surgical indications and response to (NAT)

Feature	n	%
Surgical indications		
• Widespread *in situ* component	7	41.2
• Multicentric/multifocal tumor	5	29.4
• Large tumor/breast ratio	2	11.8
• Patient preference	2	11.8
• *BRCA1* gene mutation	1	5.9
NAT status		
• NAT not given	11	64.7
• NAT applied	6	
NAT response (n=6)		
• Complete pathological response	1	16.7
• Partial response	2	33.3
• Minimal residual disease	3	50

NAT: Neoadjuvant therapy.

Table 3. Surgical procedures, pathological staging, and results

Feature	
Surgical procedure performed	**Axillary surgical approach, n (%)**
• Sentinel lymph node biopsy	14 (82.4%)
• Axillary dissection	3 (17.6%)
Pathological stage (AJCC 8th edition), n (%)	
• Stage IA	6 (35.3%)
• Stage IIA	6 (35.3%)
• Stage IIB	5 (29.4%)
Mean length of stay (days)	6.4
Early complication (<30 days), n (%)	
• Total complication rate	5 (29.4%)
• Implant rejection/removal	1
• Implant exposure/removal	1
• Nipple necrosis	1
• Hematoma	1
• Wound dehiscence	1
• Major complication rate	2 (11.8%)
Percentage of patients without complications, n (%)	12 (70.6%)

[P-373]

Use of intraoperative C-arm fluoroscopy in the excision of clip-/guidewire-marked breast lesions in patients who have received neoadjuvant chemotherapy

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Objective: In patients who have received neoadjuvant chemotherapy, difficulties may occasionally be encountered in the accurate intraoperative localization of breast lesions marked with clips or guidewires. Surgical planning is generally based on the report and imaging provided by the radiologist who placed the guidewire. In this study, we aimed to demonstrate that fluoroscopic imaging with a C-arm-performed both before the start of surgery to visualize the surgical field and after specimen excision to image the specimen-can facilitate the surgical process and reduce operative time.

Material and Methods: After excision of the clip-/guidewire-marked lesion, the specimen is sent for perioperative mammographic evaluation, and the completeness of lesion removal is assessed in collaboration with a radiologist. Over the past year, perioperative C-arm fluoroscopy has been used in our clinic in selected patients who received neoadjuvant chemotherapy and had breast lesions marked with clips/guidewires to optimize surgical planning and provide intraoperative confirmation. Cases with anticipated difficulty in intraoperative localization based on preoperative imaging and surgeon judgment were considered selected cases. Following induction of anesthesia and sterile field preparation, the C-arm fluoroscopy unit is positioned over the surgical area. Using a fine-tipped forceps, the position of the marker clip relative to the guidewire is assessed in a single fluoroscopic view to guide incision site selection and excision planning. After lesion excision, the specimen is re-evaluated intraoperatively using C-arm fluoroscopy. Once removal of the marker clip is confirmed, the specimen is sent for mammographic examination for detailed assessment and documentation, and the procedure is concluded after radiologic confirmation.

Results: In our limited initial experience, intraoperative evaluation of the excised lesion using C-arm fluoroscopy in the operating room was observed to provide an approximate 15-20 minute time reduction compared with waiting for the results of perioperative mammography/specimen mammography. This approach was considered to accelerate the surgeon's intraoperative decision-making process, positively contribute to morale and motivation, and allow earlier initiation of procedure completion while awaiting mammography/specimen mammography confirmation.

Conclusion: In patients who have received neoadjuvant chemotherapy, intraoperative localization of clip- and guidewire-marked breast lesions can be challenging. Our early experience suggests that perioperative C-arm fluoroscopy, used both before surgery and after lesion excision, is effective for target verification, facilitates surgical decision-making, and shortens operative time. Although intraoperative specimen radiography provides valuable support, its diagnostic performance may vary due to technical and operator-related factors. When combined with perioperative mammography, C-arm fluoroscopy can be considered a complementary technique that enhances surgical accuracy and safety in selected cases.

Keywords: Breast cancer, clip-/wire localization, intraoperative decision support, neoadjuvant chemotherapy, specimen radiography

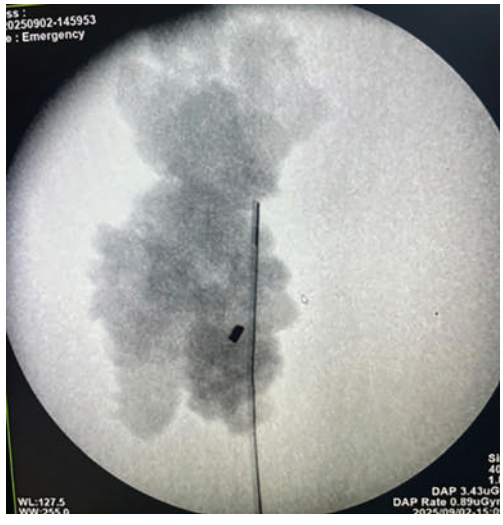

Figure 1. Specimen radiography.

Intraoperative C-arm fluoroscopic image demonstrating the relationship between the marker clip and the guidewire within the excised breast specimen.

[P-374]

Simultaneous implant reconstruction in breast cancer: Risk factors and complication analysis in a single-center series

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Objective: With the increasing adoption of skin-sparing mastectomy (SSM) and nipple-sparing mastectomy (NSM) in breast cancer surgery, immediate implant-based reconstruction has become a standard approach. However, the growing use of neoadjuvant therapies and the potential need for postoperative radiotherapy have made patient selection increasingly critical in terms of complication risk and surgical outcomes. This study aimed to evaluate early and late complications as well as potential risk factors in patients who underwent immediate permanent implant reconstruction in our single-center experience.

Material and Methods: A retrospective analysis was performed on 20 female patients who underwent mastectomy for breast cancer or prophylactic indications with simultaneous permanent implant reconstruction at our center over the past two years. Clinical stage (TNM), molecular subtype, history of neoadjuvant and adjuvant therapies, type of mastectomy (NSM/SSM), implant placement plane (prepectoral/subpectoral), and postoperative complications were recorded. Data were analyzed using descriptive statistical methods.

Results: The mean patient age was 44.1 years (range: 29-53), and the mean body mass index (BMI) was 26.2 kg/m^2 (range: 22-30). Active smoking was present in 30% of patients. Oncologic profile: At diagnosis, 70% of patients had invasive ductal carcinoma, 15% invasive lobular carcinoma, and 5% papillary carcinoma. Molecular subtype distribution was as follows: luminal A 40%, luminal B 35%, and triple-negative 10%. Two patients (10%) underwent prophylactic surgery. Neoadjuvant chemotherapy was administered in 45% of patients, and 45% received postoperative radiotherapy. The most common clinical stage was T2 (55%) with N0 disease observed in 60% of cases. Surgical data: NSM was performed in 85% of cases, while SSM was performed in 15%. Subpectoral implant placement was preferred in 19 patients, and prepectoral placement in one patient. The mean implant volume was 323 cc. Complications: Early complications included one case of skin necrosis, one case of nipple necrosis, and one case of wound complication. The overall implant loss rate was 10% (n=2). Both patients with implant loss had T2 disease, lymph node positivity, and had received neoadjuvant therapy; one patient had a BMI of 30, while the other was an active smoker. As a late complication, scar revision was required in six patients.

Conclusion: Immediate permanent implant reconstruction provides acceptable complication rates when appropriate patient selection is applied. However, the coexistence of neoadjuvant therapy, lymph node positivity, elevated BMI, and active smoking appears to constitute a notable risk profile for implant loss. Therefore, careful evaluation is recommended when considering single-stage implant reconstruction in this patient population.

Keywords: Breast, complication, implant

[P-375]

Prognostic value of HALP score in patients with gallbladder carcinoma

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Objective: Gallbladder carcinoma is an aggressive malignancy with poor prognosis. Recently, inflammation-based biomarkers have gained attention as potential prognostic indicators in various cancers. The hemoglobin, albumin, lymphocyte, and platelet (HALP) score reflects both nutritional and inflammatory status and has been associated with survival outcomes in several malignancies. However, its prognostic role in gallbladder carcinoma remains unclear. This study aimed to investigate the association between HALP score and overall survival in patients with gallbladder carcinoma.

Material and Methods: This retrospective study included patients diagnosed with gallbladder carcinoma at Bursa Uludağ University in 2010-2025. HALP score was calculated using the formula: HALP = hemoglobin × albumin × lymphocyte/platelet. Clinical and laboratory data were obtained from medical records. Overall survival was evaluated, and patients were categorized into groups according to their HALP scores. Survival outcomes were compared between groups.

Results: The mean age of the 85 patients was 70 years. There were 28 male and 57 female patients. The median HALP score of the patients was 44. In preliminary analyses, patients with lower HALP scores tended to have shorter overall survival, with a mean survival of 6 months. In contrast, patients with higher HALP scores had a longer mean survival of 12 months. The difference between the groups was statistically significant. These findings suggest that the HALP score may be associated with prognosis in patients with gallbladder carcinoma.

Conclusion: The HALP score may serve as a simple and easily accessible biomarker reflecting systemic inflammation and nutritional status in patients with gallbladder carcinoma. Further studies with larger patient cohorts are required to confirm its prognostic value.

Keywords: Gallbladder carcinoma, HALP score, survival

[P-378]

Metaplastic breast cancer: Case series

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Objective: Metaplastic breast carcinoma (MBC) is a rare subtype accounting for less than 1% of all invasive breast cancers. Clinically, it is typically observed in women over 50 years of age and is characterized by rapid growth, larger tumor size, lower rates of axillary lymph node involvement, and poorer prognosis compared with other breast cancer subtypes. Axillary lymph node metastasis has been reported in 25-30% of cases. Even in node-negative patients, recurrence rates range from 35-62% within 2-5 years. The risk of distant metastasis is higher than that of invasive ductal carcinoma. Due to its rarity, aggressive biological behavior, and limited response to standard treatment approaches, diagnosis and management remain challenging. In this study, we present a single-center series of 54 patients with MBC.

Material and Methods: A retrospective analysis was performed on 54 patients diagnosed with MBC and treated at our institution. Surgical management consisted of modified radical mastectomy or breast-conserving surgery. Axillary lymph node dissection or sentinel lymph node biopsy was performed when indicated. Demographic characteristics, surgical procedures, tumor size, axillary lymph node status, tumor stage, and adjuvant treatments were obtained from the institutional database. Statistical analyses were conducted using SPSS version 21. Continuous variables were expressed as mean ± standard deviation or median (interquartile range), as appropriate.

Results: A total of 54 female patients who underwent surgery between 2010 and 2025 were included in the study. The mean tumor diameter was 41.9 mm, and 83.3% of the patients had tumors larger than 20 mm. Histopathological evaluation demonstrated that the most common subtype was metaplastic carcinoma with mesenchymal differentiation (31.4%), followed by the squamous cell subtype (27.7%). Axillary lymph node metastasis was detected in 20.4% of the patients. Surgically, modified radical mastectomy was performed in 57.4% of cases, while 42.6% underwent breast-conserving surgery. Nearly all patients received postoperative adjuvant therapy. The lung was the most common site of distant metastasis.

Conclusion: Despite a relatively low rate of axillary lymph node involvement, MBC demonstrates aggressive clinical behavior characterized by large tumor size, high proliferation index, and hormone receptor negativity. Our single-center experience contributes to the existing literature regarding the clinicopathological features of MBC. A multidisciplinary approach and larger prospective studies are needed to optimize management strategies.

Keywords: Metaplastic, breast cancer, case series

[P-380]

Return to work after obesity surgery

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Objective: Obesity is a public health problem with increasing global prevalence and numerous comorbidities. Obesity surgery is considered an effective treatment option for achieving permanent weight loss and metabolic improvement. Reduced mortality and morbidity in the postoperative period, as well as increased functional capacity and reintegration into social life, are among the key indicators determining the success of the treatment. In this context, the return-to-work process after obesity surgery is important in terms of individual, social, and economic outcomes. The timing of return-to-work after obesity surgery varies depending on the surgical technique, perioperative complications, rate of weight loss, comorbidities, and the physical and psychosocial requirements of the individual's job. However, the literature shows limited data on the timing of return-to-work, suitability criteria, and long-term workforce participation after obesity surgery. This study was conducted to evaluate the postoperative return-to-work processes and the factors affecting this process in individuals who underwent bariatric surgery.

Material and Methods: Our study was conducted on patients who underwent bariatric surgery within the last year and are actively employed. Individuals who agreed to participate in the study were given questionnaires prepared via Google Forms.

Results: Patients invited to the study, 16 were actively employed. Eight (50.0%) patients reported taking at least threedays of sick leave due to health problems, and nine(56.2%) reported visiting a healthcare facility at least twice a year. The average postoperative hospital stay was 8.3±2.1 days. After returning to work following surgery, nine (56.2%) patients reported visiting ahealthcare facility at least once due to health problems, six (37.5%) reported taking sick leave due to health problems. Three pre-operative (18.7%) and one post-operative (6.2%) patients reported having to change jobs due to health problems. Post-operative work efficiency increased in six patients (37.5%), remained unchanged in eight patients (50.0%), and decreased in two patients (12.5%). During the return-to-work process, four of the six patients reported receiving support from their family, and two from their colleagues. One of three patients reported feeling like a burden to their colleagues before surgery, one after surgery, and one both before and after surgery. Eight patients (50.0%) reported experiencing psychological problems before surgery. Postoperatively, psychological problems decreased in four of these patients and increased in one. Access to appropriate postoperative dietary recommendations was available at work for eight patients (50.0%) and at home for fifteen patients (93.7%).

Conclusion: The findings indicate that developing supportive policies in workplaces and integrating them into the organizational culture to mitigate the challenges of the return-to-work process can improve employee job adjustment and productivity.

Keywords: Obesity and working life, obesity surgery, return to work after surgery

[P-381]

Postoperative intensive care patients the role of human factors and equipment use in fall prevention

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Objective: This study aimed to evaluate the role of human factors and equipment use in preventing falls among patients monitored in the postoperative intensive care unit (ICU). Postoperative ICU patients are at high-risk of falls due to factors such as altered consciousness, limited mobility, and the use of analgesic and sedative medications. In this context, the study aimed to systematically assess fall risk and to determine the contribution of nursing care practices to patient safety.

Material and Methods: This retrospective and descriptive study was conducted in the adult general ICU 3 of a training and research hospital. Between 01/06/2025 and 31/12/2025, the records of 835 ICU patients were reviewed. According to the inclusion and exclusion criteria, 381 patients were excluded, and the study sample consisted of 454 postoperative patients. Data were collected using the patient identification form and the İTAKİ fall risk assessment scale. As part of standard care practices, bedside rails, wheelchairs, patient lifting slings, transfer boards, walkers, and non-slip, appropriately sized slippers were used in the unit.

Results: The mean fall risk score of the patients included in the study was 19.66. Female patients had higher fall risk scores compared with male patients (21.09 vs. 17.81). Higher fall risk scores were observed in patients with a length of stay longer than three days, a body mass index ≥25, three or more drains or catheters, and the presence of chronic disease.

Conclusion: Postoperative intensive care patients were found to be at high-risk for falls. Nursing care practices focusing on human factors, along with the standard and appropriate use of fall-prevention equipment, play a significant role in enhancing patient safety and reducing fall risk.

Keywords: Fall risk assessment, patient safety, postoperative intensive care

Table 1. Distribution of equipment used to prevent falls in postoperative intensive care patients according to their areas of use

Equipment type	Equipment used
Bed safety	Bed rails
Transfer equipment	Patient lifting lifts, transfer boards
Mobilization equipment	Wheelchair, walker
Personal protective equipment	Non-slip, patient-sized slippers/shoes

Fall prevention equipment by application area.

Table 2. Distribution of fall risk scores according to patients' demographic and clinical characteristics

Variable	Category	Average fall risk score
Gender	Woman	21.09
Gender	Men	17.81
Hospitalization duration	>3 day	23.19
BMI	≥25	20.02
Chronic disease	Yes	20.11

Fall risk scores based on patients' demographic and clinical characteristics (low risk: <10 points, high-risk: ≥10 points).

[P-382]

Comparison of early phase inflammatory markers in open and laparoscopic right hemicolectomy

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Objective: With the widespread adoption of laparoscopic techniques today, laparoscopic surgery is increasingly preferred over open surgery due to the benefits of minimally invasive surgery. One of the proposed benefits is that it causes less trauma due to more minimal skin, subcutaneous tissue, and fascia incisions. In this study, the aim was to compare postoperative inflammatory markers in right hemicolectomy cases to assess the body's inflammatory response to trauma following these procedures.

Material and Methods: The study included 229 patients who underwent right hemicolectomy due to colon cancer between 2015 and 2025. Emergency cases and patients who underwent surgery for benign reasons other than colon cancer were excluded from the study. Preoperative and postoperative leukocyte, neutrophil, lymphocyte, and CRP values were recorded on days 1, 3, and 5 for the included patients. Before comparison, propensity score matching was performed at a 1:3 ratio, and 41 patients from the laparoscopy group were matched with 123 patients from the open surgery group. Age, gender, history of neoadjuvant therapy, and tumor histopathology were used for propensity score matching.

Results: Preoperative leukocyte, lymphocyte, neutrophil, and CRP values showed no difference between the two groups, indicating that the groups were evenly distributed. ($p>0.05$) On the first day after surgery, the CRP value was measured as an average of 105.11 in the open group and 79.91 in the laparoscopic group ($p=0.009$), showing that the CRP value was significantly lower in the laparoscopic group. Although statistically insignificant, the mean values of leukocytes, lymphocytes, and neutrophils on the first postoperative day tended to be lower in the laparoscopic group. There was no statistically significant difference in leukocyte, lymphocyte, and neutrophil values between the open and laparoscopic methods on the third postoperative day. On the 5th postoperative day, the mean CRP, leukocyte, and neutrophil values were minimally lower in the laparoscopic group, although this was not statistically significant.

Conclusion: In the comparison of early-phase acute-phase reactants in open and laparoscopic right hemicolectomy, it was determined that the CRP value on day 1 was significantly lower in the laparoscopic method. Although there was no difference between the groups on days 3 and 5, there was a tendency for lower values in the laparoscopic group.

Keywords: Inflammatory marker, laparoscopic, right hemicolectomy

[P-385]

Artificial intelligence-based prediction of length of hospital stay after colorectal surgery

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Objective: Length of hospital stay is among the most frequent concerns expressed by surgical patients. Colorectal procedures may necessitate prolonged hospitalization due to postoperative care requirements and potential complications. Artificial intelligence systems have recently become widely accessible and may serve as practical decision-support tools for clinicians in predicting hospital stay. This study aimed to assess the reliability of AI-assisted estimation of postoperative length of stay in patients undergoing colorectal surgery.

Material and Methods: This retrospective observational study included randomly selected patients operated between 2018 and 2026 at Hacettepe University Faculty of Medicine Hospital. Demographic features, perioperative characteristics, surgical details, and oncologic treatment data were extracted from medical records and standardized for analysis. A total of 90 patients representing nine different colorectal procedures were evaluated. These operations included right hemicolectomy, total abdominal colectomy, rectopexy, left hemicolectomy, abdominoperineal resection, sigmoid resection, colocolonic anastomosis, low anterior resection, and segmental colon resection. Exclusion criteria comprised age <18 years, missing data, mortality within 30 days, ICU stay >48 hours, concurrent major surgery, non-surgical complications likely to prolong hospitalization, and cases without AI-generated predictions.

Results: Forty-nine patients were male and 41 were female; median age was 64 years and median hospital stay was 8 days. Twenty-seven procedures were emergency and 63 elective. Eigh-teen patients received chemotherapy, nine radiotherapy, and four both. Stoma formation was performed in 11 patients and was significantly associated with emergency surgery (p=0.001). Allowing a ±1 day margin, accuracy rates were 77% for ChatGPT, 74% for Gemini, and 72% for Grok. Advanced age, comorbidity burden, emergency surgery, and stoma creation were associated with longer hospitalization. Because the dataset consisted of paired non-parametric measures, the Wilcoxon signed-rank test was applied; p<0.05 was considered significant. No difference was observed for GPT (p=0.642) or Gemini (p=0.851), whereas Grok demonstrated significant deviation (p=0.00021).

Conclusion: AI-based approaches may meaningfully support clinical decision-making when estimating hospital stay after colorectal surgery. Nevertheless, model performances are not interchangeable, making appropriate selection essential for routine practice.

Keywords: Artificial intelligence, colorectal surgery, clinical decision support systems

[P-386]

A single surgeon's 6-year experience in 181 cases of thyroid surgery: A retrospective analysis from a tertiary center

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Objective: Thyroid disorders are a common clinical challenge, with surgical intervention serving as a cornerstone of management for conditions ranging from symptomatic benign goiters to various types of thyroid carcinoma. The impact of surgeon volume on patient outcomes is a well-established principle in surgical oncology and endocrine surgery. High-volume surgeons, often defined as those performing more than 25 thyroidectomies annually, have consistently demonstrated lower rates of surgical complications such as permanent hypocalcemia and recurrent laryngeal nerve (RLN) injury. This is attributed to a refined surgical technique, meticulous attention to preserving the parathyroid glands and RLN, and a streamlined approach to complex cases. As such, single-surgeon series from high-volume tertiary centers serve as critical benchmarks for evaluating surgical safety and efficacy against international standards. This study retrospectively analyzes a single endocrine surgeon's 6-year experience, encompassing 181 consecutive thyroid surgeries. We present a comprehensive overview of patient demographics, the distribution of thyroid pathologies, and the indications for surgery.

Material and Methods: This retrospective cohort study included 181 consecutive patients who underwent thyroidectomy or lobectomy by a single endocrine surgeon at a tertiary referral center between March 2019 and August 2025. All procedures were performed under general anesthesia within a dedicated endocrine surgery unit.

Results: The cohort was predominantly female (85.1%) with a mean age of 53.9 years. The most common preoperative diagnoses were non-toxic multinodular goiter (37.0%) and papillary thyroid carcinoma (PTC) (23.2%). A significant proportion of non-toxic goiters (34.3%) were operated on due to two prior biopsies showing atypia of undetermined significance. The overall malignancy rate was 24.9%, consistent with published literature. The most frequent procedure was total thyroidectomy (61.9%), with bilateral central neck dissection performed in 14 PTC patients due to suspicious lymph nodes and in one patient with medullary thyroid carcinoma. The mean operation time was 85 minutes, and the average hospital stay was 1.2 days. Postoperative complications included transient hypocalcemia in 12.7% of patients and permanent hypocalcemia in 1.7%. A hematoma requiring reoperation occurred in a single hemodialysis patient. Transient voice quality reduction was observed in 2.8% of patients, with no permanent RLN palsy, superior laryngeal nerve injury, or swallowing difficulty.

Conclusion: The low incidence of complications highlights the safety and efficacy of thyroid surgery when performed by a specialized, high-volume surgeon in a dedicated center. These results align with international benchmarks and underscore the importance of surgical expertise in optimizing patient outcomes.

Keywords: Single surgeon, superior laryngeal nerve injury, thyroid surgery

Table 1. Complications and incidence rates

Complication	Incidence (n, %)	Details
Transient hypocalcemia (≤1 month)	23 (12.7)	Resolved with supplementation
Permanent hypocalcemia (>6 months)	3 (1.7)	Lifelong supplementation required
Hematoma requiring reoperation	1 (0.6)	Single hemodialysis patient
Transient voice reduction (≤6 weeks)	5 (2.8)	Resolved spontaneously or with voice therapy
Permanent RLN palsy	0 (0)	-
Superior laryngeal nerve injury	0 (0)	-
Swallowing difficulty	0 (0)	-
Tracheomalacia	0 (0)	- (All BAS-symptomatic patients informed preoperatively)
Infection	1 (0.6)	Superficial, managed medically
Total complications	33 (18.2)	-

RLN: Recurrent laryngeal nerve.

Table 2. Performed surgical procedures

Procedure	Number of patients (n, %)
Total thyroidectomy	112 (61.9%)
Hemithyroidectomy	45 (24.9%)
Total thyroidectomy + bilateral central neck dissection	15 (8.3%)
Completion thyroidectomy	5 (2.8%)
Other (e.g., subtotal)	4 (2.2%)
Total	181 (100%)

[P-387]

Clinicopathological characteristics and follow-up outcomes of patients undergoing hepatectomy for colorectal liver metastases: A single-center experience

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Objective: Colorectal liver metastases (CRLM) are among the most important factors determining the prognosis of colorectal cancer. In selected patients, hepatic resection constitutes the cornerstone of curative treatment. Previous studies have reported 3-year survival rates of 30-60% and 5-year survival rates of 16-51% following liver resection in patients with CRLM. This study aimed to descriptively evaluate the clinicopathological characteristics, treatment approaches, and follow-up outcomes of patients who underwent liver resection for CRLM at our center.

Material and Methods: This retrospective, single-center study included patients who underwent liver resection for CRLM. Demographic data, primary tumor characteristics, patterns of metastatic disease, surgical and oncological treatments, and follow-up data were reviewed. The data were analyzed using descriptive statistics and presented as median (range) or number (percentage).

Results: A total of 49 patients were included in the study. The median age at the time of liver resection was 59 years (25-85), and 65.3% of the patients were male. The primary tumor was located in the rectum in 55.1% of patients, in the left colon in 24.5%, and in the right colon in 14.3%. Liver metastases were synchronous in 44.9% and metachronous in 55.1% of cases. The median number of liver metastases was 1 (range, 1-11), and the median diameter of the largest metastasis was 4.0 cm (1.0-12.3). Bilobar involvement was present in 34.7% of patients. Resection of two or fewer segments was performed in 51.02% of patients, while resection of three or more segments was performed in 48.98%. At 24 months of follow-up, 73.47% of patients were alive, whereas 26.53% had died. No evidence of disease was observed in 24.5% of patients, while persistent or recurrent disease was present in 67.3%.

Conclusion: This single-center descriptive study demonstrates that, in patients undergoing surgical treatment for colorectal liver metastases, hepatic resection can provide acceptable long-term survival and disease control with careful patient selection. Despite heterogeneous metastatic patterns and varying tumor burdens, the achievement of disease-free follow-up in a substantial proportion of patients underscores the importance of a multidisciplinary approach and individualized treatment strategies. The findings highlight the central role of surgery in the management of colorectal liver metastases and reflect a valuable institutional experience that may serve as a basis for further survival analyses as well as prognostic and predictive modeling studies.

Keywords: Colorectal cancer, colorectal liver metastases, hepatectomy

Table 1. Liver metastases characteristics

Synchronous metastases	**22 (44.9%)**
Metachronous metastases	27 (55.1%)
Number of metastases, median (range)	1 (1-11)
Largest metastasis diameter, cm, median (range)	4.0 (1.0-12.3)
Bilobar involvement	17 (34.7%)

Timing, number, and distribution of liver metastases.

Table 2. Follow-up outcomes and disease status

Alive	28 (57.1%)
Deceased	18 (36.7%)
Disease-free follow-up	12 (24.5%)
Persistent/recurrent disease	33 (67.3%)

Patients' vital and oncological status.

Table 3. Demographics and primary tumor characteristics

Number of patients	**49**
Age, median (range)	59 (25-85)
Male	32 (65.3%)
Rectum	27 (55.1%)
Left colon	12 (24.5%)
Right colon	7 (14.3%)

Demographic characteristics of the patients and the location of the primary tumor.

[P-388]

Recurrence and omental metastasis 10 years after distal pancreatectomy in a young patient due to solid pseudopapillary tumor: Discussion of the decision for total pancreatectomy

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Objective: Solid pseudopapillary tumor is a rare pancreatic neoplasm with low malignant potential, typically observed in young patients. Although the prognosis after surgical resection is favorable, local recurrence and metastases are rarely reported during long-term follow-up. This case is presented to highlight the challenges in the surgical decision-making process due to recurrence and omental metastasis following a long-term follow-up period.

Material and Methods: This is the study of a patient undergoing treatment in our clinic.

Results: A 25-year-old male patient underwent a distal pancreatectomy 10 years ago due to an intra-abdominal mass, with the pathology reported as a solid pseudopapillary neoplasm. Following a 10-year period without follow-up, he was referred to our clinic after a pancreatic mass was detected during a routine check-up. The patient was asymptomatic at the time of admission, and his physical examination was unremarkable. Sectional imaging revealed an approximately 6.5×5.5 cm lesion at the head and body of the pancreas, along with multiple omental lesions, the largest measuring 2 cm. PET-CT demonstrated FDG uptake in the pancreas and omentum. After evaluation by the tumor board, an excisional biopsy was planned. During laparotomy, a mass in the pancreas and multiple malignant masses in the omentum were identified, and an omentectomy was performed. The pathological examination was reported as "Solid Pseudopapillary Tumor Metastasis" (Ki-67: 1%). Due to the low malignant character but the presence of progression, options for total pancreatectomy or continued observation are currently being evaluated by a multidisciplinary team.

Conclusion: In patients diagnosed with solid pseudopapillary tumors, recurrence and distant organ metastasis should be kept in mind even more than 10 years after surgery. Treatment decisions must be individualized, taking into account the patient's age and quality of life. Despite a low proliferation index in young patients, radical surgical decisions such as total pancreatectomy should be carefully evaluated. This case emphasizes the significance of long-term follow-up and an individualized treatment approach

Keywords: Omental metastasis, solid pseudopapillary tumor, total pancreatectomy

[P-389]

Laparoscopic appendectomy: A reliable multi-action approach and clinical outcomes

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Objective: Acute appendicitis is one of the most common abdominal pathologies requiring emergency surgery. Laparoscopic appendectomy offers advantages such as low morbidity, short hospital stay, and rapid recovery due to its minimally invasive nature. However, the sustainability of surgical success is possible not only through technical proficiency but also through a multi-faceted approach that involves the integrated management of preoperative, intraoperative, and postoperative processes.

Material and Methods: In this study, patients who underwent laparoscopic appendectomy with a diagnosis of acute appendicitis were retrospectively evaluated. The surgical process was examined under three main headings: preoperative optimization, step-by-step intraoperative surgical technique, and evidence-based postoperative follow-up. In the preoperative period, patients were optimized according to clinical, laboratory, and imaging findings. During the intraoperative phase, reliable multiple actions were performed step-by-step using the standard three-port technique. In the postoperative period, patients were followed up according to evidence-based monitoring protocols. Clinical outcomes were evaluated based on length of hospital stay, readmission rates, and postoperative complications. Complications were categorized according to the Clavien-Dindo classification.

Results: A total of 51 patients were included in the study. The median age of the patients was 36±8.97. Thirty-nine patients were male (76.5%), and 12 were female (23.5%). The median length of hospital stay was 1±0.40 days. The median time to readmission was 2±0.39 days. Postoperative complications were evaluated according to the Clavien-Dindo classification. Accordingly, no complications were detected in 49 patients (96.1%) (Clavien-Dindo 0). One patient (2.0%) developed a Clavien-Dindo class I complication, and one patient (2.0%) developed a Clavien-Dindo class II complication. No further complications were observed. No patient required conversion to open surgery, and no mortality was detected.

Conclusion: Laparoscopic appendectomy is a reliable and effective surgical method when performed using a multi-action approach that includes preoperative optimization, standardized intraoperative surgical steps, and evidence-based postoperative follow-up processes. This comprehensive approach provides positive clinical outcomes with low complication rates, short hospital stays, and limited readmission rates. The fact that postoperative complications are largely low-grade (Clavien-Dindo class I-II) indicates that the method is a predictable and manageable surgical option in terms of patient safety. Consequently, the structured multi-action approach integrated into laparoscopic appendectomy improves surgical quality and establishes an effective standard in modern acute appendicitis management.

Keywords: Laparoscopic appendectomy, surgical safety, reliable multi-action

[P-407]

Excisional biopsy with radiolabeled occult lesion localization (ROLL) in non-palpable inguinal and axillary lymph nodes: A single-center experience

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Objective: Radioguided Occult Lesion Localisation (ROLL) technique was developed to locate the target lesion intraoperatively in non-palpable lymph nodes; however, data in extra-mammary locations is lacking. The aim of this study is to evaluate the diagnostic efficacy and safety of excisional biopsy performed with ROLL in non-palpable lymph nodes and to demonstrate the clinical contribution of the ROLL technique in this patient group.

Material and Methods: Patients who underwent ROLL-guided excisional biopsy for non-palpable enlarged lymph nodes at Mersin University Faculty of Medicine between 2021 and 2025 were retrospectively reviewed. Patients who has palpable lymph nodes and diagnosed with breast cancer excluded from study. Patients were evaluated in terms of diagnostic adequacy, correlation of ultrasound with histopathology, complications, and differences between localizations.

Results: The study included 86 patients. The mean age was 52.9±16.5 years, and 55.8% of patients (n=48) were female. Thirty-two patients (37.2%) underwent surgery in the inguinal region, and 54 patients (62.8%) underwent surgery in the axillary region. The preliminary diagnosis were lymphoma/lymphoproliferative disease (n=46, 53.5%), suspected malignancy/metastasis (n=20, 23.3%), solid tumor (n=8, 9.3%), cutaneous lymphoma (n=7, 8.1%), inflammatory/infectious disease (n=3, 3.5%), and rheumatological disease (n=2, 2.3%). The mean ultrasound size of lymph nodes was 20.7±8.5 mm. Malignant histology was detected in a total of 21 patients (24.4%). When comparing lymph nodes removed from the axillary and inguinal regions, the mean USG size (23 vs. 15 mm) and the size of the excised lymph node (3.1±1.5 vs. 2.2±0.8 cm) were found to be statistically significant ($p<0.05$). Age was identified as the only significant predictor of malignancy (57.8±15.9 years vs. 51.3±16.5 years; $p=0.049$). Of the patients who underwent preoperative FNAB (n=31), 15.1% (n=13) were benign, 18.6% (n=16) were atypical/excision recommended, and 2.3% (n=2) were malignant. Of the 18 patients with atypical or malignancy reported on FNAB, true malignant histology was detected in 66.7% (n=12) (PPV: 66.7%). None of the 13 patients with benign FNAB results had malignant histology. Malignant histology was detected in 16.4% of the 55 patients who did not undergo FNAB. The mean length of hospital stay was 1.63±0.93 days. Complications were observed in 14 patients (16.3%), including seroma (n=7), hematoma (n=5), and abscess (n=2).

Conclusion: The ROLL-guided excisional biopsy performed at our clinic is an effective and safe method for non-palpable lymph nodes. In situations where imaging alone is insufficient, considering the diagnostic limitations and risk of false negatives associated with FNAB, the ROLL technique should be integrated into the diagnostic algorithm for this patient group.

Keywords: Lymph node excision, ROLL

[P-409]

Clinical outcomes of arterial reconstruction techniques in kidney transplant recipients with multiple renal arteries

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Objective: Over recent decades, refinements in operative techniques together with the use of contemporary immunosuppressive protocols have led to marked improvements in both graft function and patient survival. Despite these advances, the ongoing scarcity of suitable donor organs remains a significant limitation, compelling transplant surgeons to utilize grafts with complex anatomical features. In this context, vascular anatomical variations—most notably multiple renal arteries (MRA)—represent a frequent and clinically relevant challenge. In the present study, we retrospectively analyzed the effectiveness and clinical outcomes of the vascular reconstruction techniques employed in kidney transplant recipients with MRA.

Material and Methods: A total of 67 kidney transplant recipients were analyzed by dividing them into three groups according to the arterial anastomosis technique used: Epigastric artery anastomosis (group 1, n=21), double artery side-by-side anastomosis (group 2, n=36), and two separate iliac artery anastomoses (group 3, n=10). Postoperative urea, creatinine, complications, and Doppler ultrasound images were compared between the groups.

Results: The rates of seroma or hematoma development detected by ultrasonography in the postoperative period were found to be comparable between the groups (p=0.99). While no significant difference was found in early postoperative serum creatinine levels (p=0.73), the mean follow-up periods were also similar between the groups (p=0.82). Overall, no statistically significant difference was observed between the three arterial anastomosis techniques in terms of short-term postoperative clinical and laboratory results.

Conclusion: Multiple renal arteries can be safely managed using a variety of vascular reconstruction techniques without compromising graft function or increasing perioperative complication rates. In our cohort, no significant differences in clinical outcomes were observed among the different anastomotic strategies, suggesting that the choice of technique may be guided primarily by anatomical considerations and surgical expertise.

Keywords: Renal transplant, multiple artery, epigastric anastomosis

Figure 1. Renal artery anastomosis.

Table 1. Postoperative findings

Değişken	Grup 1	Grup 2	Grup 3	p
Postop US anormalliği (seroma/hematom), n (%)	6 (28.6)	10 (27.8)	3 (30.0)	0.99
Postoperatif kreatinin (mg/dL), ortalama ± SS	1.9±1.2	2.1±1.3	2.3±1.1	0.73

Table 2. Postoperastive creatinin

Değişken	Grup 1	Grup 2	Grup 3	p
Preoperatif kreatinin (mg/dL), ortalama ± SS	6.3±2.8	7.1±3.1	6.6±2.5	0.61
Preoperatif albumin (g/dL), ortalama ± SS	4.2±0.4	4.1±0.5	4.0±0.4	0.53

[P-410]

Evaluation of 4th-year medical students' perspectives on the general surgery specialty in the context of clerkship experience

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Objective: In recent years, it has been observed that medical students are increasingly distancing themselves from surgical specialties and leaning towards "lifestyle" specialties due to demanding working conditions and malpractice concerns. This study aims to evaluate the perceptions of 4th-year medical students regarding the general surgery specialty and to investigate the impact of early clinical exposure (clerkship experience) on their career choices.

Material and Methods: This observational, cross-sectional study included 133 4th-year medical students. The participants were divided into two groups: those who "have completed/are taking the general surgery clerkship" (n=65) and those who "have not yet taken it" (n=68). Data were collected using a 6-item questionnaire with a 5-point Likert scale, which evaluated demographic characteristics and professional perceptions (prestige, work-life balance, malpractice, professional satisfaction, and intention to choose surgery in the Medical Specialty Examination - TUS). Mann-Whitney U and chi-square tests were used for statistical analysis, with $p<0.05$ considered significant.

Results: The mean age of the participants was 23.3±0.8 years, and 53.4% were female. There was no significant difference between the groups in terms of age and gender ($p>0.05$). Initial interest in surgery and the perceived prestige of the profession were similarly high in both groups ($p>0.05$). Although agreement with the idea that "general surgeons can allocate enough time to their families" was low overall, this negative perception was significantly more pronounced in the group that had not yet taken the clerkship ($p<0.001$). Medicolegal anxiety regarding malpractice and complications was found to be significantly higher in the group with clerkship experience compared to the non-clerkship group ($p<0.001$). Conversely, the belief that general surgery provides adequate professional satisfaction ($p=0.048$) and the intention to choose general surgery in TUS ($p<0.001$) were significantly higher in the group that had received the clerkship training.

Conclusion: The general surgery clerkship increases students' medicolegal concerns, such as malpractice, as they face the realities of the field. However, operating room practice and clinical experience help mitigate unfounded prejudices regarding work-life balance, positively influencing the sense of professional satisfaction and the motivation to pursue a surgical career. To reduce vacancies in surgical residency programs, it is critical to increase active clinical involvement and foster positive role-model relationships during clerkship education.

Keywords: General surgery, clerkship, career choice

[P-412]

Surgical treatment and oncological outcomes in gastrointestinal stromal tumors: A single-center experience

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Objective: Gastrointestinal stromal tumors (GISTs) are the most common mesenchymal tumors of the gastrointestinal tract. Surgical management is guided by tumor location, size, and risk classification, and laparoscopic approaches have become increasingly adopted. This study evaluated the clinicopathological features, surgical strategies, and oncological outcomes of patients undergoing surgery for GIST.

Material and Methods: Eighty-eight patients who underwent surgery for GIST between 2015 and 2025 were retrospectively analyzed. Demographic characteristics, tumor features, surgical approach, pathological risk classification (modified NIH), oncological treatment, recurrence, metastasis, and survival were assessed.

Results: Of the patients, 42 (47.7%) were female and 46 (52.3%) were male, with a mean age of 58.7±12.5 years (median, 61). The most common presenting symptoms were abdominal pain (60.2%) and upper gastrointestinal bleeding (31.8%). Emergency surgery was required in 22.7% (n=20), mainly due to bleeding. Tumor localization and risk distribution are summarized in Tables 1 and 2. Tumors were gastric in 72.7% and small intestinal in 26.1%. Within the stomach, the corpus (38.6%) and fundus (22.7%) were most frequently involved. Two incidental GISTs were detected during sleeve gastrectomy. High-risk disease was more common in non-gastric tumors (50.0%) than gastric tumors (21.9%). The median tumor diameter was 65 mm (5-450). Histologically, 55.7% were spindle cell type. Tumor necrosis, ulceration, and serosal invasion were observed in 48.9%, 34.1%, and 28.4%, respectively. Laparoscopic surgery was performed in 47.7% (n=42). The most common procedure was wedge resection (53.4%), followed by segmental resection and gastrectomy. Operative time and hospital stay were shorter in the laparoscopic group. R0 resection was achieved in 94.3%. Positive margins (4.5%) occurred in high-risk patients with tumor perforation. Adjuvant imatinib was administered to 28.4%, predominantly in high-risk cases; one patient received neoadjuvant therapy. Median follow-up was 4 years. Recurrence occurred in 4.5% and metastasis in 10.2%, most commonly to the liver. No recurrence or metastasis was observed in low-risk patients, whereas metastasis occurred in 30.8% of high-risk patients. Second primary malignancy was detected in 8.0%. Overall mortality was 3.4%.

Conclusion: Median follow-up was 4 years (1-10). Recurrence occurred in 4.5% and metastasis in 10.2%, most commonly to the liver. No recurrence or metastasis was observed in low-risk patients, whereas metastasis occurred in 30.8% of high-risk patients. Second primary malignancy was detected in 8.0%. Overall mortality was 3.4%. Laparoscopic surgery is safe and provides satisfactory oncological outcomes. The higher risk profile in non-gastric GISTs suggests the need for localization-specific follow-up, and risk stratification accurately predicts prognosis.

Keywords: Gastrointestinal stromal tumor, oncological outcomes

Table 1. Distribution of tumor localization

Localization	n (%)
Stomach	64 (72.7)
Corpus	34 (38.6)
Fundus	20 (22.7)
Antrum	6 (6.8)
Cardia	4 (4.5)
Small bowel	23 (26.1)
Jejunum	15 (17.0)
Duodenum	3 (3.4)
Ileum	3 (3.4)
Colorectal	1 (1.1)

Table 2. Pathological risk classification and metastasis according to tumor localization

Risk classification	Total (n=88)	Stomach (n=64)	Non-gastric (n=24)	Metastasis, n (%)
Very low	23 (26.1)	23 (35.9)	0 (0.0)	0 (0.0)
Low	25 (28.4)	19 (29.7)	6 (25.0)	0 (0.0)
Intermediate	14 (15.9)	8 (12.5)	6 (25.0)	1 (7.1)
High	26 (29.5)	14 (21.9)	12 (50.0)	8 (30.8)

[P-413]

Is minimally invasive truly superior? Pre-evaluating laparoscopic and open incisional hernia repair based on single-center experience

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Objective: Incisional hernia is a significant complication of abdominal surgery with considerable morbidity potential. Although laparoscopic repair is increasingly preferred due to its minimally invasive advantages, open surgery continues to play a role in complex defects. This study aims to compare the clinical performance of both approaches in light of the experience of İstanbul University-Cerrahpaşa, Cerrahpaşa Faculty of Medicine, Department of General Surgery.

Material and Methods: Patients operated on for incisional hernia in our clinic were treated either with an open or laparoscopic approach. The choice of surgical technique was determined by defect characteristics, patient comorbidities, number of previous operations, and abdominal wall integrity. The perioperative process and early clinical outcomes were evaluated based on institutional experience.

Results: The laparoscopic approach was observed to be associated with lower wound-site complications and faster functional recovery in appropriately selected patients. The reduced tissue trauma of minimally invasive surgery provided an advantage in early postoperative comfort. However, in large and complex defects, open surgery offered a more controlled field for anatomical reconstruction and component separation techniques. Particularly in cases with advanced abdominal wall weakness, the technical reliability of the open approach was prominent.

Conclusion: Our single-center experience demonstrates that there is no single "best" method for incisional hernia repair. While the minimally invasive approach offers early postoperative advantages, the key determinant of surgical success is appropriate patient selection and an experienced surgical team. Laparoscopic and open techniques are not competing approaches but complementary methods when applied with proper indication.

Keywords: Incisional hernia, laparoscopic repair, open surgery, abdominal wall, minimally invasive surgery

[P-414]

Patient profile, burn etiologies, and admission patterns in University of Health Sciences Türkiye, Antalya City Hospital burn center: A retrospective descriptive study

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Objective: This study aimed to evaluate the early-period patient profile, burn etiologies, age distribution, and admission patterns of the ACH Burn Center, which became operational in 2024. By analyzing data from the initial phase, we sought to describe the clinical workload of the center and to generate practical information that may guide future planning regarding patient referral pathways, bed capacity, and intensive care unit requirements.

Material and Methods: This retrospective descriptive study included all patients treated at the University of Health Sciences Türkiye, Antalya City Hospital, Burn Center between March 1, 2024, and February 3, 2026. Patients were evaluated according to age groups (0-18, 18-55, and over 55 years), burn etiology (flame, electrical, and scald burns), mode of admission, and treatment location. Admission routes were categorized as outpatient clinic visits or emergency medical services referrals. Treatment settings were classified as outpatient clinics, inpatient wards, or intensive care units.

Results: During the study period, a total of 4.237 patients were managed at the burn center. Of these, 3.741 patients (77.2%) were followed in the adult outpatient clinic and 205 patients (4.2%) in the pediatric outpatient clinic. Inpatient treatment was required for 305 adult patients (6.3%) and 205 pediatric patients (4.2%). Intensive care follow-up was necessary for 93 adults (1.9%) and 5 pediatric patients (0.1%). Flame burns were the most common etiology, accounting for 48.4% of all admissions. Among patients with flame burns, 48.4% were aged 18-55 years, 34.6% were aged 0-18 years, and 17% were older than 55 years. A substantial proportion of flame burn patients were admitted via emergency medical services. Electrical burns constituted a smaller proportion of overall cases but were predominantly observed in adults. Patients aged 18-55 years accounted for 82.4% of electrical burn cases. The rate of admission through emergency medical services for electrical burns was 58.8%, which was higher than that observed for other burn etiologies. Scald burns were more frequent in the pediatric population, with 62.8% of cases occurring in patients aged 0-18 years. Most scald burn patients were managed on an outpatient basis, and the emergency medical services admission rate for this group was 29%.

Conclusion: The early-period experience of this newly established burn center demonstrates that while outpatient visits constitute the majority of admissions, patients requiring inpatient and intensive care treatment represent a considerable clinical workload. The observed distribution of burn etiologies and age groups is consistent with the existing literature. These findings provide real-world data that may support future institutional planning and optimization of burn care services.

Keywords: Burn center, etiology, retrospective study

[P-415]

The effect of intraperitoneal bupivacaine on postoperative analgesia in laparoscopic donor nephrectomy

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Objective: Kidney transplantation is the gold standard treatment for end-stage renal disease. Laparoscopic donor nephrectomy (LDN) has become the preferred approach in living donors due to reduced morbidity and faster recovery compared to open surgery. However, postoperative visceral and port-site pain may delay recovery and impair patient comfort. Inadequate postoperative pain control may contribute to chronic pain development. Intraperitoneal local anesthetic instillation has been shown to improve pain control in laparoscopic surgery. This study evaluated the effect of intraperitoneal bupivacaine on postoperative pain following LDN.

Material and Methods: In this study, 120 adult living kidney donors who underwent LDN between January 1, 2021 and May 1, 2025 at University of Health Sciences Türkiye, Gaziantep City Hospital Organ Transplant Center were analyzed. Patients were divided into two groups: those who received 20 mL of 0.25% intraperitoneal bupivacaine at the end of surgery (group A, n=75) and those who did not (group B, n=45). Postoperative Visual Analog Scale (VAS) scores at 6, 12, and 24 hours and additional analgesic requirements were evaluated. A p-value <0.05 was considered statistically significant.

Results: Among 120 patients, 75 received intraperitoneal bupivacaine and 45 did not. VAS scores at 6 and 12 hours were significantly lower in group A compared to group B ($p<0.05$). No significant difference was observed at 24 hours ($p>0.05$). Additional analgesic requirements were lower in the bupivacaine group. No significant difference in complication rates was detected.

Conclusion: Intraperitoneal bupivacaine administration during LDN reduces early postoperative pain and analgesic requirements. Consistent with previous literature, this technique can be safely incorporated into multimodal analgesia protocols in living donors.

Keywords: Kidney transplantation, postoperative pain, donor nephrectomy

[P-416]

The role of artificial intelligence in robotic surgery: A bibliometric analysis

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Objective: The field of surgery is undergoing a profound technological transformation driven by minimally invasive approaches and rapid technological advancements. While robotic surgery enhances surgical precision, artificial intelligence (AI)-based methods increasingly support clinical decision-making processes. The widespread adoption of machine learning and computer vision technologies necessitates a systematic evaluation of thematic trends within the literature. In this context, bibliometric analysis provides a robust analytical framework for mapping the intellectual landscape of the field. This study aimed to analyze the scientific literature on robotic and AI technologies in surgery using bibliometric methods to identify publication trends, thematic evolution, and emerging research priorities.

Material and Methods: A bibliometric analysis was conducted using the Web of Science Core Collection database on January 22, 2026. The literature search employed combinations of the following keywords: "surgery OR surgical procedure OR operative procedure," "AI OR machine learning OR deep learning," and "robotic surgery OR robot-assisted surgery." The retrieved data were analyzed in RStudio using relevant bibliometric packages to examine publication trends, citation patterns, and keyword distributions.

Results: Analysis of 66 studies published across 43 journals between 2018 and 2026 revealed a marked acceleration in publication and citation output, particularly after 2022, with research productivity peaking during 2024-2025. The United States demonstrated clear leadership in global scientific production (n=671). Keyword network analyses indicated that AI and robotic surgery have rapidly moved from peripheral topics to the intellectual core of surgical research. Collectively, these findings suggest that the field is approaching a technology-driven paradigm shift, with surgical care increasingly evolving toward data-intensive and intelligent systems.

Conclusion: This bibliometric study delineates the intellectual structure of the global literature on robotic and AI-driven surgical technologies, identifies critical research gaps, and highlights evolving thematic trajectories and scientific production dynamics. Future research should prioritize addressing these gaps and generating robust evidence to support clinical integration. The growing incorporation of AI and robotic technologies is redefining perioperative care, clinical decision-making processes, and patient safety responsibilities, underscoring the strategic need to strengthen the roles and competencies of nurses within technology-mediated care environments.

Keywords: Artificial intelligence, robotic surgery, bibliometric analysis, surgical innovation, research trends

[P-417]

Clinical implications of the immune microenvironment in breast cancer: An analysis of tumor-infiltrating lymphocytes

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Objective: Breast cancer is a heterogeneous disease shaped not only by the biological characteristics of tumor cells but also by the dynamic structure of the tumor microenvironment (TMIC). Tumor-infiltrating lymphocytes (TILs), a key component of the TMIC, represent immune cells located in the tumor stroma and peritumoral connective tissue and are considered a histopathological indicator of the antitumor immune response. Recent studies have shown that high TIL levels are associated with better survival and treatment response, particularly in biologically aggressive subtypes, especially triple-negative breast cancer. It has been reported that TILs increase pathological complete response rates after neoadjuvant chemotherapy in this patient group, thus possessing not only prognostic but also predictive biomarker potential. This study aimed to evaluate the presence and level of TILs and their relationship with clinical and histopathological features in patients diagnosed with breast cancer, and to reveal the possible prognostic and predictive clinical implications of TILs.

Material and Methods: This retrospective and observational study included a total of 37 patients who underwent surgery between January 2024 and December 2025 and whose pathology reports indicated the percentage of TILs (transient ischemic epithelial cells). The relationship between the patients' demographic, clinical, and pathological data and their TILs levels was evaluated.

Results: The mean age of the patients was 60.1±9.2 years. 45.9% (n=17) of the cases were in the high TILs (≥20%) group. Lymphovascular invasion (58.8% vs. 15.4%; p=0.019) and perineural invasion (64.7% vs. 23.1%; p=0.024) were significantly higher in the high TILs group compared to the low TILs group. A positive correlation was found between high TILs and a high Ki-67 index (r=0.482; p=0.003). No significant association was observed between TILs levels and age, tumor size, stage, hormone receptor status, and HER2 status.

Conclusion: In breast cancer, high TILs levels are associated with aggressive tumor features such as lymphovascular invasion, perineural invasion, and a high proliferative index. These findings suggest that TILs may have prognostic significance as an indicator of the local immune microenvironment. Further prospective studies are needed to elucidate their role, particularly in luminal subtypes.

Keywords: Tumor-infiltrating lymphocytes, lymphovascular invasion, perineural invasion, Ki67, prognostic markers

Table 1. Descriptive statistics of demographic and clinicopathological characteristics of patients (n=37)

Feature	Value
Age (years)	60.1±9.2
Tumor grade	
Grade 1	12 (32.4%)
Grade 2	20 (54.1%)
Grade 3	5 (13.5%)
Immunohistochemistry	
ER status (positive)	33 (89.2%)
PR status (positive)	29 (78.4%)
HER2 status (positive)	4 (10.8%)
Molecular typing	
Luminal A	8 (21.6%)
Luminal B	26 (70.3%)
Other (triple-/HER2+)	3 (8.1%%)
Ki-67 median (min-max)	10 (2-50%)
Lymphovascular invasion (present)	13 (35.1%)
Perineural invasion (present)	15 (40.5%)
Multifocality (present)	32 (86.5%)
Mean tumor size (mm)	15.5 (6-37)
TILs median (min-max)	10 (1-70%)
TILs categories	
<10%	13 (35.1%)
10-19%	7 (18.9%)
≥%20	17 (45.9%)

min-max: Minimum-maximum, TILs: Tumor-infiltrating lymphocytes.

Table 2. Comparison of clinicopathological variables according to TILs categories

Feature	TILs <10% (n=13)	TILs 10-19% (n=7)	TILs ≥20% (n=17)	p
Age (mean ± SD)	62.2±10.1	58.6±8.3	59.4±8.9	0.562
Grade (1/2/3)	5/6/2	2/4/1	5/10/2	0.872
ER positive (n, %)	12 (92.3%)	7 (100%)	14 (82.4%)	0.512
PR positive (n, %)	11 (84.6%)	6 (85.7%)	12(70.6%)	0.456
HER2 positive (n, %)	1 (7.7%)	0 (0%)	3 (17.6%)	0.432
Median Ki-67	10%	15%	20%	0.003
Lymphovascular invasion (present, %)	2 (15.4%)	2 (28.6%)	10 (58.8%)	0.019
Perineural invasion (present, %)	3 (23.1%)	2 (28.6%)	11 (64.7%)	0.024
Median tumor size (mm)	14	16	15	0.897

SD: Standard deviation.

Table 3. Correlation between TILs and continuous variables

Variable	Correlation coefficient (r)	p-value
Age	-0.172	0.312
Ki-67	0.482	0.003
Tumor size	0.022	0.003

TILs: Tumor-infiltrating lymphocytes.

[P-419]

The place of urachal cyst and related anomalies in the scientific literature: A bibliometric analysis based on PubMed

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Objective: Urachal canal anomalies,and particularly urachal cysts,are largely represented in the literature by case reports and limited series due to their rarity and heterogeneous clinical manifestations. The aim of this study is to reveal the historical development, thematic structure, prolific authors, institutions, and countries of the scientific literature published on urachal canal cysts and related anomalies based on the PubMed database,and to analyze research trends in the field using bibliometric methods.

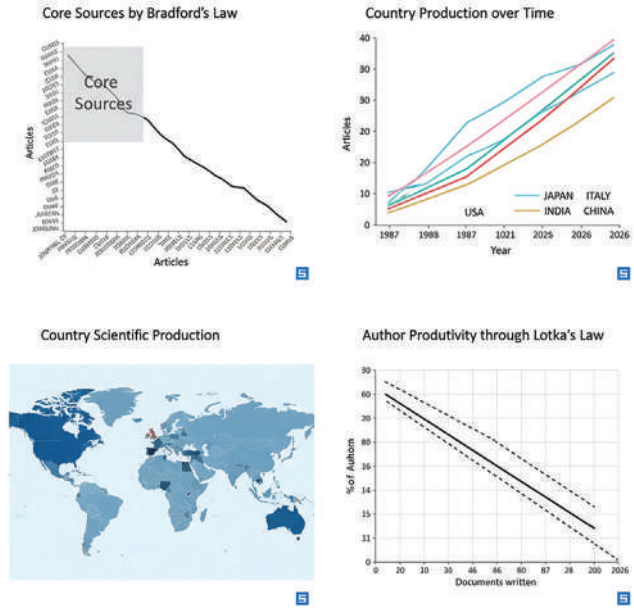
Material and Methods: Studies published in the PubMed database between 1956 and 2026 were searched using the keywords"urachal cyst,"urachus cyst","urachal anomaly,","urachal anomalies", and "urachal remnant". The data obtained were analyzed using Bibliometrix (R)-based software. Publication production trends,author and institutional contributions, distribution by country, keyword frequencies, Lotka and Bradford laws, thematic maps, and time-dependent topic trends were evaluated.

Results: A total of 924 publications published in PubMed between 1956 and 2026 were analyzed. The publications appeared in 364 journals; a total of 4.216 authors contributed. The annual growth rate was 2%,with a particularly noticeable increase in production after the 2000s. Bradford's Law showed that the literature was concentrated in a limited number of core journals. The most productive sources included the Journal of Pediatric Surgery, Cureus, Hinyokika Kiyo: Acta Urologica Japonica, Urology, and The Journal of Urology. Production dynamics supported a clustering tendency in Journals Focused on Pediatric Surgery and Urology. The US led production by country, followed by Japan, China, South Korea, and ürkiye. Analysis of corresponding authors revealed that most publications involved contributions from a single country, with limited international collaboration. Consistent with Lotka's Law, most authors contributed with a single publication, while a limited core group showed continuity. At the institutional level, universities/hospitals based in Japan and North America were particularly prominent. Keyword and theme analyses showed that the literature was concentrated on-the clinical-demographic axis; "humans", "male", "female" "adult", and "infant, newborn" were the most frequent terms. In thematic mapping, imaging, prenatal diagnosis, and surgical approaches were among the main themes, while topics such as cystectomy, immunohistochemistry, and urachus/pathology/surgery represented a more niche cluster. Trend analyses revealed that descriptive/pathology-heavy themes dominated in the early period, while imaging,minimally invasive surgery, and outcome-focused themes have increased in recent years.

Conclusion: This PubMed-based bibliometric analysis revealed that the literature on urachal canal cysts/urakus anomalies showed a steady but increasingly rapid production trend in recent years between 1956 and 2026; publications were concentrated around a small number of core journals (particularly in pediatric surgery and urology). Production is predominantly sourced from the US and Japan, with limited international collaboration and author contributions clustered around a small core group. The thematic pattern shows that, alongside basic clinical-demographic and imaging-focused themes, more specialized sub-themes such-as pathology/surgery (cystectomy, immunohistochemistry) are becoming increasingly prominent. By presenting a structural map of the literature on a scattered and rare clinical topic, this study provides a measurable reference framework for future multicenter, standardized, and outcome-focused research.

Keywords: Bibliometric analysis, clinical research trends, PubMed, urachal cyst, ureteral anomalies

Table 1.



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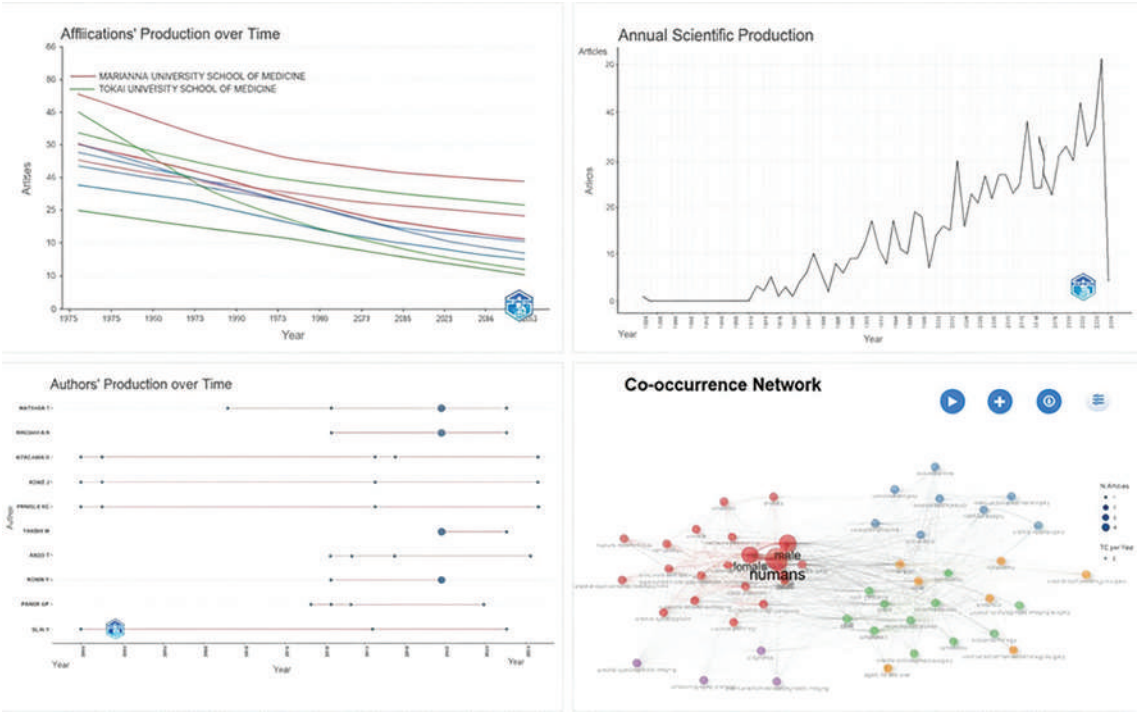

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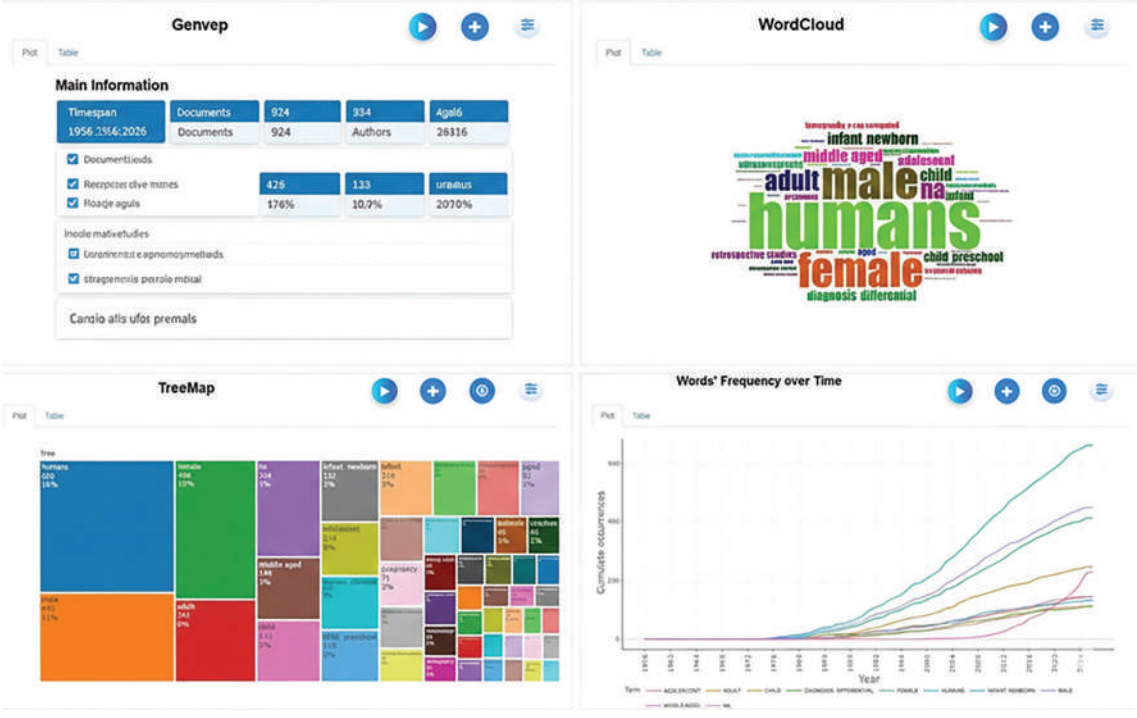

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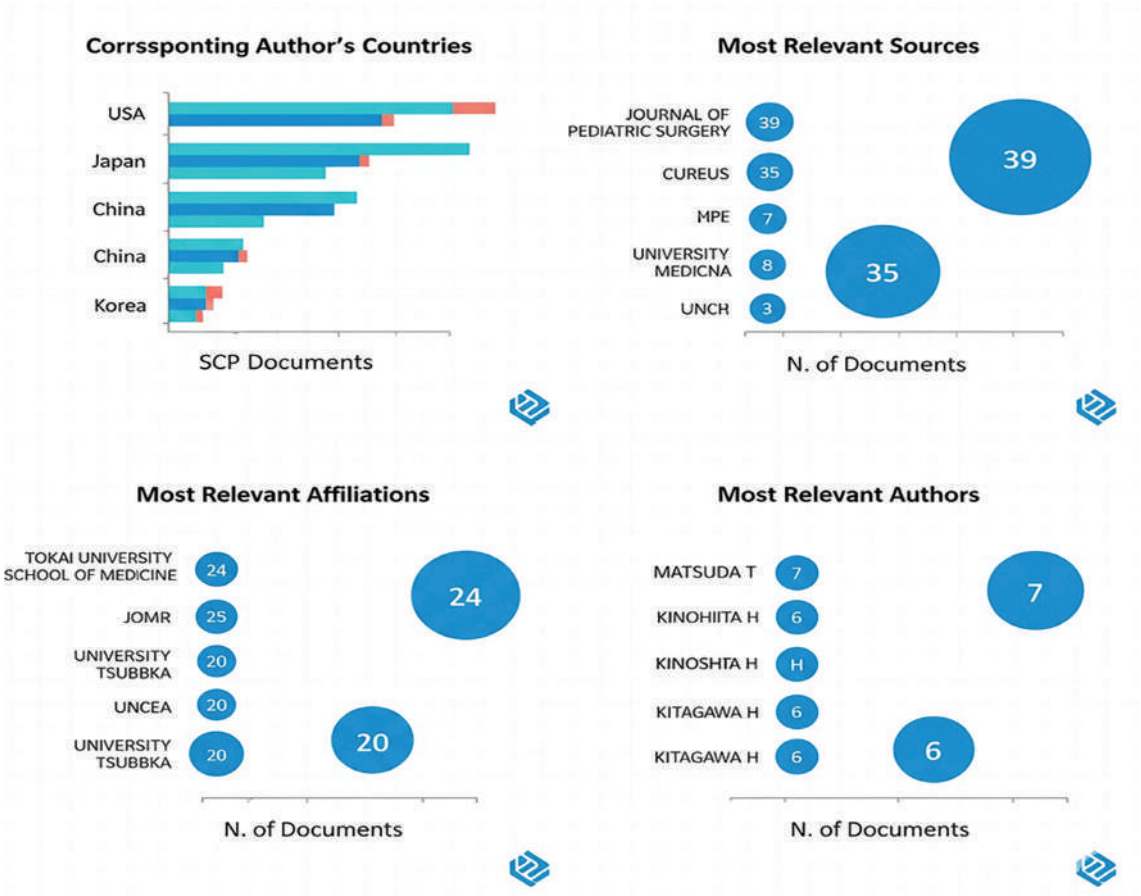

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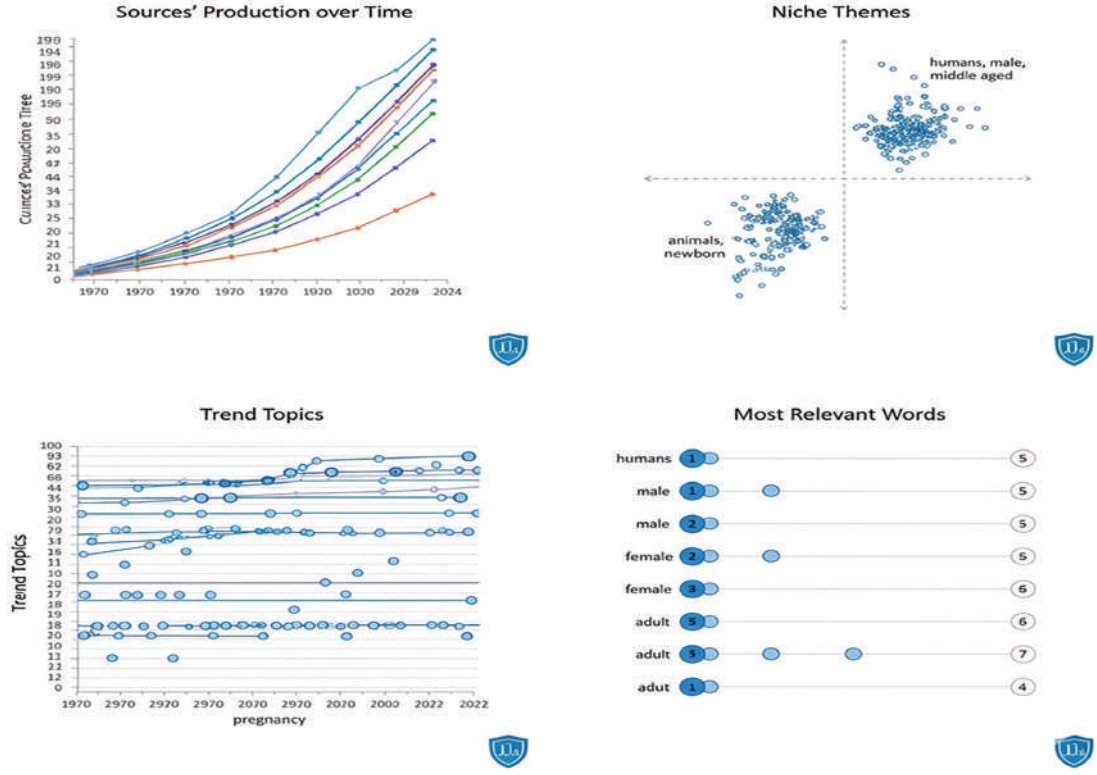

[P-420]

The etiology of surgical referrals from a second-level district hospital: Why can't we treat patients locally?

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[2]*University of Health Sciences Türkiye, Ankara Etlik City Hospital, Ankara*

[3]*Etimesgut Martyr Sait Ertürk State Hospital, Ankara*

Objective: We aimed to examine the etiological causes and organizational dynamics-of surgical referrals from secondary-level district hospitals to higher-level centers,assess the burden on the system in terms of local treatment options,determine the extent to which these referrals could be prevented,and reveal the potential cost implications for the healthcare system.

Material and Methods: In this retrospective observational study,patients referred from Payas State Hospital to other tertiary healthcare institutions for general surgical reasons were evaluated. Records of referrals made between January 2025 and January 2026 were reviewed, and a total of 75 patients were included in the study. Demographic data and clinical characteristics (age, gender, ASA score, triage code, hemodynamic status, andpresence/number of comorbidities), timing-of referral (during/after hours, weekday/weekend), referral etiology (primary and detailed reasons), referral logistics (transportation vehicle, distance,and-duration), and on-site treatment options were obtained from patient files and referral records. All variables were analyzed using descriptive statistics; continuous variables were presented as mean ± standard deviation or median (interquartile range), while categorical variables were presented as-counts and percentages.

Results: Seventy-five patients referred to a tertiary center for surgical reasons were included. The mean age was 44.1±18.0 years (median 40; range 27.5-58.5), and 54.7% were female. ASA distribution was ASAI 24.0%, ASAII 53.3% and ASA III 22.7%, with no ASA IV cases. Triage categories were yellow 68.0% and green 32.0%, with no red triage; 4.0% of cases were unstable. Comorbidity was present in 46.7%,with a mean of 0.83±1.10 (median 0; range 0-1). The most common diagnoses were urgent surgical need (30.7%), acute abdomen (29.3%), and follow-up for cholecystitis/pancreatitis/ileus (21.3%). Referrals occurred outside working hours in 77.3% and on weekends in 26.7%. Main referral reasons were lackof relevant specialists (60.0%) and equipment/devices (38.7%), while blood product shortage was rare (1.3%). The leading specific causes were absenceof a general surgeon (50.7%), CT malfunction/unavailability (18.7%), and lack of ultrasound (14.7%), followed by lack of anesthesia/staff (5.3%), endoscopy (4.0%), MRI and blood stock (each 2.7%), and patient request (1.3%). Transfers were mainly by regular transport (80.0%) or 112 ambulance (20.0%). Mean transfer distance and time were 14.1±18.7 km and 14.1±19.4 min (both median 8; IQR: 8-8), with no need for accompanying healthcare personnel. In-all cases, on-site treatment was-not feasible, primarily due to lack of specialist physicians (58.7%) and equipment/devices (40.0%), and rarely blood center limitations (1.3%).

Conclusion: This-study demonstrates that most surgical-referrals from secondary district hospitals to tertiary-centers stem from systemic and organizational constraints rather than clinical necessity. The predominance of stable, low-to-moderate risk patients suggests that referrals are driven more by deficiencies in human resources and basic infrastructure than by disease severity. The clustering of referrals during non-working hours and the prominence of factors such as lack of service continuity and basic imaging capacity contribute to unnecessary congestion and resource imbalance at tertiary centers. From-a-policy perspective,addressing referrals solely as an "advanced center requirement" is insufficient; targeted strengthening-of-human resources and basic infrastructure at the secondary level could substantially reduce referral burden. Viewed through a sociological lens,referral decisions reflect institutional capacity, shift conditions,and risk perception rather than isolated clinical judgment. Consequently, effective strategies should focus on-system-level planning and institutional design, enabling referral reduction while preserving patient safety and healthcare system efficiency.

Keywords: Cost effectiveness, on-site treatment, secondary hospital, surgical referral, tertiary healthcare

Table 1. Demographic and clinical characteristics of patients (n=75)

Parametre	Değer
Yaş (yıl), ortalama ± SS	44,1 ± 18,0
Yaş (yıl), medyan (ÇAA)	40 (27,5–58,5)
Cinsiyet	
Kadın	41 (%54,7)
Erkek	34 (%45,3)
ASA skoru	
ASA I	18 (%24,0)
ASA II	40 (%53,3)
ASA III	17 (%22,7)
ASA IV	0 (%0,0)
Triyaj kodu	
Yeşil	24 (%32,0)
Sarı	51 (%68,0)
Kırmızı	0 (%0,0)
Hemodinamik durum	
Stabil	72 (%96,0)
Unstabil	3 (%4,0)
Komorbidite varlığı	
Yok	40 (%53,3)
Var	35 (%46,7)
Tanı kategorisi	
Acil cerrahi ihtiyacı	23 (%30,7)
Akut batın	22 (%29,3)
Takip (kolesistit/pankreatit)	16 (%21,3)
Yumuşak doku enfeksiyonu	6 (%8,0)
GİS kanama	3 (%4,0)
Malignite şüphesi / tümör	2 (%2,7)
Elektif cerrahi ihtiyacı	3 (%4,0)

Table 2. Time of application and organizational factors (n=75)

Parametre	Değer
Başvuru zamanı	
Mesai içi (08:00–17:00)	17 (%22,7)
Mesai dışı / Nöbet	58 (%77,3)
Başvuru günü	
Hafta içi	55 (%73,3)
Hafta sonu	20 (%26,7)

Table 3. Referral etiology: Primary and secondary causes (n=75)

A. Sevk Ana Nedenleri

Sevk Ana Nedeni	n	%
İlgili branş eksikliği	45	60,0
Donanım / cihaz eksikliği	29	38,7
Kan ürün yetersizliği	1	1,3
Yoğun bakım yetersizliği	0	0,0
Yüksek risk / defansif tıp	0	0,0
Sosyal endikasyon	0	0,0
Diğer	0	0,0

B. Sevk Detay Nedenleri

Sevk Detay Nedeni	n	%
Genel cerrah yok	38	50,7
BT bozuk / yok	14	18,7
USG yok	11	14,7
Anestezi / personel yok	4	5,3
Endoskopi yok	3	4,0
MR yok	2	2,7
Kan stoğu yok	2	2,7
Hasta talebi	1	1,3

Table 4. Referral logistics and system load (n=75)

Parametre	Değer
Sevk aracı	
112 ambulans	14 (%18,7)
Özel ambulans	1 (%1,3)
Mutat taşıt	60 (%80,0)
Sevk mesafesi (km)	
Ortalama ± SS	14,1 ± 18,7
Medyan (ÇAA)	8 (8–8)
Sevk süresi (dk)	
Ortalama ± SS	14,1 ± 19,4
Medyan (ÇAA)	8 (8–8)
Refakatçi sağlık personeli	
Yok	75 (%100)
Var	0 (%0,0)

Table 5. On-site treatment facilities and necessary missing resources (n=75)

Parametre	Değer
Yerinde tedavi mümkünlüğü	
Hayır	75 (%100)
Evet	0 (%0,0)
Yerinde tedavi için gerekli eksik kaynak	
Cihaz / donanım	30 (%40,0)
Uzman hekim	44 (%58,7)
Yoğun bakım	0 (%0,0)
Kan merkezi	1 (%1,3)

Table 6. Distribution of referrals by age groups and seasons (n=75)

Parametre	n (%)
Yaş grubu	
< 65 yaş	63 (%84,0)
≥ 65 yaş	12 (%16,0)
Mevsimlere göre başvuru	
Kış (Aralık–Şubat)	28 (%37,3)
İlkbahar (Mart–Mayıs)	16 (%21,3)
Yaz (Haziran–Ağustos)	12 (%16,0)
Sonbahar (Eylül–Kasım)	19 (%25,4)

[P-423]

A rare complication: Management of wire fracture during preoperative radiological wire localization in breast surgery

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Objective: Wire-guided excision is a widely-used and effective method for the surgical management of non-palpable breast lesions or suspicious microcalcifications. The overall complication rate has been reported to range between 2-10% in the literature. Wire-related complications are quite rare. The rate of wire fracture is reported to be less than 0.1%. In this study, we present a rare case of wire fracture occurring during radiological localization and discuss the management strategies of this complication with literature.

Material and Methods: A 59-year-old female patient underwent screening mammography, which revealed scattered punctate microcalcifications in the upper-outer quadrant of the left breast, classified as BI-RADS 4C. No palpable lesion was detected on physical examination. An excisional biopsy using wire-guided localization was planned. During the radiological localization procedure, the radiology department reported that the wire had fractured within the breast tissue. Careful and wider surgical excision was performed with the wire guidance. Complete removal of the wire and suspicious microcalcifications, and all fractured wire segments was confirmed by specimen mammography and anteroposterior chest x-ray intraoperatively. The patient was followed for 24 hours postoperatively and was discharged without any complications. Histopathological examination revealed findings consistent with fibrocystic changes (fibrosis, adenosis, ductal ectasia) and chronic mastitis. As the patient remained asymptomatic, annual clinical and imaging follow-up was recommended.

Results: Wire-guided excision of breast lesions is a safe and widely-used technique. The overall complication rate has been reported to range between 2-10% in the literature. The most common complications include hematoma (2-5%), infection (1-3%), and seroma. Positive surgical margin rates vary between 15-40% depending on the lesion type. Wire-related complications are less common. The incidence of wire migration has been reported to range between 0.1-0.7%, while wire fracture is reported to occur in less than 0.1% of cases. Possible causes of wire fracture include excessive manipulation, traction or tension during surgery, and structural weakness of the wire. Retained wire fragments may lead to serious complications such as migration, chronic inflammation, pain, and progression into the thoracic cavity. Therefore, intraoperative assessment of wire integrity, routine specimen mammography, and additional imaging in suspicious cases are recommended.

Conclusion: Wire-guided excision is a safe method for non-palpable breast lesions. Wire fracture is a rare but clinically significant complication. Awareness of this condition by both surgeons and radiologists, along with a multidisciplinary approach and the use of intraoperative imaging, plays a crucial role in preventing retained foreign bodies within the tissue.

Keywords: Intraoperative complication management- breast surgery, preoperative complication, wire-guided excisional biopsy

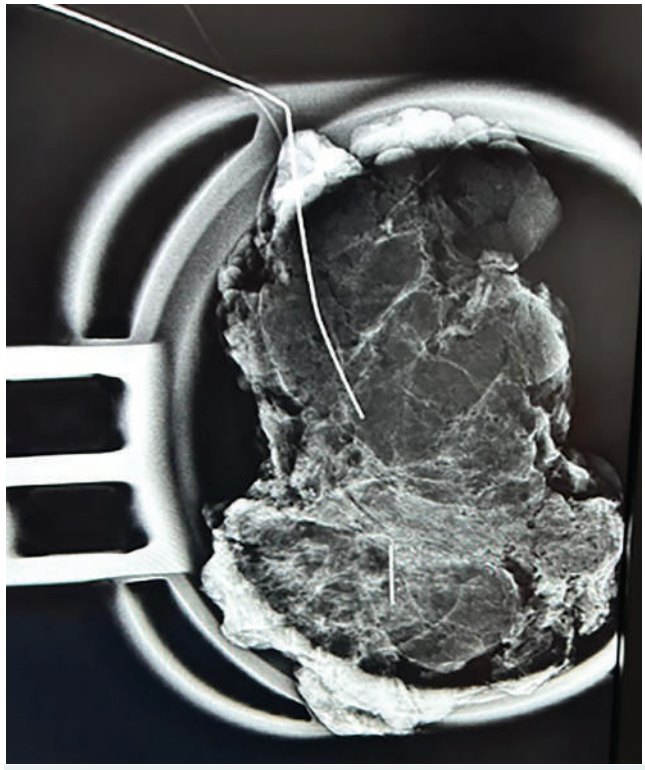

Figure 1. Examination of the specimen by mammography confirming complete removal of the microcalcification cluster and all fractured wire segments.

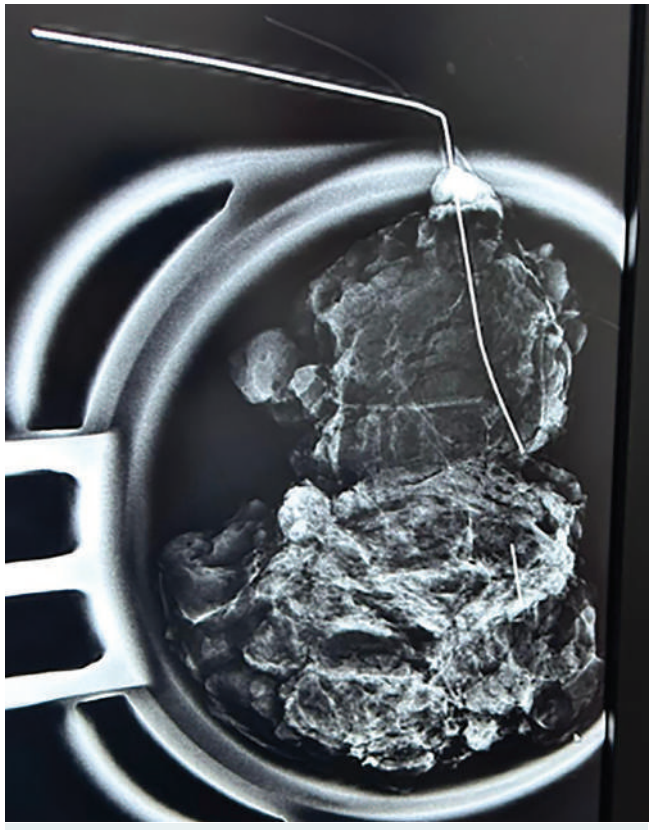

Figure 2. Examination of the specimen by mammography confirming complete removal of the microcalcification cluster and all fractured wire segments.

[P-424]

The role of open surgery in recurrent inguinal hernia after laparoscopic primary repair: Is national data needed?

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[2]*ENKA Schools, İstanbul*

Objective: Recurrences following laparoscopic inguinal hernia repair (TEP/TAPP) remain a significant clinical challenge in surgical practice. Although anterior open repair is frequently preferred in this patient group, the existing literature largely consists of small case series, with insufficient national-level data regarding technical preferences, complication profiles, and long-term outcomes. This study aims to share our single-center experience and lay the groundwork for a multicenter national study.

Material and Methods: Patients who had previously undergone laparoscopic inguinal hernia repair and subsequently required open surgery for recurrence at Koç University Hospital between 2020 and 2025 were retrospectively reviewed. Demographic data, type of primary repair, side of recurrence, open repair technique employed, complications, and recurrence status during follow-up were recorded.

Results: Seven patients were included (mean age: 64.1±6.9; all male). Six patients had undergone TEP and one had undergone TAPP as the primary procedure. The distribution of recurrences was four right-sided, two left-sided, and one bilateral. Lichtenstein repair was performed in six patients and Shouldice technique in one. In one patient, the procedure was initiated laparoscopically and converted to open surgery. Mean operation duration was 114.3±37.1 minutes. Postoperatively, one patient developed hematoma and one developed orchitis. Median follow-up was 24 months (IQR: 5-42), with no re-recurrence detected in any patient.

Conclusion: Anterior open repair is a viable option for recurrent inguinal hernia following laparoscopic primary repair, with acceptable re-recurrence rates in the short-to-medium term; however, complication rates should not be overlooked. The existing literature on surgical management of recurrent inguinal hernia predominantly addresses recurrences after open primary repair. A multicenter, national-scale retrospective study is needed to reliably characterize complication predictors, technical preferences, and long-term re-recurrence rates. The data presented herein serve as a preliminary study toward this goal, with the aim of establishing a collaborative protocol.

Keywords: Inguinal hernia, recurrence, laparoscopy

[P-425]

An innovative approach in the management of hepatic hydatid cysts: Laparoscopic PAIR

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Objective: The liver is the most commonly affected organ in hydatid disease. Although not every hepatic hydatid cyst requires intervention, surgery has traditionally been regarded as the standard treatment. In recent decades, minimally invasive techniques with outcomes comparable to open surgery have increasingly been adopted.We present a modified minimally invasive approach termed laparoscopic PAIR for selected hepatic hydatid cysts. In conventional practice, percutaneous puncture-aspirate-inject-reaspirate (PAIR) is performed under ultrasonographic guidance by interventional radiologists, provided that an adequate thickness of hepatic parenchyma overlies the cyst. Cysts lacking this safety margin are typically referred for surgery. In such cases, we perform PAIR under laparoscopic guidance in the operating room under general anesthesia. The procedural steps mirror classical PAIR, but visualization is achieved laparoscopically rather than with ultrasonography.

Material and Methods: With the patient in the supine position, pneumoperitoneum was established via an infraumbilical trocar. After diagnostic laparoscopy, additional trocars (one 10-mm and two accessory ports; total three trocars) were placed according to cyst location. Following careful isolation of the operative field, puncture, aspiration, injection of scolicidal agent, and re-aspiration were performed in accordance with the standard PAIR technique. Puncture was intentionally made at the dome of the cyst. Only Gharbi type I and II cysts were included. All patients received albendazole at 15 mg/kg/day for at least 20 days preoperatively.

Results: Over a 13-month period, laparoscopic PAIR was performed in 7 patients with a total of 11 cysts. Three patients were female and four were male; mean age was 48.3±15.9 years. Seven cysts were located in the right lobe and four in the left lobe. Mean cyst diameter was 91.2±24.3 mm. Mean operative time was 118.6±15.5 minutes, and mean hospital stay was 3.3±2.3 days.Routine drainage was not performed; drains were placed selectively when minimal leakage was suspected. Drain output was typically serous, and no viable or non-viable scolices were detected. Four patients underwent simultaneous treatment of two cysts. No anaphylaxis, infection, bile leakage, or recurrence occurred. One case required conversion to laparoscopic unroofing.

Conclusion: Laparoscopic PAIR appears to be a feasible and safe alternative for selected hepatic hydatid cysts unsuitable for percutaneous intervention. The absence of major complications in this preliminary series may relate to controlled operating room conditions and direct laparoscopic visualization. Larger comparative studies are warranted.

Keywords: Hydatid cyst, puncture-aspiration-injection-reaspiration (PAIR), minimally invasive surgical procedures

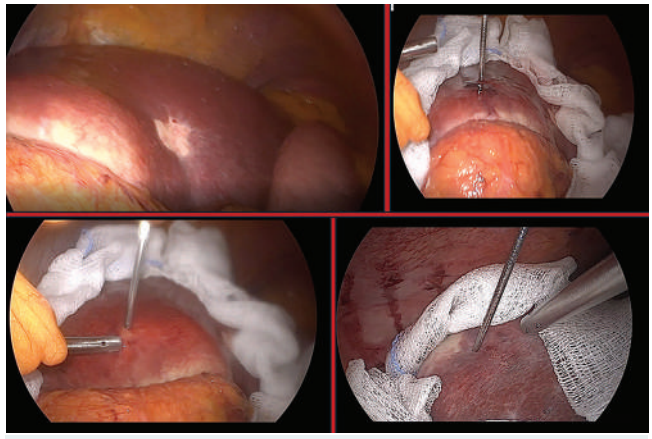

Figure 1. Intraoperative image.

[P-426]

Is routine drain placement necessary in acute appendicitis? A single-center retrospective study

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Objective: Acute appendicitis is one of the most common causes of emergency abdominal surgery, and appendectomy remains one of the most frequently performed emergency surgical procedures. Intraoperative drain placement has traditionally been used during appendectomy to prevent postoperative intraabdominal infections and fluid collections. However, the routine use of drains remains controversial. Recent studies suggest that routine drain placement does not significantly reduce postoperative complications and may be associated with prolonged hospital stay. Despite this, drain usage is still commonly preferred, particularly in cases of complicated appendicitis, and there is no clear consensus regarding its necessity. The aim of this study was to evaluate the impact of intraoperative drain use on postoperative outcomes in patients undergoing surgery for acute appendicitis.

Material and Methods: A total of 50 patients who underwent appendectomy for acute appendicitis over a one-year period were included in this retrospective study. Patients were divided into two groups according to intraoperative drain usage: drain group and no-drain group. Demographic characteristics, type of appendicitis (complicated or uncomplicated), drain usage, duration of hospital stay, postoperative fever, and reoperation rates were analyzed and compared between the two groups.

Results: Drain placement was performed in 23 patients (46%), while 27 patients (54%) did not receive a drain. The mean length of hospital stay was 3 days in the drain group and 1.8 days in the no-drain group. Patients who received a drain had a longer hospital stay compared to those without drains. Reoperation rates were similar between the two groups, and no clear reduction in reoperation or postoperative complications was associated with drain usage. Postoperative fever rates did not differ significantly between groups. Drain placement was more frequently preferred in cases of complicated appendicitis.

Conclusion: Odur findings suggest that routine drain placement during appendectomy for acute appendicitis does not provide a significant benefit in reducing postoperative complications and may be associated with prolonged hospital stay. Therefore, drain usage should not be routine and should be selectively applied based on intraoperative findings and patient characteristics. Further prospective studies with larger patient populations are needed to support these findings.

Keywords: Acute appendicitis, drain placement, appendectomy, postoperative complications, length of hospital stay

[P-427]

Retrospective analysis of repair using the TEPP and TAPP techniques in patients diagnosed with bilateral inguinal hernia

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Objective: There are many techniques available for the surgery of patients diagnosed with bilateral inguinal hernia. Laparoscopic techniques have many advantages over open surgical techniques. Less pain after surgery, smaller incisions, and less tissue trauma. Rapid recovery and return to work; most patients can return to daily activities within 1 week. Cosmetically superior, with smaller and more aesthetic scars. An advantage in bilateral hernias is that both sides can be repaired in a single session. Advantageous in recurrent hernias, especially if a hernia has recurred after open surgery. The only disadvantages are the need for general anesthesia and higher costs. Advantages of laparoscopic techniques over open surgical techniques.

Material and Methods: The files of patients diagnosed with bilateral inguinal hernia who underwent laparoscopic total extraperitoneal (TEP) and laparoscopic transabdominal preperitoneal (TAPP) surgery at Ataşehir Florence Nightingale Hospital between September 2022 and December 2025 were retrospectively reviewed. Patients were evaluated in terms of their surgery, postoperative data, and demographic characteristics. The data of patients operated on with these two techniques were compared with each other.

Results: A total of 77 patients were examined in this study. Of these patients, 55 (71.43%) underwent surgery using the laparoscopic TEP technique, and 22 patients (28.57%) underwent surgery using the laparoscopic TAPP technique. The reason for surgery using the TAPP technique was due to previous lower abdominal surgery in these patients. Of the 55 patients who underwent TEP, 20 (36.3%) were female and 35 (63.7%) were male, with an average age of 36.3 years. All 55 patients had a bilateral inguinal diagnosis. The average hospital stay was 1.07 days for the TEP technique and 1.23 days for the TAP technique. Ecchymosis was observed in 3 patients in the TEP technique and 2 patients in the TAP technique. Postoperative seroma was observed in 3 patients with the TEP technique and in 1 patient with the TAP technique. Wound site infection was observed in 1 patient with the TEP technique and in 2 patients with the TAP technique. There were no bilateral recurrences with either technique. Unilateral recurrence was observed in 2 patients with the TEP technique and in 1 patient with the TAP technique.

Conclusion: No significant difference was observed between laparoscopic TEP and laparoscopic TAPP hernia repair in terms of superiority. It is considered appropriate to decide which method to use based on the surgeon's experience and the patient's surgical history.

Keywords: Bilateral inguinal herni, TEP, TAPP

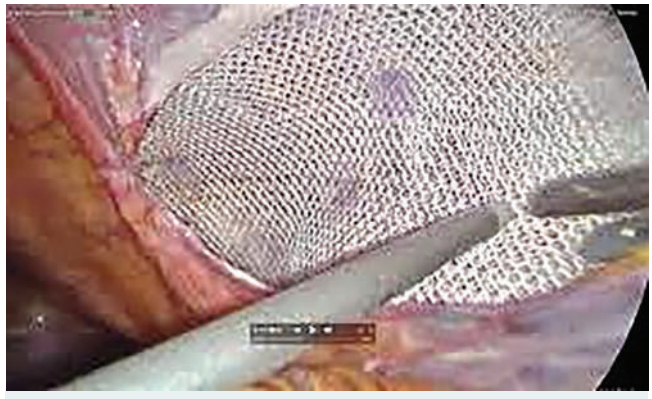

Figure 1. Retrospective analysis of repair using the TEPP and TAPP techniques in patients diagnosed with bilateral inguinal hernia.

[P-428]

Characteristics of recurrent gastrointestinal tumors

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Objective: Gastrointestinal stromal tumors (GISTs) are the most common mesenchymal tumors originating from the gastrointestinal system. They originate from the precursors of the interstitial Cajal cells, located in and around the myenteric plexus, which regulate peristalsis. They are most commonly seen in the stomach, and less frequently in the small intestine, colon, rectum, and omentum.

Material and Methods: This article evaluates the gender, medical treatment use, age, tumor localization, elective/emergency status, time of recurrence, and follow-up period of 9 patients who experienced recurrence among 75 GIST patients treated between 2009 and 2025.

Results: Recurrence occurred in 75 patients (12%), 5 of whom were female and 4 male. All were receiving medical treatment for GIST. The mean age at the time of their first surgery for GIST was 61.5 (49-68). The primary tumor locations were jejunum, stomach, ileum, colon, and rectum. Seven patients (78%) underwent elective surgery, and two patients (22%) underwent emergency surgery. The mean time to recurrence was (26.3±23.8) months, and the mean follow-up period was 65 months.

Conclusion: In this study, the GIST recurrence rate was found to be 12%, and the mean time to recurrence was 26 months.

Keywords: GIST, gastrointestinal stromal tumor, surgical oncology

[P-429]

Comparison of short and long term outcomes of surgical technique selection in distal rectal cancer

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Objective: The diagnosis and treatment of rectal cancer constitute a complex process requiring a multidisciplinary approach. Although there are certain differences between APR and ULAR in terms of clinical and surgical outcomes, tumor location, extent of invasion, and surgeon experience play key roles in patient selection. With advances in surgical techniques, both quality of life and oncological outcomes have improved. The choice of surgical method should be individualized in order to achieve optimal benefit for each patient.

Material and Methods: We compared the preoperative and postoperative outcomes of abdominoperineal resection and ultra-low anterior resection, performed in 63 patients aged 29-82 years who underwent surgery for rectal cancer at our clinic between 2015 and 2024, with each other and with the existing literature.

Results: Clinical and demographic differences were observed between APR and LAR surgical techniques; however, no statistically significant differences were found between the groups in terms of age (APR: 59.73±9.73; LAR: 59.48±14.11; p=0.935), sex distribution (APR: 72.50% male; LAR: 91.30% male; p=0.146), or BMI categories (p=0.149). Histopathological evaluation demonstrated similar rates of lymphatic invasion (APR: 58.97%; LAR: 63.64%; p=0.932), venous invasion (APR: 56.41%; LAR: 54.55%; p=1.000), and perineural invasion (APR: 38.46%; LAR: 36.36%; p=1.000) between the groups. Bowel obstruction was observed in 7.89% of APR patients and 13.04% of LAR patients (p=0.833). Stoma retraction occurred only in the APR group at a rate of 3.03% (p=1.000), whereas parastomal hernia was detected only in the LAR group at a rate of 10% (p=0.268). Regarding surgical approach, the open/laparoscopic surgery rates were 40%/60% in the APR group and 30.43%/69.57% in the LAR group (p=0.626). The distal surgical margin measured 4.00 (2.5-5.25) cm in APR patients and 2.00 (1.25-2.75) cm in LAR patients, demonstrating a statistically significant difference (p=0.008). Furthermore, the absence of local recurrence in any patient may be associated with improvements in surgical technique and increased surgical experience.

Conclusion: In patients with distal rectal cancer undergoing abdominoperineal resection or ultra-low anterior resection, no significant difference in oncological outcomes has been observed, consistent with the literature, and the choice of surgical technique appears to depend mainly on tumor localization and patient characteristics. Therefore, current approaches favor individualized treatment strategies that consider patient comfort and functional outcomes, with minimally invasive surgical techniques preferred whenever feasible to achieve optimal results.

Keywords: Cancer, rectum, surgical technique

[P-430]

Surgical and endoscopic treatment of colonic volvulus: our clinical experience and results, Bartın State Hospital

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Objective: Colon volvulus is an acute abdominal condition requiring prompt diagnosis and treatment. The treatment approaches, morbidity, mortality, and recurrence rates of cases operated on at Bartın State Hospital between 2010 and 2024 were evaluated and compared with the literature.

Material and Methods: Thirty-six patients diagnosed with KV and treated over a 10-year period were retrospectively examined. Age, gender, preoperative WBC, lactate, and CRP levels, colon diameter on abdominal CT (APCT), treatment protocols,morbidity and mortality rates, and recurrence at 1-year follow-up were compared. Twenty-five (69.4%) were female and 11 (30.6%) were male, with a mean age of 78 (range 48-95). Twenty-five (69.4%) had comorbidities (CVA, HT, DM, or severe CHF). Abdominal pain, distension, constipation, and vomiting were the most common symptoms. Approximately half of the cases had a history of previous attacks. ADBG (we believe it is not a definitive diagnostic tool due to its low sensitivity) was used to diagnose 70% of the cases, while APCT (superior to ADBG for diagnosis) was performed on all patients. Colon diameter was found to be 6-10 cm in those who underwent endoscopic procedures and ≥10 cm in those who underwent resection. Sigmoid colon volvulus was detected in 34 patients, cecal volvulus in 1 patient, and transverse colon volvulus in 1 patient.

Results: Surgical treatment was performed on 22 patients: 12 (54%) underwent resection and colostomy, 5 (22%) underwent resection and anastomosis (in patients with good general condition), 2 (9%) underwent detorsion, 1 (4%) underwent right hemicolectomy + ileotransversostomy (in cecal volvulus), 1 (4%) underwent detorsion and sigmoidopexy, and 1 (4%) underwent transverse colon resection and anastomosis. The remaining 14 patients were treated with endoscopic decompression. The mortality rate was 5.5% (2 patients, due to necrosis and delayed diagnosis). Endoscopic decompression was recorded at 20% and postoperative recurrence rates at 25%. Delayed presentation to the emergency department, high WBC, lactate, and CRP levels increased the need for resection. Emergency decompression and elective sigmoid resection resulted in low mortality; however, emergency resection in the presence of gangrene or perforation was associated with increased mortality and morbidity rates.

Conclusion: In the treatment of colonic volvulus, endoscopic interventions are the preferred choice in uncomplicated cases. Surgical treatment is required in patients with necrosis, perforation, or a transverse colon diameter >11 cm. Sigmoidopexy may be an appropriate option in cases without shock or necrosis. In patients with stable general condition, endoscopic decompression should be the first choice; however,in cases of gangrene, ischemia, or perforation, surgical intervention is mandatory along with optimal fluid resuscitation and preoperative preparation.

Keywords: Colonic volvulus, endoscopic decompression, sigmoidopexy

[P-431]

Obstructive defecation syndrome is a spectrum: Diagnosis-based surgical algorithm

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Objective: Obstructive defecation syndrome (ODS) represents a heterogeneous clinical spectrum in which rectal prolapse, rectocele, and functional impairment coexist in varying degrees. This study aimed to determine the diagnostic surgical approach, the percentage distribution of the methods used, and the preferred surgeries after recurrence in patients who underwent surgery due to ODS.

Material and Methods: Retrospectively, a total of 44 patients who underwent surgical treatment for ODS at our clinic were evaluated. Patients were grouped according to the predominant anatomical pathology as rectal prolapse, pelvic relaxation, and rectocele. The surgical methods applied in each diagnostic group were analyzed in terms of number and percentage. In addition, secondary surgeries performed in patients who experienced recurrence after primary surgery were recorded.

Results: Of the 23 patients diagnosed with rectal prolapse, 82.6% underwent laparoscopic ventral mesh rectopexy (LVMR). In the remaining patients, altemeier (4.3%), laparoscopic suture rectopexy (4.3%), LAR + laparoscopic suture rectopexy (4.3%), and delorme (4.3%) procedures were preferred. Of the 14 patients diagnosed with pelvic organ prolapse, 85.7% underwent LVMR and 14.3% underwent ventral mesh rectopexy (VMR). In the 7 patients diagnosed with rectocele, all surgical approaches were transperineal rectocele repair; 42.9% used the mesh technique and 57.1% used the non-mesh technique. Three patients who developed recurrent ODS after LVMR or VMR underwent secondary surgery: two patients underwent stapler transanal rectal resection (STARR), and one patient underwent transperineal rectocele repair (without mesh). In one case where laparoscopic suture rectopexy was performed, full-thickness rectal injury developed intraoperatively, and primary repair was performed. This same patient underwent re-operation via laparotomy on the third day due to early postoperative bleeding. In one patient who underwent Delorme surgery, ileus and anal stricture developed, requiring emergency colostomy followed by elective LAR. In one patient who underwent LVMR, an enterocutaneous fistula developed, and fistula repair was performed via elective surgery.

Conclusion: ODS is not a homogenous disease that can be treated with a single surgical technique. The surgical approach should be individualized according to the dominant anatomical and functional phenotype of the disease, rather than isolated diagnoses. A diagnosis-based algorithmic approach facilitates the selection of appropriate surgery and contributes to the determination of rational secondary surgical strategies in cases of recurrence.

Keywords: Obstructive defecation syndrome (ODS), rectal prolapse, rectocele

Table 1. Surgical methods applied according to diagnosis

Diagnosis	Surgical method	n	%
Rectal prolapse (n=23)	LVMR	19	82.6
	Altemeier	1	4.3
	Laparoscopic suture rectopexy	1	4.3
	LAR + laparoscopic suture rectopexy	1	4.3
	Delorme	1	4.3
Pelvic organ prolapse (n=14)	LVMR	12	85.7
	VMR	2	14.3
Rectocele (n=7)	TP rectocele repair (with mesh)	3	42.9
	TP rectocele repair (without mesh)	4	57.1

In 3 patients who developed recurrent obstructive defecation syndrome after LVMR or VMR, secondary surgery was performed: STARR (Stapler Transanal Rectum Resection) in 2 patients and transperineal rectocele repair (without mesh) in 1 patient.

[P-432]

Retrospective analysis of patients operated on due to intestinal obstruction

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Objective: Mechanical intestinal obstruction is a surgical problem that still presents difficulties in terms of diagnosis and treatment modalities today. In this study, we aimed to examine the etiological analysis of our cases operated on due to intestinal obstruction.

Material and Methods: A retrospective analysis was performed on 54 patients who were admitted to our clinic with a diagnosis of intestinal obstruction between January 2019 and December 2023, and who underwent surgery after a mechanical cause was found through necessary physical examination and imaging methods. The patients' gender, age, cause of obstruction, previous surgeries (if any), postoperative complications, and mortality rates were recorded.

Results: Of the patients operated on, 30 were male and 24 were female. The average age of men was 55 and that of women was 50. The overall average age was 52, and the age range was determined as (20-95). When the causes of obstruction were examined, the most common waspostoperative adhesions (42 patients, 77.7%), followed by incarcerated hernias (inguinal and incisional, 6 patients, 11.1%), tumors (5 patients, 9.2%), and volvulus (1 patient, 1.8%). When the most frequent cause of adhesions was examined, it was determined that they were caused by previous operations (ulcus perforation, cholecystectomy, gastrectomies, gynecological operations, and appendectomy). The necessary surgical procedure was applied to the patients according to the cause of intestinal obstruction. The most important criterion affecting mortality and morbidity in patients was the timing of intervention and appropriate resuscitation performed preoperatively. Our complication rate in the postoperative period was 16.6%, and mortality was 5.5%. The most frequently encountered problems, especially in delayed cases, were infection (7.4%), paralytic ileus (3.7%), and anastomotic problems (5.5%).

Conclusion: In conclusion, when examining the causes of mortality and morbidity in intestinal obstruction, it was emphasized that early and accurate diagnosis, good preoperative resuscitation, and prompt surgery of patients presenting with mechanical intestinal obstruction are important in minimizing complications and mortality, and preventing intestinal damage.

Keywords: A retrospective analysis of experience in intestinal obstructions

[P-433]

Early outcomes of laser hemorrhoidoplasty in our series

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Objective: Hemorrhoidal disease is one of the most common anorectal disorders worldwide and significantly affects individuals' quality of life. It is among the most frequently encountered conditions in patients presenting to general surgery outpatient clinics. Treatment options include medical management, minimally invasive interventions, and surgical procedures. This study aimed to evaluate the early outcomes of patients who underwent laser hemorrhoidoplasty in our clinic.

Material and Methods: The data of patients who underwent laser hemorrhoidoplasty for hemorrhoidal disease in our clinic between January 2025 and January 2026 were retrospectively analyzed. Treated patients were evaluated in terms of demographic characteristics, clinical features, operative details, and postoperative outcomes. A one-year follow-up was also analyzed.

Results: A total of 25 patients who underwent laser hemorrhoidoplasty for hemorrhoidal disease were included in the study. Of these, 19 were male and 6 were female, with a mean age of 50.6 years. Seventeen patients had grade III and 8 patients had grade II hemorrhoidal disease. The mean number of hemorrhoidal packages per patient was 2. Laser hemorrhoidoplasty was performed on each package using an average of 6-8 applications, with a power of 6 watts and a total energy of 18 joules per package. The mean hospital stay was 1 day, and no postoperative pain was observed. At the one-year follow-up, patients were re-evaluated, and persistent symptoms were noted in 5 patients. The gender, hemorrhoid stage, and one-year post-treatment symptom status of the 25 patients included in the study are presented as percentages

Conclusion: Laser hemorrhoidoplasty is a minimally invasive technique used in the surgical management of hemorrhoidal disease. Consequently, in appropriately selected patients, it can be considered a safe and effective treatment option, offering a short postoperative recovery period and minimal or no pain, thereby providing a comfortable therapeutic approach.

Keywords: Hemorrhoidal disease, laser hemorrhoidoplasty, recovery period

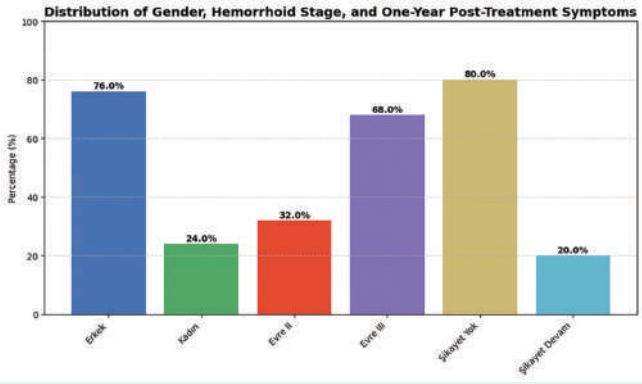

Figure 1. The gender, hemorhoid stage, and one-year post-treatment symptom status of the 25 patiens included in the study are presented as percentages.

[P-434]

The importance of laboratory parameters in the development of perianal fistula following perianal abscess

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Objective: Perianal fistula development after perianal abscess is common and increases patient morbidity. This study aimed to evaluate the potential role of inflammatory and hematological laboratory parameters at the time of admission in predicting perianal fistula development in patients presenting with perianal abscess.

Material and Methods: This retrospective, single-center study included 15 patients who underwent surgical drainage for perianal abscess at Hacettepe University between 2020 and 2025. Patients were followed for one year and divided into two groups according to the development of perianal fistula: Those who developed fistula (n=11) and those who did not (n=4). Demographic characteristics, including age, sex, and presence of diabetes mellitus, were recorded. Laboratory parameters at admission included white blood cell count, neutrophil and lymphocyte counts, C-reactive protein (CRP), neutrophil-to-lymphocyte ratio (NLR), platelet-to-lymphocyte ratio (PLR), and mean platelet volume (MPV). Data were analyzed using descriptive statistics.

Results: The mean age of the patients was 44.5 years, and 11 patients (73.3%) were male. During the follow-up period, perianal fistula developed in 73.3% of the patients. Higher white blood cell count, CRP, and NLR values were observed in patients who developed fistula. When a CRP cut-off value of 10 mg/L was applied, the majority of patients who developed fistula had CRP levels above this threshold. The mean CRP level in the fistula group was approximately 12 mg/L, and the mean NLR was 6.90. In contrast, patients without fistula development had lower CRP and NLR values. Changes in neutrophil and lymphocyte counts were consistent with the observed increase in NLR. No marked differences were observed between the groups in terms of PLR and MPV.

Conclusion: Elevated inflammatory laboratory parameters at admission in patients presenting with perianal abscess may serve as risk indicators for subsequent perianal fistula development. In particular, CRP ≥10 mg/L and elevated NLR appear to be practical and easily applicable parameters that may contribute to clinical decision-making. Prospective studies with larger patient cohorts are needed to further clarify the clinical utility of these findings.

Keywords: Perianal abscess, perianal fistula, C-reactive protein

[P-435]

Short- and mid-term outcomes of laser hemorrhoidoplasty: A single-center experience

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Objective: Introduction hemorrhoidal disease is a common anorectal condition that significantly affects quality of life. Conventional surgical techniques are often associated with postoperative pain and prolonged recovery. Laser hemorrhoidoplasty has emerged as a minimally invasive alternative in recent years. This study aimed to evaluate the short- and mid-term clinical outcomes of laser hemorrhoid surgery.

Material and Methods: This retrospective, single-center study included 32 patients with grade I-III hemorrhoidal disease who underwent laser hemorrhoidoplasty. Demographic characteristics, postoperative pain (VAS), length of hospital stay, time to return to daily activities, postoperative bleeding, patient satisfaction, recurrence, and reoperation rates were analyzed. Data were obtained from medical records and telephone-based patient-reported outcomes. Descriptive statistical analysis was performed.

Results: The mean age was 46.3±14.1 years, and 71.9% of patients were male. Grade II-III hemorrhoidal disease was present in 81.2% of cases. The median postoperative VAS score was 2 (IQR: 0-3), with 78.1% of patients reporting VAS ≤3. Median length of hospital stay was 1 day, and median time to return to daily activities was 2 days. Postoperative bleeding occurred in only two patients, both of whom required early reoperation (6.3%). Additionally, six patients underwent reoperation due to recurrent hemorrhoidal symptoms (18.8%). Patient satisfaction was 90.6%, and 87.5% of patients would recommend the procedure. The recurrence rate was 25%.

Conclusion: Laser hemorrhoidoplasty provides low postoperative pain and rapid recovery. Although postoperative bleeding and reoperation rates require careful consideration, high patient satisfaction supports the feasibility of this technique in clinical practice.

Keywords: hemorrhoidal disease, laser hemorrhoidoplasty, minimally invasive surgery

[P-436]

Clinical outcomes of crystallized phenol application in patients with uncomplicated pilonidal sinus disease

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Objective: Pilonidal sinus disease commonly affects young and active individuals and may result in considerable discomfort and work absenteeism. Although surgical techniques remain effective, they are associated with postoperative morbidity and extended recovery periods. Consequently, minimally invasive and outpatient treatment modalities have gained growing interest.

Material and Methods: In this retrospective study, 110 patients with uncomplicated pilonidal sinus disease containing a maximum of two pits were included. Twenty-seven patients (24.5%) were female and 83 (75.5%) were male, with a mean age of 24 years. Local anesthesia was achieved using lidocaine infiltration prior to the procedure. In patients with narrow sinus openings preventing clamp insertion, minimal incision was performed to widen the orifice. After mechanical curettage and removal of hair and debris, crystallized phenol was liquefied near body temperature and applied at an 80% concentration into the cavity. The mean procedure time was 10 minutes. No routine prophylactic antibiotics were administered. The first follow-up visit was scheduled 15-20 days after the initial session, and all patients were followed for 6 months.

Results: During the 6-month follow-up, recurrence was observed in 25 patients (22.7%), while 85 patients (77.3%) remained recurrence-free. Among the recurrence group, 16 patients (64%) had two pits. Single-session treatment was sufficient in 35 patients (31.8%). Complications included abscess formation in 7 patients (6.4%) and transient severe sacral pain in 2 patients (1.8%). Abscess cases were successfully managed with antibiotics and drainage.

Conclusion: Crystallized phenol application appears to be an effective, safe, and minimally invasive treatment option for uncomplicated pilonidal sinus disease when appropriate patient selection is applied. The short mean procedure time of 10 minutes, outpatient feasibility, and the absence of routine antibiotic requirement represent significant clinical advantages. The observed success rate of 77.3% and the manageable complication profile support the clinical applicability of this technique. An increased number of pits may be associated with a higher risk of recurrence. These findings suggest that crystallized phenol can be considered a viable alternative to surgical treatment in selected patients. Nevertheless, prospective and comparative studies with longer follow-up periods are required to further validate these results.

Keywords: Pilonidal sinus, crystallized phenol, minimally invasive treatment

Figure 1. A patient with a single pit treated with phenol.

Table 1. Patient demographic characteristics (n=110)
Variable value
Total number of patients 110
Female 27 (24.5%)
Male 83 (75.5%)
Mean age (years) 24
Follow-up duration 6 months

Table 2. Clinical outcomes
Parameter value
Recurrence-free 85 (77.3%)
Recurrence 25 (22.7%)
Single-session success 35 (31.8%)
Abscess formation 7 (6.4%)
Transient severe sacral pain 2 (1.8%)
Overall complication rate (8.2%)

[P-437]

Breast hamartoma as a rare benign entity: Surgical outcomes, risk factors for concomitant malignancy, and follow-up results: A single-center retrospective study

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Objective: Breast hamartomas are rare benign breast lesions with diagnostic challenges in imaging and histopathology. There is no consensus on the optimal management or follow-up strategy following excisional biopsy. The aim of our study was to evaluate the follow-up data of patients who were diagnosed with breast hamartoma by excisional biopsy in our center.

Material and Methods: This retrospective study included patients diagnosed with breast hamartoma after excisional biopsy between 2018 and 2024. Demographic, clinical, surgical, and pathological characteristics, along with follow-up outcomes, were analyzed.

Results: A total of 23 female patients (median age 46 years) were included. The most common symptom was a palpable mass (56%), and 30% were referred after lesion detection in screening. Radiological imaging revealed that 17 patients (72%) were categorized as BI-RADS 4a. Preoperative core biopsy showed fibroepithelial lesions in 52% of patients. Lumpectomy was performed in 21 patients, while the remaining two patients underwent reduction mammoplasty. The median lesion size was 40 mm. During a median follow-up of 42 months, no recurrence, *in situ* carcinoma, or breast cancer was observed.

Conclusion: Breast hamartomas exhibit a benign course, and no malignancy was detected during follow-up. Routine breast cancer screening protocols appear sufficient for these patients, and no additional follow-up strategy is necessary post-excision.

Keywords: Benign breast lesion, breast cancer risk, hamartoma

[P-438]

Clinical, biochemical, and surgical characteristics of patients with pheochromocytoma: A single-center retrospective study

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Objective: Pheochromocytoma is a rare endocrine tumor that requires a multidisciplinary approach due to its variable clinical presentation and challenges in perioperative management. This study aims to descriptively evaluate the demographic, clinical, biochemical, and surgical characteristics of patients who underwent surgery with a diagnosis of pheochromocytoma.

Material and Methods: Twenty-five patients who underwent surgical treatment for pheochromocytoma at our center were included in this retrospective descriptive study. Demographic data, admission findings, hypertension characteristics, biochemical diagnostic methods, tumor characteristics, preoperative preparation process, surgical approach, perioperative complications, and follow-up results were recorded. Continuous variables were presented as median and minimum-maximum values, while categorical variables were presented as numbers and percentages.

Results: The median age of the patients was 57 years; 72% were female, and 72% were classified as ASA III. The most common findings at admission were hypertension (44%) and incidentaloma (40%), while the distribution of symptoms included headache (40%), palpitations (40%), and sweating (32%). Sustained hypertension was observed in 84% of patients, while paroxysmal hypertension occurred in 16%. Diagnosis was established via plasma metanephrines in 52% and 24-hour urine analysis in 48% of cases; median metanephrine was 385.0 (min-max 4.4-4111.0), and median normetanephrine was 1400.0 (min-max 61.0-42880.0). While 48% of patients had a diagnosis of pheochromocytoma preoperatively, 52% were not preoperatively predicted. Of the tumors, 68% were located in the right adrenal gland with a median diameter of 40 mm (14-120); extra-adrenal localization was detected in 4%. In preoperative preparation, alpha-blockade was administered to 60% (median duration 20 days, 0-150) and beta-blockade to 40%. The surgical approach consisted of laparoscopic (56%) and open adrenalectomy (44%), with a median operative time of 120 minutes (45-315). Intraoperative hypertensive crisis occurred in 12%, while postoperative complications were observed in only one patient (Clavien-Dindo 3A); the median hospital stay was 6 days (3-11). Resolution of hypertension was achieved in 76% of patients postoperatively. No malignancy/metastasis, recurrence, or mortality was detected during a median follow-up of 21 months (2-32) (Table 1).

Conclusion: This retrospective series confirms the heterogeneous clinical presentation of pheochromocytoma, frequently manifesting as incidentalomas or via atypical symptoms. Nevertheless, guideline-concordant preoperative medical optimization and surgical management maintained low rates of intraoperative hypertensive crises and postoperative complications. The safe, frequent utilization of laparoscopic adrenalectomy aligns with the documented efficacy of minimally invasive surgery. Furthermore, postoperative hypertension resolution in most patients, alongside the absence of recurrence or mortality, underscores the favorable outcomes attainable in specialized centers. These descriptive findings emphasize the critical role of early diagnostic suspicion, meticulous preoperative preparation, and multidisciplinary management in pheochromocytoma care (Table 2).

Keywords: Adrenal tumor, adrenalectomy, hypertension, metanephrine, pheochromoc

Table 1. Demographic, clinical, biochemical, and surgical characteristics of patients with pheochromocytoma

PARAMETRE	AÇIKLAMA / BİRİM
Hasta sayısı	25
Yaş (yıl)	52.7 ± 13.4; medyan 57.0 [45.0–62.0] (min–maks 25.0–75.0)
Cinsiyet	Erkek: 7 (28%); Kadın: 18 (72%)
ASA	ASA II: 7 (28%); ASA III: 18 (72%)
Baskın başvuru bulgusu	Hipertansiyon: 11 (44%); Baş ağrısı: 3 (12%); Çarpıntı: 1 (4%); İnsidentaloma: 10 (40%)
Paroksismal hipertansiyon	Yok: 21 (84%); Var: 4 (16%)
Sürekli hipertansiyon	Yok: 4 (16%); Var: 21 (84%)
Baş ağrısı	Yok: 15 (60%); Var: 10 (40%)
Çarpıntı	Yok: 15 (60%); Var: 10 (40%)
Terleme	Yok: 17 (68%); Var: 8 (32%)
Tanı testi	Plazma metanefrin: 13 (52%); 24 saat idrar: 12 (48%)
Metanefrin düzeyi	n=25; medyan 385.0 [65.0–1196.0] (min–maks 4.4–4111.0)
Normetanefrin düzeyi	n=25; medyan 1400.0 [737.0–5352.0] (min–maks 61.0–42880.0)
Preop feokromasitoma tanısı	Hayır: 13 (52%); Evet: 12 (48%)
Genetik test	Yapılmadı: 15 (60%); Pozitif: 4 (16%); Negatif: 6 (24%)
Tümör tarafı	Sağ: 17 (68%); Sol: 8 (32%)
Tümör çapı (mm)	40.0 [31.0–60.0] (min–maks 14.0–120.0)
Ekstra-adrenal (paraganglioma)	Hayır: 24 (96%); Evet: 1 (4%)
Malign/metastatik	Hayır: 25 (100%)
Preop alfa-blokaj	Hayır: 10 (40%); Evet: 15 (60%)
Alfa-blokaj süresi (gün)	20.0 [20.0–20.0] (min–maks 0.0–150.0)
Beta-blokaj	Hayır: 15 (60%); Evet: 10 (40%)
Cerrahi yaklaşım	Açık: 11 (44%); Laparoskopik: 14 (56%)
Ameliyat süresi (dk)	120.0 [120.0–175.0] (min–maks 45.0–315.0)
İntraop hipertansif kriz	Yok: 22 (88%); Var: 3 (12%)
Postop komplikasyon	Yok: 24 (96%); Var: 1 (4%)
Clavien–Dindo	0: 24 (96%); 3A: 1 (4%)
Hastanede yatış süresi (gün)	6.0 [4.0–7.0] (min–maks 3.0–11.0)
Postop hipertansiyonun düzelmesi	Hayır: 6 (24%); Evet: 19 (76%)
Nüks	Hayır: 25 (100%); Evet: 0 (0%)
Takip süresi (ay)	21.0 [11.0–25.0] (min–maks 2.0–32.0)
Takipte mortalite	Hayır: 25 (100%); Evet: 0 (0%)

Table 2. Comparison of the current study with contemporary and reliable literature

ÇALIŞMA (YAZAR, YIL)	TASARIM / ÖRNEKLEM	LİTERATÜRDE RAPORLANAN ANA BULGU	ÇALIŞMAMIZ (n=25)	BİZİM SERİ İLE YORUM
Bojoga ve ark., 2024	UK çok merkezli ulusal veri; **2007** PPGL operasyonu	Operasyonların **%69'u laparoskopik**; **medyan yatış 4 gün**; merkezlerin **%48'inde** periop protokol var; alfa-blokajda phenoxybenzamine sık tercih.	Laparoskopik **%56**; yatış **medyan 6 gün [4–7]**	Bizde laparoskopik oranı yüksek; yatış süresi UK verisine göre daha uzun
Wang ve ark., 2023	Sistematik derleme + güncel meta-analiz	**Preop α-blokaj**, "α-blokaj yok"a kıyasla **daha stabil intraop hemodinami** veya **daha iyi periop sonuç** sağlamamış; daha güçlü RCT lere ihtiyaç vurgulanıyor.	Alfa-blokaj **%60**; intraop hipertansif kriz **%12**; postop komplikasyon **%4**	Literatürde α-blokajın sonuçlara etkisi tartışmalı; bizim seride düşük komplikasyon ve kriz oranları, uygun seçilmiş hastalarda/iyi anestezi-cerrahi koordinasyonunda güvenli sonuçlar elde edilebildiğini destekler
Bojoga ve ark., 2024 (PMC tam metin)	UK uygulama analizi (PPGL cerrahisi)	"2016 sonrası" dönemde yatış süresinin azaldığı; **medyan 3–4 gün** düzeylerinin raporlandığı belirtiliyor.	Yatış **medyan 6 gün**	Bizde yatış daha uzun; bu, olası daha temkinli takip, komorbidite dağılımı (ASA III oranı yüksek) olabilir
Fagundes ve ark., 2022	Güncel derleme (perioperatif yönetim)	Cerrahi/anestezi yönetimindeki gelişmelerle fonksiyone PPGL cerrahisinde mortalitenin **yaklaşık %0–2.9** aralığına gerilediği vurgulanıyor.	Mortalitenin olmaması **(%0)**	Serimizin mortalitesiz seyri, güncel derlemelerdeki "düşük mortalite" çerçevesiyle uyumlu; tek merkez küçük seri olduğundan genellenebilirlik sınırlıdır.
Taïeb ve ark., 2023	Klinik konsensüs/guideline	PPGL yönetiminde biyokimyasal tanı, görüntüleme, genetik değerlendirme ve perioperatif hazırlığın standardizasyonu vurgulanır.	Genetik test: yapılmadı **%60**, pozitif **%16**, negatif **%24**; preop tanı **%48**	Serimiz, kılavuzların vurguladığı "tanı + periop hazırlık" eksenini sahada yansıtıyor; genetik testin her olguda uygulanmaması gerçek yaşam pratiği ile uyumlu bir bulgudur.
Zhang ve ark., 2022	Sistematik derleme + meta-analiz (RLA vs TLA)	Retroperitoneal ve transperitoneal laparoskopik yaklaşımların etkinlik/güvenlik karşılaştırmaları; hemodinami ve periop sonuçlarda yaklaşım farkı tartışılır.	Laparoskopik oran **%56**; intraop kriz **%12**	Bizde yaklaşım alt kırılımı (RLA/TLA) olmadığı için doğrudan kıyas sınırlı; ancak minimal invaziv cerrahinin uygulanabilirliği ve düşük komplikasyon oranı literatür çerçevesiyle uyumlu.

[P-439]

The importance of preoperative parameters in detecting lymph node metastases in patients with medullary thyroid cancer

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Objective: This study aims to establish objective criteria for surgical planning in patients diagnosed with medullary thyroid cancer (MTC). It evaluates the relationship between preoperative calcitonin (CT) and carcinoembryonic antigen (CEA) levels, as well as preoperative inflammation indices (NLR, PLR, and SII), with the clinicopathological and molecular characteristics of MTC. Additionally, it assesses the utility of these parameters in predicting lymph node (LN) metastases. Accurate prediction of LN metastases may help unnecessary extensive surgical dissections, improve patient comfort, and reduce complications while enhancing survival outcomes.

Material and Methods: A retrospective analysis was conducted on patients aged 18-90 who underwent surgery for MTC at Ankara Bilkent City Hospital between 2019 and 2024. The patients' clinical examination findings, laboratory results, surgical notes, pathology reports, imaging data, age, and gender were reviewed. A total of 54 patients diagnosed with MTC (2.25% of all thyroid cancers) were identified. After excluding four patients due to missing laboratory results, surgical notes, or pathology reports, the study proceeded with 50 patients. Preoperative and postoperative CT, CEA, NLR, PLR, and SII values, pathological staging, immunohistochemical staining results, and surgical notes were meticulously examined and recorded. Patients were categorized into groups with and without LN metastases, and the effect of the analyzed parameters on LN metastasis was statistically evaluated. Statistical analyses were performed by BUİSTDAM.

Results: No statistically significant relationship was found between LN metastases and patient age, gender, preoperative CT, CEA, NLR, PLR, or SII levels. However, the presence of LN metastases was significantly higher in nodules with microcalcifications detected ultrasonography ($p=0.010$) and in nodules that stained positively for chromogranin A in pathology reports ($p=0.031$).When comparing preoperative and postoperative CT, CEA, and hemoglobin (Hb) levels, a statistically significant decrease was observed regardless of the type of surgery performed ($p=0.004$, $p=0.039$, and $p=0.002$, respectively). Biochemical improvement was detected in 68.75% of patients postoperatively. Among patients who underwent only total thyroidectomy (BTT), 93.3% achieved biochemical improvement and were included in a follow-up program.In stage 1-2 patients (those without LN metastases), postoperative CT levels were significantly lower ($p=0.003$).

Conclusion: This study demonstrates the relationship between preoperative CT and CEA levels, as well as inflammation scores, with LN metastases in MTC patients. It also highlights the significance of postoperative biomarker changes in evaluating surgical success and patient recovery. However, considering the study's limitations, larger-scale and prospective studies are needed to validate these findings. This approach could contribute to the development of multidisciplinary treatment protocols and help improve long-term survival rates while minimizing complications in MTC patients.

Keywords: Medullary thyroid cancer, calcitonin, carcinoembryonic antigen

[P-440]

Laparoscopic and open approaches in adrenal mass surgery: A single-center experience from 2012 to 2025

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Objective: Adrenal masses are being detected with increasing frequency in clinical practice due to the widespread use of advanced imaging modalities, and patients requiring surgical treatment constitute a significant subgroup. Although laparoscopic adrenalectomy is currently accepted as the gold standard approach for the surgical management of benign adrenal masses, factors such as tumor size, hormonal activity, and suspicion of malignancy continue to play a decisive role in the selection of the surgical approach. The aim of this study was to evaluate the demographic characteristics, hormonal activity status, surgical approaches, and perioperative outcomes of patients who underwent surgical treatment for adrenal masses at a tertiary education and research hospital.

Material and Methods: Patients who underwent surgical treatment with the diagnosis of adrenal mass between 2012 and 2025 were retrospectively analyzed. Demographic data, tumor sizes, adrenal gland localization (right/left), hormonal activity status, surgical approaches (laparoscopic or open), conversion rates from laparoscopic to open surgery, and histopathological diagnostic subgroups were recorded. The obtained data were evaluated using descriptive statistical methods.

Results: A total of 140 patients were included in the study. Of these, 41 were male (29.3%) and 99 were female (70.7%). Sixty-five masses were located in the right adrenal gland (46.4%) and 75 in the left adrenal gland (53.6%). The mean tumor size was 5.02 cm, with a minimum of 1.4 cm and a maximum of 20 cm. Hormone-active adrenal masses were identified in 65 patients (46.4%), while non-functioning adrenal masses were present in 86 patients (61.4%); metastatic involvement was observed in 9 patients (6.4%). Among hormone-active patients, Cushing syndrome was detected in 36 cases (55.4%), Conn syndrome in 16 cases (24.6%), and pheochromocytoma in 13 cases (20.0%). Regarding the surgical approach, laparoscopic adrenalectomy was performed in 103 patients (73.6%), whereas primary open surgery was applied in 23 patients (16.4%). Conversion from laparoscopic to open surgery was required intraoperatively in 14 patients (13.6%).

Conclusion: This large patient series demonstrates that the laparoscopic approach can be safely and effectively applied at a high rate in adrenal mass surgery in tertiary centers. Larger tumor size and the presence of hormonal activity were found to be associated with the need for open surgery or conversion from laparoscopic to open surgery. It was concluded that adrenal surgery can be performed effectively and safely with acceptable morbidity rates in experienced centers.

Keywords: Adrenal mass, adrenalectomy, surgery

[P-441]

Intraoperative parathyroid hormone dynamics in predicting surgical cure in double parathyroid adenomas in primary hyperparathyroidism

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Objective: The incidence of double adenomas in primary hyperparathyroidism (pHPT) ranges between 2-20% and represents an important cause of persistent disease. In this study, we aimed to evaluate intraoperative parathyroid hormone (iPTH) dynamics in predicting surgical cure in patients with double adenomas.

Material and Methods: We retrospectively analyzed patients who underwent parathyroidectomy for pHPT between 2015 and 2025 and achieved surgical cure after removal of two pathological glands. In all operations, peripheral venous blood samples for iPTH measurement were obtained pre-excision and at the 10th and 20th minutes after excision. A ≥50% decrease in PTH compared to the pre-excision value was considered sufficient for surgical success. For the 8 patients with persistent disease after the first operation, iPTH values from both the first and second surgeries were evaluated. Among patients cured after the first surgery, iPTH measurements were analyzed separately in 19 patients in whom measurements were obtained after removal of both pathological glands, and in 7 patients in whom iPTH was measured after removal of the first gland and again after removal of the second gland. In total, 49 iPTH measurements were evaluated. Normocalcemia at 6 months was defined as surgical cure. Two criteria were assessed for predicting surgical cure: •Method 1: >50% decrease in iPTH at the 10th and/or 20th minute compared to the pre-excision value. •Method 2: >50% decrease in iPTH at the 10th and/or 20th minute plus a decline to within or below the normal reference range (PTH <65 ng/mL). Sensitivity, specificity, positive predictive value (PPV), negative predictive value, and overall accuracy were calculated. False-positive and false-negative rates were compared.

Results: Thirty-four patients (mean age 57 years) were included; 28 (82.4%) were female and 6 were male. Surgical cure was achieved with a single operation in 26 patients, while 8 (23.5%) required reoperation due to persistent disease. Of the second adenomas, 20 (59%) were located contralaterally and 14 (41%) ipsilaterally. For predicting surgical cure, Method 1 had 6 (12.2%) false positives, whereas Method 2 had none (p=0.0312). False-negative rates were 1 (2.9%) and 2 (4.1%) patients for Methods 1 and 2, respectively (p=1). Although Method 2 showed slightly lower sensitivity (94.1% vs. 97.1%), it demonstrated higher specificity (100% vs. 60%), PPV (100% vs. 84.6%), and overall accuracy (95.9% vs. 85.7%).

Conclusion: Double adenomas carry a high risk of persistent disease, with most second adenomas located contralaterally. In addition to a >50% decrease in iPTH, a decline into the normal reference range improves overall performance, significantly reduces false positives, and may help minimize the risk of persistent disease.

Keywords: Primary hyperparathyroidism, double adenoma, intraoperative parathyroid hormone

Table 1. Distribution of true and false positives, true and false negatives in Methods 1 and 2

Criteria	TP	TN	FP	FN	Total (N)
Method 1	33	9	6	1	49
Method 2	31	15	0	2	49

Table 2. Sensitivity, specificity, PPV, NPV, and overall accuracy of Methods 1 and 2

Criteria	Sensitivity	Specificity	PPV	NPV	Accuracy
Method 1	97.1% (85.1-99.5)	60.0% (35.7-80.2)	84.6% (70.3-92.8)	90.0% (59.6-98.2)	85.7% (73.3-92.9)
Meyhod 2	94.1% (80.9-98.4)	100.0% (79.6-100.0)	100.0% (89.3-100.0)	88.2% (65.7-96.7)	95.9% (86.3-98.9)

[P-442]

The relationship between tumor size and hounsfield unit values in adrenal masses and their correlation with pathological results

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Objective: Tumor size and computed tomography (CT) Hounsfield Unit (HU) values are used as key criteria in predicting malignancy risk in the management of adrenal masses. However, in selected patient populations who undergo surgery, it is unclear to what extent these parameters predict pathological outcomes. In this study, we aimed to evaluate the relationship between tumor size and HU values and pathological results in patients who underwent adrenal surgery.

Material and Methods: Seventy-eight patients who underwent adrenal surgery were retrospectively analyzed. Tumor size was classified based on the largest diameter as <4 cm, 4-6 cm, and ≥6 cm. CT attenuation values were categorized as <10 HU and ≥10 HU. Pathological results were grouped as adrenocortical adenoma and non-adenoma lesions (pheochromocytoma, myelolipoma, cysts, and malignant tumors). Chi-square and Fisher's exact tests were used for comparisons between groups.

Results: Among the 78 cases, adrenocortical adenoma was detected in 37 patients (47.4%) and non-adenoma pathology in 41 patients (52.6%). Seven cases (9.0%) were malignant. The rate of non-adenoma pathology increased significantly in parallel with tumor size (<4 cm: 32.4%; 4-6 cm: 52.9%; ≥6 cm: 86.4%; p=0.00032). All malignant cases were in the ≥6 cm group, and no malignancy was detected in masses <6 cm (p=0.00034). No significant association was found between HU value and pathological results (<10 HU: 55.4% non-adenoma; ≥10 HU: 33.3% non-adenoma; p=0.405). When size and HU were evaluated together, the non-adenoma rate was 30.8% in the <4 cm and <10 HU group, whereas it increased to 76.7% in the ≥4 cm and <10 HU group (p=0.001).

Conclusion: In patients undergoing adrenal surgery, increasing tumor size is strongly associated with non-adenoma pathology and malignancy. Malignancy was detected only in masses ≥6 cm. HU values provided limited contribution in predicting pathological outcomes in this selected surgical population. Tumor size remains the most decisive factor in the surgical decision-making process for adrenal masses.

Keywords: Adrenal mass, tumor size Hounsfield unit

Table 1. Combined analysis of tumor size and Hounsfield unit (HU) values with pathological outcomes. Table showing the comparative analysis of tumor size, size cut-off value, CT attenuation (HU) values, and size + HU combinations with adenoma, non-adenoma, and malignant pathology rates in patients undergoing adrenal surgery. Increasing tumor size is significantly associated with non-adenoma pathology and malignancy, whereas HU value alone shows limited predictive value for pathological outcomes

Değişken	Grup	Adenom n (%)	Non-adenom n (%)	Malign n (%)	Toplam	p değeri
Tümör boyutu	<4 cm	25 (67.6)	12 (32.4)	0 (0)	37	
	4–<6 cm	8 (47.1)	9 (52.9)	0 (0)	17	
	≥6 cm	3 (13.6)	19 (86.4)	6 (27.3)	22	**0.00032***
Boyut cut-off	<6 cm	33 (61.1)	21 (38.9)	0 (0)	54	
	≥6 cm	3 (13.6)	19 (86.4)	6 (27.3)	22	**0.00034†**
BT attenüasyonu (HU)	<10 HU	25 (44.6)	31 (55.4)	–	56	
	≥10 HU	4 (66.7)	2 (33.3)	–	6	**0.405**
Boyut + HU kombinasyonu	<4 cm & <10 HU	18 (69.2)	8 (30.8)	0 (0)	26	
	≥4 cm & <10 HU	7 (23.3)	23 (76.7)	5 (16.7)	30	
	<4 cm & ≥10 HU	3 (75.0)	1 (25.0)	0 (0)	4	
	≥4 cm & ≥10 HU	1 (50.0)	1 (50.0)	1 (50.0)	2	**0.001‡**

* Ki-kare testi (non-adenom patoloji için)
† Fisher exact testi (malignite için)
‡ Fisher exact testi (boyut + HU kombinasyonu için)

[P-443]

Diagnostic challenges in gallbladder adenomyomatosis: A retrospective analysis of clinical, radiological, and histopathological findings

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Objective: Adenomyomatosis is a benign lesion of the gallbladder; however, it poses diagnostic challenges. Clinically, it is frequently associated with cholelithiasis and may often be overlooked in the preoperative period due to its non-specific symptoms. This study aimed to evaluate the demographic, clinical, radiological, and pathological characteristics of patients who underwent cholecystectomy at the University of Health Sciences Türkiye, Ankara Etlik City Hospital General Surgery Clinic between October 2022 and October 2025 and were histopathologically diagnosed with adenomyomatosis, as well as to assess the concordance between radiological diagnosis and histopathological findings.

Material and Methods: A total of nine cases that underwent laparoscopic cholecystectomy during the specified period and were reported as adenomyomatosis on pathological examination were retrospectively analyzed. The patients' age, sex, presenting symptoms, indication for surgery, presence of gallstones, radiological findings (US and MRI/MRCP), type of adenomyomatosis, localization, gallbladder wall thickness, associated pathologies, and radiology-pathology concordance were evaluated.

Results: Seventy-seven point eight percent of the cases were female, and the mean age was 53.3±8.7 years. The most common presenting symptom was abdominal pain (77.8%), and the most frequent indication for surgery was cholelithiasis (77.8%). All patients underwent laparoscopic cholecystectomy. Gallstones were present in 77.8% of the patients. On ultrasonography, the most common diagnoses were adenomyomatosis (44.4%) and cholelithiasis (44.4%), whereas no significant findings were detected in 66.7% of the cases who underwent MRI/MRCP. Histopathological examination revealed that 77.8% of the cases were of the focal type, and 66.7% were located in the fundus. The mean gallbladder wall thickness was 3.25 mm. The most common associated pathology was cholelithiasis (22.2%). No dysplasia or malignancy was detected in any of the cases. Radiology-pathology concordance was achieved in only 44.4% of the cases.

Conclusion: Despite its benign nature, adenomyomatosis is a gallbladder pathology that is frequently overlooked in the preoperative period and may be confused with malignancy. As reported in the literature, imaging modalities may not always accurately reflect the type and extent of adenomyomatosis. This is consistent with the low radiology-pathology concordance rate observed in our study. In our series, the predominance of the focal type and fundus localization supports the most commonly reported morphological pattern in the literature. These findings once again emphasize that, despite the benign nature of adenomyomatosis, routine histopathological examination of surgical specimens is indispensable for clinical safety.

Keywords: Adenomyomatosis, cholelithiasis, gallbladder, histopathology, laparoscopic cholecystectomy

Table 1. Demographic characteristics

Variable	Category	n	%
Sex	Female (f)	7	77.8
	Male (m)	2	22.2
Age(year)	mean±SS	53.3±8.7	
	Median (min-max)	51 (45-69)	

Table 2. Clinical characteristics

Değişken	Kategori	n	%
Semptom	Karın ağrısı	7	77.8
	Karın ağrısı, hazımsızlık, şişkinlik	1	11.1
	Karın ağrısı, bulantı	1	11.1
Operasyon Endikasyonu	Kolelitiazis	7	77.8
	Adenomyomatozis	2	22.2
Safra Taşı Varlığı	Var	7	77.8
	Yok	2	22.2
Operasyon Tipi	Laparoskopik	9	100

Table 3. Imaging findings

Değişken	Kategori	n	%
USG Tanısı	Adenomyomatozis	4	44.4
	Kolelitiazis	4	44.4
	Kolesistit	1	11.1
MR/MRCP Tanısı	Yok	6	66.7
	Adenomyomatozis	2	22.2
	Polip	1	11.1
Adenomyomatozis Tipi	Fokal	7	77.8
	Segmenter	2	22.2
Lokalizasyon	Fundus	6	66.7
	Fundus ve korpus	2	22.2
	Korpus	1	11.1
Duvar Kalınlığı (mm)	Ortalama ± SS	3.25 ± 1.1	
	Medyan (min–maks)	3 (2–5)	

Table 4. Pathological findings

Variable	Category	n	%
Accompanying pathology	None	5	55.6
	Cholelithiasis	2	22.2
	Cholecystitis	1	11.1
	Cholesterolosis	1	11.1
Dysplasia/malignancy	None	9	100
Radiology/pathology compatibility	Yes	4	44.4
	No	5	55.6

[P-444]

Serum vitamin B12 levels and etiological distribution before liver transplantation a single-center experience

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Objective: Vitamin B12 levels are frequently altered in liver diseases. Markedly elevated serum Vitamin B12 levels may be observed in advanced cirrhosis, hepatocellular carcinoma (HCC), and fulminant hepatitis. The aim of this study was to evaluate pre-transplant serum vitamin B12 levels and their relationship with underlying disease etiology in patients undergoing liver transplantation.

Material and Methods: This retrospective study included 60 patients who underwent liver transplantation at our center between 2024 and 2025. Pre-transplant serum vitamin B12 levels (pg/mL) and etiological diagnoses were recorded from patient files. Etiologies were classified as HBV, HBV + HCC, alcoholic cirrhosis, NASH, autoimmune hepatitis, cryptogenic cirrhosis, fulminant hepatitis, HCC, and other causes. Descriptive statistics and intergroup comparisons were performed. A p-value <0.05 was considered statistically significant.

Results: Serum Vitamin B12 levels ranged between 197 and 771 pg/mL. Patients with fulminant hepatitis and alcoholic cirrhosis had significantly elevated vitamin B12 levels (>2000 pg/mL) ($p<0.05$). High levels were also observed in patients with HCC. In contrast, NASH, cryptogenic cirrhosis, and some HBV-related cases showed relatively lower vitamin B12 levels. A statistically significant difference in serum vitamin B12 levels was found among etiological groups.

Conclusion: Pre-transplant serum vitamin B12 levels differ significantly according to liver disease etiology. Extremely high levels were detected in fulminant hepatitis and advanced HCC, whereas relatively lower levels were observed in NASH and cryptogenic cirrhosis. Preoperative vitamin B12 measurement may serve as a supportive biomarker in assessing disease severity and prognosis in liver transplant candidates.

Keywords: Liver transplantation, vitamin B12, etiology

[P-445]

Risk stratification approach based on clinical and imaging findings in patients with invasive and premalignant lesions in cholecystectomy specimens

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Objective: Gallbladder carcinoma is a clinically important malignancy due to its aggressive course and late diagnosis, despite its low incidence. Invasive malignancy and true premalignant gallbladder lesions may be detected incidentally following cholecystectomy performed for benign indications; however, in most cases, no specific preoperative clinical or imaging findings suggestive of malignancy are observed. The aim of this study was to evaluate the clinical and imaging characteristics of invasive and true premalignant lesions detected in cholecystectomy specimens and to identify meaningful patterns for risk stratification.

Material and Methods: This single-center, retrospective, observational study reviewed the pathology reports of 1,588 adult patients who underwent cholecystectomy for benign indications between 1, January, 2024 and 31, December, 2025. Cases with invasive gallbladder malignancy or true premalignant lesions—defined as biliary intraepithelial neoplasia (BilIN), epithelial dysplasia, or adenoma—were identified. Demographic characteristics, clinical presentation, laboratory findings, imaging results, surgical data, and pathological outcomes of these patients were analyzed in detail. Descriptive statistics were used, and proportion comparisons and binomial testing were applied where appropriate.

Results: Among 1,588 cholecystectomy specimens, one invasive gallbladder adenocarcinoma (0.06%) and nine true premalignant lesions (0.57%) were identified, yielding a combined invasive/premalignant incidence of 0.63%. The majority of premalignant lesions were low-grade BilIN, with only one case of adenoma; no high-grade dysplasia was observed. The invasive malignancy was a 20 mm adenocarcinoma staged as pT3, with lymphovascular invasion present. All invasive and premalignant cases occurred in female patients, and 80% were aged 50 years or older (median age: 57). The exclusive female distribution was statistically significant compared with the expected sex distribution (binomial test, $p<0.05$). Most patients (90%) underwent elective surgery for biliary colic. Acute cholecystitis was uncommon, and no cholestatic laboratory pattern was observed. On ultrasonography, gallbladder wall thickening ≥5 mm was detected in 60% of cases, while no patient demonstrated a mass or imaging-based suspicion of malignancy. All invasive and premalignant lesions were detected incidentally (100%).

Conclusion: Although invasive and true premalignant gallbladder lesions are rare in cholecystectomies performed for benign indications, they may remain completely silent clinically and radiologically and can be detected incidentally even at advanced stages. The incidence rates observed in our center appear to be consistent with those reported in the literature (0.1-0.4%) and in national series from Türkiye (approximately 0.2-0.3%). These findings suggest that reliance on a single clinical or radiological alarm sign may be insufficient, and that risk stratification approaches incorporating female sex, older age, and non-specific imaging findings may improve preoperative awareness.

Keywords: Gallbladder carcinoma, incidental carcinoma, cholecystectomy, premalignant lesions, risk stratification

Table 1. Histopathological distribution of cholecystectomy specimens for benign disease (n=1.588)

TABLO 1. BENİGN ENDİKASYONLARLA YAPILAN KOLESİSTEKTOMİLERDE HİSTOPATOLOJİK SONUÇLARIN DAĞILIMI (N = 1588)		
Histopatolojik Sonuç	**Hasta Sayısı (n)**	**Oran (%)**
Benign inflamatuvar değişiklikler*	1093	68,8
Pilorik metaplazi	225	14,2
İntestinal metaplazi	46	2,9
Kolesterol polip	129	8,1
Adenomiyomatozis	85	5,4
Gerçek premalign lezyonlar†	**9**	**0,57**
İnvaziv safra kesesi karsinomu	**1**	**0,06**
Toplam	**1588**	**100**

* Akut/kronik kolesistit, kolesterolozis vb.
† Biliyer intraepitelyal neoplazi (BilIN), epitelyal displazi, adenom

Table 2. Clinical and pathological features of invasive and premalignant gallbladder lesions (n=10)

TABLO 2. İNVAZİV VE PREMALİGN SAFRA KESESİ LEZYONU SAPTANAN OLGULARIN KLİNİK, GÖRÜNTÜLEME VE PATOLOJİK ÖZELLİKLERİ (n = 10)					
Değişken	**n**	**%**	**Değişken**	**n**	**%**
Kadın cinsiyet (p=<0.05*)	10	100	WBC ≥10 ×10³/µL	3	30
≥50 yaş	8	80	CRP yüksekliği	3	30
Medyan yaş (min–maks)	57	(29–65)	Kolestatik laboratuvar paterni	0	0
Elektif cerrahi	9	90	Safra taşı varlığı	8	80
Biliyer kolik endikasyonu	9	90	US duvar kalınlığı ≥5 mm	6	60
Premalign lezyon (BilIN / adenom)	9	90	Perikolesistik sıvı	2	20
İnvaziv adenokarsinom	1	10	US kitle/malignite şüphesi	0	0
İnsidental tanı	10	100	İleri görüntüleme (BT/MRCP)	1	10

[P-446]

Outcomes of percutaneous gallbladder drainage in high-risk surgical patients: A bridge treatment vs. surgery

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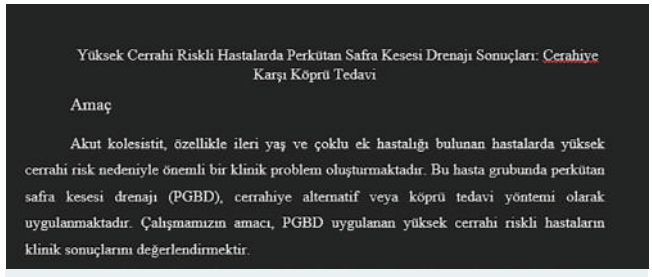
Objective: Acute cholecystitis poses a significant clinical problem, particularly in elderly patients with comorbidities, due to its high surgical risk. In this patient group, percutaneous gallbladder drainage (PGBD) is used as an alternative or bridging treatment to surgery. The aim of our study is to evaluate the clinical outcomes of high-surgical-risk patients undergoing PGBD.

Material and Methods: This study included patients who underwent PGBD and were followed up in our Interventional Radiology unit between April 2021 and July 2025. Demographic characteristics, comorbidities, indications for the procedure, procedure-related complications, mortality rates, and the need for surgery during the follow-up period were evaluated.

Results: The mean age was 71.9, with an age range of 33-94. 46 patients (45.54%) were male and 55 (54.45%) were female. The most common comorbidities were diabetes mellitus (32.6%, n=33), hypertension (28.7%, n=29), and coronary artery disease (19.8%, n=20). A large proportion of patients had multiple comorbidities. Regarding the indications for the procedure, acute cholecystitis was found in 84.1% (n=85), gallbladder perforation in 9.9% (n=10), and emphysematous cholecystitis in 6.9% (n=7). Fifteen patients died before being discharged from the hospital. The mean hospital stay was 21 (1-56) days, the mean catheter removal time was 27.2 (1-60) days, and the mean follow-up period was 36 (0-48) months. Procedure-related complications were observed in 15.8% (n=16) of patients. Complications included severe post-procedure pain (n=5), intra-gallbladder hemorrhage (n=4), catheter displacement (n=4), and intra-abdominal bile leakage (n=3). Additional intra-abdominal drains were placed in patients who developed intra-abdominal bile leakage. The overall mortality rate was 14.8%. The majority of patients who died were those followed in the intensive care unit due to comorbidities and had a higher mean age. During the follow-up period, 19.8% (n=20) of patients were discharged, and 15.8% (n=16) underwent cholecystectomy. The mean cholecystectomy time was 2 months. In four of the patients who underwent surgery, laparoscopic surgery was converted to open surgery. Of these patients, one underwent partial cholecystectomy, one underwent choledoch-jejunostomy due to choledochal injury, and two underwent open cholecystectomy.

Conclusion: PGBD is a safe and effective method for managing acute cholecystitis and its complications in elderly patients and those with high surgical risk. Thanks to its acceptable complication rates and the advantages it provides as a bridging treatment to surgery, it can be considered an effective treatment option in the appropriate patient group.

Keywords: Acute cholecystitis, high surgical risk, percutaneous cholecystostomy


Yüksek Cerrahi Riskli Hastalarda Perkütan Safra Kesesi Drenajı Sonuçları: Cerrahiye Karşı Köprü Tedavi

Amaç

Akut kolesistit, özellikle ileri yaş ve çoklu ek hastalığı bulunan hastalarda yüksek cerrahi risk nedeniyle önemli bir klinik problem oluşturmaktadır. Bu hasta grubunda perkütan safra kesesi drenajı (PGBD), cerrahiye alternatif veya köprü tedavi yöntemi olarak uygulanmaktadır. Çalışmamızın amacı, PGBD uygulanan yüksek cerrahi riskli hastaların klinik sonuçlarını değerlendirmektir.

Figure 1. Outcomes of percutaneous transhepatic cholecystostomy in high-risk surgical patients.

[P-447]

Bibliometric analysis of subtotal cholecystectomy publications

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Objective: Subtotal cholecystectomy has emerged as a critical damage-control strategy for managing difficult gallbladders when complete cholecystectomy poses unacceptable risk of bile duct injury. Despite growing clinical adoption, no comprehensive bibliometric analysis has characterized the scholarly landscape of this technique. This study aimed to quantify publication trends, identify leading contributors, and map the evidence base for subtotal cholecystectomy.

Material and Methods: A bibliometric analysis was conducted using PubMed-indexed publications on subtotal cholecystectomy. Data extracted included publication year, journal, first author, title, and open access status. Temporal trends were analyzed across decades (pre-1990, 1990s, 2000s, 2010s, 2020s). Study types were classified based on title keywords into categories including case reports/series, reviews/meta-analyses, cohort studies, technique papers, and clinical trials. Descriptive statistics summarized publication patterns, journal distribution, and author productivity.

Results: A total of 567 publications spanning 1954-2026 were identified, contributed by 509 unique first authors across 196 journals. Publication activity demonstrated exponential growth: only 21 papers appeared before 1990, compared to 302 (53.3%) in the 2020s alone. Annual output peaked at 63 publications in 2025. Surgical Endoscopy was the leading journal with 55 publications (9.7%), followed by Cureus (n=28, 4.9%) and American Surgeon (n=26, 4.6%). The most prolific first authors were Lucocq J (n=7), Lunevicius R, Ramírez-Giraldo C, and Kohga A (n=6 each). Title-based classification revealed case reports/series (n=43, 7.6%), reviews/meta-analyses (n=39, 6.9%), technique/method papers (n=36, 6.3%), and cohort studies (n=34, 6.0%). Notably, only 3 publications (0.5%) were identified as clinical trials. Open access availability was 40.7% (n=231 with PMC indexing).

Conclusion: The literature on subtotal cholecystectomy has expanded significantly, with more than half of all publications appearing in the last decade. This increase reflects the growing acceptance of subtotal cholecystectomy as a safe salvage procedure for difficult cholecystectomies. However, the evidence base remains limited due to the predominance of case reports and retrospective studies and the striking lack of randomized controlled trials. Future research priorities should include prospective multicenter studies comparing fenestration and reconstruction subtypes, standardized outcome reporting, and randomized trials evaluating long-term outcomes. The concentration of publications in surgical endoscopy journals highlights the relevance of this technique to minimally invasive surgical practices.

Keywords: Difficult cholecystectomy, subtotal cholecystectomy, bibliometric analysis, minimally invasive surgery

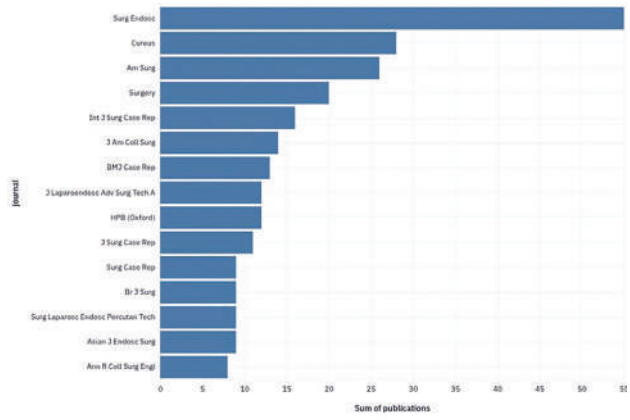

Figure 1. Distributions of the articles to journals.

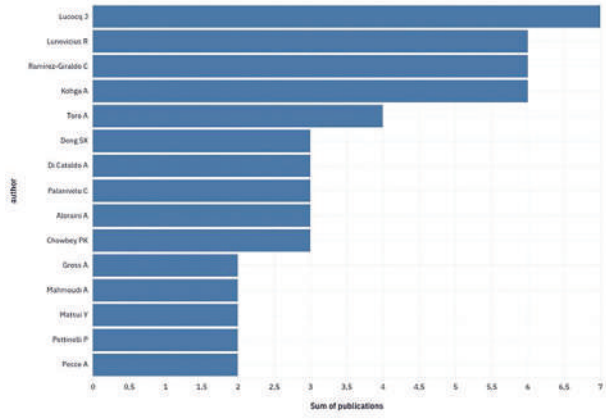

Figure 2. Top authors.

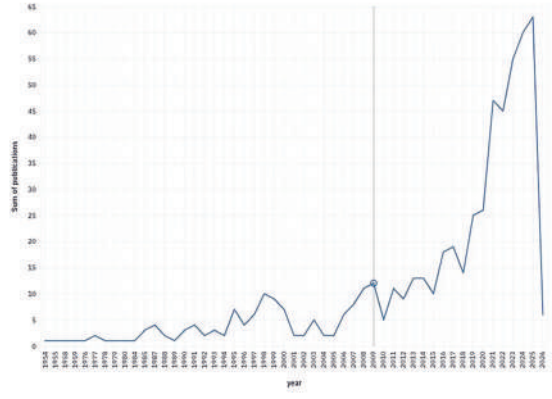

Figure 3. Publication trends.

[P-448]

Gastric diverticula: Diagnostic challenges, adrenal lesion mimicry, and conservative management outcomes - a single-center case series

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Objective: Gastric diverticula are among the rarest forms of gastrointestinal diverticular disease and are most often detected incidentally. Although symptoms are frequently attributed to coexisting gastric pathology rather than the diverticulum itself, data regarding diagnostic pitfalls and optimal management strategies remain limited. This study aimed to evaluate the clinical characteristics, diagnostic challenges, and outcomes of conservative management in patients diagnosed with gastric diverticula.

Material and Methods: This single-center retrospective case series included adult patients who underwent upper gastrointestinal endoscopy between September 2024 and December 2025. Patients in whom gastric diverticula were identified during endoscopic evaluation were included. Demographic characteristics, presenting symptoms, diverticulum location and type, associated gastric pathology—particularly *Helicobacter pylori* infection—imaging findings, management strategies, and clinical outcomes during follow-up were reviewed.

Results: Five patients (three females and two males; median age 67 years, range 35-81) were identified. Two patients were asymptomatic, with diverticula detected incidentally. Three patients presented with epigastric pain and/or dyspepsia. Diverticula were located in the fundus in two patients and in the antrum in three patients. Four diverticula were classified as true diverticula. In one patient, an ulcer-related antral pseudodiverticulum associated with significant food retention was identified, resulting in severe symptoms. Despite its size and symptomatic presentation, this lesion regressed both clinically and morphologically following medical therapy. *Helicobacter pylori* infection was detected in four patients, including all symptomatic cases. In one case, a posterior fundal gastric diverticulum mimicked a left adrenal mass on abdominal computed tomography, prompting endocrine evaluation before endoscopic confirmation. All patients were managed conservatively, and no surgical intervention was required.

Conclusion: This case series highlights the heterogeneous presentation of gastric diverticula and underscores several important clinical lessons. Posterior fundal diverticula may mimic adrenal lesions on cross-sectional imaging, representing a significant diagnostic pitfall. Ulcer-related antral pseudodiverticula with food retention may represent a reversible condition rather than a fixed structural abnormality and can be successfully managed with medical therapy. Overall, symptoms are often driven by associated gastric pathology, and an individualized conservative management strategy is appropriate for most patients.

Keywords: Adrenal lesion mimicry, conservative management, food retention, gastric diverticulum, pseudodiverticulum

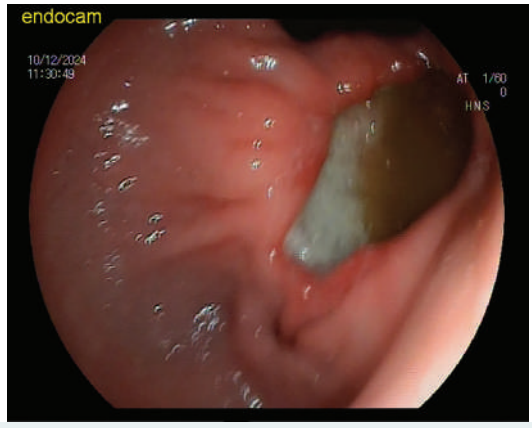

Figure 1. Ulcer-related antral pseudodiverticulum with food retention. Upper gastrointestinal endoscopy demonstrating an ulcer-related antral pseudodiverticulum. Marked food retention is observed within the diverticular cavity. This finding suggests that clinical symptoms may be driven by the associated ulcer disease rather than the diverticulum itself.

Figure 2. Computed tomography appearance of an antral pseudodiverticulum. Abdominal computed tomography demonstrating an ulcer-related antral pseudodiverticulum (red box). The cystic configuration and location of the lesion may mimic other intraabdominal masses, highlighting the importance of endoscopic correlation for accurate diagnosis.

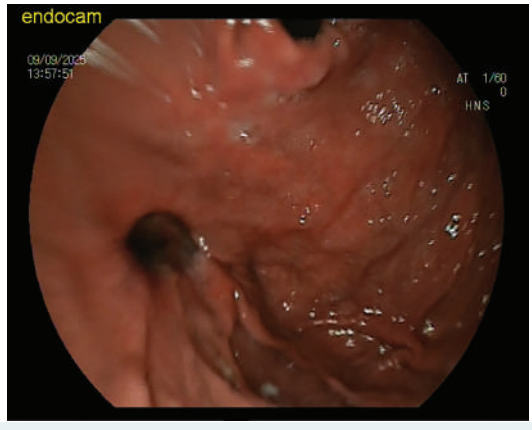

Figure 3. Endoscopic appearance of a posterior fundal gastric diverticulum. Upper gastrointestinal endoscopy demonstrating a true (congenital) gastric diverticulum located on the posterior wall of the gastric fundus. Due to its posterior fundal location, this lesion may mimic left adrenal pathology on cross-sectional imaging, representing an important diagnostic pitfall.

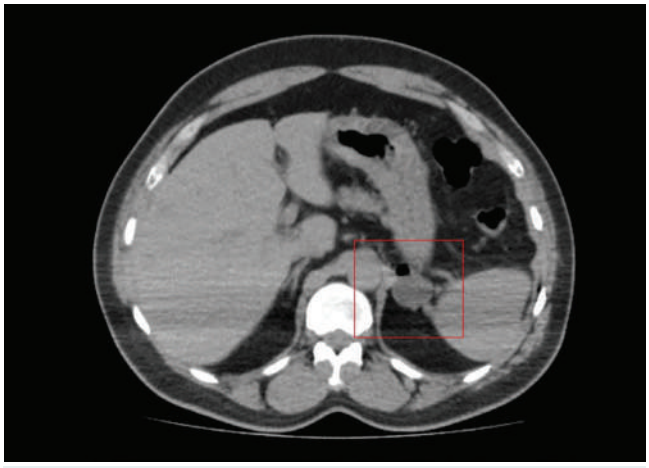

Figure 4. Computed tomography appearance of a posterior fundal gastric diverticulum. Abdominal computed tomography demonstrating a gastric diverticulum arising from the posterior wall of the gastric fundus (red box). Due to its retrogastric location and cystic appearance adjacent to the left adrenal gland, this lesion may mimic an adrenal mass, representing an important diagnostic pitfall. Endoscopic correlation is essential for accurate diagnosis.

[P-449]

Frailty-based risk stratification in emergency general surgery: A systematic review and meta-analysis of 30-day mortality and patient-centered outcomes

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Objective: Emergency general surgery is associated with substantial mortality and morbidity, particularly among older patients and those with significant comorbidity. Chronological age alone may fail to capture physiologic reserve and vulnerability to surgical stress. Accordingly, frailty assessment has gained prominence for preoperative risk communication, planning the required level of care, and supporting shared decision-making. We aimed to synthesize the evidence on the association between frailty and early clinical outcomes in emergency general surgery, and to quantify this relationship through meta-analysis.

Material and Methods: Following a PRISMA-based approach, we searched for studies assessing frailty in emergency general surgery populations and included eligible reports. Frailty instruments (Clinical Frailty Scale, modified Frailty Index, and other validated tools) were recorded. The primary outcome was 30-day mortality. Secondary outcomes included major complications, length of stay, and escalation of post-discharge care needs/loss of independence. Data suitable for pooling were synthesized using a random-effects model, with effects reported as odds ratios (OR).

Results: Across included studies, frail patients consistently experienced higher early mortality. Frailty was also associated with clinically meaningful patient-centered outcomes beyond death, including major postoperative complications, prolonged hospitalization, and increased need for post-discharge support or loss of independence. In the pooled analysis, frailty was significantly associated with increased 30-day mortality (pooled OR: 2.91; 95% CI: 2.00-4.23, p<0.001). The direction of effect remained consistent across different frailty instruments, supporting frailty as a broadly applicable risk marker within heterogeneous emergency surgical indications.

Conclusion: Frailty is a strong predictor of adverse short-term outcomes in emergency general surgery. Incorporating rapid, pragmatic frailty tools into routine risk stratification may enhance the quality of risk communication, facilitate proactive planning of perioperative care level, and strengthen shared decision-making. Prospective studies with standardized definitions and patient-centered endpoints are warranted to refine instrument selection and establish actionable clinical thresholds.

Keywords: Frailty, emergency general surgery, 30-day mortality

[P-450]

Comparison of quality of life and general health status in kidney transplant recipients and hemodialysis patients

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Objective: End-stage renal disease (ESRD) is a serious health condition that significantly affects individuals' quality of life in multiple dimensions. Dialysis and kidney transplantation are the primary treatment modalities for sustaining the lives of patients with ESRD. The effects of these treatments on quality of life vary, and existing literature suggests that kidney transplant recipients generally report higher quality of life compared to hemodialysis patients. This study aims to compare and evaluate the quality of life of transplant and dialysis patients followed at Marmara University Pendik Training and Research Hospital in specific domains.

Material and Methods: This cross-sectional study was conducted with patients undergoing kidney transplantation and hemodialysis at Marmara University Pendik Training and Research Hospital. Ethical approval (dated 19.11.2024) and institutional permission were obtained. Data were collected through face-to-face surveys after receiving written informed consent from participants. The questionnaire consisted of two parts: the first included socio-demographic questions, and the second utilized the Turkish-validated version of the SF-36 form. SF-36 is a reliable and validated scale composed of eight subdomains that assess physical and mental health. Data were analyzed using SPSS software through the Mann-Whitney U and Kolmogorov-Smirnov tests, with a significance level set at "p<0.05".

Results: The study reached 88% of the target sample (n=155), including 59 dialysis and 96 transplant patients. Significant differences were found in 7 of the 8 SF-36 subdomains (physical functioning, role limitations due to physical health, role limitations due to emotional problems, vitality, mental health, bodily pain, and general health), with transplant patients scoring higher than dialysis patients (p-values respectively: <0.001, <0.001, <0.001, <0.001, <0.001, 0.003, 0.024). No statistically significant difference was observed in the "social functioning" subdomain (p=0.093).

Conclusion: The findings indicate that kidney transplant patients have higher quality of life in both physical and psychological dimensions compared to hemodialysis patients. However, no significant difference was found between the two groups in terms of social functioning. These results highlight kidney transplantation as a more favorable treatment option in improving quality of life among ESRD patients.

Keywords: Kidney transplantation, hemodialysis, quality of life

[P-451]

Clinical habits or medical necessity? Safety and cost analysis of discontinuing routine postoperative tests (hemogram-biochemistry) in elective laparoscopic cholecystectomy

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Objective: Conventional surgical practice frequently involves the request of routine blood counts and biochemical tests in the postoperative period, irrespective of the patient's clinical condition. Nevertheless, "Choosing Wisely" campaigns and ERAS protocols advocate the utilisation of evidence-based and cost-effective strategies for patient management. The objective of this study is to evaluate the impact of discontinuing routine haematology and biochemistry monitoring on patient safety and the resulting cost-effectiveness in uncomplicated elective laparoscopic cholecystectomy cases.

Material and Methods: The files of 956 patients who underwent elective laparoscopic cholecystectomy were retrospectively reviewed. In order to ensure the homogeneity of the study, cases with major intraoperative complications or conversion to open surgery were excluded from the analysis. The patients' ASA scores, the early postoperative clinical findings (tachycardia, hypotension, etc.), and the 30-day postoperative major events (need for ERCP, reoperation, biliary tract injury) were examined. The indications for postoperative laboratory tests were categorised as either "clinical suspicion" or "routine". The rates at which these tests influenced clinical decisions, including imaging, prolonged hospitalisation and reoperation, were then compared. The presence of events such as readmission within 30 days, delayed bleeding, and biliary tract injury was also examined.

Results: Of 956 patients (mean age: 50.4±13.7, 70.2% female), 98.3% were postoperatively stable. Labs were omitted in 698 patients and requested in 230 (199 routinely, 31 upon clinical suspicion). Symptom-driven tests altered management in 10 patients, whereas routine tests merely prolonged hospitalization in 38 (p=0.009). These prolongations reflected defensive medicine addressing isolated anomalies, generating unnecessary costs. No major surgical complications occurred in the routine group; the sole event was an unpredictable cardiac pathology. Multivariate analysis identified advancing age (OR: 1.013, 95% CI: 1.002-1.025, p=0.027) and higher ASA scores as independent predictors for unnecessary testing, while gender was insignificant (p=0.301). Patients with ASA ≥3 were 2.3 times more likely to undergo routine testing, regardless of clinical status (OR: 2.298, 95% CI: 1.447-3.649, p<0.001).

Conclusion: The request for routine tests in stable patients following uncomplicated elective laparoscopic cholecystectomy does not represent a medical necessity, but rather a defensive habit that results in the inefficient use of resources. The present study demonstrates that tests only influence decisions when there is clinical suspicion. In the interest of patient safety and cost-effectiveness, this conventional routine should be wholly discontinued in favour of a symptom-driven clinical approach.

Keywords: Laparoscopic cholecystectomy, cost analysis, Choosing Wisely

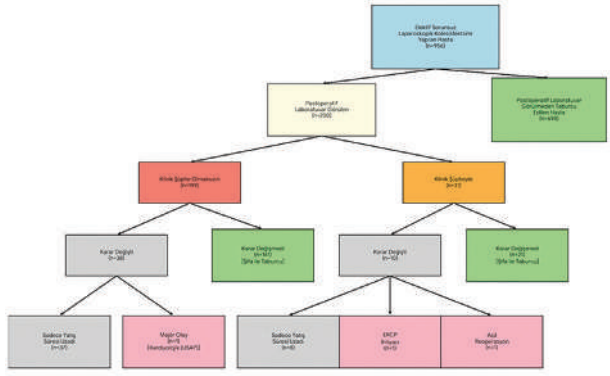

Figure 1. Flow chart.

[P-461]

A rare cause of acute abdomen: Perforated jejunal diverticulitis and surgical management

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Objective: Small bowel diverticulosis is a rare clinical entity, most commonly seen in the jejunum after the duodenum, and is typically classified as acquired "false" diverticula. While usually asymptomatic, complications such as diverticulitis, perforation, hemorrhage, or obstruction may develop in 10-30% of cases. Among these, perforation is one of the most serious complications, with mortality rates reaching up to 40%. The aim of this study is to present the surgical management of a case admitted with signs of acute abdomen and diagnosed with perforated jejunal diverticulitis.

Material and Methods: A 64-year-old male patient with a history of lung cancer with brain metastasis presented to the emergency department with severe abdominal pain lasting for 2 hours. The diagnostic workup included physical examination, laboratory tests (WBC, CRP), and multi-slice contrast-enhanced abdominal computed tomography (CT). The patient was diagnosed with acute abdomen and underwent exploratory laparotomy, with the surgical procedure determined based on intraoperative findings.

Results: Physical examination revealed tenderness in all four quadrants and defense in the left quadrant; laboratory tests showed WBC: 5 and CRP: 35. CT imaging revealed multiple diverticula reaching 2.5 cm in diameter in jejunal loops, stranding in peridiverticular fat tissue, and free air in the left upper quadrant. Surgical exploration identified a perforated diverticulum 60 cm distal to the Treitz ligament, accompanied by fibrinopurulent exudate in the surrounding tissues. Due to the wide base of the diverticulum and extensive inflammation, a 10 cm segmental small bowel resection with end-to-end anastomosis was performed. Pathological examination confirmed serosal active chronic inflammation. The patient was discharged without complications on the 6th postoperative day.

Conclusion: Jejunal diverticulitis should be considered in the differential diagnosis of acute abdominal pain, particularly in the elderly population. CT is the gold standard for diagnosis. In the presence of perforation, simple diverticulectomy carries risks of leakage and recurrence; therefore, segmental resection of the affected segment with primary anastomosis is the safest surgical approach to reduce morbidity and mortality.

Keywords: Acute abdomen, jejunal diverticulum, perforation

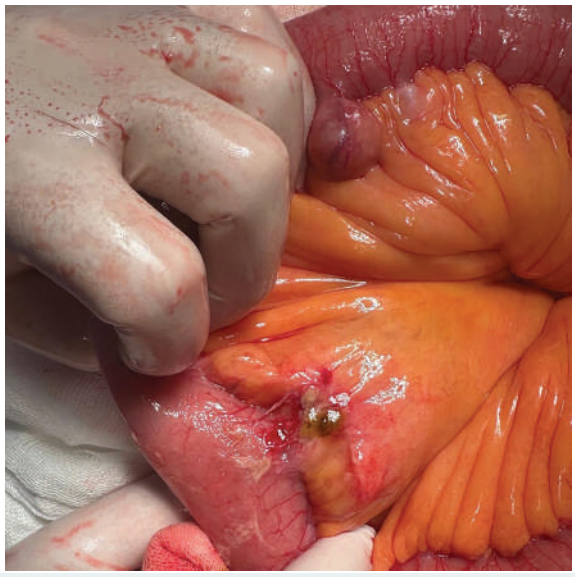

Figure 1. Intraoperative appearance of perforated diverticulum during laparotomy.

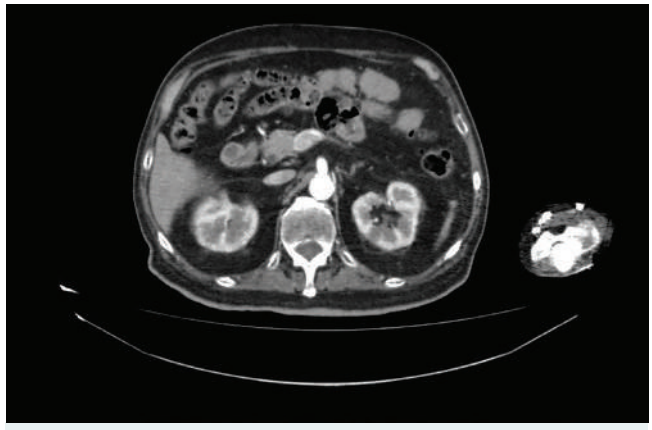

Figure 2. Computed tomography (CT) ımage of jejunal diverticula.

[P-479]

Evaluation of the necessity of re-excision in patients with positive surgical margins after breast-conserving surgery: Analysis of residual malignancy in re-excision specimens

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Objective: Although re-excision is the standard approach for patients with positive surgical margins after breast-conserving surgery (BCS), residual malignancy is not detected in all re-excision specimens. This situation may lead to potentially unnecessary surgical interventions, increased morbidity, and additional patient burden. The aim of this study was to compare the clinicopathological characteristics of patients with and without residual malignancy in re-excision specimens, to identify potential factors associated with residual malignancy, and to contribute to more rational and individualized clinical decision-making regarding the necessity of re-excision.

Material and Methods: This retrospective, single-center study was conducted at Hacettepe University and included patients who underwent re-excision due to positive surgical margins following BCS between 2018 and 2026. A total of 37 patients were evaluated. A positive surgical margin was defined as the presence of invasive carcinoma or ductal carcinoma *in situ* (DCIS) at the inked surgical margin. Patients who received neoadjuvant therapy were excluded from the study. Patients were divided into two groups according to the presence (Group 1) or absence (Group 2) of residual malignancy in the re-excision specimen. Continuous variables were expressed as mean ± standard deviation, and categorical variables as numbers and percentages. Group comparisons were performed using descriptive statistical methods.

Results: The mean age of the study population was 51.9 years. Residual malignancy was detected in 14 patients (37.8%), while no malignancy was identified in 23 patients (62.2%). The mean age was lower in patients with residual malignancy compared with those without residual malignancy (48.1 vs. 54.2 years). The rate of concomitant DCIS was 85.7% in patients with residual malignancy and 95.7% in those without residual malignancy. High tumor grade (Grade 3) was more frequently identified in patients without residual malignancy than in those with residual malignancy (60.9% vs. 28.6%). A low rate of residual malignancy was identified in patients with single positive surgical margins and a limited invasive component. Among the 14 patients with residual malignancy, five required a second re-excision due to persistent positive surgical margins in the re-excision specimen.

Conclusion: Routine re-excision in all patients with positive surgical margins after BCS may result in unnecessary surgical procedures in a substantial proportion of patients. An individualized patient selection strategy based on clinicopathological risk factors may contribute to a more accurate determination of the necessity for re-excision. This approach may help reduce patient morbidity and improve clinical decision-making. Further prospective studies with larger patient cohorts are warranted to validate these findings.

Keywords: Breast-conserving surgery, positive surgical margin, re-excision

[P-480]

Impact of treatment approaches on recurrence in granulomatous mastitis cases: A single-center experience

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Objective: Granulomatous mastitis is a chronic inflammatory breast disease that can clinically and radiologically mimic malignancy and presents a challenge for clinicians due to high recurrence rates during treatment. Although recent consensus studies recommend individualizing treatment decisions according to the clinical subtype of the disease and advise against the routine use of surgery as first-line therapy, surgical treatment is still frequently used as an initial approach in daily clinical practice. This study aimed to evaluate the clinical outcomes and the effect of medical and surgical treatment approaches on recurrence in patients with granulomatous mastitis followed at our center.

Material and Methods: Patients diagnosed with granulomatous mastitis and followed at our center over the past five years were retrospectively evaluated. Demographic characteristics, presenting symptoms, diagnostic methods, treatment approaches, and follow-up outcomes were analyzed. Treatment approaches were classified into two groups: medical treatment (topical and/or oral corticosteroids) and surgical treatment (segmental excision). Recurrence was defined as the development of a new lesion in the same breast after achieving clinical and/or radiological remission. Treatment groups were compared in terms of recurrence rates.

Results: A total of 26 patients were included in the study. Unilateral breast involvement was observed in 23 patients (88.5%), and the most common presenting complaints were breast mass (n=13, 50%) and pain (n=13, 50%). Diagnosis was predominantly established by tru-cut biopsy (n=19, 73.1%). Surgical treatment was performed in 11 patients (42.3%), while 15 patients (57.7%) received medical treatment. The median follow-up duration was 22 months (range, 4-60 months). Recurrence occurred in 7 of the 11 surgically treated patients (63.6%) and in 4 of the 15 medically treated patients (26.7%). Although recurrence rates were higher in the surgical treatment group, no statistically significant difference was observed between the treatment groups due to the limited sample size (p=0.06).

Conclusion: The higher recurrence rates observed in patients undergoing surgical treatment support the view that surgery should not be reflexively used as first-line therapy in granulomatous mastitis. Treatment decisions should be individualized according to disease stage and clinical subtype.

Keywords: Granulomatous mastitis, recurrence, steroid therapy

[P-481]

Early postoperative outcomes and oncologic safety of video endoscopic nipple-sparing mastectomy and axillary evaluation with immediate breast reconstruction in breast cancer patients

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Objective: Video endoscopic nipple-sparing mastectomy (VENSM) with axillary evaluation and immediate breast reconstruction (IBR) is an evolving technique in the surgical management of breast cancer. This study aims to evaluate the oncological safety, cosmetic outcomes, and early postoperative results of this minimally invasive approach.

Material and Methods: Between January 2021 and December 2025, a prospective cohort of breast cancer patients underwent VENSM with axillary evaluation (sentinel lymph node biopsy or axillary lymph node dissection) and IBR at Bursa Uludağ University Faculty of Medicine, General Surgery Department. Patient demographics, tumor characteristics, surgical details, oncological outcomes, and early postoperative results were collected and analyzed.

Results: A total of 224 patients underwent mastectomy where 57 (25.4%) were bilateral, 167 (74.6%) were unilateral. 103 (46%) had implant-based reconstruction. A total of 22 patients (9.82%) had VENSM in the cohort and 40 mastectomy and implant-based reconstructions were performed. The median follow-up period was 8 months. The mean age of the patients was 48 years. Pathological analysis confirmed positive margins in one case (4.5%). The sentinel lymph node biopsy was performed in all patients, and 3 patients underwent axillary lymph node dissection. The mean operative time was 210 minutes, and the median hospital stay was 1 days. Early postoperative complications included minor wound complications in one breast (2.5%) and nipple areola complex in three breasts (7.5%), all of which were managed conservatively. In total two implants (5%) were lost during follow-up. Overall complication rates were higher in conservative mastectomy and reconstruction group (n=32, 15.84%, p=0.81), with higher implant loss rates (n=8, 7.76%, p=0.84). The cosmetic outcomes were rated with Breast-Q.

Conclusion: The early results of this study demonstrate that VENSM with axillary evaluation and IBR is an oncologically safe and cosmetically favorable option for selected breast cancer patients. The technique is associated with minimal complications and excellent cosmetic outcomes. Further studies with longer follow-up are needed to confirm these findings and assess long-term oncological safety.

Keywords: Breast cancer, early outcomes, video endoscopic nipple-sparing mastectomy

Figure 1. Trans-axillary approach for video endoscopic nipple-sparing mastectomy (VENSM) with implant-based reconstruction. Postoperative first-week appearance in a patient who underwent total mastectomy with implant-based reconstruction.

[P-482]

Small intestine and vermiform appendix lengths in healthy adults: Intraoperative morphometric data from a living donor cohort

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Objective: Small intestine and vermiform appendix lengths are critical anatomical parameters in bariatric surgery and short bowel syndrome management. However, reliable normative data from direct *in vivo* measurements in healthy individuals are limited. This study aimed to establish reference values in healthy living liver donors and investigate the potential morphometric relationship between these structures.

Material and Methods: Data from 99 healthy living liver donors representing a multi-ethnic population were analyzed retrospectively. Intraoperative measurements were performed using a standardized technique: small intestine length (SIL) from the ligament of Treitz to the ileocecal valve, and appendix length from base to tip. Relationships between morphometric and anthropometric variables were evaluated.

Results: The mean SIL was 630±104.7 cm, and the mean appendix length was 84.8±21.1 mm. SIL was significantly greater in males (654.8 cm vs. 601.5 cm, p=0.011), while no sex-based difference was found for appendix length (p=0.389). A weak but significant positive correlation was found between SIL and appendix length (r=0.237, p=0.021). An appendix length ≥8 cm was associated with a higher probability of SIL >600 cm. Additionally, Meckel's diverticulum was incidentally detected in 2.0% (n=2) of donors. Notably, the retrocecal appendix position was observed in only 4.0% of donors, which is significantly lower than rates reported in appendicitis series.

Conclusion: This study provides reference values for SIL and appendix length based on direct measurements in healthy individuals. The weak relationship between SIL and appendix length suggests a biological continuum based on shared embryological origin and immunological roles but should not be used as a standalone clinical predictor.

Keywords: Appendix, living donors, small intestine

Figure 1. Meckel's diverticulum. Intraoperative view of an incidental Meckel's diverticulum detected during surgery in a healthy living donor (prevalence: 2.0%).

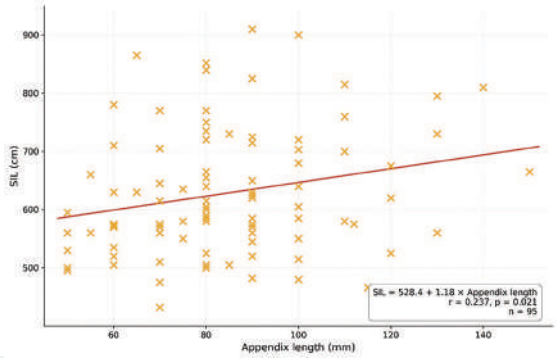

Figure 2. Correlation between small intestine length (SIL) and appendix length. Scatter plot illustrating the relationship between SIL and appendix length (n=95). The linear regression equation is SIL=528.4+1.18×appendix length (mm). The plot demonstrates a weak but statistically significant positive correlation (r=0.237, p=0.021).

Table 1. Small intestine and appendix length measurements by sex

Parameter	Entire cohort	Female	Male	p-value*
SIL (cm)	630.0±104.7	601.5±91.1	654.8±110.2	**0.011**
Appendix (mm)	84.8±21.1	82.8±21.4	86.5±21.0	0.389

Data are presented as mean ± standard deviation. * Differences between groups were evaluated using Student's t-test. SIL: Small intestine length.

[P-483]

Approach to splenic artery aneurysm - a single-center 13-year retrospective analysis

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Objective: Splenic artery aneurysm is an abnormal dilatation of the splenic artery and is usually asymptomatic; however, rupture may present with sudden abdominal pain, hemorrhagic shock, and high mortality. Clinical significance increases particularly in female patients, pregnancy, and conditions such as portal hypertension.

Material and Methods: Patients diagnosed with splenic artery aneurysm at İstanbul University-Cerrahpaşa, Cerrahpaşa Faculty of Medicine between 2013 and 2026 were evaluated retrospectively. Demographic data; clinical presentation, imaging modality, aneurysm diameter, location, multifocality, treatment applied, and follow-up outcomes were obtained from medical records.

Results: Of the 41 patients, 34 were female, and the age range was 27-80 years. The median aneurysm diameter was 18 mm (range: 5-70). The mean follow-up duration was 42.5 months. Twenty-nine patients were asymptomatic, while 12 were symptomatic with abdominal pain. The management strategy was determined according to the patient's clinical status and aneurysm characteristics. One patient was evaluated emergently due to rupture; one patient was diagnosed during pregnancy. Surgical treatment was performed in eight patients; transcatheter coil embolization was used in three patients (definitive treatment in two patients and a preoperative attempt prior to surgery in one patient). The remaining patients were managed with conservative follow-up. Aneurysm diameter was significantly larger in patients who underwent an intervention compared with the follow-up group (median 45 mm vs. 13.5 mm). Postoperative collection was observed in two patients.

Conclusion: In conclusion, splenic artery aneurysms present with a broad clinical spectrum. While regular imaging follow-up may be an appropriate option for small and asymptomatic aneurysms, active treatment with surgery or embolization can be safely applied in symptomatic or large aneurysms, as well as in high-risk situations such as pregnancy and rupture.

Keywords: Aneurysm, splenectomy, embolization

[P-488]

Bibliometric analysis of machine learning and artificial intelligence applications in postoperative pancreatic fistula (2020-2026)

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Objective: Postoperative pancreatic fistula (POPF) remains a major determinant of morbidity and mortality after pancreaticoduodenectomy (Whipple procedure). In recent years, machine learning (ML) and artificial intelligence (AI)–based predictive models have increasingly been applied to surgical complication forecasting. This study aimed to bibliometrically evaluate publication trends, thematic structure, and scientific production dynamics of ML/AI applications in POPF following pancreaticoduodenectomy.

Material and Methods: Publications between 2020 and 2026 were retrieved from PubMed using the following query: ("pancreaticoduodenectomy" OR "Whipple procedure") AND ("postoperative pancreatic fistula" OR "pancreatic fistula" OR "POPF") AND ("machine learning" OR "artificial intelligence" OR "deep learning" OR "neural network"). Data were analyzed using Bibliometrix/Biblioshiny. Annual scientific output, country and institutional contributions, author productivity (Lotka's law), core journals (Bradford's law), keyword co-occurrence networks, thematic mapping, and temporal keyword trends were assessed.

Results: A total of 31 publications were included. Output markedly increased after 2023, peaking in 2024-2025. The studies involved 289 authors (≈10 authors per article), with no single-author publications. The international collaboration rate was 19.35%. China emerged as the leading contributor, particularly after 2023, followed by the United States, the Netherlands, Italy, and Germany. The University of Zurich and several Chinese institutions were prominent at the institutional level. Frequently occurring keywords included "retrospective studies," "risk factors," "humans," "pancreaticoduodenectomy/adverse effects," and "ROC curve," indicating a predominantly retrospective, risk-modeling-based methodology. Thematic mapping identified "machine learning" and "postoperative complications/etiology" as motor themes, whereas "deep learning" and "neural networks" appeared as low-density, emerging themes. These findings suggest a transitional phase from conventional clinical risk assessment toward ML-driven predictive modeling.

Conclusion: Between 2020 and 2026, AI/ML research in POPF after pancreaticoduodenectomy accelerated significantly, yet remains concentrated in a limited number of countries and institutions and is largely retrospective in design. Thematic analysis indicates that ML has become the field's driving theme, while deep learning and neural networks are still in early developmental stages. By quantitatively delineating growth patterns and methodological orientations, this study highlights priority gaps—multicenter datasets, prospective validation, standardization, and generalizable modeling—thereby providing a roadmap for future research.

Keywords: Pancreaticoduodenectomy, postoperative pancreatic fistula, machine learning

Figure 1.

Figure 2.

[P-489]

Comparison of preoperative, perioperative and postoperative outcomes of emergency and elective inguinal hernia surgery in geriatric patients using antiaggregants

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Objective: The proportion of the geriatric population is increasing worldwide, leading to continuous updates in medical management for elderly patients. Polypharmacy is common in this group, and antiplatelet therapy is among the most frequently prescribed treatments. However, these agents complicate surgical decision-making due to increased perioperative bleeding risk and potential rises in morbidity and mortality. This study aimed to compare preoperative characteristics and postoperative outcomes of elective and emergency inguinal hernia repair in patients over 65 years of age receiving antiplatelet therapy.

Material and Methods: This retrospective study included patients over 65 years who underwent inguinal hernia surgery between January 2025 and February 2026 while receiving regular antiplatelet therapy (acetylsalicylic acid, clopidogrel, P2Y12 receptor antagonists, GPIIb/IIIa receptor antagonists, or combination therapy). Patients were divided into two groups: Group 1 (emergency surgery) and Group 2 (elective surgery). Preoperative evaluation included age, gender, ASA score, and comorbidities. Postoperative complications were assessed using the Clavien-Dindo classification. Postoperative bleeding, seroma, hematoma, wound infection, chronic pain, recurrence, and length of hospital stay were compared.

Results: A total of 101 male patients were included; 29 (28%) underwent emergency surgery and 72 (72%) underwent elective surgery. The mean age was 75 years, with no significant age difference between groups ($p<0.35$). However, the ASA score was significantly higher in the emergency group ($p<0.001$). Operative time was significantly longer in the emergency group (mean 88 minutes) compared to the elective group (mean 62 minutes) ($p<0.001$). Postoperative complications showed no statistically significant differences between groups. Seroma occurred in 3.6% of emergency cases and 6.9% of elective cases ($p=1$). Hematoma was observed in 21.4% of emergency patients and 9.7% of elective patients ($p<0.18$). Chronic pain occurred in 32.1% of emergency patients and 16.7% of elective patients ($p<0.15$). Recurrence was detected in 7.1% of emergency cases and 4.2% of elective cases ($p<0.61$).

Conclusion: Elective inguinal hernia repair in geriatric patients receiving antiplatelet therapy can be performed safely with acceptable complication rates in patients with an appropriate preoperative risk profile. Delaying surgery may result in emergency presentation, higher preoperative risk, and increased morbidity. Therefore, elective surgery under optimal conditions may improve postoperative outcomes in this patient population.

Keywords: Inguinal hernia, geriatrics, antiplatelet

ANTİAGREGAN KULLANAN GERİATRİK HASTALARDA ACİL VE ELEKTİF İNGÜİNAL HERNİ CERRAHİSİNİN PREOPERATİF,PERİOPERATİF VE POSTOPERATİF SONUÇLARININ KARŞILAŞTIRILMASI

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GİRİŞ

Dünya genelinde geriatrik popülasyonun oranı normal popülasyona göre artmakta ve geriatrik hastalarda tıbbi operasyon ve medikasyonların sürekli güncellenmesine neden olmaktadır.Geriatrik hastalarda polifarmasi sık görülmekle birlikte en sık kullanılan ilaç gruplarından olan antiagregan tedaviler ,perioperatif kanama riski açısında cerrahi karar sürecini zorlaştırırken morbidite ve mortalitede de artışa neden olmaktadır .Bu çalışmada antiagregan kullanan 65 yaş üstü hastalarda elektif ve acil ingüinal herni cerrahisinin preoperatif ,perioperatif ve postoperatif sonuçlarının karşılaştırılması amaçlanmıştır.

YÖNTEMLER

Bu retrospektif çalışmaya Ocak 2025-Şubat 2026 yılları arasında kliniğimizde ingüinal herni nedeniyle opere edilen ,düzenli antiagregan tedavi alan (asetilsalisik asit,klopidogler, P2Y12 (ADP) Reseptör Antagonistleri, GPIIb/IIIa Reseptör Antagonistleri veya multiple tedavi)hastalar dahil edildi . Çalışmaya dahil edilen hastalar grup 1 (acil) ,grup 2 (elektif) olarak 2 gruba ayrılmıştır Hastaların preoperatif değerlendirmede yaş ,cinsiyet ,ASA skorları ,ek hastalıkları değerlendirilirken,postoperastif komplikasyonlar Clavien-Dindo sınıflamasına göre analiz edildi .Postoperatif kanama,seroma ,yara yeri enfeksiyonu,hastanede kalım süresi ,kronik ağrı ve nüks açısından karşılaştırılarak değerlendirildi .

BULGULAR

Çalışmaya dahil edilen 101 hastanın 29'u (%28) acil, 72'si (%72) elektif cerrahi geçirmiştir.Tüm hastalar erkek cinsiyete sahiptir.Yaş ortalaması 75'tir (72.8 ±77.0). Gruplar arasında yaş açısından istatistiksel olarak anlamlı bir fark saptanmamıştır($p<0.35$) .Buna karşın ASA skoru acil grupta 3,0 (3,0±4,0) ile elektif gruba kıyasla 2,0 (2,0 ±4,0) istatistiksel olarak anlamlı biçimde daha yüksek bulunmuştur ($p<0,001$)..

Operatif parametreler incelendiğinde cerrahi süresinin acil grupta elektif gruba kıyasla istatistiksel olarak anlamlı düzeyde daha uzun olduğu görülmüştür. Cerrahi süresi acil grupta ortalama 88,0(77.8 ± 103.2) dakika iken elektif grupta medyan 62,0 (53.8 –±72.0) dakika olup istatistiksel olarak anlamlı bulunmuştur ($p<0,001$).

Postoperatif komplikasyonlar değerlendirildiğinde acil cerrahi yapılan 1 hastada (%3.6) elektif cerrrahi yapılanlarda 5 hastada (%6,9) seroma , acil cerrahi yapılanlardan 6 hastada (%21.4),elektif cerrahi yapılanlardan 7 hastada (%9.7) hematom , acil cerrahi yapılan 9 hastada (%32.1) ,elektif cerrahi yapılan 12 hastada (%16.7) kronik ağrı ve acil cerrahi yapılan 2 hastada (%7.1elektif cerrahi yapılan 3 hastada (%4.2) nüks saptanmış olup bu bulgular istatistiksel olarak anlamlı bulunamamıştır ($p<1,p<0.18,p<015,p<0.61$).

SONUÇLAR

Antiagregan kullanan geriatrik hastalarda elektif inguinal herni onarımı, preoperatif risk profili uygun hastalarda kabul edilebilir postoperatif komplikasyon oranları ile güvenli bir şekilde uygulanabilmektedir. Buna karşılık cerrahinin ertelenmesi acil başvuruya, daha yüksek preoperatif risk profiline ve belirgin şekilde artmış postoperatif morbiditeye yol açmaktadır. Bu nedenle geriatrik antiagregan kullanan hastalarda, uygun koşullarda elektif cerrahinin tercih edilmesi postoperatif sonuçları iyileştirebilir.

Figure 1. Comparison of preoperative, perioperative and postoperative outcomes of emergency and elective inguinal hernia surgery in geriatric patients using antiaggregants.

Table 1. Results

Değişken	Test	Acil (n=28) Med/n [IQR%]	Elektif (n=72) Med/n [IQR%]	p-değeri
Yaş	Mann-Whitney U	75.0 [72.8-77.0]	75.0 [73.0-83.0]	0.357
ASA	Mann-Whitney U	3.0 [3.0-4.0]	2.0 [2.0-3.0]	***
Anestezi süresi	Mann-Whitney U	88.0 [77.8±103.2]	62.0 [53.8±72.0]	***
Operasyon süresi	Mann-Whitney U	80.5 [69.0-97.2]	54.0 [45.0-61.0]	***
Yatış süresi	Mann-Whitney U	1.0 [1.0-2.0]	1.0 [1.0-2.0]	0.274
Komplikasyon	Chi-square	14 (50.0%)	24 (33.3%)	0.189
Seroma	Fisher's exact	1 (3.6%)	5 (6.9%)	1.0
Hematom	Fisher's exact	6 (21.4%)	7 (9.7%)	0.181
Ağrı	Chi-square	9 (32.1%)	12 (16.7%)	0.152
Nüks	Fisher's exact	2 (7.1%)	3 (4.2%)	0.617
Ek hastalık	Chi-square	20 (71.4%)	40 (55.6%)	0.219
Anti-agregan	Chi-square	28 (100.0%)	18 (25.0%)	***

[P-494]

Three port laparoscopic sleeve gastrectomy: One year single center results

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Objective: Laparoscopic sleeve gastrectomy (LSG) is a widely performed and effective procedure in the surgical management of morbid obesity. The conventional technique typically requires four to five ports. This study aimed to evaluate the safety, feasibility, and early clinical outcomes of the three-port LSG technique.

Material and Methods: Patients who were scheduled for three-port LSG between January 2024 and January 2025 were retrospectively analyzed. A total of 54 patients were initially planned for a three-port approach. Due to intraoperative technical requirements, a fourth port was inserted in three patients, and these cases were excluded from the final analysis. The study cohort consisted of 51 patients. The evaluated parameters included: demographic characteristics, operative time, number of staplers used, length of hospital stay, intraoperative and postoperative complications, Clavien-Dindo classification, percentage of excess weight loss (%EWL), percentage of total weight loss (%TWL), comorbidity response. All procedures were performed by the same surgical team.

Results: The mean age of the patients was 35.7±9.4 years, and the mean body mass index (BMI) was 43.3±3.0 kg/m^2. Females constituted 70.5% of the study population. The mean operative time was 61.3±5.4 minutes. No intraoperative complications were observed. The overall postoperative morbidity rate was 5.8% (3/51). According to the Clavien-Dindo classification: One patient developed a Grade I complication, one patient required blood transfusion due to postoperative bleeding (Grade II), one patient underwent reoperation under general anesthesia due to a Veress needle-related injury (Grade IIIb). The major complication rate was 1.9%. No staple-line leakage or mortality was observed. A fourth port was required in 3 patients (5.5%). The mean length of hospital stay was 2-3 days. The mean %EWL was 77.6%, and the mean %TWL was 33%. A complete response was achieved in the majority of obesity-related comorbidities.

Conclusion: Three-port LSG demonstrated a low major complication rate (1.9%), acceptable operative time, and satisfactory early weight loss outcomes in this series. When performed by an experienced surgical team in appropriately selected patients, the three-port approach may represent a safe and feasible alternative to the conventional multi-port technique.

Keyword: Laparoscopic sleeve gastrectomy

Figure 1. Three port laparoscopic sleeve gastrectomy.

Figure 2. Three port laparoscopic sleeve gastrectomy.

[P-496]

Does debridement technique affect bacterial load? A comparison of jet lavage and surgical debridement

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Objective: Diabetic foot ulcers are among the most serious and costly complications of diabetes mellitus. The development of infection in these patients prolongs the healing process and increases the risk of major amputation. Debridement is a cornerstone in infection control, as it facilitates both the removal of necrotic tissue and the reduction of bacterial load. In recent years, jet lavage-assisted debridement has emerged as a technique that enhances mechanical cleansing. However, the effect of this method on bacterial load, in comparison with conventional surgical debridement, remains unclear. The aim of this study is to compare the effects of jet lavage-assisted debridement and conventional surgical debridement on bacterial load in diabetic foot ulcers.

Material and Methods: This study was designed as a prospective, randomized controlled trial. Patients diagnosed with Wagner grade 2-3 diabetic foot ulcers were included in the study. The patients were randomized into two groups: Group A: Jet lavage-assisted debridement. Group B: Conventional surgical debridement. From each patient, tissue biopsy samples were obtained from the wound bed both before debridement and after debridement. Microbiological evaluation was performed using a quantitative culture method, and the results were expressed as colony-forming units per gram (CFU/g). A p-value of <0.05 was considered statistically significant.

Results: According to the findings obtained at the end of the study, a statistically significant reduction in bacterial load after debridement was observed in the jet lavage group ($p<0.001$). The reduction in bacterial load was significantly greater compared to the conventional surgical debridement group.In addition, the need for repeat debridement was lower in the jet lavage group. Clinically, the wound bed appeared cleaner and more suitable for granulation tissue formation.

Conclusion: According to the results of our study, jet lavage-assisted debridement may be a more effective method than conventional surgical debridement in reducing bacterial load in diabetic foot ulcers. This technique may contribute positively to infection control, wound healing, and the overall success of surgical treatment. We believe that integrating jet lavage-assisted debridement into surgical practice, in appropriately selected patients, may be beneficial.

Keywords: Chronic wound, diabetic foot

[P-497]

Use of cadaveric iliac vein graft in recipient after laparoscopic right donor nephrectomy

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Objective: In living donor kidney transplants, laparoscopic harvesting of the right kidney is technically challenging due to the short and thin-walled nature of the right renal vein. This anatomical limitation can increase the risk of vascular complications and graft failure during implantation. Various venous lengthening techniques are used to overcome these challenges and ensure a tension-free, safe anastomosis. The aim of this study is to evaluate the technical feasibility and clinical outcomes of using a cadaver iliac vein graft for lengthening the right renal vein in cases undergoing laparoscopic right donor nephrectomy.

Material and Methods: Consecutive laparoscopic donor nephrectomy cases performed at our center were retrospectively reviewed. In this study, cases undergoing right donor nephrectomy were analyzed in terms of recipient and donor demographic characteristics, the anatomical structure of the renal vein, and the vascular reconstruction techniques applied. In cases where the right renal vein was found to be thin-walled and of insufficient length for anastomosis during the operation, venous lengthening was performed using a cadaveric iliac vein segment during the "back-table" preparation phase. Technical success was evaluated using parameters such as hot and cold ischemia times, peroperative vascular complications, and long-term graft survival.

Results: Of the 96 laparoscopic donor nephrectomy cases examined, 13 (13.5%) were from right donor nephrectomy. The mean age of recipients was 43 (27-69; 5 women, 8 men), and the mean age of donors was 49 (24-63; 10 women, 3 men). Due to right renal vein anatomy, reconstruction with a cadaveric iliac vein graft was performed in 10 cases (77%). No intraoperative complications occurred in any of the cases that underwent vascular reconstruction, and cold ischemia times remained within clinically acceptable limits despite the additional time spent in back-table preparation. No renal vein thrombosis, vascular stenosis, or primary graft failure related to the use of venous lengthening grafts was observed in the postoperative period. During a median follow-up period of 20 months (1-60 months), two patients died due to COVID-19 and one patient died due to pulmonary mycosis. The kidney function of the 10 surviving patients is within normal limits.

Conclusion: Venous lengthening with a cadaveric iliac vein graft after laparoscopic right donor nephrectomy offers a reliable and permanent solution to the technical challenges posed by a short renal vein. This approach allows for the safe expansion of the donor pool for centers that traditionally prefer the left kidney due to surgical difficulties.

Keywords: Right donor nephrectomy, laparoscopic nephrectomy, renal vein extension, cadaveric iliac graft, vascular reconstruction, renal transplantation, right laparoscopic donor nephrectomy, renal vein lengthening, cadaveric iliac vein graft

[P-500]

The diagnostic value of mammography in young breast cancer patients

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Objective: Currently, mammography is the most commonly used imaging method for breast cancer screening in the population over 40 years of age. While it is not routinely used for screening in the population under 40, its use is recommended for identifying and supporting diagnoses of lesions with a high suspicion of malignancy during physical examination. Current studies show that mammography has high sensitivity, particularly in less dense breasts.

Material and Methods: Based on this information, in order to evaluate the contribution of mammography to diagnosis in breast cancer patients diagnosed under the age of 40, 65 patients under the age of 40 who underwent surgery at University of Health Science Türkiye, Kayseri City Training and Research Hospital between 2023 and 2025 were retrospectively evaluated.

Results: Mammography was not performed in 35 operated patients (53.8%), whereas 30 patients (46.2%) underwent mammographic evaluation. Among those who underwent mammography, 3 patients (10%) were reported as BI-RADS 0, while 27 patients (90%) had BI-RADS 4-6 findings. Of the 16 patients classified as BI-RADS 6, mammography was performed after histopathological confirmation and prior to treatment, following breast ultrasound and magnetic resonance imaging (MRI) by breast surgery specialists. In contrast, cases without mammography were managed by surgeons without breast surgery subspecialization. These findings indicate that mammography use in young patients may vary according to physician specialization. At initial diagnosis, 39 patients (60%) were in advanced stages. Specifically, 29 patients (44.6%) were stage III and 10 patients (15.4%) stage IV. Early-stage breast cancer (stage I-II) was observed in 26 patients (40%). When stratified by stage, the diagnostic contribution of mammography appeared independent of disease stage.Regarding surgical management, 25 patients (38.5%) underwent mastectomy, while 40 patients (61.5%) received breast-conserving surgery. No statistically significant association was found between mammography use during diagnosis and surgical treatment. Among mastectomy patients, mammography was not used in 17 (26.16%) and was used in 8 (12.31%). Similarly, among breast-conserving surgery patients, mammography was not performed in 18 (27.69%) and was performed in 22 (33.84%). Breast MRI was performed in all patients who did not undergo mammography.

Conclusion: Current guidelines recommend clinical mammography for all patients aged 30 and over with palpable masses and suspicious findings for breast cancer. In our cases, it was observed to contribute to the diagnosis. Mammography should not be avoided due to young breasts or dense breast tissue.

Keywords: Mammography, young breast cancer

Table 1. Preference for mammography in diagnosis of breast cancer in patients under 40 years of age

Viewing preference	n	%
Mammogram taken	35	53.8
Mammogram not performed	30	46.2
Total	**65**	**100**

Table 2. Mamografi çekilen hastalar BI-RADS dağılımı (n=30) (2023-2025)

Mammography result	n	%
BI-RADS 0	3	10.0
BI-RADS 4	5	16.7
BI-RADS 5	6	20.0
BI-RADS 6	16	53.3
Total	**30**	**100**

BI-RADS 4-6 constitutes the patient group in which mammography supports diagnosis (n=27, 90%).

[P-501]

The role of preoperative CA19-9 in predicting resectability and survival in intrahepatic cholangiocarcinoma: A single-center retrospective study

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Objective: Intrahepatic cholangiocarcinoma (ICC) is a primary liver malignancy known for its aggressive clinical course and low surgical resectability rates. Surgical resection remains the only curative treatment option. In this study, we aimed to evaluate the clinicopathological characteristics, surgical outcomes, and the impact of tumor marker levels on survival in patients diagnosed with ICC at our center over the last 10 years.

Material and Methods: A total of 43 patients (21 males, 22 females) diagnosed with ICC between 2015 and 2025 at our center were retrospectively analyzed. Patients were divided into two groups: Surgical resection (Group 1, n=10) and inoperable/advanced disease (Group 2, n=33). Demographic data, preoperative CA19-9 levels, and overall survival were analyzed and compared between the groups.

Results: The median age of the entire cohort was 68 years (range: 35-84). Eleven patients underwent surgical exploration, and one patient was deemed inoperable intraoperatively, resulting in a resectability rate of 23.2%. R0 resection was achieved in 80% (n=8) of the patients in Group 1. The median overall survival was 28.5 months (range: 2-56 months) in Group 1, whereas it was significantly shorter at 3 months (range: 1-26 months) in Group 2. The median CA19-9 level was 138.5 U/mL in Group 1, while marker levels in Group 2 showed a wide distribution, reaching extremely high values up to 920,926 U/mL in some cases. In Group 1, 20% of patients (n=2, at 24 and 56 months) were still alive at the time of analysis and continued follow-up. In contrast, 85% of patients in Group 2 died within the first 6 months after diagnosis.

Conclusion: Our findings demonstrate that surgical resection, particularly achieving R0 margins, is the most important determinant of survival in patients with ICC. Overall survival was markedly longer in patients who underwent curative resection compared to those with unresectable disease. Significantly elevated preoperative CA19-9 levels in the inoperable group suggest that this marker may reflect increased tumor burden and aggressive tumor biology. However, CA19-9 alone is insufficient to determine surgical resectability and should be considered as an adjunctive biomarker in preoperative risk stratification and clinical decision-making. Larger prospective multicenter studies are needed to validate these findings.

Keywords: Intrahepatic cholangiocarcinoma, CA19-9, surgical resectability

[P-505]

The effect of intracorporeal knot-tying in laparoscopic appendectomy on the learning curve of laparoscopic intracorporeal suturing

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Objective: For surgeons engaged in laparoscopic surgery, suturing and knot-tying techniques are of critical importance. With the development and widespread adoption of reconstructive surgeries in the new century, laparoscopic suturing has gained even greater significance. Laparoscopic suturing techniques are more technically demanding than conventional open surgical suturing techniques, and the learning curve is considerably longer. This is primarily because, unlike in open surgery, the surgeon operates using a two-dimensional image in laparoscopic surgery and lacks depth perception. In addition, the tactile feedback that allows assessment of suture tension in open surgery is largely absent in laparoscopic procedures. During the operation, patient positioning, trocar placement, and the surgeon's stance often restrict both the surgeon's movements and the maneuverability of the suturing instruments. In most cases, surgical manipulation is limited to the angles permitted by the trocars. Furthermore, factors beyond the surgeon's direct control-such as camera angle, the movements of the assisting surgeon, and patient respiratory motion-also contribute to movement limitations. These and similar challenges encountered in advanced laparoscopic procedures may sometimes make such operations difficult or even impossible to perform. Therefore, learning and effectively applying intracorporeal knot-tying techniques in laparoscopic appendectomy is of great importance for achieving laparoscopic proficiency prior to performing advanced laparoscopic surgeries.

Material and Methods: In our clinic, 801 laparoscopic appendectomy surgeries have been performed by residents over the past 10 years. In 670 of these laparoscopic appendectomy cases, the appendix was secured using intracorporeal surgical knot tying, with two intracorporeal knots placed proximally and one placed distally. These cases were evaluated in terms of their contribution to resident training prior to advanced laparoscopic surgeries.

Results: Before starting laparoscopic surgery, surgeons must know basic entry and suturing techniques, both in theory and practice. By learning intracorporeal knot tying during laparoscopic appendectomy in our clinic, residents develop key skills: seeing in 3D on a 2D screen, hand-eye coordination, working with limited touch sensation, operating in a small space, handling the camera, placing trocars, and controlling instruments with both hands for intracorporeal suturing. Keeping up with new technology and combining it with open surgery experience makes even complex laparoscopic procedures possible and successful.

Conclusion: Intracorporeal suturing is one of the most difficult skills in laparoscopic surgery. The goal is to create an ideal suture, and attention to detail is essential. With experience, even complex intracorporeal anastomoses can be performed. Mastering safe laparoscopic suturing techniques helps surgeons gain experience before advanced procedures and improves their success in advanced laparoscopic surgery.

Keywords: Intracorporeal knot, laparoscopic appendectomy, learning curve

[P-506]

Postoperative pain management approach in patients undergoing anti-reflux surgery for hiatal hernia

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Objective: Postoperative pain following laparoscopic hiatal hernia repair significantly impacts patient recovery, hospital length of stay, andhealthcare resource utilization. Traditional opioid-based anesthesia protocols are associated with substantial complications including postoperative nausea and vomiting (PONV), respiratory depression, delayed discharge, and potential for dependence. Recent advancesin regional anesthesia techniques, long-acting local anesthetic formulations, and multimodal opioid-sparing protocols havedemonstrated promising outcomes in reducing opioid consumption while maintaining effective analgesia. This comprehensive review examines contemporary evidence-based pain management strategies for hiatal hernia repair surgery.

Material and Methods: A systematic literature review was conducted acrossfive databases (SciSpace Deep Search, Google Scholar, and PubMed), retrieving 636 articles. Following artificial intelligence-powered relevance ranking and deduplication, 125 unique paperswere identified. Studies were filtered to include only publicationsfrom 2019 onwards to ensure maximum currency of evidence. The top 30 most relevant studies were analyzed in detail, including randomized controlled trials, cohort studies, and systematic reviews evaluating regional anesthesia techniques (crural blocks, fascial plane blocks), local anesthetic infiltration strategies, opioid-free anesthesia protocols (OFAP), and multimodal systemic analgesic regimens.

Results: OFAP demonstrated superior clinical outcomes compared to opioid-based protocols (OBAP). OFAP achieved 94.3% same-day discharge rates versus 60.7% with OBAP ($p<0.001$), with median length of stay of 0 days versus 1 day ($p=0.006$). OFAP significantly reducedperioperative nausea and retching (0% versus 15.6%, $p=0.020$) while maintaining comparable pain control. Post-discharge opioid requirements were significantly lower with OFAP (66.7% versus 100%, $p<0.001$), with odds of same-day surgery 8.21 times greater (95% CI: 3.10-21.71; $p<0.001$). Regional anesthesia showed opioid-sparing effects: crural blocks reduced daily morphine requirements by 2 mg with decreased peak pain scores. A systematic review of 12 studies (983 patients) demonstrated that multimodal opioid-free anesthesia significantly reduced early postoperative pain, PONV incidence, and analgesic consumption while improving quality of recovery (QoR-40) scores. Combination systemic regimens provided superior analgesia: at 45 minutes post-surgery, acetaminophen monotherapy resulted in mean pain scores of 7.91, while acetaminophen plus pethidine achieved 5.99 and acetaminophen plus parecoxib achieved 6.87 on the numeric rating scale.

Conclusion: Contemporary evidence supports a paradigm shift toward multimodal, opioid-sparing approaches. Opioid-free anesthesia protocols facilitate same-day discharge, reduce opioid-related complications, and decrease post-discharge opioid requirements while maintaining effective pain control. Regional anesthesia demonstrate opioid-sparing benefits as valuable adjuncts. Multimodal systemic analgesic combinations consistently outperform monotherapy. Implementation of individualized, evidence-based multimodal pain management strategies should beprioritized to optimize patient outcomes, enhance recovery, andminimize healthcare resource utilization in clinical practice.

Keywords: Crural block/crural infiltration, cruroplasty/crural repair, laparoscopic hiatal hernia repair, minimally invasive surgery, nissen fundoplication

[P-507]

Bibliometric analysis of the literature on splenic endometriosis: A PubMed-based evaluation

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Objective: Splenic endometriosis is an extremely rare clinical entity, and its diagnosis and treatment are often established through postoperative histopathological examination. This study aimed to systematically analyze the bibliometric characteristics of the literature addressing the relationship between splenic endometriosis and splenectomy and to reveal the dynamics of scientific production in this field.

Material and Methods: Publications retrieved using the keywords (endometriosis [Title/Abstract]) AND (spleen OR splenic) AND (splenectomy OR surgery OR histopathology) in the PubMed database were evaluated using bibliometric analysis methods. Publications were examined in terms of production by year, journal and author distribution, country and institutional contributions, keyword trends, and within the framework of Bradford and Lotka laws. Analyses were performed using Bibliometrix/Biblioshiny software.

Results: A total of 31 publications published between 1976 and 2026 across 30 journals were analyzed, involving 136 authors with a mean of 4.42 authors per paper and no single-author publications. The international collaboration rate was low (3.23%), with an annual publication growth rate of 1.4% and a marked increase after 2015. Source analysis demonstrated a highly dispersed publication pattern, with no core journal identified; the Journal of Minimally Invasive Gynecology was the most frequent source (n=2), while most journals contributed only a single article. Lotka analysis revealed predominantly single-publication authorship, with the most productive author contributing only two publications. Country output was mainly concentrated in the United States, Italy, China, Israel, and France. Keyword analysis identified "humans," "female," "adult," and "diagnosis, differential" as the most frequent terms, with increasing prominence over time of themes related to endometriosis diagnosis and magnetic resonance imaging.

Conclusion: Splenic endometriosis is an exceptionally rare entity, most often diagnosed only by postoperative histopathology, and to date lacks a dedicated bibliometric evaluation. To our knowledge, this study is among the first to systematically map the splenic endometriosis literature using PubMed-based bibliometric indicators. The low publication volume and dispersed authorship and journal distribution suggest that a mature research ecosystem has not yet developed, which may partly explain the lack of standardized clinical management. Keyword and trend analyses indicate a temporal shift in focus from surgical techniques toward diagnostic challenges, differential diagnosis, and imaging, particularly magnetic resonance imaging. The concentration of contributions within a limited number of institutions further reflects the fragmented and case-based nature of the field. Overall, this study delineates the current structure of the literature and highlights the need for future multicenter, standardized research to improve diagnostic approaches.

Keywords: Bibliometric analysis, PubMed, rare diseases, splenic endometriosis, surgical pathology

[P-508]

High trauma score accidents: Tractor accidents

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Objective: Tractor accidents typically occur in rural areas, involving drivers and passengers without protective equipment, and exhibiting characteristics of both in-vehicle and out-of-vehicle traffic accidents, often resulting in high trauma scores. Given our hospital's characteristics as a regional referral hospital for traumatology, we believe that trauma scoring systems and evaluation based on these scores are crucial, as we can conduct detailed examinations and provide necessary consultations.

Material and Methods: Between January 1, 2024, and December 31, 2025, 10 cases evaluated in our hospital's emergency department or referred to our emergency department from other centers were assessed. The patients' age, gender, trauma ultrasound (e-FAST) results (if performed), CT scans taken in the emergency department and after admission, and surgical notes were evaluated to determine their current pathologies, clinical or intensive care unit needs, and mortality rates. Based on these findings, the new injury severity score (NISS) was calculated.

Results: The mean age of the patients included in the study was 55.5 (21-83), and all 10 patients were male (100%). e-FAST was applied in 6 (60%) cases, with 4 (66.7%) cases being positive and 2 (33.3%) cases being negative. Of the 4 cases that were considered positive for e-FAST, 3 (75%) were due to hemothorax and 1 (25%) case was due to widespread intra-abdominal fluid. The mean NISS score in the cases was 25.3 (13-41), and 4 (40%) cases were admitted to the thoracic surgery clinic and 6 (60%) cases were admitted to the intensive care unit. Mortality occurred in 2 cases with a NISS score of 41 in the intensive care unit. The mean NISS scores of the 4 patients admitted to the thoracic surgery clinic were 13.2 (9-18), while the mean NISS scores of the patients admitted to the intensive care unit were 35 (13-41).

Conclusion: The NISS score indicates the need for intensive care and is a highly accurate indicator of mortality. Tractor injuries, occurring frequently in rural areas due to the lack of protective equipment and the common occurrence of being crushed under the vehicle, are cases with high morbidity and mortality and should be rapidly referred to tertiary healthcare centers.

Keywords: Traffic accident, tractor, NISS

[P-509]

Biliary obstruction after deceased donor liver transplantation: Incidence and risk factors

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Objective: Biliary complications remain a significant source of morbidity following liver transplantation (LT). Among these, biliary anastomotic stricture (BAS) has been reported in some series at rates as high as 40%. BAS is commonly attributed to biliary ischemia, small bile duct diameter, and the need for multiple anastomoses. In addition, several recipient- and donor-related factors -including demographic characteristics, etiology, MELD-Na score, donor age, graft-to-recipient weight ratio, and cold/warm ischemia times- have been investigated as potential risk factors. In contrast to the extensive literature on BAS after living-donor LT, studies focusing on deceased-donor LT are limited. This study aimed to evaluate the incidence of BAS after deceased-donor LT and to analyze potential recipient- and donor-related risk factors.

Material and Methods: Patients who underwent deceased-donor LT at our center between January 1, 2019, and February 6, 2025, were included. Prospectively recorded data were retrospectively reviewed. Patients with follow-up shorter than 12 months, those undergoing living-donor LT, patients who died within 90 days, and those who developed rejection were excluded. Recipient and donor age, age difference, sex and Rh incompatibility, body mass index, MELD-Na score, cold and warm ischemia times, and intraoperative transfusion volume were evaluated. Time to BAS development and follow-up duration were recorded. In all patients, duct-to-duct biliary anastomosis was performed using interrupted 6/0 polypropylene sutures. Patients presenting with signs of biliary obstruction and/or cholangitis underwent CT to assess graft vascularity and MRCP for biliary evaluation. The cohort was divided into BAS and non-BAS groups for comparison.

Results: A total of 48 patients met the inclusion criteria. Fifteen (31.3%) were female, and the mean age was 56 (18-69) years. BAS developed in 16 patients (33%), with a median time to diagnosis of 4.7 (0.3-20) months. Median follow-up was 50 (12-85) months. In the final study year, only one case of BAS was observed. None of the evaluated variables were statistically significant predictors of BAS in univariate analysis.

Conclusion: The incidence of BAS in this series was relatively high (33%), and no significant risk factors were identified. This may be related to the limited sample size and evaluated parameters. The marked reduction in BAS during the final study year suggests a potential effect of increasing institutional experience and technical refinement. Larger, multicenter prospective studies are needed to better define risk factors for BAS following deceased-donor LT.

Keywords: Cadaveric liver transplant, biliary anastomosis stenosis

Table 1. Patient characteristics				
	Total	**BAS -**	**BAS +**	**p**
n	48	32	16	
Donor age	45.5 (17-83)	44 (19-83)	46 (17-69)	0.861
Donor gender M	24 (50%)	15 (62.5%)	9 (37.5%)	0.38
Donor BMI	25.98±3.32	26.00±3.54	25.95±2.93	0.958
Recipient age	56 (18-69)	55 (18-66)	58.5 (27-69)	0.273
Recipient gender F	15 (31.3%)	8 (53.3%)	7 (46.7%)	0.161
Recipient BMI	26.11±4.19	26.43±4.30	25.59±4.02	0.518
Donor-recipient gender mismatch				
No	25 (52.1%)	17 (68%)	8 (32%)	0.836
F→M	16 (33.3%)	11 (68.8%)	5 (31.3%)	
M→F	7 (14.6%)	4 (57.1%)	3 (42.9%)	
Donor-recipient age difference	13.5 (0-44)	16 (0-41)	11 (2-44)	0.518
D < R	33 (68.8%)	21 (63.6%)	12 (36.4%)	0.742
D > R	15 (31.3%)	11 (73.3%)	4 (26.7%)	
Meld NA	17 (15-29)	17 (15-23)	18 (15-29)	0.379
Cold ischemia time	513 (246-827)	492.5 (303-827)	582.5 (246-812)	0.457
Warm ischemia time	76 (25-215)	75 (25-121)	84 (35-215)	0.135
Blood transfusion	13.5 (2-36)	11.5 (2-36)	15 (2-32)	0.717
Length of hospital stay	16 (10-31)	16 (10-31)	17 (11-30)	0.462

[P-510]

Parathyroid adenoma located between the bifurcated branches of the recurrent laryngeal nerve: A rare case of primary hyperparathyroidism

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Objective: Primary hyperparathyroidism (PHPT) is most commonly caused by a solitary parathyroid adenoma and is curatively treated by surgery, the success of which depends on precise localization and careful dissection. Extralaryngeal bifurcation or trifurcation of the recurrent laryngeal nerve (RLN) represents a clinically significant variation, as preservation of all branches is crucial to prevent vocal cord paralysis. When early branching occurs, localization of a parathyroid adenoma between the nerve branches complicates dissection and increases the risk of injury. We present a rare case of a parathyroid adenoma located between bifurcated RLN branches and discuss the surgical approach in light of the literature.

Material and Methods: A 29-year-old female patient presented with complaints of fatigue and muscle weakness. Preoperative laboratory evaluation revealed a serum calcium level of 11.5 mg/dL, 25-OH vitamin D level of 17 ng/mL, and PTH level of 210 pg/mL. The findings were consistent with PHPT. SPECT/CT imaging demonstrated focal increased radiotracer uptake in a mildly hypodense nodular lesion measuring approximately 12×8 mm, located posterior to the mid-inferior portion of the right thyroid lobe. Neck ultrasonography revealed a 13×16 mm iso- to hypoechoic nodular lesion inferior to the right thyroid gland, outside the thyroid capsule. Both imaging modalities were considered compatible with a parathyroid adenoma. Minimally invasive parathyroid adenoma excision was planned. In the preoperative period, the lesion was marked by the department of nuclear medicine using the radioguided occult lesion localization technique. During intraoperative exploration, early bifurcation of the RLN was observed, and the parathyroid adenoma was found to be located between the two nerve branches. Under intraoperative nerve identification and monitoring, and with gamma probe guidance, the parathyroid adenoma was carefully dissected and completely excised. Postoperatively, serum calcium decreased to 9.2 mg/dL and PTH to 32.1 pg/mL. No postoperative hoarseness or vocal cord paralysis developed. Biochemical normocalcemia was achieved, and the patient's symptoms resolved.

Results: RLN bifurcation increases the risk of nerve injury during surgery. Although parathyroid glands may lie medial or posterior to the nerve due to embryologic migration, localization between its branches is exceedingly rare. As preoperative imaging cannot reliably predict nerve variations, selective excision under intraoperative nerve monitoring is recommended. Intraoperative view demonstrating early extralaryngeal bifurcation of the RLN, with the parathyroid adenoma located between the two nerve branches. The adenoma was excised under careful microdissection and intraoperative nerve monitoring. This rare anatomical variation increases the risk of nerve injury, highlighting the importance of meticulous surgical technique and anatomical awareness.

Conclusion: Parathyroid adenoma located between the bifurcated branches of the RLN represents a rare anatomical variation. Careful dissection and intraoperative nerve monitoring are critical for surgical success. Reporting such cases contributes to increased surgical awareness and prevention of potential complications.

Keywords: Recurrent laryngeal nerve, parathyroid adenoma, recurrent laryngeal nerve variation

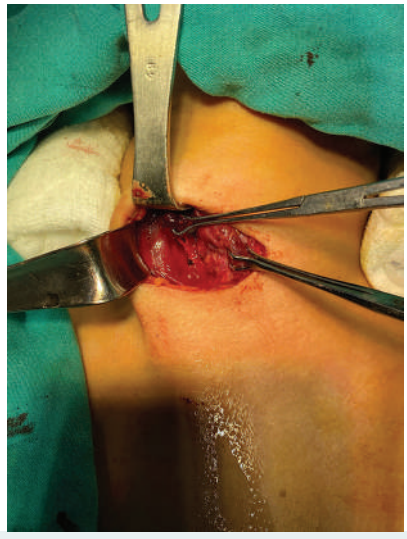

Figure 1. Parathyroid adenoma located between the bifurcated branches of the recurrent laryngeal nerve.

[P-515]

An alternative approach in acute inguinal hernia: Hernioscopy

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Objective: Inguinal hernia repair is one of the most frequently performed surgical procedures in general surgery, using both open and laparoscopic techniques. However, postponement of elective surgery by some patients leads to an increased number of emergency admissions. In patients presenting with acute incarcerated inguinal hernia, mechanical obstruction may necessitate emergency bowel resection, resulting in a significant increase in morbidity and mortality. On the other hand, when spontaneous reduction of the hernia sac occurs after induction of anesthesia, evaluation of the abdominal organs contained within the sac is often not feasible. In such cases, the inability to exclude potential pathological processes may force the surgeon to proceed with diagnostic laparotomy. At this point, hernioscopy, as a less invasive alternative to diagnostic laparotomy, gains clinical importance.

Material and Methods: Hernioscopy is a technique that enables diagnostic laparoscopy through a single trocar inserted via the hernia sac, performed under low insufflation pressure without the need for additional incisions. A review of the literature reveals that hernioscopy was first described in 1992; however, subsequent reports remain limited.

Results: In our clinic, hernioscopy was performed in selected patients. Following standard open surgical technique, the hernia sac was dissected free, a purse-string suture was placed on the peritoneum, and a 10-mm trocar was inserted to allow laparoscopic evaluation. In our practice, hernioscopy was performed in a total of seven patients who underwent surgery for incarcerated inguinal hernia in whom the contents of the hernia sac could not be clearly evaluated intraoperatively. No pathological findings were detected in the bowel loops in any of the cases. In the presence of pathological findings, continuation with laparoscopic intervention using additional ports or conversion to laparotomy based on a risk-benefit assessment was considered. Particularly in patients with hemodynamic instability or significant comorbidities, in whom laparotomy was expected to increase morbidity and mortality, diagnostic laparoscopy performed via the hernia sac provides an important alternative approach that supports and accelerates the surgeon's intraoperative decision-making process.

Conclusion: In patients undergoing emergency surgery with a preliminary diagnosis of incarcerated hernia, in whom the contents of the hernia sac cannot be clearly evaluated and there is a risk of underlying bowel pathology, hernioscopy using the hernia sac should be considered, especially in situations where laparotomy may lead to a significant increase in morbidity and mortality or when laparoscopic surgery cannot be continued due to patient-related comorbidities.

Keywords: Acute hernia, hernioscopy, strangulated hernia

Figure 1. Hernioscopy procedure. Image of a hernioscopy procedure performed using a trocar inserted into the hernia sac.

[P-516]

Our 7-year clinical experience with parastomal hernias

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Objective: Parastomal hernias are uncommon but clinically significant complications that may develop following stoma creation. There is no clear consensus in the literature regarding the optimal management and treatment of these patients. This study aimed to retrospectively evaluate the demographic and clinical characteristics of patients who underwent surgery for parastomal hernia in our clinic.

Material and Methods: This retrospective study included 45 patients who underwent surgical treatment for parastomal hernia at the General Surgery Department of University of Health Sciences Türkiye, Gülhane Training and Research Hospital between January 2018 and January 2025. Patient demographics, including age and sex, were recorded. Preoperative laboratory parameters, including hemoglobin, leukocyte, platelet, and albumin levels, were evaluated to assess baseline clinical status. Imaging modalities used for diagnosis, stoma type, mesh use during surgical repair, and whether the operation was performed under elective or emergency conditions were reviewed using patient files and the hospital information system. The mean age of the patients was 62 years (range: 28-86), and 22 patients (48.9%) were male and 23 (51.1%) were female.

Results: Evaluation of stoma types revealed loop ileostomy in 25 patients (55.6%), loop colostomy in 9 patients (20%), end ileostomy in 2 patients (4.4%), end colostomy in 8 patients (17.8%), and urostomy in 1 patient (2.2%). The mean preoperative hemoglobin level was 12.59 g/dL, mean leukocyte count was 7.02×10^9/L, mean platelet count was 226.5×10^9/L, and mean albumin level was 3.98 g/dL. Computed tomography was the most commonly used imaging modality, performed in 35 patients (77.8%), while ultrasonography was used in 10 patients (22.2%). All patients underwent surgical repair for parastomal hernia. The majority of procedures were performed under elective conditions in 44 patients (97.8%), whereas only 1 patient (2.2%) required emergency surgery. Repair without mesh was performed in 41 patients (91.1%), while mesh reinforcement was used in 4 patients (8.9%).

Conclusion: Parastomal hernias represent clinically important complications with heterogeneous clinical presentations and management strategies. The fact that all patients in this study underwent surgical treatment and that most procedures were performed electively highlights the central role of surgery in their management. The relatively limited use of mesh suggests that surgical decision-making was individualized based on patient-specific and intraoperative factors. These findings emphasize the importance of tailored surgical planning in the management of parastomal hernias. Further prospective studies with larger patient populations are needed to establish standardized treatment protocols and optimize surgical outcomes.

Keywords: Parastomal hernia, clinical experiences

[P-520]

The effect of anti-thymocyte globulin (ATG) use on postoperative surgical complications and graft function in living donor renal transplant patients

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Objective: Renal transplantation is considered to be the most effective treatment option compared to dialysis for patients with end-stage renal failure. One of the commonly used agents as an induction immunosuppressive after transplantation is anti-thymocyte globulin (ATG). In this study, the effects of ATG use on postoperative surgical complications and graft functions are evaluated.

Material and Methods: The data of 76 patients who underwent living donor kidney transplantation at Marmara University Pendik Training and Research Hospital between 2015 and 2020 and met the research criteria were retrospectively examined. Surgical complications, graft function (serum creatinine, eGFR) were examined. The chi-square test, Fisher's exact test, t-test, ANOVA test and Mann-Whitney U test were used for statistical analyses, and the significance level was determined as $p<0.05$.

Results: Thirty-three (43.42%) of the patients received ATG and 43 (56.58%) received basiliximab. A total of 22 patients (28%) developed surgical complications. These complications were observed in 7 patients (21.2%) in the ATG group and in 15 patients (34.9%) in the basiliximab group. These complications include hemorrhage (n=5), vascular complications (renal artery or vein thrombosis or stenosis) (n=3), urinary complications (ureteral stenosis, hematuria, bladder dysfunction, vesicoureteral reflux) (n=8), lymphocele (n=2) and surgical site infections (n=5). There was no significant relationship between ATG use and the development of surgical complications ($p=0.193$). There was a significant change in serum creatinine levels over time ($p=0.024$), but ATG use did not show a significant effect on creatinine ($p=0.780$) and eGFR ($p=0.660$). The bacterial infection rate was found to be low in the ATG group and CMV positivity was found to be high; however, these differences are not statistically significant.

Conclusion: There was no significant effect of ATG use on surgical complications, graft function and delayed graft function. ATG was preferred more often in recipients with a high immunological risk (PRA positive, high HLA missmatch number, pretransplant DSA positive). Therefore, when interpreting the results obtained, it should be taken into account that patients who were given ATG initially had a higher immunological risk profile.

Keywords: Anti-thymocyte globulin, surgical complication, renal transplantation

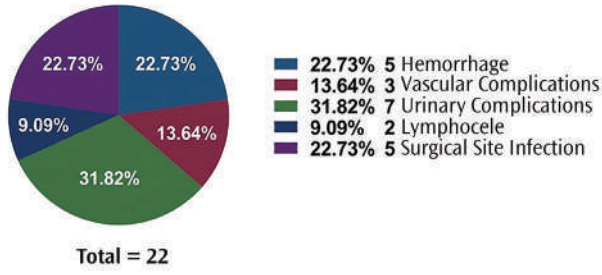

Figure 1. Distribution of surgical complications.

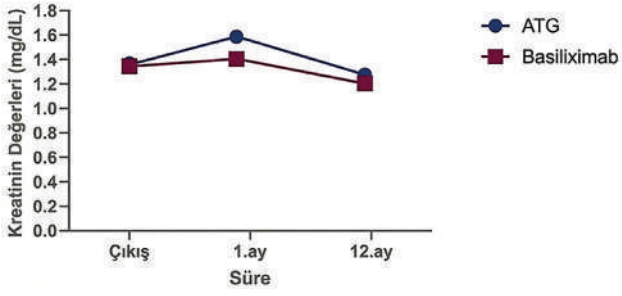

Figure 2. Evolution of serum creatinine levels according to induction therapy: ATG vs. basiliximab.

[P-521]

Rare but critical: Our clinical experience in the diagnosis and surgical management of Spigelian hernia

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Objective: Spigelian hernia is an important abdominal wall hernia that is prone to diagnostic delay due to its rarity, variable clinical presentation, and often inconspicuous findings on physical examination, carrying a risk of emergency presentation and complications. The aim of this study was to present the clinical characteristics, diagnostic process, surgical management, and outcomes of patients with Spigelian hernia who underwent emergency surgical treatment at the General Surgery Department of University of Health Sciences Türkiye, Ankara Etlik City Hospital, and to compare our findings with the literature.

Material and Methods: Five patients who underwent emergency surgical treatment for Spigelian hernia at University of Health Sciences Türkiye, Etlik City Hospital were retrospectively analyzed. Demographics, comorbidities, and risk factors; clinical presentation and diagnostic delay; imaging modalities and CT reports; surgical approach and repair technique; postoperative complications, hospital stay, follow-up,and recurrence data were evaluated using descriptive statistics.

Results: The mean age of the patients was 64.0±14.6 years, with 80% being female. All patients had comorbidities, with a mean ASA score of 2.6±0.9. A history of previous abdominal surgery was present in 80%, and chronic constipation in 60% of cases. All patients presented with abdominal pain. The mean time from symptom onset to diagnosis was 45.6±27. Four hours, with diagnostic delay (≥48 hours) observed in 60% of cases. A palpable mass was noted in 80% of patients, while in one case (20%) the diagnosis was made solely through imaging. Incarceration occurred in 60% and strangulation in 20%. CT imaging was crucial, diagnosing 80% of cases, although the explicit mention of "Spigelian hernia" in reports was low. All patients underwent open surgical repair, with mesh used in 60% (most commonly in the IPOM position). Postoperatively, seroma developed in one patient (20%), while surgical site infection and ileus were not observed. ICU admission was required in 40%, the mean hospital stay was 5.0±3.0 days, and no recurrence was observed during a mean follow-up of 20.4±8.8 months.

Conclusion: The experience at University of Health Sciences Türkiye, Etlik City Hospital demonstrates that, despite its rarity, Spigelian hernia is a clinically significant pathology, particularly in emergency presentations, with a high risk of diagnostic delay (60%) and complications such as incarceration and strangulation. Although CT played a decisive role in diagnosis in our series,the low frequency of explicit mention of "Spigelian hernia" in CT reports suggests that diagnostic success depends not only on imaging but also on clinical suspicion and radiological reporting awareness. From a surgical perspective, mesh repair was performed in 60% of cases under emergency conditions; no surgical site infections were observed, and no recurrence was noted during follow-up exceeding 20 months. These findings align with the diagnostic challenges emphasized in the literature, highlighting the need for increased awareness for early diagnosis and supporting that, with proper patient selection and technique, mesh repair can be a safe and effective option even in emergency cases. This series, providing real-world data on the diagnosis and management of this rare pathology, offers a practical guide for clinicians and underscores the need for further support from larger case series.

Keywords: Abdominal wall hernia, incarceration, mesh repair, Spigelian hernia, strangulation

Figure 1. CT image (axial) of a large Spigelian hernia.

Table 1. Demographic characteristics and comorbidity profile (n=5)

Parameter	Value
Age (years), mean ± SD	64.0±14.6
Age, median (Q1-Q3)	62 (54-71)
Sex-male, n (%)	1 (20%)
Sex-female, n (%)	4 (80%)
Body mass index (kg/m²), mean ± SD	29.2±5.9
Obesity (BMI ≥30), n (%)	1 (20%)
ASA score, mean ± SD	2.6±0.9
Charlson comorbidity index, median (min-max)	0 (0-9)
Presence of additional disease, n (%)	5 (100%)
Chronic cough/COPD, n (%)	1 (20%)
Chronic constipation, n (%)	3 (60%)
Previous abdominal surgery, n (%)	4 (80%)
Multiparity ≥2 (among female patients), n (%)	4/4 (100%)

Table 2. Clinical presentation findings

Parameter	Value
Admission type-emergency, n (%)	5 (100%)
Symptom duration (days), mean ± SD	2.0±1.0
Time from symptom onset to diagnosis (hours), mean ± SD	45.6±27.4
Diagnostic delay >48 hours, n (%)	3 (60%)
Abdominal pain, n (%)	5 (100%)
Palpable mass, n (%)	4 (80%)
Diagnosis by imaging despite absence of palpable mass on physical examination, n (%)	1 (20%)
Nausea and vomiting, n (%)	3 (60%)
Incarceration, n (%)	3 (60%)
Strangulation, n (%)	1 (20%)

Table 3. Imaging findings

Parameter	Value
Imaging modality-CT, n (%)	2 (40%)
Imaging modality-ultrasonography (USG), n (%)	1 (20%)
Imaging modality-CT + USG, n (%)	2 (40%)
Cases diagnosed by CT, n (%)	4 (80%)
Spigelian hernia explicitly stated in CT report, n (%)	1 (25%)
Content reported on CT-omentum, n (%)	1 (25%)
Content reported on CT-small bowel, n (%)	2 (50%)
Content reported on CT-colon, n (%)	0

Table 4. Surgical characteristics

Parameter	Value
Surgical approach-open surgery, n (%)	5 (100%)
Repair type-primary, n (%)	2 (40%)
Repair type-mesh, n (%)	3 (60%)
Mesh use in emergency cases, n (%)	3 (60%)
Mesh position-sublay, n (%)	1 (33%)
Mesh position-IPOM, n (%)	2 (67%)
Mesh fixation-suture, n (%)	2 (67%)
Mesh fixation-stapler/tacker, n (%)	1 (33%)
Defect closed primarily, n (%)	2 (40%)
Bowel resection, n (%)	0

Table 5. Postoperative outcomes and follow-up

Parameter	Value
Operative time (min), mean ± SD	82.0±36.8
Postoperative complications, n (%)	1 (20%)
Surgical site infection, n (%)	0
Seroma, n (%)	1 (20%)
Postoperative ileus, n (%)	0
Intensive care unit admission, n (%)	2 (40%)
Length of ICU stay (days), median (min-max)	2 (2-6)
Length of hospital stay (days), mean ± SD	5.0±3.0
Follow-up duration (months), mean ± SD	20.4±8.8
Recurrence, n (%)	0

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[P-524]

Laparoscopic transabdominal preperitoneal inguinal hernia repair (TAPP) in a young training clinic: Two-year experience

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Objective: Inguinal hernias are among the most commonly encountered surgical conditions in general surgery practice. Surgical repair is recommended for their treatment, and various surgical techniques are currently employed for this purpose. One of these techniques is laparoscopic inguinal hernia repair.

Material and Methods: The aim of this study was to present the early outcomes of transabdominal preperitoneal (TAPP) inguinal hernia repair performed on patients in a newly established general surgery clinic.

Results: A retrospective analysis was conducted on 102 patients who underwent TAPP inguinal hernia repair at our general surgery clinic between January 2024 and January 2026. Of these patients, 98 (96.1%) were male and 4 (3.9%) were female. The mean age was 55.6 years, and the mean body mass index was 26.8 kg/m^2. According to preoperative anesthesia assessment, 18 patients were classified as ASA I (17.6%), 72 as ASA II (70.6%), and 12 as ASA III (11.8%). Regarding hernia laterality, 51 patients (50%) had right-sided, 31 (30.4%) left-sided, and 20 (19.6%) bilateral inguinal hernias. Intraoperative findings revealed 48 (47.1%) direct, 46 (45.1%) indirect, 7 (6.9%) pantaloon, and 1 (1%) femoral hernia. The mean operative time was 60.9 minutes. The mean postoperative hospital stay was 1.67 days. During a two-year follow-up period, hernia recurrence was observed in 2 patients. Early postoperative complications included inguinal seroma in 2 patients, scrotal edema in 1 patient, inguinal hematoma in 2 patients, trocar site bleeding in 1 patient, and subcutaneous ecchymosis. All patients received appropriate medical management and follow-up during the postoperative period.

Conclusion: The TAPP procedure has recently become a commonly preferred method for inguinal hernia repair due to its advantages of reduced postoperative pain and shorter hospital stay, which facilitate a faster return to daily activities. In our clinic, laparoscopic inguinal hernia repair was successfully performed during the learning curve with low complication and recurrence rates, and these results support its dissemination within the general surgery residency training program.

Keywords: Hernia repair, inguinal hernia, TAPP

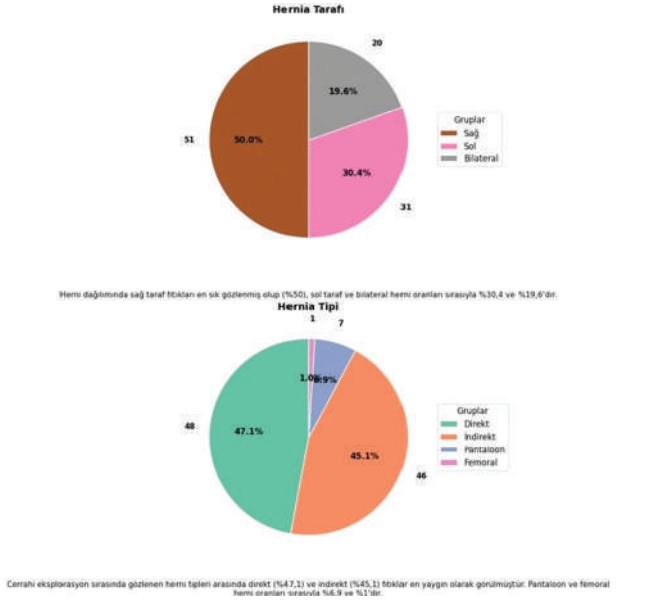

Figure 1. Characteristics and side distribution of hernias.

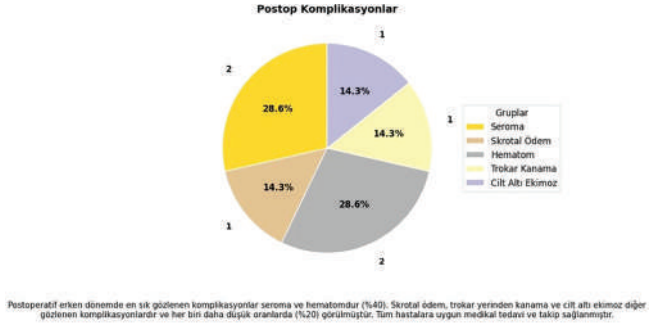

Figure 2. Rates of complications.

[P-525]

Minimally invasive pancreatic surgery: Our robotic and laparoscopic experiences

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Objective: Pancreatic cancers remain among malignancies with high mortality rates due to both theiraggressive biological behavior and the limited chance of curative surgical treatment at thetime of diagnosis. In recent years, minimally invasive approaches including laparoscopic androbotic techniques have been increasingly preferred because of their potential benefits onintraoperative and postoperative morbidity and mortality. However, comprehensive data, particularly regarding long-term outcomes and complication profiles, remain limited.

Material and Methods: In this study, laparoscopic and robotic pancreatic surgeries performed in our clinic between 2020 and 2025 were retrospectively reviewed. Various parameters were compared, including operative duration, anesthesia induction and extubation times, intraoperative blood loss andblood product transfusion requirements. Postoperative outcomes such as thromboembolic events, atelectasis, surgical site infections and mortality were analyzed. Conversion rates tolaparoscopic or open surgery and length of stay in the intensive care unit were also evaluated. In light of similar studies reported in the literature, the current status of laparoscopic and robotic pancreatic surgery and potential future trends were assessed. The aim was toprovide data that may help clarify the advantages and limitations of minimally invasive pancreatic surgery and contribute to surgical decision-making processes.

Results: In robotic pancreatic surgery cases, parameters related to surgical and anesthesiological processes were observed to improve significantly over time. A gradual reduction in operative duration was noted in later cases, indicating more efficient perioperative management. In accordance with learning curve data reported in the literature, increasing team experience led to a more predictable and stable surgical workflow. Postoperative complication rates in robotic pancreatic surgery were found to be lower compared to laparoscopic surgery. Anastomotic leakage, thromboembolic events and mortality were observed in a limited number ofcases. These findings may be associated with the precise dissection capability and stable visualization provided by robotic surgical systems.

Conclusion: Robotic pancreatic surgery appears to be a safe and feasible approach in our clinic withrespect to early surgical and clinical outcomes. The improvement observed in operative processes over time and the trend toward shorter operative durations are consistent with reports from other experienced centers. Increasing surgical and anesthesiological team experience and improved perioperative coordination support the role of robotic surgery as aneffective and sustainable option in pancreatic surgery.

Keywords: Laparoscopic pancreatic surgery, robotic pancreatic surgery

[P-526]

Stove burn complicated as diabetic foot: Case presentation

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Objective: Diabetes mellitus (DM) is a systemic disease that negatively affects the wound healing process and significantly increases the risk of chronic wound formation in patients with burn. Microvascular circulation disorders, peripheral neuropathy, prolonged inflammation, and susceptibility to infection in diabetic individuals can hinder the normal healing process of burn wounds.

Material and Methods: This case report aims to examine the progression of a chronic wound in a diabetic patient and the effect of an interdisciplinary approach to wound care on wound healing.

Results: Fifty-one-year-old male patient with a history of DM and hypertension presented to the burn unit with a second-degree burn on the plantar surface of his left foot due to a thermal burn. The burn occurred approximately 5 days earlier as a result of contact with a stove. The patient's HbA1C value was determined to be 9.6% and his blood glucose value was 282 mg/dL; findings of peripheral neuropathy and circulatory disorders were evaluated. The patient had a history of peripheral neuropathy and smoking. The patient's wound was followed up and treated by the burn unit on an outpatient basis for approximately two weeks. Due to possible uncontrolled DM, the patient's burn wound did not heal and had complicated as diabetic foot, so the patient was transferred to the Chronic Wound Care Team. The Chronic Wound Care Team sequentially applied autolytic debridement and epithelialization-supporting products to the patient's wound. At the same time, the patient's glycemic control was ensured, and signs of infection were closely monitored. The patient's wound completely healed after approximately three weeks of follow-up and treatment in outpatient clinic conditions.

Conclusion: Following the wound care applied, an increase in granulation tissue in the wound bed and a significant acceleration in the epithelialization process were observed. This case demonstrates that burn wounds in diabetic individuals carry a high risk of chronicity and that successful wound healing is possible through interdisciplinary collaboration. It should always be kept in mind that coordinated work between Burn and Chronic Wound Care Teams is critical for the effectiveness of wound management.

Keywords: Burn, chronic wound, diabetes mellitus, interdisciplinary work

Figure 1.
Initial appearance of the wound

Figure 2.
Appearance of the wound at postoperative week 1

Figure 3.
Appearance of the wound at postoperative week 2

Figure 1. The course of diabetic foot ulcer developing after a stove burn.

[P-528]

Characteristics of recurrent retroperitoneal soft tissue sarcomas

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Objective: Retroperitoneal soft tissue sarcomas constitute approximately 12-15% of all soft tissue sarcomas. Mortality is generally due to unresectable recurrent tumor complications rather than distant metastasis. In this study, the characteristics of patients with recurrent retroperitoneal soft tissue sarcoma were investigated.

Material and Methods: In this study, gender, age, presenting complaint, length of hospital stay, tumor diameter, histopathological type, type of resection, organ resection, and time of recurrence were evaluated in 30 of 49 retroperitoneal soft tissue sarcoma patients who experienced recurrence and were treated between 2009 and 2025.

Results: Recurrence occurred in 30 (61%) of the 49 patients, 17 (57%) of whom were female and 13 (43%) were male. The mean age at the time of the first surgery for retroperitoneal soft tissue sarcoma was 55 (28-81). Abdominal pain was the most frequent presenting complaint, occurring in 46.6% of patients. The mean postoperative hospital stay was 9 (2-24) days. The mean tumor diameter was 16.4 (3.5-36) cm. Thirteen different histopathological types were identified, the most frequent being dedifferentiated liposarcoma, seen in ten patients (33%). R0 resection was performed in nineteen patients (64%), R1 resection in ten patients (33%), and R2 resection in one patient (3%). Organ resection was performed in sixteen patients (53%) due to invasion. The mean time to recurrence was 40 (5-220) months.

Conclusion: In this study, the recurrence rate in retroperitoneal soft tissue sarcoma was found to be 61%, and the mean time to recurrence was 40 months.

Keywords: Sarcoma, retroperitoneal soft tissue sarcoma, surgical oncology

[P-529]

Retroperitoneal tumors: A review of six cases

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Objective: The retroperitoneal region is a complex potential space bordered by vital organs: anteriorly by the peritoneum, colon and mesocolon, liver, pancreas, and stomach. Posteriorly, it is bounded predominantly by muscular structures: the psoas, quadratus lumborum, transversus abdominis, and iliac muscles. Depending on tumor location, the diaphragm, ipsilateral kidney, ureter, and gonadal vessels may be adjacent. Medially, the boundaries may be defined by the vertebrae, paraspinal muscles, inferior vena cava, and aorta.

Material and Methods: The clinical findings, imaging modalities used for diagnosis, surgical course, and final histopathological characteristics of patients operated on in our clinic between 2023 and 2025 with a prediagnosis of "retroperitoneal tumor" were reviewed.

Results: A total of 6 (six) patients underwent surgery; mean age was 60.2 (56-67) years, and the female-to-male ratio was 4:2. Three patients had primary retroperitoneal tumors; the remaining three had secondary tumors, two presented with recurrence in the setting of prior total hysterectomy and oophorectomy, and one had a recurrence of a chordoma with very low malignant potential. The tumors primarily diagnosed were "high-grade malignant mesenchymal tumor (with areas showing rhabdomyosarcoma and leiomyosarcoma differentiation)"; high-grade liposarcoma; and retroperitoneal fibrosis. Among the secondary tumors, one patient, who had been operated on 7-8 times in the neurosurgery clinic due to chordoma, had an invasive 8.5 cm mass over the left iliopsoas; the other two had previously been operated on by the obstetrics and gynecology clinic 8 years and 2 years earlier for "granular cell ovarian tumor" and "mesonephric adenocarcinoma," respectively. The mean longest tumor diameter was 18.3 (8.5-30) cm; the largest measured 30×29×14 cm and weighed 14.5 kg. Surgical margins were negative in all patients, and they have continued their lives without recurrence to date.

Conclusion: All retroperitoneal tumors we operated on were large-volume lesions. Due to the retroperitoneal location, a multidisciplinary approach is required, and survival can be prolonged by achieving negative surgical margins and by close follow-up for recurrence.

Keywords: Retroperitoneal tumors, liposarcoma, soft tissue sarcoma

[P-530]

Initial interpretation of symptoms in acute appendicitis and the decision process for hospital admission

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Objective: The aim of this pilot study is to evaluate the effect of symptom duration, initial interpretation of pain, home interventions, and social factors on the decision-making process for hospital admission in patients diagnosed with acute appendicitis; and to explore perceptual and behavioral factors that may be associated with delayed admission.

Material and Methods: This single-center, descriptive, and exploratory pilot study involved administering a closed-ended questionnaire to 30 patients diagnosed with acute appendicitis or perforated appendicitis. The questionnaire examined the duration of symptoms, the initial assessment of pain, actions taken at home, the influence of the social environment and information sources, and the decision-making process leading to hospital admission. Clinical information was recorded by the physician. The study did not include any personally identifiable data, and all analyses were performed on an anonymized dataset. Delayed referral was dichotomized as "delay present" for all options except the "no delay" response. Categorical variables were presented with descriptive statistics. Fisher's exact test was used for exploratory comparisons, and $p<0.05$ was considered statistically significant.

Results: Twenty-three patients (76.7%) were diagnosed with acute appendicitis, and 7 (23.3%) with perforated appendicitis. %53.3 patients (n=16) had symptoms lasting more than 12 hours. Sixteen patients (53.3%) said they "did not take the pain seriously at first," 10 (33.3%) said they took it "somewhat seriously," and 4 (13.3%) said they took it "seriously from the beginning." Twenty-seven patients (90%) stated that they did not consider the possibility of appendicitis at the onset of symptoms. Twelve patients (40%) researched their symptoms on the internet. Forty percent of families (n=12) accelerated the referral process, while 53.3% (n=16) reported no effect, and 6.7% (n=2) reported delaying the referral. Thirteen patients (43.3%) stated that they delayed going to the hospital because they felt better after taking painkillers. No statistically significant relationship was found between delayed presentation and not taking the pain seriously at first ($p>0.99$), not considering the possibility of appendicitis ($p=0.43$), and relief after taking painkillers ($p>0.99$). There was a trend toward less delay in seeking medical attention among patients who assessed their pain as "severe from the outset" ($p=0.119$).

Conclusion: In conclusion, this study suggests that delayed presentation in patients with acute appendicitis may be related to the initial interpretation of symptoms and patient perception rather than clinical findings. The findings indicate that the effect of patient perception and decision-making processes on delayed presentation could be more clearly demonstrated in prospective studies with larger samples.

Keywords: Appendicitis, delay, application

Table 1. Patients' perceptual and behavioral characteristics related to symptom recognition and the decision-making process for seeking hospital care (n=30)

Perceptual/behavioral characteristics	n (%)
Didn't take the pain seriously at first	16 (53.3)
Not considering the possibility of appendicitis at first	27 (90.0)
Searching for symptoms online	12 (40.0)
Relieved after taking painkillers and postponing the application	13 (43.3)
Not making the decision to go to the hospital on their own (family/environmental influence)	14 (46.7)

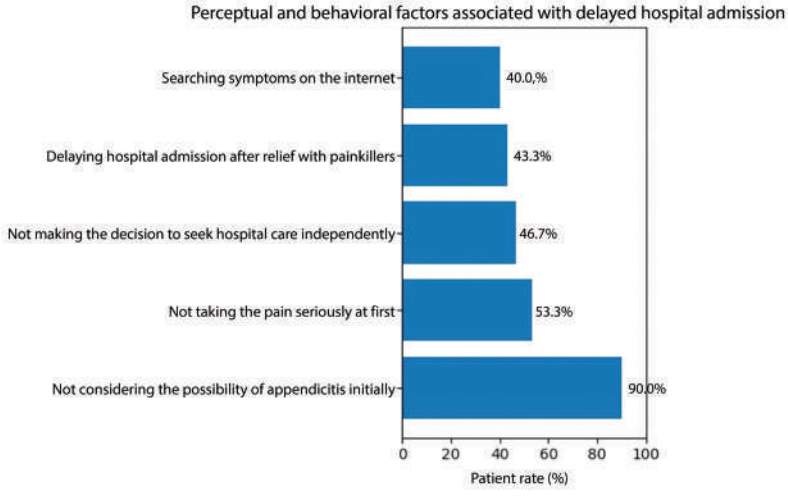

Figure 1. Application delay.

[P-531]

Surgical site infections after ileostomy and colostomy closure: A single-center experience

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Objective: The creation of an ostomy or colostomy may be required temporarily or permanently for the management of various pathological conditions, including congenital anomalies, colonic obstruction, inflammatory bowel disease, bowel trauma, and gastrointestinal malignancies. One of the most common complications following ostomy closure is surgical site infection (SSI). Compared to many other surgical procedures, the risk of SSI is relatively higher in ostomy closure operations. Therefore, meticulous adherence to sterile techniques by both the surgeon and operating room nurse is strongly recommended. In this study, we aimed to analyze the data of patients who developed SSI after ostomy closure.

Material and Methods: This retrospective study included 34 patients who underwent ostomy or colostomy closure between January 1, 2023, and January 1, 2026, at İzmir Katip Çelebi University, Atatürk Training and Research Hospital. Demographic characteristics, comorbidities, and length of hospital stay were evaluated.

Results: Among the 34 patients, 18 underwent ostomy closure and 16 underwent colostomy closure. Fourteen patients (41.2%) were female and 20 (58.8%) were male. In the colostomy closure group, 4 of 16 patients (25%) developed SSI. Two were female and two were male. All infected patients had at least one comorbidity. The mean hospital stay was 8.75 days (range: 6-11) in infected patients and 6.0 days (range: 3-8) in non-infected patients. In the ostomy closure group, 7 of 18 patients (38.9%) developed SSI. Two were female (28.6%) and five were male (71.4%). All infected patients had at least one comorbidity, and three had three or more comorbidities. The mean hospital stay was 13.14 days (range: 8-23) in infected patients and 5.36 days (range: 4-7) in non-infected patients. Additionally, one patient developed an anastomotic leak, resulting in a mortality rate of 2.94%.

Conclusion: SSI after ostomy closure is a common complication that significantly prolongs hospital stay. The presence of comorbidities appears to increase the risk of infection. Strict adherence to sterile techniques and strong collaboration between surgeons and nurses may help reduce this complication.

Keywords: Ostomy-colostomy closure, infection

Table 1. Ostomy patients

Ostomy patients	Infected	Uninfected
	7	11
Average stay duration	13.14	5.36
Age	64.85	66.90

Ostomy patients with and without infection, age, and average length of hospital stay.

Table 2. Colostomy patients

Colostomy patients	Infected	Uninfected
	4	12
Average stay duration	8.75	6.0
Age	66.50	58.25

Colostomy patients with and without infection, age, and average length of hospital stay.

[P-532]

Outcomes of stoma closure after emergency resection in patients operated for perforated diverticulitis

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Objective: The choice between Hartmann's procedure and resection with primary anastomosis plus diverting loop ileostomy in patients undergoing emergency surgery for perforated diverticulitis remains controversial. It is well established that stoma reversal rates are lower and closure times are significantly longer in patients undergoing Hartmann's procedure compared to those with loop stomas. In this study, we aimed to compare stoma closure rates and timing in patients who underwent emergency surgery with stoma formation due to diverticular perforation.

Material and Methods: We retrospectively analyzed patients who underwent emergency surgery for perforated diverticulitis with stoma formation at İzmir Katip Çelebi University Atatürk Training and Research Hospital between January 1, 2021, and January 1, 2026. Data regarding stoma closure status and timing were evaluated.

Results: A total of 36 patients underwent emergency surgery for perforated diverticulitis. Stoma formation was performed in 29 patients. Five patients who died in the postoperative period were excluded from the study. Among the remaining 24 patients, 5 underwent resection with primary anastomosis and diverting loop ileostomy, while 19 underwent Hartmann's procedure. Stoma closure was achieved in all patients (100%) with loop ileostomy. In contrast, 7 of the 19 patients (36.8%) who underwent Hartmann's procedure had not undergone stoma reversal at the time of analysis. In the Hartmann group, stoma closure was performed between 4 and 60 months postoperatively. In the loop ileostomy group, closure was achieved significantly earlier, between 8 and 14 weeks.

Conclusion: Stoma formation is frequently required in emergency surgery for perforated diverticulitis. Our findings suggest that resection with primary anastomosis and protective loop ileostomy may provide higher stoma closure rates and significantly shorter time to reversal compared to Hartmann's procedure. This approach may reduce the likelihood of permanent stoma and improve postoperative outcomes.

Keywords: Loop ileostomy, perforated diverticulitis, stoma closure

[P-533]

Clinicopathological comparison of perforated and non-perforated acute appendicitis cases

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Objective: Acute appendicitis is one of the most common surgical abdominal pathologies. Approximately 20-30% of cases present as complicated appendicitis with perforation. Appendiceal perforation can significantly increase morbidity and mortality rates. The aim of this study was to compare the clinical, laboratory, intraoperative, and histopathological data of patients who underwent surgery for appendicitis, both perforated and non-perforated.

Material and Methods: The data of 521 patients with acute appendicitis who underwent surgery between January 2016 and June 2025 were retrospectively reviewed. Patients were grouped according to the status of appendix perforation (non-perforated, perforated, plastron). Parameters such as age, duration of symptoms, laboratory values (WBC, CRP, neutrophil, lymphocyte, bilirubin), and radiological findings (appendix diameter) were compared between groups.

Results: The rates of perforation and plastron increased significantly with increasing age and duration of symptoms ($p<0.001$). In patients with perforation and plastron, preoperative leukocyte, neutrophil, CRP, total bilirubin, and indirect bilirubin levels were significantly higher than in the non-perforated group ($p<0.001$). Lymphocyte levels were significantly lower in patients with perforation and plastron. The appendix diameter was significantly smaller in non-perforated patients compared to those with perforation and plastron ($p<0.001$).

Conclusion: Advanced age, prolonged symptom duration, and elevated inflammation markers (WBC, CRP, neutrophil) along with decreased lymphocyte and elevated bilirubin levels are important clinical and pathological indicators of perforation risk in acute appendicitis cases. These findings may assist clinicians in assessing perforation risk earlier and optimizing treatment management.

Keywords: Non-perforated appendicitis, perforated appendicitis

[P-534]

A new surgical approach to incisional hernia; simultaneous hernia repair and abdominoplasty

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Objective: Simultaneous ventral hernia repair and abdominoplasty is a combined surgical approach that provides aesthetic improvement along with restoration of abdominal wall function. This study aimed to evaluate the clinical outcomes, complications, and wound management strategies of 42 patients who underwent concurrent ventral hernia repair and abdominoplasty, in light of the relevant literature.

Material and Methods: A total of 42 patients who underwent simultaneous ventral hernia repair and abdominoplasty were retrospectively analyzed. Demographic characteristics, types of hernia, concomitant surgical procedures, postoperative complications, and follow-up outcomes were assessed. Reconstructive surgical interventions and wound care strategies applied in patients who developed skin necrosis were also evaluated.

Results: Skin necrosis occurred in 5 of the 42 patients (11.9%). One of these patients was treated with a free skin graft harvested from the anterolateral thigh region, while the remaining cases were successfully managed using vacuum-assisted closure therapy. Concurrent cholecystectomy was performed in eight patients. During the mean follow-up period, no ventral hernia recurrence was observed. No major morbidity or mortality was recorded.

Conclusion: With appropriate patient selection and meticulous surgical technique, the simultaneous application of ventral hernia repair and abdominoplasty is a safe and effective approach. Skin necrosis is the most common serious complication; however, it can be successfully treated using modern wound management techniques.

Keywords: Abdominoplasty, combined surgery, skin necrosis, ventral hernia repair, wound management

Figure 1. Early postoperative abdominal appearance after simultaneous ventral hernia repair and abdominoplasty.

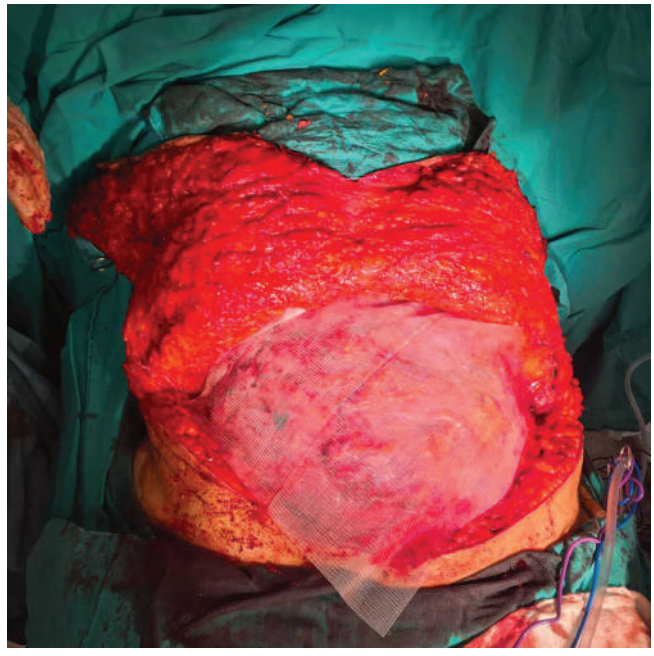

Figure 2. Intraoperative view of abdominal wall reconstruction following ventral hernia repair and abdominoplasty.

Figure 3. Intraoperative view showing mesh fixation and coverage of the hernia defect during abdominal wall reconstruction.

Figure 4. Preoperative view of the abdominal wall defect.

[P-535]

False decrease in oxygen saturation following subareolar isosulfan blue dye injection

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Objective: Sentinel lymph node biopsy (SLNB) is a widely used and reliable method for axillary staging in early-stage breast cancer surgery, with a low morbidity rate and a reported accuracy exceeding 90%. The most commonly used dyes during SLNB are isosulfan blue and methylene blue. Although rare, clinically noteworthy complications following isosulfan blue administration include a decrease in oxygen saturation due to methemoglobinemia or false readings related to pulse oximetry interference. Such events may lead to unnecessary interventions and concern during the perioperative period. In this study, we aimed to investigate whether the perioperative decrease in oxygen saturation observed after subareolar injection of isosulfan blue dye for sentinel lymph node identification was attributable to true hypoxemia or to a false measurement caused by pulse oximetry.

Material and Methods: A total of 30 patients who underwent surgery for a diagnosis of breast cancer and received SLNB were included in the study. Patients' demographic characteristics, histopathological diagnoses, surgical procedures performed, and perioperative oxygen saturation values were recorded. SpO_2 values measured by pulse oximetry before and after dye injection were compared. In patients who were found to have a decrease in oxygen saturation, arterial blood gas analysis was performed to assess true oxygen saturation.

Results: Invasive ductal carcinoma was present in 27 patients, invasive lobular carcinoma in 2 patients, and ductal carcinoma *in situ* in 1 patient. The mean age was 53.8 years (range: 32-75). Breast-conserving surgery plus SLNB was performed in 21 patients, modified radical mastectomy in 4 patients, and simple mastectomy plus SLNB in 5 patients. Fifteen patients underwent surgery following neoadjuvant chemotherapy. The mean SpO_2 value measured prior to dye injection was 99.1%, which decreased to 91.5% after injection. However, arterial blood gas analysis performed during the same period revealed a mean oxygen saturation of 97.4%. No postoperative respiratory complications were observed in any of the patients.

Conclusion: The decrease in oxygen saturation observed on pulse oximetry following isosulfan blue dye injection during SLNB does not reflect true hypoxemia. This phenomenon should be considered a measurement artifact, and in cases of clinical suspicion, confirmation with arterial blood gas analysis is recommended. Recognition of this condition may help prevent unnecessary interventions.

Keywords: Sentinel lymph node biopsy, isosulfan blue dye, breast cancer

[P-536]

Bilateral mastectomy with immediate reconstruction in a single stage

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Objective: At Maltepe University Faculty of Medicine Hospital, the outcomes of immediate silicone-based breast reconstruction performed in the same session for patients undergoing mastectomy due to a cancer diagnosis were investigated.

Material and Methods: The data of 313 patients who underwent surgery for a diagnosis of breast cancer between 2020 and 2025 were reviewed. Patients who underwent axillary dissection following sentinel lymph node biopsy were excluded from the study, and the remaining patients were divided into three groups: segmental mastectomy, simple mastectomy, and bilateral mastectomy with silicone-based reconstruction. Postoperative hospital stay duration, pain levels, and patient satisfaction were evaluated.

Results: As expected, the shortest time to discharge was observed in patients who underwent segmental mastectomy alone (median 1 day), whereas the median hospital stay was 3 days in the silicone-based reconstruction group, and the difference was statistically significant. Postoperative wound-site complications were found to be more frequent in patients who underwent reconstruction, and visual analog scale pain scores were significantly higher in this group. When patients' postoperative aesthetic satisfaction was assessed on a 10-point scale, the simple mastectomy group was found to be dissatisfied, while the other two groups showed no significant difference, with satisfaction scores of 7.8/10 in the segmental mastectomy group and 8.1/10 in the reconstruction group.

Conclusion: Although segmental mastectomy still appears to be the best option in terms of patient satisfaction, the option of silicone-based reconstruction should be offered preoperatively, taking into account the patient's age, family history, and expectations.

Keywords: Breast cancer, immediate silicone-based reconstruction

[P-537]

The effect of parathyroid autotransplantation on parathyroid hormone levels during total thyroidectomy

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Objective: Hypocalcemia due to hypoparathyroidism after total thyroidectomy is one of the common complications of surgery and may follow a transient or permanent course. Permanent hypoparathyroidism negatively affects patients' quality of life and may require long-term calcium and active vitamin D supplementation. Parathyroid autotransplantation is considered a salvage strategy aimed at preserving the function of parathyroid tissue that is thought to be devascularized intraoperatively or inadvertently excised. However, the effect of this approach on the parathyroid hormone (PTH) recovery process remains controversial in the literature. This study aimed to compare the postoperative PTH recovery process in patients with and without parathyroid autotransplantation.

Material and Methods: This retrospective comparative cohort study included 152 patients who underwent total thyroidectomy at the Endocrine Surgery Clinic of Konya City Hospital. Patients were divided into a parathyroid autotransplantation group (PAT, n=70) and a control group without autotransplantation who developed hypoparathyroidism at postoperative 24 hours (n=82). Serum PTH and calcium levels were measured preoperatively and at postoperative 24 hours, 1 month, 6 months, and 12 months. Biochemical recovery was defined as serum calcium ≥8.5 mg/dL and PTH ≥15 pg/mL. Groups were compared using appropriate statistical tests, with $p<0.05$ considered significant.

Results: The study population consisted of 20 males (13.1%) and 132 females (86.9%). Mean age was similar between the PAT and control groups (49.4±13.1 vs. 48.7±12.7 years, $p>0.05$). PTH levels at postoperative 24 hours were significantly higher in the PAT group ($p<0.001$). At 1 month, biochemical recovery was observed in 65% of the PAT group and 40% of the control group ($p=0.01$). Although median PTH and calcium levels were comparable, recovery rates were higher in the PAT group based on threshold analysis. No significant differences were observed at 6- and 12-month follow-up. Biochemical recovery was defined as a serum calcium level ≥8.5 mg/dL and a parathyroid hormone (PTH) level ≥15 pg/mL at the corresponding follow-up time point. The proportion of patients (%) meeting the recovery criteria at each follow-up time point was calculated, and intergroup comparisons were performed using the chi-square test or Fisher's exact test, as appropriate.

Conclusion: Parathyroid autotransplantation accelerates the biochemical recovery of parathyroid function after total thyroidectomy, particularly in the early postoperative period. However, similar recovery rates are achieved in both groups during long-term follow-up. In light of these findings, autotransplantation of parathyroid glands that are considered devascularized intraoperatively or inadvertently excised may be regarded as an effective surgical approach for preserving parathyroid function and facilitating early biochemical recovery.

Keywords: Parathyroid autotransplantation, parathyroid hormone recovery, total thyroidectomy

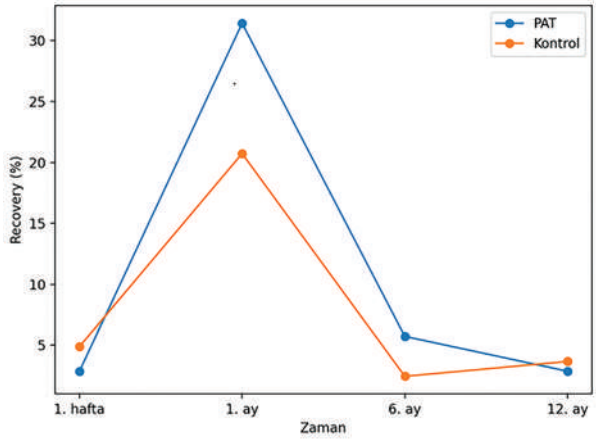

Figure 1. Time course of biochemical recovery in patients with and without parathyroid autotransplantation.

Table 1. Calcium and PTH levels over time

Variable	PAT	Control	p
Calcium-preoperative	9.40 (9.10-9.70)	9.40 (9.10-9.60)	0.798
PTH-preoperative	33.95 (21.72-43.85)	47.10 (38.55-50.25)	0.300
Calcium-24th hour	7.85 (7.40-8.30)	7.75 (7.50-8.10)	0.452
PTH-24th hour	10.30 (3.94-25.10)	5.57 (2.45-8.80)	p<0.001
Calcium-1st week	8.55 (8.00-8.80)	8.45 (7.60-8.85)	0.867
PTH-1st week	11.90 (10.60-19.25)	15.45 (7.39-39.95)	0.711
Calcium-1st month	9.10 (8.70-9.62)	8.80 (8.25-9.40)	0.188
PTH-1st month	23.25 (18.28-39.57)	27.05 (14.90-33.88)	0.731
Calcium-6th month	8.95 (8.35-9.05)	7.75 (7.50-8.68)	0.080
PTH-6th month	17.10 (15.25-35.25)	14.40 (7.13-15.30)	0.106
Calcium-12th month	8.60 (8.30-8.75)	8.75 (8.40-8.80)	0.918
PTH-12th month	18.50 (15.20-26.07)	22.30 (7.63-49.60)	0.788

Data are presented as median (25th-75th percentile). Intergroup comparisons were performed using the Mann-Whitney U test.

[P-538]

The road to total pancreatectomy: Preoperative planning or peroperative necessity?

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Objective: Pancreatic surgery is one of the most complex fields of general surgery due to its high mortality and morbidity rates and technical challenges. Postoperative pancreatogenic diabetes mellitus (DM) (type 3c DM) is one of its most significant complications. The absence of both insulin and glucagon makes glycemic regulation difficult. Deciding between pancreatoduodenectomy, distal pancreatectomy, and total pancreatectomy (TP) techniques can sometimes be complex process. TP is surgical procedure applied in multifocal lesions, particularly in intraductal papillary mucinous neoplasm (IPMN). Furthermore, it may be preferred to avoid anastomosis in patients at high risk of developing postoperative pancreatic fistula.

Material and Methods: TP cases performed in our clinic between January 2021 and December 2025 were evaluated. We analyzed whether the decision for TP was made based on preoperative radiological assessment or peroperative surgical findings and presented the reasons behind these decisions.

Results: Fifteen TP cases were performed in our clinic over the last five years. Of these patients, 8 were male and 7 were female. The mean age was 56 (min-max: 42-78). TP was planned for seven patients based on preoperative evaluations. Radiological imaging in these patients revealed lesions involving both the caput and the corpus or cauda of the pancreas. In eight patients, TP was performed due to peroperative findings and technical reasons. In 4 of 8 patients,the decision for TP was made because contrary to preoperative radiological tests the lesion size was larger, the locations were multiple, or the lesion extended toward the body and tail of the pancreas. TP was preferred in one patient due to severe pancreatic atrophy and the inability to clearly identify the Wirsung duct. In another patient, TP was chosen because the mass invaded the portal and splenic veins, necessitating vascular reconstruction. In the remaining 2 patients, TP was preferred to avoid postoperative pancreatic fistula. A common feature of these two patients was the need for gastrectomy in addition to pancreatic surgery. One patient had second center as gastric mass, and total gastrectomy was added to the surgery. In the other patient, the pancreatic mass was adherent to the posterior corpus of the stomach and distal subtotal gastrectomy was added. For these reasons, Roux-en-Y anastomosis was preferred in these patients in order to avoid pancreatic anastomosis.

Conclusion: TP is procedure rarely preferred among pancreatic surgeries but can be inevitable in selected patients. Although its indications are still not clearly defined, it is preferred in lesions that can involve the entire pancreas, such as IPMN, and in patients with high risk of developing postoperative pancreatic fistula. Determining the decision for TP in either the preoperative or peroperative period is challenging; multidisciplinary evaluation and intraoperative surgical experience plays decisive role in this process.

Keywords: Pancreas, pancreatectomy, peroperative, preoperative, total

[P-539]

From the emergency department to general surgery: Clinical course and management of traumatic pancreatic injuries

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Objective: Traumatic pancreatic injuries are rare but complex lesions associated with significant morbidity. This study aimed to evaluate the demographic characteristics, injury severity, surgical management strategies, and clinical outcomes of patients with pancreatic trauma admitted to the emergency department and treated in the general surgery clinic.

Material and Methods: Patients hospitalized for pancreatic trauma at University of Health Sciences Türkiye, Ankara Etlik City Hospital, Department of General Surgery, were retrospectively reviewed. Demographic data, mechanism of injury, laboratory and imaging findings, AAST pancreatic injury grade, surgical procedures, postoperative complications, ICU and hospital length of stay, and mortality rates were analyzed.

Results: Eight patients were included. The median age was 33 years, and 87.5% were male. Blunt and penetrating trauma were equally distributed. Concomitant extra-pancreatic organ injury was present in 75% of patients, and major vascular injury in 25%. Blood transfusion within 24 hours was required in 37.5%. The median Glasgow Coma Scale score was 15, and hypotension occurred in 25%. Amylase and lipase levels varied widely. FAST examination was negative in all patients. Computed tomography (CT) was performed in 87.5%, suggesting pancreatic injury in 37.5% and ductal injury in 25%. The median AAST grade was 1. Drainage alone was the most common surgical approach (62.5%), while distal pancreatectomy was performed in 25%. No patient required pancreaticoduodenectomy or necrosectomy. Drains were placed in all patients, and no damage control surgery was performed. All patients were managed in the ICU (median 3 days); median hospital stay was 14 days. The overall complication rate was 75%, most commonly pancreatic fistula (50%), followed by pancreatitis (37.5%) and intra-abdominal abscess (25%). No sepsis, organ failure, delayed hemorrhage, or mortality was observed.

Conclusion: Traumatic pancreatic injuries remain diagnostically challenging and are associated with substantial morbidity, even in low-grade injuries. Despite the predominance of low AAST grades in this cohort, complication rates were high, highlighting the clinical burden of pancreatic trauma. While mortality rates of 10-30% have been reported in the literature, often related to major associated injuries and delayed diagnosis, no mortality occurred in our series. Early surgical evaluation, appropriate patient selection, limited surgical strategies, and effective intensive care management may explain these favorable outcomes. In selected cases, organ-preserving approaches such as drainage alone may be sufficient. Close monitoring and management in experienced centers remain essential.

Keywords: Pancreatic trauma, emergency surgery, aast classification

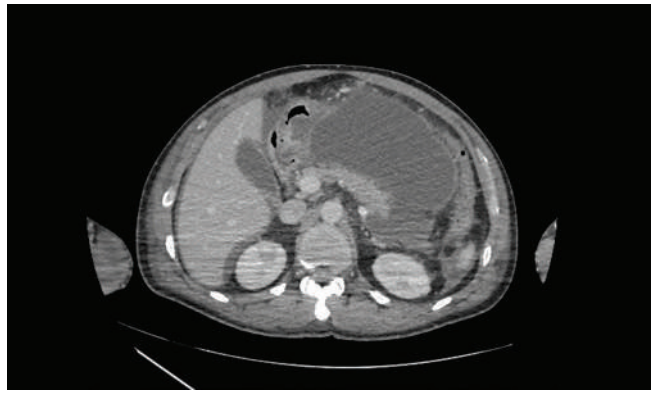

Figure 1. Traumatic pankreas injury AAST grade 3. Transection of the tail of the pancreas following an in-vehicle traffic accident.

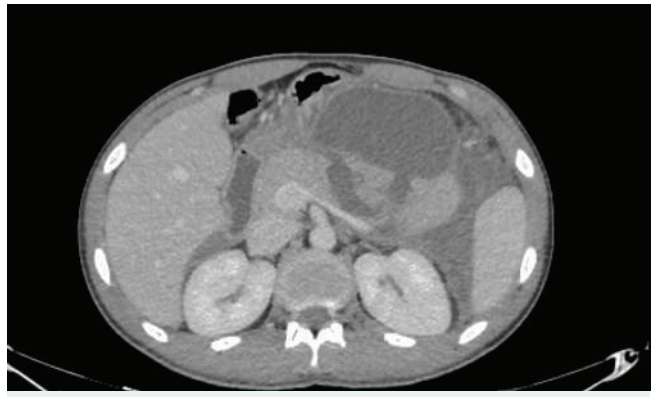

Figure 2. Traumatic pankreas injury AAST grade 3. Transection of the pancreatic tail parenchyma following blunt trauma.

Table 1. Demographics–trauma characteristics–application/lab–imaging

Variable	Value
Age, y	33.0 (25.5-39.2)
Male sex	7 (87.5)
Female sex	1 (12.5)
Mechanism–blunt	4 (50.0)
Mechanism–penetrating	4 (50.0)
Cause–traffic accident	3 (37.5)
Cause–stab wound	3 (37.5)
Cause–firearm injury	1 (12.5)
Cause–other	1 (12.5)
Glasgow Coma Scale score	15.0 (15.0-15.0)
Hypotension on admission	2 (25.0)
Base deficit	-3.2 (-5.7 to- -0.8)
Lactate, mmol/L	2.2 (1.1-3.1)
Hemoglobin, g/dL	14.2 (11.8-15.0)
White blood cell count, $\times 10^3/\mu L$	14.8 (12.2-16.2)
Amylase, U/L	59.0 (55.0-200.2)
Lipase, U/L	138.1 (48.7-305.4)
FAST positive	0 (0.0)
CT performed	7 (87.5)
Suspected pancreatic injury on CT	3 (37.5)
Suspected pancreatic duct injury	2 (25.0)
MRCP/ERCP performed	0 (0.0)
Associated injury	6 (75.0)
Liver injury	1 (12.5)
Splenic injury	1 (12.5)
Gastric injury	2 (25.0)
Duodenal injury	0 (0.0)
Hollow viscus injury	2 (25.0)
Major vascular injury	2 (25.0)
Transfusion within 24 h	3 (37.5)
PRBC units within 24 h	0.0 (0.0-1.2)

Table 2. Injury severity and surgical management

Variable	Value
AAST pancreatic injury grade (I-V)	1.0 (1.0-2.2)
Time from injury to surgery, h	3.0 (1.8-39.0)
Operative time, min	95.0 (88.8-120.0)
Primary procedure-drainage only	5 (62.5)
Primary procedure-primary repair	1 (12.5)
Primary procedure-distal pancreatectomy	2 (25.0)
Primary procedure_pancreaticoduodenectomy (Whipple)	0 (0.0)
Primary procedure-necrosectomy/debridement	0 (0.0)
Primary procedure-packing	0 (0.0)
Primary procedure-damage control laparotomy	0 (0.0)
Splenectomy	3 (37.5)
Duct management-unknown	6 (75.0)
Duct management-ligation/resection	2 (25.0)
Duct management-preserved	0 (0.0)
Duct management-stent/ERCP	0 (0.0)
Drain placement	7 (87.5)
Damage control surgery	0 (0.0)
Open abdomen	0 (0.0)
Relook/relaparotomy	0 (0.0)

[P-540]

Clinical characteristics, treatment approaches, and outcomes of common bile duct injuries following cholecystectomy over the last five years: A single-center experience

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Objective: Cholecystectomy is one of the most commonly performed surgical procedures in general surgery for the treatment of gallbladder diseases. Although the widespread use of laparoscopic techniques has reduced overall surgical morbidity, common bile duct injuries remain rare but potentially serious complications. These injuries are associated with prolonged hospital stay, the need for additional interventions, and long-term biliary complications. Early diagnosis and appropriate management are the most important factors determining prognosis in common bile duct injuries. The type of injury, timing of recognition, and initial management in experienced centers have a direct impact on long-term outcomes. In this study, we aimed to evaluate the clinical characteristics, treatment strategies, and outcomes of patients who developed common bile duct injury following cholecystectomy at our center over the last five years.

Material and Methods: In this retrospective study, six patients who were diagnosed with common bile duct injury following cholecystectomy within the last five years at our institution were analyzed. Patient age, sex, body mass index (BMI), ASA scores, whether the surgery was performed under elective or emergency conditions, surgical approach (laparoscopic/open), timing of injury recognition (intraoperative/postoperative), type of injury, and distribution according to the Strasberg classification were recorded. Diagnostic modalities, treatment strategies (endoscopic, percutaneous, and surgical), postoperative complications, and follow-up outcomes were evaluated.

Results: The mean age of the patients was 57.5 years, and the mean BMI was 26.8 kg/m². All patients underwent elective cholecystectomy. Common bile duct injury was recognized intraoperatively in one patient, whereas in the remaining patients, the diagnosis was established postoperatively based on clinical findings. The main reasons for postoperative presentation included bile leakage, jaundice, abdominal pain, and cholangitis. Injuries were distributed among Strasberg types B, C, D, and E. Ultrasonography, MRCP, and ERCP were used during the diagnostic process. Treatment modalities included ERCP with stent placement, percutaneous drainage, primary surgical repair, T-tube placement, and hepaticojejunostomy, depending on the clinical condition of the patient and the type of injury. Some patients required additional interventions and experienced prolonged hospital stay. Long-term follow-up revealed complications such as biliary stricture and recurrent cholangitis.

Conclusion: Common bile duct injuries are rare but serious complications of cholecystectomy, and early diagnosis and appropriate treatment are the most important factors determining prognosis. The type of injury, timing of diagnosis, and initial management in experienced centers have a significant impact on long-term outcomes. A multidisciplinary approach and individualized treatment strategies are essential to reduce morbidity.

Keywords: Common bile duct injury, cholecystectomy, biliary injuries, Strasberg classification, treatment approaches

[P-541]

Our experience with pancreaticogastrostomy as a reconstruction technique after pancreaticoduodenectomy

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Objective: One of the most important complications that may occur after pancreaticoduodenectomy is the development of a pancreatic fistula. One of the reconstruction techniques used after pancreatic resection is pancreaticogastrostomy. In this study, we aimed to present the clinical outcomes of patients who underwent pancreaticogastrostomy reconstruction for pancreatic drainage following pancreaticoduodenectomy and to compare the results with the existing literature.

Material and Methods: In this study, 13 patients who underwent pancreaticogastrostomy reconstruction following pancreaticoduodenectomy for periampullary tumors between January 2023 and January 2026 in the Department of General Surgery at İzmir Bakırçay University Çiğli Training and Research Hospital were evaluated in terms of demographic data, postoperative complications, and length of hospital stay.

Results: Of the 13 patients included in our study, 6 were female and 7 were male. The ASA scores of the patients were determined to be II-III. The mean age of the patients was 59.3 years. Morbidity was observed in 3 patients. Among these patients, one developed gastrointestinal bleeding, one experienced evisceration, and one had a leak from the hepaticojejunostomy anastomosis. The overall morbidity rate was 38%. One patient died on postoperative day 4 due to pulmonary embolism, resulting in a mortality rate of 7%. The mean operative time was 252 minutes, and the mean length of hospital stay was 8.3 days. According to the International Study Group on Pancreatic Surgery (ISGPS) classification, postoperative pancreatic fistula (POPF) Grade A biochemical leak was observed in 2 patients; these patients had no clinical findings and recovered with conservative management. These results are comparable to the morbidity and mortality rates reported in the literature following pancreaticoduodenectomy. No clinically relevant pancreatic fistula developed in our patients according to the ISGPS classification.

Conclusion: In our country, pancreaticogastrostomy reconstruction is not commonly performed after pancreaticoduodenectomy. In this study, our morbidity and mortality rates were found to be comparable to those reported in the literature. No clinically significant pancreatic fistula was observed. Although larger case series are needed to further evaluate the safety of this reconstruction technique in patients undergoing pancreaticoduodenectomy, we believe that it may represent a viable alternative method due to its technical simplicity and low morbidity and mortality rates.

Keywords: Pancreaticoduodenectomy, pancreaticogastrostomy, pancreatic fistula, postoperative morbidity and mortality

[P-542]

Long-term outcomes and quality of life following surgical management of gastrointestinal bezoars

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Objective: Gastrointestinal bezoars are relatively rare but can lead to serious complications such as obstruction or perforation, often requiring surgical intervention. While acute surgical outcomes are well-documented, long-term post-operative quality of life and nutritional status are less frequently studied. This study evaluates the long-term follow-up results and patient satisfaction in a cohort of patients operated on for bezoars.

Material and Methods: We conducted a retrospective survey study of patients who underwent abdominal surgery in our tertiary care surgical center for bezoars between 2020 and 2024. Data were collected via a structured questionnaire assessing post-operative symptoms (pain, nausea, vomiting), nutritional difficulties, general health status, and overall surgical satisfaction (scored 1-5). Collected data are analysed, numerical values, categorical variables are presented in percentages and statistical evaluations were done using the R package.

Results: The cohort consisted of 24 patients. Follow-up duration ranged from 1 to 5 years. At the time of follow-up, 65% (n=16) reported no current gastrointestinal complaints, while 35% (n=8) experienced intermittent symptoms, most commonly nausea or mild abdominal pain. Regarding nutritional habits, 53% (n=10) reported experiencing difficulties post-operatively. The most frequent nutritional issues identified were heartburn/reflux (48%), weight loss (25%), early satiety (21%), and dysphagia (12%). Despite these symptoms, the mean general health assessment score was 3.8/5. Patient satisfaction with the surgical outcome was high, with a mean score of 4.3/5. Notably, 80% of patients reported satisfaction scores of 4 or 5. Only 20% (n=5) of the cohort required follow-up or additional treatment at other healthcare facilities following their initial discharge.

Conclusion: Surgical treatment of gastrointestinal bezoars provides high long-term patient satisfaction and good general health outcomes. However, a significant portion of patients experience long-term nutritional sequelae, particularly reflux and early satiety. These findings suggest that postoperative management should include detailed nutritional counseling and long-term monitoring for reflux-related symptoms to improve the quality of life in this patient population.

Keywords: Bezoar surgery, patient satisfaction, post-operative follow-up

[P-543]

A hidden mimicker in the acute abdomen: Omental infarction-clinical characteristics, treatment approach, and outcomes (single-center experience)

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Objective: Omental infarction is a rare condition in patients presenting with acute abdomen, yet it can mimic common surgical pathologies both clinically and radiologically, making it diagnostically challenging. This study aimed to evaluate the clinical characteristics, laboratory and imaging findings, treatment approaches, and clinical outcomes of patients diagnosed with omental infarction, with a particular focus on the role of computed tomography (CT) in the diagnostic and clinical decision-making process.

Material and Methods: A total of 11 patients diagnosed with omental infarction in our clinic were included in the study. The patients were retrospectively analyzed based on demographics, presentation, clinical findings, laboratory parameters, imaging methods, CT findings, treatment approach (conservative or surgical), and clinical outcomes. Descriptive statistics were presented as mean ± standard deviation, median (interquartile range), and percentages.

Results: The mean age of the 11 patients was 44.4±13.1 years, with 63.6% being male. All presented with subacute abdominal pain, most commonly in the right lower quadrant (36.4%). Rebound and guarding were absent, and fever and nausea/vomiting were rare (9.1%). Laboratory results showed a mean leukocyte count of 10.8±3.6×10³/μL and CRP of 48.4±57.0 mg/L. Imaging revealed that 63.6% of patients underwent only CT, while 36.4% had both CT and ultrasound. Omental infarction was diagnosed preoperatively in 90.9% of cases. Lesions were mostly right-sided (72.7%), with an average diameter of 32.8±13.9 mm. Treatment was conservative in 63.6% and surgical in 36.4%, with diagnostic uncertainty being the main surgical indication. The CT-based approach helped avoid unnecessary surgery in 63.6%. The median hospital stay was 3 days, and all patients experienced pain relief without complications or recurrences.

Conclusion: Omental infarction, although it mimics appendicitis and other causes of acute abdomen, can generally be managed safely without surgery when diagnosed accurately with CT. Literature emphasizes CT's role in reducing unnecessary surgeries by clarifying the diagnosis, with conservative treatment being sufficient in most cases. Surgery is only needed in selected patients with persistent pain, clinical deterioration, or diagnostic uncertainty. Our series supports this approach, with a high preoperative diagnostic rate (90.9%) and successful conservative management in 63.6% of cases. The absence of complications suggests that conservative management has a high safety profile. However, surgery may shorten hospital stays, and factors like high leukocyte counts could indicate conservative treatment failure. Therefore, a strategy of "CT diagnosis + close monitoring + surgery in selected cases" seems reasonable. Early CT use and selective surgery can reduce unnecessary operations and optimize resource use.

Keywords: Acute abdomen, differential diagnosis, omental infarction

Tablo 3. Tedavi yaklaşımı ve klinik sonlanımlar

Değişken	Sonuç
Konservatif tedavi	Evet 7 (%63,6), Hayır 4 (%36,4)
Antibiyotik tedavisi	Evet 11 (%100)
Analjezik tedavi	Evet 11 (%100)
Cerrahi uygulandı	Evet 4 (%36,4), Hayır 7 (%63,6)
Cerrahi endikasyon	Tanı belirsizliği 3 (%27,3), Klinik kötüleşme / komplikasyon 1 (%9,1)
Cerrahi yaklaşım	Laparoskopik 2 (%18,2), Açık 2 (%18,2)
Patolojik doğrulama	Evet 3 (%27,3), Hayır 8 (%72,7)
BT sayesinde gereksiz cerrahiden kaçınıldı	Evet 7 (%63,6), Hayır 4 (%36,4)
Hastanede yatış süresi (gün)	3,0 ± 1,7; Medyan 3,0 (2,0–3,5); Min–Maks 1,0–7,0
Ağrının gerilemesi	Evet 11 (%100)
Komplikasyon	Yok 11 (%100)
Yeniden başvuru	Evet 9 (%81,8), Hayır 2 (%18,2)
Takip süresi (ay)	4,5 ± 5,4; Medyan 1,0 (0,5–8,0); Min–Maks 0,0–15,0
Nüks	Yok 11 (%100)

Tablo 4. Omental enfarkt olgularında bizim serimizin güncel literatürle karşılaştırması

Çalışma	Tasarım / Popülasyon	n	Yaş (ortalama)	Erkek (%)	Preoptanı (CT)	Konservatif tedavi (%)	Konservatif başarısızlık (%)	Primer cerrahi (%)	Yatış süresi (gün)	Komplikasyon / Mortalite
Bizim serimiz (Tekmerkez, 2026)	Retrospektif seri / erişkin akut karın	11	44,4	63,6	90,9%	63,6	0*	36,4	Medyan 3 (1–7)	Komplikasyon 0, nüks 0, mortalite 0
Medina-Gallardo ve ark., 2020	Sistematik derleme / CT tanılı olgular	146	45,7	61,1	CT tanılı kohort	73,3	15,9	26,7	Konservatif 5,1–5,5; Cerrahi 2,5	Mortalite yok; postop komplikasyon bildirilmedi
Nubi ve ark., 2009	Tek merkez seri / pediatrik	10	5–14 yaş aralığı	60,0	CT ile %100 (USG ek tanı %20)	40,0 (başlangıç)	30,0 (konservatiften cerrahiye geçti)	60,0 (laparoskopi)	Konservatif 4; Laparoskopi postop 2	Mortalite yok; "uneventful recovery"

Table 1. Demographic and presentation–clinical characteristics (n=11)

Variable	Result
Age (year)	44.4±13.1; median 40.0 (37.0-56.0); min-max 25.0-67.0
Sex	Male 7 (63.6%), female 4 (36.4%)
Comorbidities	Present 1 (9.1%), absent 10 (90.9%)
Presentation	Emergency 11 (100%)
Pain onset	Subacute 11 (100%)
Pain location	Right lower quadrant 4 (36.4%), right upper quadrant 2 (18.2%), left lower quadrant 2 (18.2%), diffuse 3 (27.3%)
Pain duration at presentation (hours)	42.4±26.8; median 48.0 (20.0-72.0); min-max 6.0-72.0
Rebound tenderness	Absent 11 (100%)
Guarding	Absent 11 (100%)
Fever (>38 °C)	Present 1 (9.1%), absent 10 (90.9%)
Nausea/vomiting	Present 1 (9.1%), absent 10 (90.9%)

Table 2. Laboratory and imaging findings

Variable	Result
Leukocytes (10^3/μL)	10.8±3.6; median 9.6 (8.0-12.8); min-max 7.2-18.2
CRP (mg/L)	48.4±57.0; median 23.0 (14.0-63.5); min-max 1.8-184.0
Imaging modality	CT 7 (63.6%), CT+US 4 (36.4%)
Omental infarction diagnosis on CT	Yes 10 (90.9%), no 1 (9.1%)
Lesion localization on CT	Right 8 (72.7%), left 3 (27.3%)
Typical finding on CT	Present 10 (90.9%), absent 1 (9.1%)
Largest lesion diameter on CT (mm)	32.8±13.9; median 30.0 (21.5-40.0); min-max 15.0-60.0
Initial diagnosis	Non-specific abdominal pain 7 (63.6%), acute appendicitis 3 (27.3%), cholecystitis 1 (9.1%)

[P-544]

Primary repair of penetrating gluteal and sphincteric injury due to ceramic fracture in a domestic setting

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Objective: Penetrating gluteal and perianal injuries secondary to domestic accidents are uncommon and require careful evaluation due to the potential risk of anal sphincter damage. We present a case of penetrating trauma occurred after falling onto a ceramic structure, which fractured upon impact, leading to a gluteal injury with partial involvement of the anal sphincter complex. The surgical management of the injury and the early functional outcomes are discussed.

Material and Methods: Patient presented to ED with penetrating injury to the gluteal and perianal regions after slipping on a wet floor while attempting to sit on a toilet, resulting in a forceful fall onto and subsequent fracture of toilet. Physical examination revealed a 6×18 cm laceration in left gluteal region causing a defect in muscle tissue, and a 4×15 cm laceration in the presacral area partially involving fibers of the external anal sphincter. Digital rectal examination demonstrated preserved sphincter tone, and rectum assessed as intact. The patient had a recent history of AMI and was receiving dual antiplatelet therapy; however, no active arterial was observed during PE. CT with IV+rectal contrast showed no evidence of rectal contrast extravasation.

Results: Patient was taken to emergency surgery in collaboration with plastic surgery team. Irrigation removal of ceramic fragments were performed. Intraoperative evaluation demonstrated that the integrity of external anal sphincter was largely preserved, with only minimal fiber disruption. Due to the contaminated nature of the wound and the limited extent of sphincter injury, primary sphincter repair was not performed. Full-thickness lacerations of the gluteus maximus were reconstructed. Hemostasis was achieved and soft drains were placed in both compartments, and the subcutaneous tissues were approximated carefully to avoid ischemia, followed by primary skin closure. In the postoperative period, wound care was maintained with frequent dressings, and a soft diet was initiated. LMWH was started on postoperative day 0, and the patient's previous dual antiplatelet regimen was resumed on day 2. During follow-up, no hematoma, infection, wound dehiscence, fecal incontinence or additional complications were observed. Patient was discharged after receiving wound care instructions. By postoperative day 20, complete wound healing was achieved. After 6-week follow-up, Wexner score was 0, indicating full continence. The patient experienced partial functional limitation related to the gluteal muscle injury; however, symptoms regressed with physiotherapy.

Conclusion: In cases of partial external anal sphincter injury where continence and overall tissue integrity are preserved, favorable outcomes can be achieved with limited surgical intervention and meticulous wound care. This case report aims to emphasize the importance of individualized decision-making in the surgical management of penetrating trauma involving sphincter injury, highlighting that treatment strategies should be determined on a case-by-case basis.

Keywords: Penetrating trauma, gluteal injury, sphincter injury

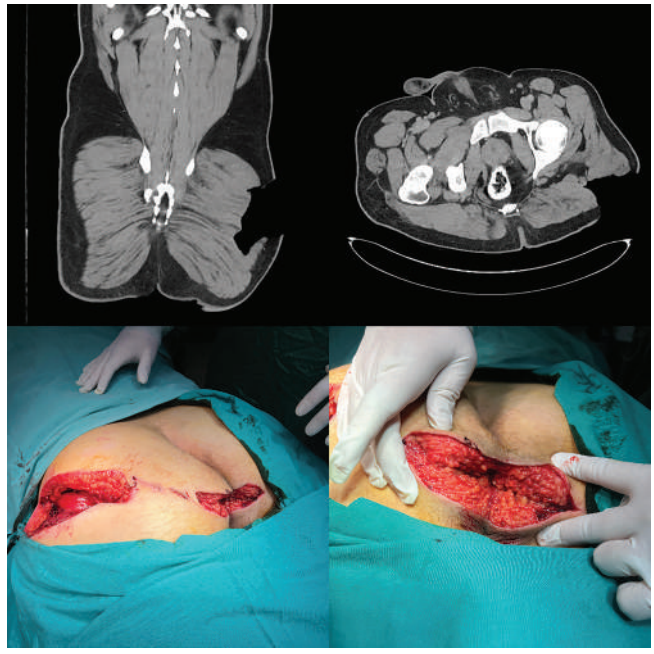

Figure 1. Computed tomography (CT)-scan and intraoperative images. On CT images, the extent of the gluteal defect is demonstrated, and no rectal contrast extravasation is observed. Intraoperative images obtained after sterile irrigation following the trauma are also presented.

Figure 2. Wound healing process. The collage demonstrates the immediate postoperative appearance on day 0 following primary repair of the gluteal and perianal lacerations, as well as well-healed wound appearance on postoperative day 25 after suture removal. No infection, wound dehiscence, or tissue necrosis was observed during the follow-up period.

[P-545]

Surgical management of severe blunt liver trauma unresponsive to packing: The role of liver resection

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Objective: Severe blunt liver trauma remains one of the most challenging entities in trauma surgery. Although non-operative management has become standard in hemodynamically stable patients, high-grade (AAST IV-V) injuries accompanied by hemodynamic instability still mandate urgent operative intervention. Damage control strategies prioritize rapid hemorrhage control, prevention of the lethal triad, and staged definitive management. Perihepatic packing is widely accepted as an initial life-saving maneuver; however, persistent bleeding despite packing requires, anatomical or non-anatomical liver resection. This study evaluates surgical strategies for blunt liver trauma unresponsive to packing and the role of liver resection in hemorrhage control.

Material and Methods: This retrospective analysis included seven patients with AAST grade IV-V blunt liver injuries who underwent operative management. Demographic characteristics, injury severity (ISS, APACHE II), transfusion requirements, operative details, and postoperative outcomes were analyzed (Table 1). Surgical management followed damage control principles. Initial packing was performed in hemodynamically unstable patients, followed by planned depacking. In cases of ongoing hemorrhage, portal triad clamping (PTC), hepatic resection (segmentectomy or right hepatectomy) were undertaken in accordance with established hepatobiliary trauma techniques. Outcomes assessed included ICU stay, total hospitalization, morbidity, and mortality.

Results: The median patient age was 29 years (range 25-69), and the majority were male. Two patients had AAST grade V injuries. Hemodynamic instability on admission was common, with hypotension and elevated lactate levels (up to 7.0 mmol/L). Five required subsequent depacking and definitive procedures. Liver resections included segment 6 resection, segment 6-7 resection, segment 8 resection, and right hepatectomy (n=2). Median operative times ranged from 105 to 355 minutes. Transfusion requirements were reflecting severe hemorrhage. ICU stay ranged from 4 to 108 days, and total hospitalization up to 150 days. Postoperative complications included biliary fistula, pleural effusion, thoracostomy requirement, and reoperations for associated injuries. Notably, no mortality occurred in this series.

Conclusion: Packing effectively controls venous parenchymal bleeding; however, major hepatic vein may remain refractory. In such cases, inflow control via PTC, mobilization of the right liver lobe, resectional debridement of fragmented segments, and direct vascular repair become mandatory. Anatomical resection, including right hepatectomy, may be lifesaving when parenchymal destruction is extensive. The absence of mortality in our series suggests that timely escalation from packing to definitive resection can improve survival in selected patients. In severe blunt liver trauma early recognition of packing failure and prompt transition to anatomical or non-anatomical resection may reduce mortality and optimize outcomes in high-grade hepatic injuries.

Keywords: Blunt liver trauma, liver resection, perihepatic packing

[P-546]

Has non-operative management become the gold standard in blunt hepatic trauma?

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Objective: The liver is the most frequently injured solid organ in blunt abdominal trauma. Historically, surgery was the primary management strategy; however, non-operative management (NOM) has recently emerged as the standard of care for hemodynamically stable patients. This study evaluates our institutional experience with operative and non-operative approaches in the management of blunt liver injuries.

Material and Methods: We retrospectively analyzed 34 patients treated for blunt abdominal trauma and varying degrees of hepatic injury at our clinic between 2016 and 2025.

Results: The mean patient age was 39 years (range: 17-73). Radiological evaluation revealed Grade 1-2 injuries in 19 patients (55.8%), Grade 3-4 in 11 (32.3%), and Grade 5 in 4 (11.7%). NOM was initiated in 19 patients (55.8%), including 16 with isolated Grade 1-2 injuries and three stable patients with Grade 3-4 injuries. Within the NOM group, two patients required laparotomy for non-hepatic reasons (one for small bowel perforation on the 3rd day; one for hemodynamic deterioration on the 2nd day). Notably, no direct liver intervention was required in these cases as no active bleeding was observed. Furthermore, three patients undergoing splenectomy for concomitant splenic trauma required no hepatic intervention. One Grade 2 patient with a 6 cm hemangioma was successfully managed with NOM followed by elective ablation. In contrast, severe cases required intensive surgical management. One Grade 4 patient with renal avulsion died postoperatively despite complex vascular and hepatic repair. Among four Grade 5 patients, two were discharged after lobectomy, one was transferred for biliary fistula management, and one died on the 2nd postoperative day. Overall, 22 patients (64.7%) were successfully managed without direct surgical intervention to the liver.

Conclusion: In blunt liver trauma, hemodynamic stability, peritoneal signs, and concomitant organ injuries should be prioritized over radiological grading when selecting treatment modalities. Our findings suggest that NOM is a safe and effective “gold standard” for Grade 1-3 and selected Grade 4 injuries, provided there is access to high-quality intensive care and rapid diagnostic imaging.

Keywords: Blunt liver trauma, non-operative approach

[P-551]

Incidental appendiceal neuroendocrine tumor in a patient presenting with clinical acute appendicitis: Surgical approach and review of the literature

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Objective: Appendiceal neuroendocrine tumors (NETs) are rare neoplasms of the gastrointestinal system but represent the most common tumor of the appendix. They are generally asymptomatic and frequently detected incidentally during histopathological examination following appendectomies performed for acute appendicitis. Tumor size, localization, and histological stage are determinant factors in treatment planning. Although simple appendectomy is generally considered curative for tumors smaller than 1 cm, positive surgical margins or the presence of risk factors may necessitate extensive surgical resection. We present a case of a patient operated on for acute appendicitis where, despite a NET smaller than 1 cm, a right hemicolectomy was recommended due to associated risk factors.

Material and Methods: A 22-year-old male patient presented to the emergency department with right lower quadrant pain, nausea, and anorexia persisting for 24 hours. Physical examination revealed tenderness and defense at McBurney's point. Laboratory tests showed elevated CRP (24 mg/L) without leukocytosis. Upon computed tomography findings consistent with acute appendicitis, the patient underwent a laparoscopic appendectomy. No gross pathology was observed in surrounding tissues during the operation, and the patient was discharged on the first postoperative day.

Results: Histopathological examination of the specimen revealed a well-differentiated (Grade 1) neuroendocrine tumor measuring 0.7x0.5 cm in the proximal appendix. Immunohistochemical staining was positive for chromogranin and synaptophysin, with a Ki-67 proliferation index of 2%. The tumor was reported to invade the mucosa, submucosa, and muscularis propria, with no evidence of lymphovascular or perineural invasion. Critically, tumor continuity was detected at the proximal surgical margin. Although the tumor size was less than 1 cm (T1a), a right hemicolectomy was recommended in accordance with ENETS and NANETS guidelines due to risk factors including location at the appendiceal base, positive surgical margins.

Conclusion: Appendiceal NETs generally have an excellent prognosis, and simple appendectomy is sufficient for tumors smaller than 1 cm without risk factors. However, as demonstrated in this case, even with small tumor dimensions, factors such as location at the appendiceal base, positive surgical margins increase the risk of metastasis. Consequently, detailed histopathological examination is crucial for incidental tumors detected after acute appendicitis, and treatment decisions must be personalized by evaluating risk factors rather than relying solely on tumor size.

Keywords: Appendiceal neuroendocrine tumor, incidental, right hemicolectomy

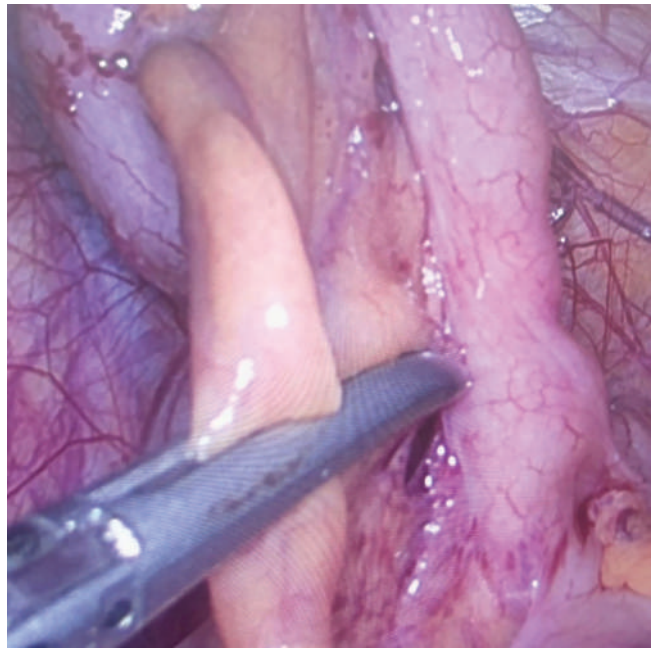

Figure 1. Intraoperative laparoscopic view of the appendix.

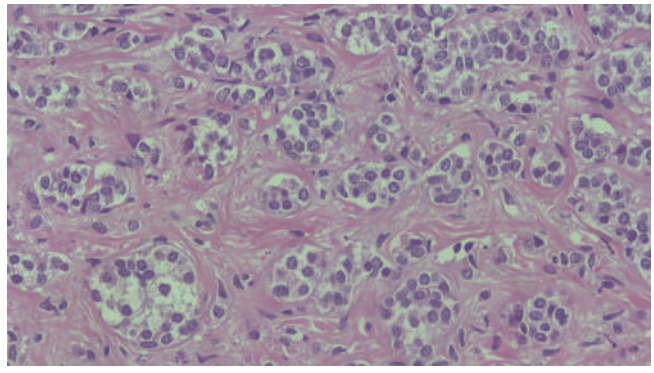

Figure 2. Microscopic appearance of the laparoscopic appendectomy specimen.

[P-561]

Comparison of pre-treatment and post-surgical status of the axilla in patients with locally advanced breast cancer who showed complete radiological response on positron emission tomography (PET-CT) after neoadjuvant treatment: A single-center retrospective study

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Objective: Breast cancer is the most common cancer in women. Despite the widespread use of screening programs in our country and worldwide, advanced/locally advanced stage cancers are still being detected. The effectiveness of adjuvant and neoadjuvant therapy has increased in patient groups where it has been shown to contribute to the prognosis. Therefore, neoadjuvant therapy has become preferred not only in locally advanced stage cancer but also in patients with indications at an early stage. The complete clinical/radiological response achieved with neoadjuvant therapy has also led to deescalation in surgical treatment. This study aims to evaluate the surgical outcomes in patients with locally advanced breast cancer who achieved a complete clinical/radiological response after neoadjuvant therapy.

Material and Methods: Between 2023 and 2025, 291 patients underwent surgery for breast cancer. Of these, 54 received neoadjuvant treatment for locally advanced breast cancer and subsequently underwent surgery. Of these 54 patients, 41 with complete axillary response after treatment were included in the study. Demographic characteristics, primary tumor pathologies, axillary lymphadenopathy (LAP) involvement in preoperative and postoperative imaging studies, and the number of lymph nodes involved as a result of axillary surgery were recorded for each patient.

Results: Forty-one female patients were examined. The mean age was 53.6 (min: 34, max: 71). Tumor pathology of the patients was: 23 (56.09%) invasive ductal carcinoma, 1 (2.4%) invasive mucinous carcinoma, 3 (7.3%) invasive lobular carcinoma, 1 (2.4%) inflammatory breast cancer, and 13 (31.7%) invasive breast carcinoma. It was observed that 16 patients underwent breast-conserving surgery (BCS) and 25 patients underwent mastectomy. Sentinel lymph node biopsy (SLNB) was positive in 21 (51.2%) patients (2 micrometastases and 1 suspected LAP were evaluated as positive). SLNB was negative in 20 (48.8%) patients. Level 2 axillary lymph node dissection was performed on 15 patients who tested positive.

Conclusion: In locally advanced breast cancer, its contribution to the prognosis in the neoadjuvant period has been proven. The issue of permanent de-escalation of axillary surgery and breast surgery has also come to the fore. Complete radiological response after treatment suggests that axillary surgery may be abandoned in this patient group. In our study, we observed that SLNB positivity (after neo-adjuvant treatment) was 51.2% in patients with complete radiological response in the axillary spectrum. However, this does not mean that all SLNB-positive patients should undergo axillary dissection. Targeted axillary surgery in a selected patient group is effective in reducing comorbidities associated with axillary surgery.

Keywords: Breast cancer, neoadjuvant therapy, axillary de-escalation

Table 1. Tumor pathology distribution

Tumor pathology	Number (%)
Invasive ductal carcinoma	23 (56.09%)
Invasive breast carcinoma	13 (31.7%)
Invasive lobular carcinoma	3 (7.3%)
Invasive mucinous carcinoma	1 (2.4%)
Inflammatory breast cancer	1 (2.4%)

Table 2. Distribution of pathological features in patients with positive SLNB after neoadjuvant treatment

Tumor pathology	Number (%)
Invasive ductal carcinoma	11 (52.3%)
Invasive breast carcinoma	7 (33.3%)
Invasive lobular carcinoma	1 (4.7%)
Invasive mucinous carcinoma	1 (4.7%)
Inflammatory breast cancer	1 (4.7%)

[P-562]

Clinical course, diagnostic process, and treatment approaches in Paget's disease of the breast: A retrospective single-center study

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Objective: Although Paget's disease of the breast is rare, it is frequently associated with underlying ductal carcinoma *in situ* (DCIS) or invasive breast cancer, and delays in diagnosis are common. This study aimed to evaluate the demographic characteristics, clinical presentation, diagnostic process, imaging and pathological features, treatment approaches, and clinical outcomes of patients diagnosed with Paget's disease of the breast.

Material and Methods: This retrospective study included a total of 2 patients diagnosed with Paget's disease of the breast. Demographic data, symptom duration, presenting symptoms, diagnostic delay, initial point of presentation, imaging findings (mammography, ultrasonography, and magnetic resonance imaging), pathological characteristics (presence of pure Paget's disease, association with DCIS or invasive cancer, tumor type, grade, hormone receptor status, HER2, and Ki-67), surgical and adjuvant treatments, follow-up duration, and recurrence status were recorded. Descriptive statistics were presented as median (IQR) or number (percentage).

Results: The median age of the patients was 60 (50-71) years. The median symptom duration was 12 (3-18) months, and the median interval between symptom onset and biopsy was 12 (2-18) months. The most common presenting symptoms were eczema (28.6%), nipple discharge (23.8%), ulceration (23.8%), and pain (23.8%). Diagnostic delay (≥6 months) was observed in 52.4% of patients, most commonly due to dermatological manifestations in the absence of a palpable breast mass (e.g., pruritus, rash). On mammography, suspicious findings were detected in 57.1% and malignant findings in 19.0% of cases, while ultrasonography revealed malignant features in 28.6%. Magnetic resonance imaging was performed in 10 patients, of whom 60% showed findings suggestive of malignancy. Pure Paget's disease was identified in 9.0% of cases, whereas DCIS and invasive cancer were present in 66.7% and 47.6%, respectively. The most common tumor type was invasive ductal carcinoma (90.5%), and 52.4% of tumors were high grade (G3). Mastectomy was performed in 71.4% of patients, and sentinel lymph node biopsy was carried out in 76.2%. The median follow-up duration was 15 (5-24) months, and the recurrence rate during follow-up was 14.3%.

Conclusion: Paget's disease of the breast is most commonly associated with underlying DCIS and/or invasive breast cancer and is notable for diagnostic delays. In our study, the presence of a diagnostic delay of ≥6 months in more than half of the patients suggests that the risk of malignancy may be overlooked in the early stages when Paget's disease presents with dermatological symptoms. In cases where mammography and ultrasonography are limited, the detection of malignancy-suggestive findings 60% of patients who underwent MRI supports the added value of MRI in selected cases within the diagnostic algorithm. The low rate of pure Paget's disease and the high prevalence of associated DCIS and invasive cancer are consistent with the literature, reinforcing the concept that Paget's disease often represents a manifestation of underlying breast malignancy. Overall, this study contributes to the literature by quantitatively demonstrating diagnostic delay and providing a comprehensive real-world evaluation of imaging and pathological spectra. Early biopsy, appropriate imaging strategies, and a multidisciplinary approach are critical for optimal management.

Keywords: Breast cancer, ductal carcinoma *in situ*, magnetic resonance imaging, multimodal imaging, Paget's disease

Bizim Çalışmamız ile Güncel Literatür Karşılaştırması

Çalışma	Tasarım / Merkez	n	Yaş	Saf Paget (%)	DCIS / non-invaziv (%)	İnvaziv (%)	Cerrahi dağılımı	SLNB / Aksilla	Lokal nüks (%)	Takip
Bizim çalışmamız (2026, Türkiye)	Retrospektif tek merkez	**21**	Medyan **60** (50–71)	**19.0**	**66.7**	**47.6**	**Mastektomi 71.4%**, MKC 28.6%	**SLNB 76.2%**, LN+ 28.6%	**14.3**	Medyan **15 ay** (5–24)
Scardina ve ark., 2022	Retrospektif tek merkez (20 yıl deneyim)	115	Medyan 60 (32–88)	9.0	40.0 (non-invaziv)	51.0	**BCS 60.0%**, mastektomi 40.0%	(Kılavuz uyumlu SLNB vurgusu)	7.8	Medyan **82 ay**
Baysal ve ark., 2023	Retrospektif tek merkez (klinik + görüntüleme odaklı)	49	Ortalama 67.1±14.4	(Tabloda "Paget" alt grup)	"Extensive DCIS" 10.2	**İnvaziv DK 65.3**	**Mastektomi 73.5%**, NAC eksizyon 16.3%, BCS 10.2%	SLN(+) + AD 6.1%, Direkt AD 42.9%	14.3	Ortalama DFS 115 ay, OS 119 ay
Lin ve ark., 2022 (SR/MA)	Sistematik derleme + meta-analiz (gerçek yaşam verisi)	—	—	—	—	—	BCS vs mastektomi sonuçları karşılaştırmalı	**SLNB pozitifliği ~%17**	Lokal nüks: invazivde daha yüksek (≈%6.7 vs %4.5)	—

Figure 1. Literature comparison.

Table 1. Demographic, clinical, and imaging characteristics of the patients (n=21)

Parameter	Value
Age, years	60 (50-71)
Sex	Female 21 (100%)
Symptom duration, months	12 (3-18)
Symptom-to-biopsy interval, months	12 (2-18)
Presenting symptom	Eczema — 6 (28.6%) Nipple discharge — 5 (23.8%) Ulceration — 5 (23.8%) Pain — 5 (23.8%)
History of dermatological treatment	No — 20 (95.2%) Yes — 1 (4.8%)
History of topical treatment	No — 20 (95.2%) Yes — 1 (4.8%)
Palpable mass	Absent — 13 (61.9%) Present — 8 (38.1%)
Laterality	Unilateral — 18 (85.7%) Bilateral — 3 (14.3%)
Initial diagnostic consultation	Dermatology — 9 (42.9%) Surgery — 10 (47.6%) Other — 2 (9.5%)
Diagnostic delay	<6 months — 10 (47.6%) ≥6 months — 11 (52.4%)
Delay group	Early — 10 (47.6%) Delayed — 11 (52.4%)
Mammography	Normal — 5 (23.8%) Suspicious — 12 (57.1%) Malignant — 4 (19.0%)
Ultrasonography	Normal — 7 (33.3%) Suspicious — 8 (38.1%) Malignant — 6 (28.6%)
MRI performed	No — 11 (52.4%) Yes — 10 (47.6%)
Malignant findings on MRI*	Absent — 4 (40.0%) Present — 6 (60.0%)

Table 2. Pathological characteristics, treatment, and clinical outcomes (n=21)

Parameter	Value
Tumor size, mm	13 (8-21)
Ki-67, %	15 (10-20)
Follow-up duration, months	15 (5-24)
Pure Paget's disease	No — 17 (81.0%) Yes — 4 (19.0%)
Associated DCIS	Absent — 7 (33.3%) Present — 14 (66.7%)
Associated invasive cancer	Absent — 11 (52.4%) Present — 10 (47.6%)
Tumor type	Invasive ductal carcinoma — 19 (90.5%) Invasive lobular carcinoma — 1 (4.8%) Other — 1 (4.8%)
Histological grade	G1 — 7 (33.3%) G2 — 3 (14.3%) G3 — 11 (52.4%)
Estrogen receptor (ER)	Negative — 9 (42.9%) Positive — 12 (57.1%)
Progesterone receptor (PR)	Negative — 12 (57.1%) Positive — 9 (42.9%)
HER2 status	Negative — 10 (47.6%) Positive — 11 (52.4%)
Type of surgery	Breast-conserving surgery (BCS) — 6 (28.6%) Mastectomy — 15 (71.4%)
Sentinel lymph node biopsy	No — 5 (23.8%) Yes — 16 (76.2%)
Axillary involvement	Absent — 14 (66.7%) Present — 7 (33.3%)
Lymph node metastasis	Absent — 15 (71.4%) Present — 6 (28.6%)
Surgical margin	Negative — 18 (85.7%) Positive — 3 (14.3%)
Chemotherapy	No — 11 (52.4%) Yes — 10 (47.6%)
Radiotherapy	No — 13 (61.9%) Yes — 8 (38.1%)
Hormone therapy	No — 12 (57.1%) Yes — 9 (42.9%)
Recurrence	Absent — 18 (85.7%) Present — 3 (14.3%)

[P-563]

Surgical and oncologic outcomes in patients with ductal carcinoma *in situ* undergoing breast-conserving surgery: A single-center experience

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Objective: Ductal carcinoma *in situ* (DCIS) has been increasingly diagnosed with the widespread implementation of screening programs. Breast-conserving surgery (BCS) combined with adjuvant radiotherapy provides excellent long-term local control. However, the optimal surgical margin width, the need for re-excision, and particularly the indication for axillary staging remain controversial. This study aimed to evaluate the clinicopathologic characteristics and surgical and oncologic outcomes of patients with DCIS treated with BCS at our center.

Material and Methods: A total of 50 patients who underwent BCS with a diagnosis of DCIS between January 2018 and December 2023 were retrospectively analyzed. Preoperative radiologic findings, clinical characteristics, operative details, pathological results, and oncologic outcomes were reviewed.

Results: The median age was 55.5 years. Preoperative imaging included mammography (96%), ultrasonography (100%), and magnetic resonance imaging (MRI) (76%). Microcalcifications were detected in 58% of patients on mammography. Pathologic findings were identified in 74% of patients on ultrasonography and in 92% on MRI, making MRI the most sensitive imaging modality. Radiologic localization was performed in 35 patients (70%); 29 underwent wire-guided excision and 6 underwent excision based on skin projection marking. Intraoperative assessment was utilized in 15 patients (30%), and 21 patients (42%) underwent re-excision during the same surgical session. Specimen radiography or ultrasonography was performed in 26 patients (52%). Final pathology revealed pure DCIS in 37 patients (74%) and invasive carcinoma in 13 patients (26%), including 3 cases of microinvasive disease. Sentinel lymph node biopsy (SLNB) was performed in 23 patients (46%). Among these, 13 patients (56%) had high-grade, 7 (30%) had intermediate-grade, and 3 (6%) had low-grade DCIS. Estrogen receptor positivity was observed in 33 patients (66%). Despite a relatively high upstaging rate, all SLNB results were negative. Margin involvement was identified in 13 patients: 4 patients (8%) had positive margins and 9 patients (18%) had margins less than 2 mm. Six patients (12%) required a second surgery (4 mastectomies and 2 re-excisions). Adjuvant radiotherapy was administered to 44 patients (88%), endocrine therapy to 33 patients (66%), and chemotherapy to 5 patients (10%). After a median follow-up of 54 months (range: 23-96), ipsilateral local recurrence occurred in one patient (2%). Two patients (4%) died due to causes unrelated to breast cancer.

Conclusion: Breast-conserving surgery for DCIS, when planned with appropriate radiologic and clinical evaluation, achieves low reoperation rates and excellent local control. Considering the low likelihood of nodal involvement, axillary intervention should not be routine but rather tailored based on individual patient risk assessment.

Keywords: DCIS, breast conserving surgery

[P-566]

High success rate in sentinel lymph node identification using the nipple traction technique

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Objective: Breast cancer is the most common malignancy among women, and axillary lymph node status plays a critical role in staging and treatment planning. Sentinel lymph node biopsy (SLNB) is currently the standard method for staging clinically node-negative breast cancer, as it provides reliable staging with lower morbidity compared to axillary dissection. However, the sentinel lymph node identification rate using blue dye alone has been reported to range between 85% and 95% in the literature. This study aimed to evaluate the contribution of the nipple traction/massage technique to the identification rate of stained lymph nodes in SLNB performed using blue dye.

Material and Methods: Following anesthesia induction and standard surgical preparation, isosulfan blue or 1% methylene blue solution diluted with saline at a ratio of 4:2 was injected into the subareolar region. After injection, routine circular breast massage was applied for approximately 6 minutes. During this period, the nipple was repeatedly pulled upward and anteriorly and released by the surgeon to create tension (nipple traction). This maneuver was intended to increase tension in the subareolar tissue and facilitate more effective participation of the dye in lymphatic flow. The maneuver did not prolong operative time and was safely applied in all cases.

Results: Over the last three years, SLNB was performed in a total of 247 patients. The nipple traction maneuver was applied in all patients, and the sentinel lymph node was identified with a high success rate. The mean number of identified stained lymph nodes was 2 (range, 1-5). One patient developed skin necrosis related to methylene blue, and one patient experienced a non-severe allergic reaction. These findings suggest that this simple maneuver may contribute positively to increasing sentinel lymph node identification rates.

Conclusion: In the literature, the sentinel lymph node identification rate using blue dye alone has been reported as 85-95%, while the dual method (blue dye + radioisotope) achieves rates of 95-99%. In our series, using blue dye alone combined with the nipple traction technique, a success rate exceeding 98% was achieved in identifying stained sentinel lymph nodes. The technique is presumed to facilitate dye transport to the axilla by stretching the subareolar plexus. As a simple, easily learned, and safe method, the nipple traction technique may represent a valuable alternative, particularly in centers with limited access to radioisotopes. Nevertheless, as this study is retrospective in nature, the results should be confirmed by larger prospective and comparative studies.

Keywords: Blue dye, breast cancer, breast massage, nipple traction technique, sentinel lymph node biopsy

[P-568]

Outpatient management of perianal fistulas with elastic seton: Clinical experience and outcomes

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Objective: Perianal fistulas are challenging perianal pathologies that can develop following the drainage of anal abscesses. The aim of fistula treatment is to minimise recurrence while preserving continence. Alongside surgical interventions, elastic seton placement is one of the preferred methods due to its low morbidity and high success rates. In this study, the effectiveness of elastic seton placement in outpatient settings and its effects on patient comfort were evaluated.

Material and Methods: Patients who underwent elastic seton placement in an outpatient setting for intersphincteric anal fistula at the general surgery clinic between 1 January 2021 and 31 December 2024 were prospectively evaluated. Patients diagnosed with Crohn's disease and ulcerative colitis were excluded from the study. The diagnosis of anal fistula was made based on physical examination and magnetic resonance imaging (MRI). The procedure was performed in the prone position under local anaesthesia in sterile conditions. Patients who underwent tight seton placement were recalled at 2-week intervals for seton re-tightening. Patients were provided with post-operative analgesia and hygiene recommendations. During the follow-up period, pain scores visual analogue scale (VAS), fistula closure time, and post-operative complications such as infection, bleeding, and incontinence were evaluated.

Results: Forty-one patients were included in the study. Their ages ranged from 35 to 43. The average procedure duration was 9 minutes. Post-procedure pain was assessed using the VAS and averaged 3-4. The time for the seton to separate from the tissue ranged from 1 to 6 weeks. Patients were followed up regularly at outpatient clinic appointments at 3-month intervals over a period of 3-18 months. No complications such as infection, bleeding, or incontinence were observed in any of the patients who underwent the procedure.

Conclusion: The application of elastic setons in outpatient settings is a safe, effective method for treating anal fistula that maintains a high level of patient comfort. Patients experience minimal pain and can quickly return to their daily lives, with a low-risk of serious complications. It offers a suitable treatment option, particularly for high-risk patients and those wishing to avoid surgical intervention.

Keywords: Elastic bandage, minimally invasive anorectal procedure, outpatient surgery, perianal fistula, Sphincter-preserving treatment

[P-569]

Use of wound dressing products in University of Health Sciences Türkiye, Antalya City Hospital Burn Center: A retrospective clinical study

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Objective: We aimed to demonstrate the relationship between the types of wound dressing products used and the length of hospital stay (LOS) in patients hospitalized and treated at the newly established University of Health Sciences Türkiye, Antalya City Hospital, Burn Center.

Material and Methods: In this retrospective clinical study, patients hospitalized and treated at the University of Health Sciences Türkiye, Antalya City Hospital, Burn Center between March 1, 2024, and February 3, 2026, were evaluated. The types of products used, number of patients, gender distribution, mean ages, and mean LOS were recorded for patients who underwent wound dressing applications.

Results: Wound dressing products were applied to a total of 263 hospitalized patients. It was observed that multiple wound dressing products were used in some cases. •Epidermal equivalents: applied to 107 patients (72% male, 28% female). The mean age was 19.1±19.2 years, and the mean LOS was 11.9±37.2 days. •Collagen dressings: used in 16 patients; mean age was 16.9 ± 21.3 years, and mean LOS was 21.8±20.7 days. •Single-layer dermal scaffolds (polyurethane): applied to 9 patients; mean age was 42.0±14.7 years, and mean LOS was 20.8±22.6 days. •Hydrocolloid dressings: used in 10 patients; mean age was 38.9±22.9 years, and mean LOS was 15.8±13.0 days. •Double-layer dermal scaffolds (dermal matrix): Applied to 18 patients; the mean age was 41.1±23.8 years, and the mean LOS was 51.7±33.4 days, which was significantly longer compared to other product groups. •Silver-impregnated hydrofiber dressings: Used in 103 patients; mean age was 29.7±21.8 years, and mean LOS was 19.7±17.2 days. When all wound dressing products were evaluated collectively, the mean age for the 263 patients was 26.2±22.0 years, and the mean LOS was 18.3±29.7 days.

Conclusion: Wound dressing products are widely utilized in our Burn Center, and a significantly longer LOS was observed particularly in patients treated with dermal matrices. While patients were initially managed with frequent dressings using only topical creams, advancements in technology and the development of modern wound dressings have reduced the frequency of dressing changes and surgical interventions. This progress shortens treatment periods while enhancing patient comfort and aesthetic outcomes. Although these technologies may currently impact healthcare budgets in terms of cost-effectiveness, we believe that more cost-effective forms of wound dressings will improve the welfare of both patients and physicians in the future.

Keywords: Wound dressıng products, burn, retrospective study

[P-573]

The experience of a surgical team new to robotic surgery: Analysis of the first year of cases

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Objective: Robotic surgery gained an important role among minimally invasive surgical techniques inrecent years. Advanced 3D imaging systems, increased instrument articulation and technicalfeatures improving surgeon ergonomics have led to its widespread adoption across surgicaldisciplines. Previous studies demonstrated that robotic surgery provides precise dissection,especially in anatomically complex regions, reduces blood loss and improves surgeon comfort. However, robotic surgical procedures require a specific level oforganization, time management and coordination between surgical and anesthesiateams. During the learning process, progressive improvement in operative workflow and teamcoordination is expected, and this experience is reported to positively influence clinical outcomes. The aim of this study was to evaluate surgical and anesthetic process-related parameters, early clinical outcomes and temporal changes in robotic surgery cases performed in our clinic.

Material and Methods: Robotic surgery cases performed in our clinic were retrospectively reviewed. The total numberof cases and types of surgical procedures were recorded. Concordance between preoperativeand postoperative diagnoses was evaluated. Conversion to laparoscopic or open surgery wasanalyzed. Intraoperative blood loss and the need for blood transfusion wererecorded. Anesthesia-related processes were evaluated in detail, including anesthesia inductiontime, time to surgical handover, interval between completion of surgery and extubation, andtotal operative duration. Postoperative drain output and urine volume during the first twopostoperative days were recorded. Early postoperative complications, embolic events andmortality were assessed.

Results: A significant improvement in surgical and anesthetic timing parameters was observed overtime in robotic surgery cases. Operative durations were found to decrease in later cases,andperioperative processes were managed more efficiently. In accordance with theliterature, operative workflow became more stable as team experience increased. Conversionrates to laparoscopic or open surgery were low. Postoperative complication rates werelimited, and anastomotic leakage and embolic events were rarely observed. Mortality rateswere low in the early postoperative period.

Conclusion: The literature emphasizes that robotic surgery is a safe and effective technique, and highlights the critical role of surgical and anesthesia team experience in determining clinicaloutcomes. Our findings are consistent with previous reports, demonstrating that increasingteam experience over time contributes to shorter operative durations and improvedperioperative management. Robotic surgery was found to be a safe and feasible approach inour clinic in terms of early clinical outcomes and operational processes. It is concluded thatrobotic surgery can be effectively implemented with appropriate patient selection andexperienced multidisciplinary teams.

Keywords: Minimally invasive surgery, robotic surgery

[P-574]

The initial liver transplantation experience of a surgical team: An evaluation of seven cases performed over a seven-month period

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Objective: Liver transplantation is the cornerstone treatment for end-stage liver disease and acute liver failure, significantly reducing mortality. This study aimed to evaluate the patient characteristics, transplantation indications, and early clinical outcomes of liver transplantations performed at our center over a seven-month period.

Material and Methods: A total of seven patients who underwent liver transplantation at our center within a seven-month period were included in the study. Demographic data, transplantation indications, urgency status (elective vs. emergency), and length of hospital stay were retrospectively analyzed.

Results: Among the patients included in the study, 43% were male (n=3) and 57% were female (n=4), with a mean age of 44 years. The mean duration of hospitalization was 30 days. Of the liver transplantations performed, 71% (n=5) were carried out electively, whereas 29% (n=2) were performed under emergency conditions. The indications for elective liver transplantation were identified as hepatocellular carcinoma arising in the context of hepatitis C–related chronic liver disease (n=1), primary sclerosing cholangitis complicated by recurrent episodes of cholangitis (n=1), liver cirrhosis secondary to hepatitis B infection (n=1), hepatocellular carcinoma developing on the background of hepatitis B infection (n=1), and hepatopulmonary syndrome (n=1). Of the patients who underwent emergency liver transplantation, one received a cadaveric graft for acute liver failure secondary to drug-induced liver injury associated with hepatitis B infection, while the other underwent cadaveric liver transplantation for acute liver failure resulting from toxic hepatitis. One of the patients who underwent surgery in an intubated state due to acute hepatic encephalopathy died of multiorgan failure during postoperative intensive care unit follow-up after transplantation, despite satisfactory graft function and the lack of recovery of cerebral function.

Conclusion: The liver transplantations performed by our newly established liver transplantation unit over a limited time period for different etiological indications demonstrate that liver transplantation is an effective and feasible treatment modality for both chronic liver diseases and acute liver failure.

Keywords: Liver, transplantation, urgent, elective

Table 1. Liver transplantation

Diagnosis	1 HCC on the background of HCV 1 PSC 1 Liver cirrhosis on the background of HBV 1 HCC on the background of HBV 1 HP syndrome	1 Polypharmacy, toxic hepatitis, acute liver failure 1 Acute liver failure due to polypharmacy on the background of hepatitis B infection
Gender	3 Male 2 Female	2 Female
Median age	50	27
LOS	30	30

[P-577]

Retrospective analysis of 347 patients: Effectiveness of a synchronized model in preoperative evaluation with joint surgeon and anesthesiologist visit

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Objective: Preoperative preparation is a significant determinant of surgical outcomes. Separate evaluations by the surgeon and anesthesiologist can lead to communication gaps and oversight of uncontrolled comorbidities. In this study, we aimed to assess the impact of a synchronized preoperative visit mode conducted jointly by the surgeon and anesthesiologist on surgery cancellation/postponement rates, detection and optimization of uncontrolled comorbidities, time efficiency, and stakeholder satisfaction.

Material and Methods: This retrospective study included 347 patients scheduled for elective general surgery between December 1, 2025, and January 5, 2026. The patients were divided into two groups: The Joint Visit Group (n=150) and the traditional Separate Visit Group (n=197). Patients in the Joint Visit Group were evaluated simultaneously by both specialists during designated afternoon hours on three days per week. The two groups were compared regarding demographic characteristics, surgery cancellation/postponement rates and reasons, detected uncontrolled comorbidities [hypertension (HT), diabetes mellitus (DM)], visit durations, and satisfaction scores of patients, surgeons, and anesthesiologists measured on a 5-point Likert scale.

Results: No significant difference existed between the groups in terms of age and gender distribution. In the Joint Visit Group, a total of 21 patients (14%) experienced cancellation/postponement in the preoperative period (11 mutual decision, 5 patient refusal, 3 upper respiratory tract infection, 2 uncontrolled HT/DM). In the Separate Visit Group, this number was 41 patients (20.8%) (19 anesthesiology deferral, 7 patient refusal, 5 no-show, 10 intraoperative postponement). The most significant finding was the difference in the management of uncontrolled comorbidities. In the Joint Visit Group, uncontrolled HT/DM was detected in 33 patients (22%), allowing for complete preoperative optimization. In the Separate Visit Group, despite a similar prevalence of comorbidities, uncontrolled disease was present in 26 patients (13.2%). Optimization was incomplete in a significant portion of these patients, which was observed as the primary reason for intraoperative postponements (24.4%) in this group.The joint visit model saved 5-6 minutes per patient. All satisfaction scores were significantly higher in the Joint Visit Group (4.4, 4.3, 4.6 vs. 3.9, 4.1, 4.0, respectively).

Conclusion: The joint surgeon-anesthesiologist visit model stands out due to its capacity to proactively screen for the control status of these conditions and optimize them in the preoperative period within a population with a similar comorbidity burden. This approach has the potential to reduce intraoperative surprises and postponements, increases time efficiency, and enhances satisfaction among all stakeholders. This model presents a viable multidisciplinary strategy for improving the safety and quality of elective surgical programs.

Keywords: Multidisciplinary team, patient satisfaction, preoperative evaluation, surgery cancellation

İPTAL/ERTELEME ORANLARININ KARŞILAŞTIRILMASI

İptal/Erteleme Türü	Ortak Vizit(150 Hasta)	Ayrı Vizit (197 Hasta)
Toplam İptal/Erteleme	21(%14)	41(%20.8)
İntraoperatif İptal/Erteleme	0(%0)	10(%5.1)

Özet tablo

Özellik	Ortak Vizit Grubu (150 Hasta)	Ayrı Vizit Grubu(197 Hasta)
Toplam İptal/Erteleme	21 Hasta (%14	41 Hasta(%20.8)
İntraop Erteleme	0 hasta(%0)	10 Hasta(5.1)
Kontrolsüz HT/DM Tespiti	33 Hasta(%22)	26 Hasta(%13.2)
Kontrolsüz HT/DM Optimizasyonu	TAMAMI	Kısmi/Eksik
Ort Vizit Süresi	7 dk	12-13 dk
Hasta Memnuniyeti	4.4	3.9
Cerrah memnuniyeti	4.3	4.1
Anestezi memnuniyeti	4.6	4.0

[P-579]

Co-occurrence of acute appendicitis and urinary tract infection: Prevalence and clinical characteristics

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Objective: This study aimed to evaluate urinary system findings in patients with acute appendicitis, particularly their association with perforation, diabetes mellitus (DM), age, and gender.

Material and Methods: A retrospective analysis was performed on 100 patients who underwent appendectomy with a diagnosis of acute appendicitis. Demographic data, comorbidities [(especially DM), laboratory tests white blood cell (WBC), C-reactive protein (CRP)], urinalysis parameters (urine WBC, red blood cell, squamous epithelium), and intraoperative perforation status were recorded. Patients were divided into perforated and non-perforated groups. Mann-Whitney U and chi-square tests were used for statistical analysis, and $p<0.05$ was considered significant.

Results: A total of 100 patients diagnosed with acute appendicitis were included in the study. The mean age of the cohort was 37.8±14.6 years, and 47.2% of the patients were female. Perforation was detected in 18 patients (18.0%), while DM was present in 13 patients (13.0%). Comparison of laboratory parameters between perforated and non-perforated cases revealed significant differences. The mean WBC count was 16.1±4.3 $\times 10^3/\mu L$ in the perforated group compared with 12.6±3.4 $\times 10^3/\mu L$ in the non-perforated group ($p<0.05$). Similarly, mean CRP levels were markedly higher among patients with perforated appendicitis (73.1±56.3 mg/L) compared with those without perforation (21.0±21.3 mg/L, $p<0.05$). Urinary abnormalities were also evaluated according to DM status. Hematuria was more frequently observed in patients with DM (69.2%) compared to non-diabetic patients (41.4%); however, this difference did not reach statistical significance ($p=0.113$). The prevalence of leukocyturia was similar between DM-positive (30.8%) and DM-negative (27.6%) groups ($p>0.05$). Female patients demonstrated a higher prevalence of hematuria (56.9%) than male patients, who exhibited lower rates. Leukocyturia was also more common in women (31.4%). Age-stratified analysis showed that patients younger than 40 years presented with urinary abnormalities more frequently compared to those aged 40 years or older.

Conclusion: Urinary abnormalities such as hematuria and leukocyturia are common in acute appendicitis and can mimic urinary tract infections. These findings are significantly more pronounced in perforated cases. The presence of DM further increases both perforation risk and hematuria frequency. Clinicians should therefore consider appendicitis in patients presenting with acute abdomen and urinary abnormalities.

Keywords: Appendicitis, urinary tract, hematuria

Table 1. Akut apandisitli hastalarda demografik, laboratuvar ve üriner bulgular

Değişken	Perfore (n=18)	Perfore olmayan (n=82)	p-değeri	DM (+)	DM (-)
İdrar WBC (ortalama)	12.6±4.3	2.7±1.1	<0.05	4.46±2.1	4.45±1.9
İdrar RBC (ortalama)	13.2±5.2	2.7±1.0	<0.05	8.77±3.4	3.93±1.8
Kan WBC (x10³/µL)	15.8±4.2	12.3±3.7	<0.05	14.9±3.9	13.2±3.6
CRP (mg/L)	115±35	48±20	<0.05	102±28	65±24
Perforasyon oranı (%)	100%	0%	—	30.8%	16.1%
Yaş (ortalama, yıl)	31.9±12.2	33.9±11.8	>0.05	—	—
Cinsiyet (% perfore)	20.4% (E)	15.7% (K)	<0.05	—	—
Hastanede kalış (gün)	6.2 ± 2.1	2.4 ± 1.2	<0.05	5.1 ± 1.7	3.2 ± 1.4

WBC: White blood cell, RBC: Red blood cell, CRP: C-reactive protein, E: erkek, K: kadın.

[P-580]

To do or not to do: Primary anastomosis in emergency colorectal tumors

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Objective: Colorectal cancer is a common disease that can be found in emergency and daily clinics. They can be admitted with obstruction, perforation or bleeding. They can undergo emergency surgery. In emergency surgeries major challenges are less evaluation time, lack of bowel preparation and intestinal distention due to obstruction. Because of these factors surgeons may be tentative to perform primary anastomosis. Anastomosis leakage is a major problem especially with patients which have age greater than 70 and American Society of Anesthesiologists physical status score–Grade III to V, cardiorespiratory comorbidities, poor nutritional status. In our study, we evaluate emergency colorectal surgeries with primary anastomosis in our clinic within selected time period.

Material and Methods: This retrospective study has 37 patients who underwent colorectal surgery and primary anastomosis at University of Health Sciences Türkiye, Ankara Etlik City Hospital between August, 2024 and December, 2025. Demographically, there are 23 (62.2%) male and 14 (37.8%) female patients and their mean age is 67.1 (min-max, 39-89). When we evaluate them according to tumor localisation 22 left colon tumors and 15 right colon tumors present. All of them are T3 or T4 locally-extensive tumors. After following suitable oncological resection, primary anastomosis has been performed via circular/lineer stapler or manuel. Leakage status, distribution and management have been evaluated.

Results: Anastomosis leak has been seen in 10 (27%) patients. Six of them are clinically stable, have Clavien-Dindo Class I-II leakage and resulted in successful closure without any additional complication. Four of these 10 leak patients need additional surgery for diverting stoma but they have no further complications and successfully discharged. There is no statistical difference between anastomosis with circular stapler, linear stapler or manual anastomosis according to leak status. Tumor localisation is statistically significant, left colon tumors have higher risk for leak ($p=0.016$; $p<0.05$). Proximal intestinal dilation in diameter is also analysed for leak but there is no statistical difference according to diameter of intestine. Length of hospitalisation is longer and statistically significant in leak patients. (Without leak min-max: 5-23; leak min-max: 12-52; $p=0.006$; $p<0.01$) There was one mortality among patients without leak due to comorbidities.

Conclusion: Colorectal tumoral obstructions can be challenged in emergency surgeries but as in elective procedures, patients have a chance of primary anastomosis without additional morbidity or mortality. In experienced centers, patient follow-up has a key role in leak management. Our study shows, primary anastomosis in emergency colorectal tumors can be preferable in suitable patients and should not be a taboo.

Keywords: Anastomosis, colorectal, emergency surgery

[P-581]

Laser surgery in recurrent proctological cases: Early results and clinical experience

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Objective: Recurrent proctologic diseases constitute a challenging patient population due to fibrosis and distorted anatomy resulting from previous surgical interventions. Conventional surgical approaches in these cases often require wider dissection and may increase the risk of sphincter injury, particularly in anal fistula patients. In recent years, laser surgery has gained increasing attention in proctologic practice because of its minimally invasive and sphincter-preserving characteristics. The aim of this study was to evaluate the early clinical outcomes and feasibility of laser surgery in patients with recurrent hemorrhoidal disease, anal fistula, and pilonidal sinus.

Material and Methods: This retrospective, single-center pilot study included patients who underwent laser surgery for recurrent proctologic disease. A total of 20 patients with recurrent hemorrhoids, recurrent anal fistula, or recurrent pilonidal sinus were analyzed. Early outcomes were assessed within the first two months of follow-up. Demographic characteristics, previous surgical history, laser technique applied, operative time, length of hospital stay, postoperative complications, early clinical improvement, and early recurrence were evaluated using descriptive statistics.

Results: Among the included patients, 10 had recurrent pilonidal sinus, 4 had recurrent hemorrhoidal disease, and 4 had recurrent anal fistula. The mean operative time was approximately 16 minutes, and 90% of patients were discharged on the same day or within 24 hours. No major postoperative complications were observed, while minor complications occurred in 20% of patients. The overall early clinical improvement rate was 80%. In the recurrent pilonidal sinus group, the healing rate was 80% with an early recurrence rate of 10%. In the hemorrhoid group, early recurrence was observed only in a patient with Grade IV disease. In the anal fistula group, complete healing was achieved in 50% of patients. One patient underwent a staged approach with loose seton placement followed by laser ablation during a second session, resulting in marked symptom relief. No permanent continence impairment was observed during the early follow-up period.

Conclusion: Laser surgery appears to be a safe and feasible treatment option for recurrent proctologic diseases, offering low morbidity, short hospital stay, and acceptable early recurrence rates. Particularly in recurrent anal fistula, laser treatment may serve as a valuable component of a sphincter-preserving, stepwise treatment strategy. However, careful patient selection remains essential, especially in advanced hemorrhoidal disease and complex recurrent cases. Larger studies with long-term follow-up are required to define the durable efficacy of laser surgery in recurrent proctologic disorders.

Keywords: Recurrent proctologic diseases, laser surgery, sphincter-preserving treatment

Table 1. Disease-based early clinical outcomes

Disease group	Number of patients (n)	Early recovery	Early recurrence	Minor complication	Reoperation
Recurrent hemorrhoids	4	100%	25% (grade IV)	25%	0
Recurrent anal fistula	4	50%*	50%	25%	0
Recurrent pilonidal cyst	10	80%	10%	20%	10%
Total	20	80%	20%	20%	5%

*In one patient in the anal fistula group, laser treatment was applied during the second session after a loose seton application. Although complete anatomical closure was not achieved, a significant reduction in symptoms was observed. No loss of continence was observed in any patient during the early period.

[P-582]

The overlooked etiology behind renal stone disease: Delayed diagnosis of parathyroid adenoma in a young adult

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Objective: Parathyroid adenoma is a benign endocrine tumor and represents the most common cause of primary hyperparathyroidism, accounting for approximately 80-85% of cases. Although many patients are currently diagnosed through incidental detection of asymptomatic hypercalcemia, some present with end-organ complications such as nephrolithiasis. In young adults, recurrent renal stone disease without comprehensive metabolic evaluation may lead to delayed recognition of the underlying endocrine etiology. In this case, we wanted to present our case both to ensure that patients receive early treatment with accurate diagnosis, and to facilitate the functioning of the healthcare system in our country without burdening different branches and resources.

Material and Methods: This study presents a retrospective evaluation of a young patient who was managed symptomatically for recurrent nephrolithiasis and was subsequently diagnosed with parathyroid adenoma. Clinical records, laboratory findings, imaging studies, surgical details, and postoperative outcomes were reviewed. Biochemical assessment included measurement of serum calcium and parathyroid hormone (PTH) levels. Lesion localization was performed using cervical ultrasonography. Surgical treatment consisted of focused parathyroidectomy. Postoperative biochemical response and follow-up outcomes were analyzed.

Results: A 28-year-old male with no known comorbidities was evaluated in multiple urology clinics over a two-year period due to recurrent nephrolithiasis and received medical treatment. During this time, no comprehensive metabolic investigation was performed, and management focused solely on urinary tract pathology. Upon referral to our center, laboratory analysis revealed persistent hypercalcemia and markedly elevated PTH levels. Neck ultrasonography demonstrated a hypoechoic lesion located posterior to the inferior pole of the thyroid gland, consistent with parathyroid adenoma. Following localization studies, the patient underwent focused parathyroidectomy. Histopathological examination confirmed the diagnosis. In the early postoperative period, serum calcium and PTH levels returned to normal ranges. No recurrence of nephrolithiasis was observed during follow-up.

Conclusion: Hypercalcemia secondary to parathyroid adenoma promotes increased bone resorption and renal calcium excretion, predisposing patients to nephrolithiasis. In young patients, exclusive focus on symptomatic urinary management may obscure the underlying endocrine etiology. Diagnostic delay can result in prolonged morbidity, repeated hospital visits, and unnecessary interventions. Surgical excision remains the definitive and curative treatment. Early diagnosis and timely surgical intervention not only normalize biochemical parameters but also significantly reduce the risk of recurrent renal stone formation. Recurrent nephrolithiasis in young adults should prompt evaluation for parathyroid adenoma as a potential underlying cause. Simple biochemical screening may prevent delayed diagnosis and avoidable morbidity. Early multidisciplinary assessment and definitive surgical management are essential for optimal clinical outcomes.

Keywords: Parathyroid adenoma, nephrolithiasis, endocrine surgery

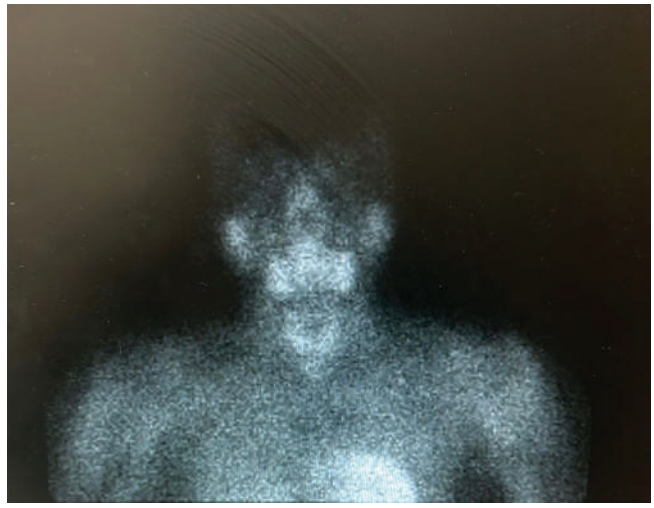

Figure 1. Thyroid scintigraphy. Parathyroid adenoma demonstrating increased radiotracer uptake in the upper paratracheal region.

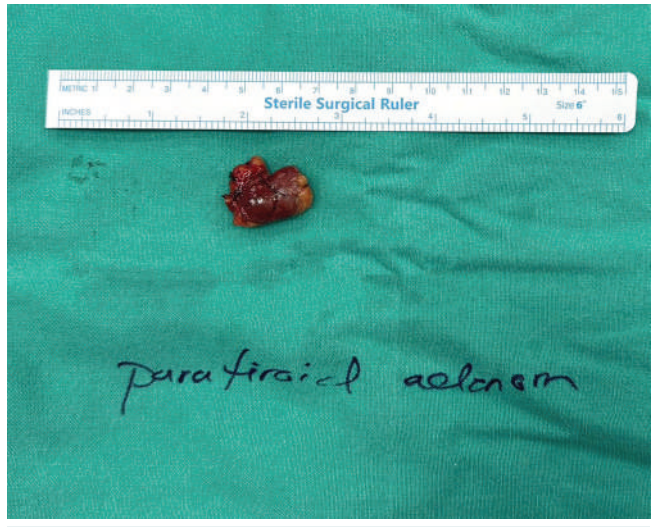

Figure 2. Parathyroid adenoma specimen. Enlarged, nodular parathyroid adenoma specimen.

[P-583]

Early clinical, metabolic, and nutritional outcomes following mini gastric bypass: A single-center early experience

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Objective: Mini-gastric bypass (MGB) is an effective surgical treatment for morbid obesity, providing significant weight loss and metabolic improvement; however, it requires careful postoperative follow-up because of potential complications and nutritional consequences. This study aimed to evaluate the demographic, clinical, operative, and postoperative outcomes of patients who underwent MGB for obesity and to assess early safety and nutritional results.

Material and Methods: In this retrospective observational study, data from six patients who underwent MGB for obesity were analyzed. Demographic characteristics, preoperative clinical status, comorbidities, operative and perioperative data, as well as early and late postoperative complications were evaluated. Metabolic and nutritional outcomes during follow-up were also assessed. Continuous variables were presented as median (IQR) and minimum–maximum values, and categorical variables as numbers and percentages.

Results: All patients were female, with a median age of 48.5 years (33-55). The median preoperative body mass index was 43.8 kg/m² (26.7-49.4), and most patients were in the class III obesity group. Type 2 diabetes was present in 33.3% of patients, with a median disease duration of 10 years. MGB was successfully completed in all cases. No major perioperative complications, blood transfusions, or intensive care requirements were observed. The median length of hospital stay was 3 days. During postoperative follow-up, one patient developed a marginal ulcer and one developed dumping syndrome, while no reactive hypoglycemia was observed. Cholelithiasis was detected in two patients during follow-up, and cholecystectomy was performed in these cases. No anastomotic leaks, reoperations, or mortality occurred. Evaluation of the lowest albumin levels during follow-up showed that no patient developed severe hypoalbuminemia. Metabolic remission was achieved in all patients with type 2 diabetes.

Conclusion: This small series demonstrates that MGB is a safe and effective option for obesity treatment in the early period. The absence of major perioperative complications, intensive care need, reoperation, or mortality indicates a high safety profile in appropriately selected patients. Marginal ulcer and dumping syndrome were rare, and no severe nutritional deficiency was observed. All patients with type 2 diabetes achieved metabolic remission, supporting the metabolic benefits of the procedure. Despite the limited sample size, these findings suggest that MGB provides favorable clinical and nutritional outcomes, which should be confirmed in larger studies with long-term follow-up.

Keywords: Bariatric surgery, mini gastric bypass, morbid obesity, obesity surgery, postoperative complications

Tablo 1. Demografik ve Preoperatif Klinik Özellikler (n=6)

Parametre	Değer
Yaş (yıl)	48.5 (44.2–52.8) [33–55]
Cinsiyet	Kadın: 6 (100.0%)
Preop BMI (kg/m²)	43.8 (36.8–46.6) [26.7–49.4]
Obezite sınıfı	Sınıf II (35–39.9): 1 (16.7%) · Sınıf III (≥40): 5 (83.3%)
Sigara	Var: 1 (16.7%) · Yok: 5 (83.3%)
Alkol	Var: 0 (0.0%) · Yok: 6 (100.0%)
ASA	ASA II: 2 (33.3%) · ASA III: 4 (66.7%)
Önceki abdominal cerrahi	Var: 0 (0.0%) · Yok: 6 (100.0%)
Önceki bariatrik cerrahi	Var: 0 (0.0%) · Yok: 6 (100.0%)
DM2	Var: 2 (33.3%) · Yok: 4 (66.7%)
DM süresi (yıl) *(yalnız DM2 olanlarda, n=2)*	10 (5.5–14.5) [1–19]
Hipertansiyon	Var: 2 (33.3%) · Yok: 4 (66.7%)
Dislipidemi	Var: 1 (16.7%) · Yok: 5 (83.3%)
OSAS	Var: 0 (0.0%) · Yok: 6 (100.0%)
GERD (preop)	Var: 1 (16.7%) · Yok: 5 (83.3%)

Tablo 2. Operatif ve Perioperatif Özellikler (n=6)

Parametre	Değer
Cerrahi yaklaşım	Mini Gastrik Bypass: 6 (100.0%)
Ameliyat süresi (dk)	120 (105–135) [90–150]
Peroperatif komplikasyon	Var: 0 (0.0%) · Yok: 6 (100.0%)
Kan transfüzyonu	Var: 0 (0.0%) · Yok: 6 (100.0%)
Dren kullanımı	Var: 6 (100.0%)
Yoğun bakım ihtiyacı	Var: 0 (0.0%) · Yok: 6 (100.0%)
Hastanede yatış süresi (gün)	3 (3–4) [2–5]

Tablo 3. Postoperatif Erken ve Geç Komplikasyonlar (n=6)

Komplikasyon	n (%)
Marjinal ülser	1 (16.7%)
Dumping sendromu	1 (16.7%)
Reaktif hipoglisemi	0 (0.0%)
Kolelitiazis (takipte)	2 (33.3%)
Postop kolesistektomi	2 (33.3%)
Anastomoz kaçağı	0 (0.0%)
Kanama	0 (0.0%)
Yeniden operasyon	0 (0.0%)
Mortalite	0 (0.0%)

Tablo 4. Takip ve Nütrisyonel / Metabolik Sonuçlar (n=6)

Parametre	Değer
Takip süresi (ay)	**12 (9–15) [6–18]**
Albümin – takipte en düşük (g/dL)	**42.0 (37.0–46.0) [34.7–48.3]**
Ciddi hipoalbuminemi (<3.0 g/dL)	**0 (0.0%)**
Nütrisyonel destek ihtiyacı	**0 (0.0%)**
DM2 remisyonu *(DM2 olanlarda, n=2)*	**2 (100.0%)**

Tablo 5. Mini Gastrik Bypass Literatürü ile Bizim Serimizin Karşılaştırması

Çalışma	Tasarım / Kapsam	Örneklem / Takip	Literatürde öne çıkan sonuçlar	Bizim seriyle kıyas (n=6)
Mitra 2025 (Obesity Surgery)	**Sistematik derleme + meta-analiz** (≥5 yıl takip)	**32 çalışma, 19.125 hasta**, ort. takip **6,7 yıl**	5+ yılda: **T2DM düzelme ~%80, bile reflü ~%4, marjinal ülser ~%2, malnütrisyon ~%1**	Bizde: **MU %16,7 (1/6), ciddi malnütrisyon/hipoalbuminemi yok, T2DM remisyonu %100 (2/2).** MU oranımız küçük n nedeniyle şişebilir; ama **ciddi komplikasyon yokluğu** güçlü.
Musella 2025 (PMC)	Sistematik derleme/meta-analiz (primer OAGB endikasyon/sonuçlar, 5+ yıl)	Çoklu çalışma	Uzun dönemde en çok tartışılan/çekinilenler: **GERD/bile reflü, malnütrisyon, marjinal ülser**; reflü semptomlarında düzelme/kötüleşme aralıkları raporlanıyor	Bizim veri setimiz reflü/bile reflü başlığını içermiyorsa, **takip formuna eklenebilir**; nütrisyonel güvenlik (albümin) bizde iyi.
Lee 2023 (PubMed) – MU meta-analizi	**Sistematik derleme + meta-analiz** (OAGB sonrası marjinal ülser)	Çoklu çalışma	**MU "uncommon"**; çoğu olgu **PPI ile konservatif** yönetiliyor	Bizde MU **1 olgu**; pilot seride **PPI/NSAİİ/sigara** gibi risk faktörleriyle ilişkilendirilecek şekilde tartışma güçlenir.
Abu-Abeid 2024 (J Clin Med)	Tek merkez kohort (MU perforasyonu nedeniyle revizyon)	Merkez verisi: **MU perforasyon oranı %0,98 (15/1522)**; 22 revizyon olgusu	MU perforasyonu nadir ama ciddi; risk faktörleri arasında **sigara/NSAII** vurgulanıyor	Bizde **perforasyon yok, kaçak yok, mortalite yok** → erken dönem güvenlik mesajını güçlendirir.
Son 2023 (PMC) –	Derleme (bariatrik cerrahi	Çoklu çalışma	Bariatrik cerrahi sonrası safra taşı **%10–38**;	Bizde **kolelitiazis %33,3 (2/6)** ve **kolesistektomi %33,3 (2/6)** → oran
Safra taşı/UDCA derlemesi	sonrası safra taşı, UDCA)		UDCA'nın (ilk 3–6 ay) safra taşı/KK riskini azaltabildiği bildiriliyor	literatür aralığıyla uyumlu; ancak kolesistektomi oranı küçük n nedeniyle yüksek görünebilir. UDCA profilaksisi verildiyse/verilmediyse tartışmada kritik.
Bizim çalışma	Tek merkez retrospektif tanımlayıcı seri	**n=6**, takip değişkenlerine göre	**Majör periop komplikasyon yok, kaçak/yeniden operasyon/mortalite yok.** Komplikasyonlar: **MU %16,7, dumping %16,7, reaktif hipoglisemi %0, kolelitiazis %33,3, postop kolesistektomi %33,3. Ciddi hipoalbuminemi yok. T2DM remisyonu %100 (2/2)**	Literatüre katkı: "erken deneyim/pilot" çerçevesinde **güvenlik + nütrisyon + metabolik sonuçların birlikte raporlanması**. En güçlü taraf: **majör morbidite ve nütrisyonel ağır sorun olmaması**; sınırlılık: **küçük örneklem**.

[P-584]

Discriminatory performance of systemic inflammatory indices in identifying tumor stage in gastric cancer: A retrospective study

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Objective: Systemic inflammatory biomarkers have emerged as accessible indicators of tumor biology in gastric cancer. However, their ability to reliably discriminate tumor stage remains incompletely elucidated. This study aimed to evaluate the discriminatory performance of commonly used systemic inflammatory indices for identifying advanced-stage gastric cancer using both group-based and classification-oriented analytical approaches.

Material and Methods: This retrospective observational study included 151 patients with histologically confirmed gastric cancer, categorized into early-stage and advanced-stage disease according to pathological staging criteria. The neutrophil-to-lymphocyte ratio (NLR), platelet-to-lymphocyte ratio (PLR), lymphocyte-to-monocyte ratio, mean platelet volume, systemic immune-inflammation index (SII), and systemic inflammation response index (SIRI) were calculated from pre-treatment complete blood count data.

Results: Group-level comparisons revealed no statistically significant differences in median values of any inflammatory indices between early- and advanced-stage disease (all $p>0.05$). However, classification-oriented analyses demonstrated preserved discriminatory performance for selected markers. Receiver operating characteristic analysis showed good discrimination for both NLR and PLR, with areas under the curve exceeding 0.85, whereas composite indices including SII and SIRI exhibited limited discriminatory ability. In multivariable logistic regression analysis, both NLR and PLR remained independently associated with advanced-stage disease after mutual adjustment, confirming their preserved discriminatory value despite overlapping group distributions.

Conclusion: Despite the absence of statistically significant group-level differences, NLR and PLR demonstrated preserved discriminatory capacity and independent associations with advanced-stage gastric cancer when evaluated using classification-oriented analytical approaches. These findings support the role of systemic inflammatory indices as accessible adjunctive biomarkers when interpreted within multimodal staging and risk stratification frameworks rather than as standalone staging tools.

Keywords: Gastric cancer, systemic inflammation, neutrophil-to-lymphocyte ratio

[P-585]

The evolution of HALP score literature: A global bibliometric perspective

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Objective: The hemoglobin, albumin, lymphocyte, and platelet (HALP) score is an emerging immune-nutritional biomarker that integrates systemic inflammation, nutritional status, and immune competence. While clinical studies have associated low HALP scores with poor survival outcomes in multiple malignancies, the global research landscape of HALP remains unmapped.

Material and Methods: A comprehensive literature search was conducted in the Web of Science Core Collection without language or time restrictions. Eligible publications explicitly mentioning HALP were analyzed using the Bibliometrix R package and Biblioshiny interface. Descriptive indicators, citation metrics, and source-level analyses were reported in line with BIBLIO guidelines. Co-authorship networks, keyword co-occurrence, thematic maps, and trend analyses were employed to examine the intellectual structure and evolution of the field.

Results: A total of HALP-related publications showed a sharp rise after 2020, reaching their highest output in 2025. China dominated in publication volume, while the United States led in citation impact. Institutional productivity was concentrated in a limited group of centers, particularly the University of Health Sciences and Qingdao University (Figure 1). Co-citation and keyword network analyses revealed three major thematic clusters, anchored by a foundational core of early studies and a rapidly expanding new research wave. The conceptual structure of the field consistently revolved around inflammation, nutrition, and oncologic outcomes (Figure 2). Despite rapid growth, international collaboration remained limited and methodological heterogeneity was pronounced.

Conclusion: HALP research is expanding quickly but remains in an early developmental stage, characterized by uneven global distribution, inconsistent cut-off values, and fragmented methodological approaches. This bibliometric analysis clarifies the current landscape, identifies research gaps, and highlights the need for standardized methods and broader collaborative networks. Strengthening multicenter studies and harmonizing analytical frameworks will be essential for advancing the clinical utility and global adoption of the HALP score.

Keywords: Biomarkers, prognosis, cancer, inflammation, bibliometrics, HALP score

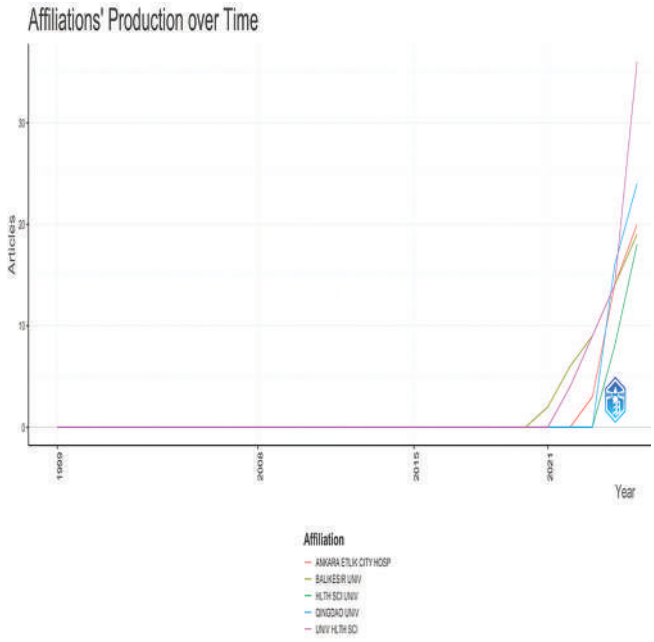

Figure 1.

Figure 2.

[P-586]

The value of computed tomography findings in predicting perforation and malignancy in acute appendicitis: A single-center retrospective cohort study

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Objective: Acute appendicitis is one of the most common indications for emergency surgical intervention. Accurate preoperative prediction of complications such as perforation and underlying malignancy is critical for clinical decision-making and surgical timing. Although computed tomography (CT) is widely used in the diagnostic evaluation of acute appendicitis, the diagnostic performance of standalone radiological interpretation remains limited, particularly in complicated cases. Moreover, the relative value of CT-based composite scoring systems compared with direct CT interpretation in predicting pathological outcomes has not been clearly established. This study aimed to evaluate the diagnostic performance of CT findings and composite CT scores in predicting perforation and malignancy in patients with acute appendicitis.

Material and Methods: Between January 1, 2024, and December 31, 2025, histopathological reports of 1,187 adult patients (≥18 years) who underwent appendectomy with a diagnosis of acute appendicitis established solely by CT were retrospectively reviewed. Among these, 212 patients with pathological findings consistent with complicated appendicitis and/or neoplastic or malignant lesions (Table 1) constituted the study cohort (Figure 1). Patients were analyzed in three cohorts based on pathological perforation (n=92), presence of neoplasia (n=37), and presence of malignancy (n=17). Because individual CT findings of complicated appendicitis demonstrate high specificity but limited sensitivity, composite scoring systems were developed to reduce false-negative results. A composite CT perforation score based on 8 imaging parameters and a composite CT neoplasia/malignancy score based on 5 parameters were constructed according to previously reported imaging features (Table 2). Demographic, clinical, laboratory, and CT findings were recorded. Standalone CT interpretations and composite scores were evaluated using pathology as the reference standard (Figure 4).

Results: The mean age of the patients was 45.9 years, and 49.5% were female. The mean symptom duration was 60.1 hours, and the mean Alvarado score was 7.71. Patients with intraoperative and pathological perforation had significantly higher age, symptom duration, Alvarado scores, white blood cell count, C-reactive protein levels, and length of hospital stay ($p<0.001$) (Figure 2). The perforation detection rate on CT was 25.5%, where as the pathological perforation rate was 43.4%. Wall defect, extraluminal air, periappendiceal fat stranding, free intraperitoneal fluid, and signs of peritonitis were significantly associated with perforation ($p<0.001$). Patients with pathological perforation had significantly larger appendiceal diameters and higher composite CT perforation scores ($p<0.001$) (Figure 3). While standalone CT interpretation of perforation showed a sensitivity of 41.3% and specificity of 86.7%, the composite perforation score (V≥2) increased sensitivity to 82.6%. In cases with neoplasia and malignancy, suspected mass, suspected mucocele, mural calcification, and periappendiceal lymphadenopathy were significant. The composite malignancy score (W≥1) demonstrated a sensitivity of 82.4% and a negative predictive value of 98.0.

Conclusion: Although standalone CT interpretation in acute appendicitis demonstrates high specificity, its sensitivity for predicting perforation and malignancy is limited. The composite CT scores developed in this study significantly reduce false-negative rates and provide a more balanced and clinically reliable risk stratification.

Keywords: Acute appendicitis, computed tomography, diagnostic scoring systems, malignancy, perforation

Patolojik tanı dağılımı (n = 212)		
Patolojik Tanı	**n**	**%**
Perfore apandisit	122	57,5
Periappendiküler apse / periappendisit	18	8,5
Supüratif / flegmonöz apandisit	10	4,7
Serrated lezyon / hiperplastik polip*	10	4,7
LAMN*	10	4,7
Gangrenöz apandisit	9	4,2
NET / Karsinoid**	9	4,2
Endometriozis	7	3,3
Appendiks divertikülü / divertikülit	5	2,4
Paraziter apandisit	3	1,4
HAMN**	3	1,4
Müsinöz adenokarsinom**	2	0,9
Plastron / flegmon	1	0,5
Lenfoid hiperplazi*	1	0,5
Goblet cell adenocarcinoma**	1	0,5
Adenokarsinom (kolonik tip)**	1	0,5
Toplam	**212**	**100**

Figure 1. Distribution of pathological diagnoses.

Tablo 1a. İntraoperatif Perforasyona Göre Hasta Özelliklerinin Karşılaştırılması

Değişken	Tüm hastalar (N=212)	Perforasyon (−) (n=99)	Perforasyon (+) (n=113)	p
Yaş (yıl)	45,9	41,8	49,5	**0,001**
Kadın, n (%)	105 (49,5)	56 (56,6)	49 (43,4)	0,08
Erkek, n (%)	107 (50,5)	43 (43,4)	64 (56,6)	—
Semptom süresi (saat)	60,1	44,2	74	**<0,001**
Alvarado skoru	7,71	7,3	8,1	**<0,001**
WBC (10^3/µL)	14,3	12,6	15,8	**<0,001**
CRP (mg/L)	134,5	86,4	176,8	**<0,001**
Yatış süresi (gün)	5,3	3,9	6,6	**<0,001**

Tablo 1b. Patolojik Perforasyona Göre Hasta Özelliklerinin Karşılaştırılması

Değişken	Tüm hastalar (N=212)	Patolojik perf (−) (n=120)	Patolojik perf (+) (n=92)	p
Yaş (yıl)	45,9	42,9	49,9	**0,003**
Kadın, n (%)	105 (49,5)	65 (54,2)	40 (43,5)	0,13
Erkek, n (%)	107 (50,5)	55 (45,8)	52 (56,5)	—
Semptom süresi (saat)	60,1	47,8	77,6	**<0,001**
Alvarado skoru	7,71 ± 0,90	7,4 ± 0,8	8,2 ± 0,9	**<0,001**
WBC (10^3/µL)	14,3	13	16,2	**<0,001**
CRP (mg/L)	134,5	98,7	186,3	**<0,001**
Yatış süresi (gün)	5,3	4,1	6,9	**<0,001**

Figure 2. Comparison of patient characteristics according to intraoperative and pathological perforation.

Tablo 2a. İntraoperatif Perforasyona Göre BT Bulgularının Karşılaştırılması

BT bulgusu	Tüm hastalar (N=212)	Perforasyon (−) (n=99)	Perforasyon (+) (n=113)	p
Duvar defekti, n (%)	46 (21,7)	6 (6,1)	40 (35,4)	**<0,001**
Ekstraluminal hava, n (%)	23 (10,8)	3 (3,0)	20 (17,7)	**<0,001**
Periappendiküler kirlenme, n (%)	180 (84,9)	73 (73,7)	107 (94,7)	**<0,001**
Serbest sıvı, n (%)	65 (30,7)	15 (15,2)	50 (44,2)	**<0,001**
Peritonit, n (%)	41 (19,3)	5 (5,1)	36 (31,9)	**<0,001**
Appendikolit, n (%)	54 (25,5)	20 (20,2)	34 (30,1)	0,1
Plastron / flegmon, n (%)	2 (0,9)	0 (0)	2 (1,8)	0,5
Appendiks çapı (mm)	12,4	10,9	13,7	**<0,001**
BT perforasyon skoru (V)	1,42	0,7	2,1	**<0,001**

Tablo 2b. Patolojik Perforasyona Göre BT Bulgularının Karşılaştırılması

BT bulgusu	Tüm hastalar (N=212)	Patolojik perf (−) (n=120)	Patolojik perf (+) (n=92)	p
Duvar defekti, n (%)	46 (21,7)	8 (6,7)	38 (41,3)	**<0,001**
Ekstraluminal hava, n (%)	23 (10,8)	4 (3,3)	19 (20,7)	**<0,001**
Periappendiküler yağlanma, n (%)	180 (84,9)	88 (73,3)	92 (100)	**<0,001**
Serbest sıvı, n (%)	65 (30,7)	19 (15,8)	46 (50,0)	**<0,001**
Peritonit, n (%)	41 (19,3)	7 (5,8)	34 (37,0)	**<0,001**
Appendikolit, n (%)	54 (25,5)	24 (20,0)	30 (32,6)	**0,06**
Plastron / flegmon, n (%)	2 (0,9)	0 (0)	2 (2,2)	**0,19**
Appendiks çapı (mm)	12,4	11,1	14	**<0,001**
BT perforasyon skoru (V)	1,42	0,8	2,3	**<0,001**

Figure 3. Comparison of CT findings according to intraoperative and pathological perforation.

CT: Computed tomography.

BT'nin perforasyon ve maligniteyi öngörme performansının patoloji referanslı karşılaştırması

Klinik sonuç	BT yöntemi	TP	FN	FP	TN	Duyarlılık (%)	Özgüllük (%)	PPV (%)	NPV (%)
Patolojik perforasyon	CT perforasyon yorumu	38	54	16	104	41,3	**86,7**	70,4	65,8
	CT kompozit skoru (V)	**76**	**16**	32	88	**82,6**	73,3	70,4	**84,6**
Patolojik malignite	CT malignite yorumu	7	10	**2**	**193**	41,2	**99**	**77,8**	95,1
	CT kompozit skoru (W)	**14**	**3**	46	149	**82,4**	76,4	23,3	**98**
Altın standart: Patoloji									
Cut-off'lar:									
V skoru (+): ≥ 2									
W skoru (+): ≥ 1									

Figure 4. Pathology-based comparison of CT performance in predicting perforation and malignancy using composite scores.

CT: Computed tomography.

Table 1.	
Neoplasia*	**Malignancy****
Mucocele (benign)	NET/carcinoid tumor
Serrated lesion/hyperplastic polyp	Goblet cell adenocarcinoma
Adenoma/dysplasia (without invasion)	Adenocarcinoma (colonic type)
NET/carcinoid tumor	Mucinous adenocarcinoma
Goblet cell adenocarcinoma	HAMN
Adenocarcinoma (colonic type)	MiNEN
Mucinous adenocarcinoma	Lymphoma/hematolymphoid malignancy
Low-grade appendiceal mucinous neoplasm (LAMN)	Metastasis (secondary)
High-grade appendiceal mucinous neoplasm (HAMN)	Other malignancies
Mixed neuroendocrine–non-neuroendocrine neoplasm (MiNEN)	
Lymphoma/hematolymphoid malignancy	
Metastasis (secondary)	
Other malignancies	

Table 2. Parameters of the composite scoring system	
CT composite perforation score	**CT composite malignancy score**
Wall defect	Suspected mass
Extraluminal air	Suspected mucocele
Periappendiceal abscess	Mural calcification
Free intraperitoneal fluid	Pathologic lymphadenopathy
Peritonitis	Implant/pseudomyxoma
Phlegmon/plastron	
Appendicolith	
Periappendiceal lymphadenopathy	

[P-587]

Predictors of recurrence in the management of breast abscesses

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Objective: Inflammatory breast pathologies represent a significant clinical challenge in general surgery, profoundly impacting patient morbidity and quality of life due to their high propensity for recurrence. Mastitis and breast abscesses constitute the majority of these cases. While the current therapeutic paradigm prioritizes conservative measures—specifically targeted antibiotherapy and ultrasound-guided needle aspiration—surgical intervention remains the definitive recourse for refractory cases. This study seeks to elucidate the clinicopathological predictors of recurrence in patients who transitioned to surgical drainage following the failure of primary conservative management.

Material and Methods: A retrospective cohort of 196 patients diagnosed with breast abscesses between 2021 and 2025 was reviewed. Analysis focused on 109 patients who exhibited clinical persistence despite initial intervention, subsequently requiring surgical drainage. Multiple variables, including anatomical localization, microbiological profiles, systemic inflammatory markers (WBC and CRP), smoking status, diabetes mellitus, and the presence of underlying granulomatous mastitis, were analyzed to determine their association with disease recurrence.

Results: The mean age of the cohort was 35.95 years (range: 21–52), with a predominant distribution of non-puerperal cases (n=107) over puerperal ones (n=2). Statistical modeling demonstrated that positive microbiological cultures and non-granulomatous etiologies were significantly associated with reduced recurrence rates ($p<0.05$). Conversely, granulomatous mastitis, active smoking, and diabetes mellitus emerged as potent independent predictors of recurrence ($p<0.05$). Notably, neither leukocytosis nor elevated CRP levels demonstrated sufficient sensitivity as predictors for recurrence ($p>0.05$).

Conclusion: Conservative management via needle aspiration and antibiotherapy remains the cornerstone of breast abscess treatment. However, when these measures prove insufficient, surgical drainage becomes mandatory. In such instances, routine microbiological and histopathological sampling is paramount to delineate the underlying etiology. A precise diagnosis facilitates a tailored therapeutic approach, which is critical for mitigating the risk of chronicity and minimizing the necessity for repeated surgical interventions. In summary while aspiration is our first line of defense, understanding the underlying pathology is what ultimately prevents the scalpel from being needed a second time.

Keywords: Mastitis, non-puerperal mastitis, granulomatous mastitis, breast abscess

[P-588]

Reducing incorrect home interventions and unregistered topical product use in burn treatment: A multilevel roadmap for evidence-based first aid and risk communication

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Objective: Common "home/alternative" remedies (oil, yogurt, toothpaste, ice, etc.) used in the community after thermal burns, and the recent increase in the availability of unregistered, unidentified topical preparations (so-called "burn creams") in some rural areas, can increase the risk of burn depth, wound infection, allergic/irritant reactions, delayed treatment, and ultimately sepsis, extensive scarring, and tissue loss. The aim of this report is to discuss the reasons for the continuation of these incorrect practices and to propose an awareness-behavioral change-access program that can be implemented, particularly in rural communities.

Material and Methods: Evidence-based burn first aid recommendations and application barriers are compiled within a "multi-level" intervention framework involving stakeholders such as primary care, emergency services (112), pharmacies, schools, local government, and the tourism sector. The text also discusses the risks of "unregistered products" based on anonymized field observations encountered in clinical practice.

Results: Many guidelines emphasize that the first approach in burns is to safely remove heat; cooling the burn with cool running tap water for 20 minutes, removing constricting jewelry/clothing, covering the burn with a clean dressing, and seeking medical attention. Applying ice and oily/creamy substances is not recommended; excessive/prolonged cooling may increase the risk of hypothermia. There is clinical data reporting that topical "traditional material" applications can increase infection and mortality in acute burns. Infection and subsequent sepsis in burn wounds are significant determinants of morbidity/mortality. Safety issues such as microbial contamination and heavy metal content have been reported in unregistered/community-produced topical products; additionally, herbal/topical preparations may cause allergic contact dermatitis.

Conclusion: One-off informational campaigns are insufficient to reduce harmful home care practices in burn treatment. An effective approach should include: (i) simple and repetitive messaging ("20 min water"), (ii) culturally appropriate communication with local opinion leaders, (iii) care pathways that facilitate access in rural areas, and (iv) risk communication and feedback loops targeting the use of unregistered products.

Keywords: Burn, unregistered topical product, traditional treatment, infection

[P-589]

Bibliometric analysis of general surgery, emergency surgery, and trauma surgery literature in the context of Gaza (2023–2026)

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Objective: Armed conflicts cause devastating health outcomes for civilians, and surgical care is vital in managing these crises. This study aims to analyze the scientific literature on general, emergency, and trauma surgery in the context of Gaza (2023-2026) using bibliometric methods to reveal publication trends, geographical contributions, and thematic evolution.

Material and Methods: A search was conducted in the PubMed database using keywords such as "Gaza", "Gaza Strip", "General Surgery", "Trauma", and "Armed Conflict". Studies published between 2024 and 2026 were included. Bibliometric analyses were performed via Bibliometrix/Biblioshiny software, evaluating annual production, author/institutional productivity, core journals (Bradford's Law), keyword co-occurrence, and thematic maps.

Results: Thirty publications indexed in PubMed across 12 journals were analyzed, involving 217 authors. The literature showed a highly collaborative structure (10.2 co-authors per document) with a 13.33% international co-authorship rate. Scientific production peaked in 2025 before a relative decline in 2026. While institutional contributions centered on Gaza-based entities, India, Pakistan, Türkiye, and the USA provided significant global contributions. Thematic analysis indicated that studies primarily focused on demographics, risk factors, and global disease burden. These emerged as "basic themes" with high centrality, whereas themes regarding specific surgical interventions and clinical outcomes remained limited.

Conclusion: This bibliometric analysis reveals that while literature concerning general surgery, emergency surgery, and trauma surgery in the context of Gaza has shown a quantitative increase in the post-2023 period, it remains largely descriptive and demographically focused in terms of content. It is noteworthy that systematic and high-level evidence regarding surgical clinical decision-making, intervention outcomes, and care strategies under conflict conditions is limited. The thematic findings demonstrate that the impacts of war on the civilian population are primarily addressed through the concepts of human and disease burden, while surgical practice is mostly reflected indirectly as a consequence of this humanitarian load. This situation highlights that the events in Gaza are not only a humanitarian crisis but also a surgical care problem that is insufficiently documented scientifically. In conclusion, although the existing literature makes the vital role of surgery in conflict environments quantitatively visible, it fails to sufficiently reflect the actual clinical needs and ethical responsibilities on the ground. By emphasizing that surgical care in wartime is not merely technical but a field of scientific responsibility centered on human dignity, this study provides an objective framework for future patient-centered and systematic research.

Keywords: Gaza, general surgery, humanitarian crisis

[P-601]

Fundoplication preferences and early outcomes in laparoscopic hiatal hernia repair: A single-center retrospective analysis

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Objective: The choice of fundoplication technique during laparoscopic hiatal hernia repair remains individualized, particularly in patients with esophageal motility disorders. This study aimed to evaluate the distribution of fundoplication types and assess early clinical outcomes in our center.

Material and Methods: A retrospective analysis was performed on 117 consecutive patients who underwent laparoscopic hiatal hernia repair in 2025. Demographic characteristics, surgical indications, type of fundoplication, concomitant procedures, and early postoperative outcomes were analyzed. The mean age was 46.7 years, with the majority of patients in the middle-aged group. A 360° Nissen fundoplication was the preferred technique in most cases. Posterior partial (Toupet) fundoplication was performed in patients with documented esophageal motility disorders or increased risk of postoperative dysphagia. In selected cases, additional procedures such as Heller myotomy, revisional surgery, or simultaneous cholecystectomy were performed. Patients were evaluated at 1-, 3-, and 6-month follow-up visits.

Results: Primary hiatal repair and fundoplication were successfully completed in all patients. Nissen fundoplication was the most commonly performed procedure, followed by Toupet fundoplication. Early postoperative morbidity was low, and the rate of major complications was minimal. Reoperation was rarely required. Concomitant procedures did not significantly increase complication rates. Symptomatic improvement was observed in the majority of patients during early follow-up.

Conclusion: Laparoscopic hiatal hernia repair is a safe and effective procedure in our center. The type of fundoplication should be individualized according to patient characteristics and esophageal motility findings. Long-term functional outcomes are required to better define the optimal fundoplication strategy.

Keywords: Hiatal hernia, laparoscopic surgery, fundoplication, Nissen, Toupet

[P-602]

Structured communication models in surgical intensive care units: The effect of SBAR and current protocols on team awareness

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Objective: Surgical intensive care units (SICUs) are high-risk areas where patient care is complex and continuous information flow is required among multidisciplinary team members. When the root causes of medical errors are examined in the literature, it is seen that communication deficiencies and errors rank first with a rate of over 60%, and approximately half of these errors occur during patient handovers. Traditional and unstructured communication paves the way for information loss. The aim of this study is; this study aims to evaluate the effects of current structured communication protocols, primarily Situation, Background, Assessment, Recommendation (SBAR), but also I-PASS and Introduction, Situation, Background, Assessment, and Recommendation (ISBAR), on team awareness and patient safety in the CYCU (SICU) in light of literature data.

Material and Methods: This study is a systematic review of national and international literature published between 2015 and 2024 examining the use of structured communication models in surgical and intensive care settings. Studies using SBAR, ISBAR, and related checklists were included by searching PubMed, CINAHL, Medline, and National Databases. Data were analyzed in terms of communication clarity, omission rates, team collaboration, and adverse event frequency parameters.

Results: In the studies reviewed, it was found that the use of standard protocols such as SBAR increased the accuracy of the information conveyed. In the study by Wang et al., it was determined that the use of SBAR-based checklists reduced the rate of "missing information" in patient handover in SICUs from 7.26% to 2.02%. A recent study in Türkiye reported that 66.7% of nurses stated that the SBAR model positively contributed to the handover process. Furthermore, it was observed that the SBAR model reduced hierarchical barriers among team members and increased nurses' confidence in offering "suggestions." Looking at clinical outcomes, it was found that unexpected deaths decreased after the use of structured communication, and communication-related incident reporting decreased from 31% to 11%.

Conclusion: The use of SBAR and similar structured communication protocols in SICUs not only standardizes information transfer but also improves team awareness and patient safety culture. It is recommended that institutions adapt these protocols to their own dynamics, support them with simulation training, and integrate them into electronic health records.

Keywords: SBAR, surgical intensive care, communication, patient safety

[P-605]

The importance of clinical decision-making processes in resident education: The necrotizing course of mild-onset biliary pancreatitis

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Objective: In the surgical training process, decision-making competence in patient management is shaped not only by theoretical knowledge but also by clinical intuition, multifaceted assessment, and repetitive observation skills. Diseases such as acute pancreatitis, which initially present mildly but can rapidly worsen, are of high educational value in surgical assistant training. In this presentation, the dynamic structure and educational importance of the "safe discharge" decision in assistant training will be discussed using the example of a patient who was initially diagnosed with mild biliary pancreatitis but quickly developed a necrotizing course, resulting in the need for intensive care.

Material and Methods: A 57-year-old man presented with right upper quadrant pain and nausea. Laboratory tests showed amylase levels more than three times the normal limit, and imaging findings were consistent with biliary pancreatitis. He was admitted with mild acute pancreatitis and treated with intravenous fluids and empirical broad-spectrum antibiotics. Although initially stable and evaluated for discharge on day four after tolerating oral intake, the patient developed fever, tachycardia, hypoxia, and leukocytosis on day five. Contrast-enhanced CT revealed necrotizing pancreatitis, and the patient was transferred to the intensive care unit due to sepsis. Two percutaneous drainage catheters were placed under interventional radiology guidance on separate days, and antibiotic therapy was adjusted according to culture results. The patient gradually improved and was discharged on day 46.

Results: This case highlights three key concepts in surgical assistant training: 1. The relativity of clinical stability: the patient showed signs of improvement on the 4th day but experienced a significant deterioration on the 5th day, illustrating how sensitive an assessment is required for the concept of "early discharge." 2. Multidisciplinary patient management: the coordinated approach of the surgical, intensive care, infectious diseases, and interventional radiology units provides an ideal example for residents to develop their clinical leadership and communication skills in such patients. Clinical intuition and continuous observation: the fluctuating course observed in this case emphasizes the need to teach residents not only clinical algorithms but also decision-making based on individualized observation.

Conclusion: Even in cases of mild biliary pancreatitis, residents must be cautious when making early discharge decisions due to the dynamic clinical course and must develop the habit of performing multidimensional patient assessments, not just laboratory and imaging tests. This case highlights the educational value of incorporating patient monitoring processes into surgical training curricula not only based on complications but also on decision-making processes.

Keywords: Surgical education, clinical decision-making, biliary pancreatitis, resident training, multidisciplinary patient management

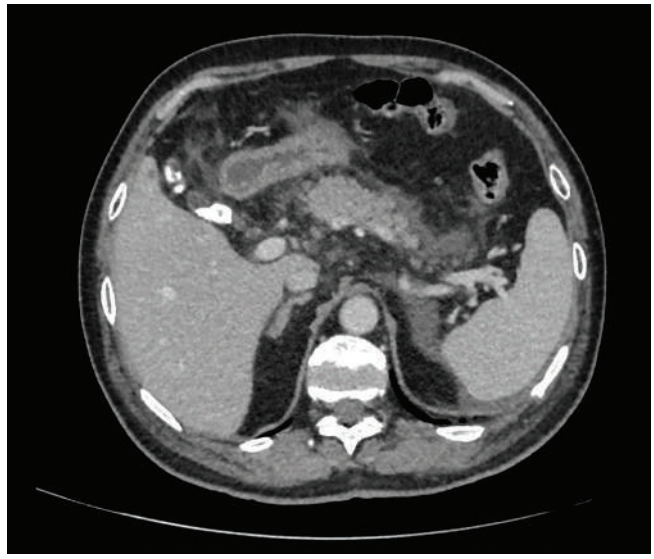

Figure 1.

Figure 2.

Figure 3.

Figure 4.

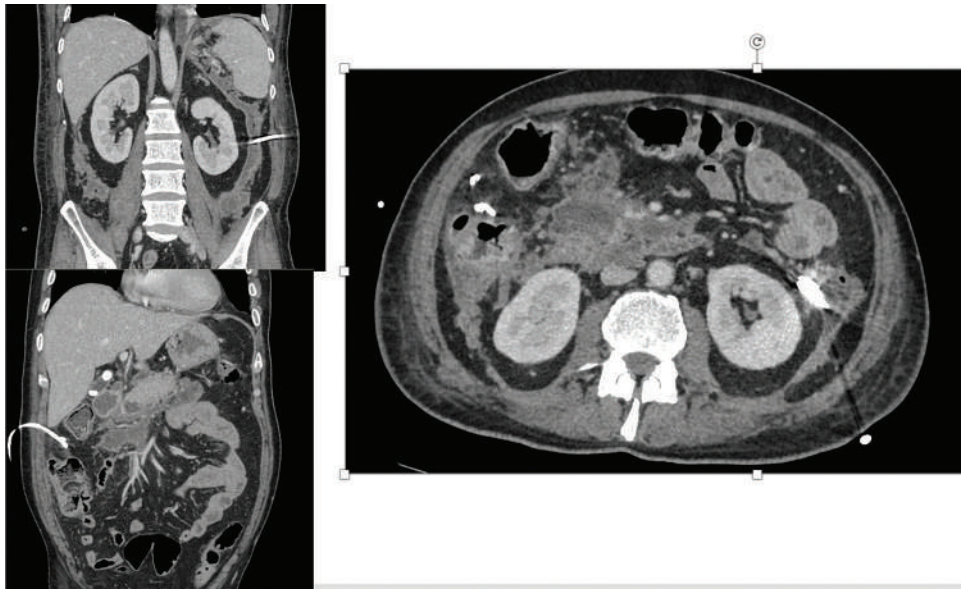

Figure 5.

[P-606]

Health care quality literacy scale

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Objective: With the launch of the Health Transformation Program by the Ministry of Health in 2003, a healthcare delivery model emphasizing efficiency, effectiveness, patient safety, and patient satisfaction was adopted, and performance- and quality-based evaluation mechanisms were systematically developed. Currently, quality practices in Türkiye are conducted on the basis of patient safety, clinical quality indicators, accreditation processes, and continuous quality improvement cycles, aiming to institutionalize a sustainable and measurable culture of quality within healthcare services. Nevertheless, the failure to fully internalize and embed a quality culture at the hospital level remains a significant challenge. In this study, we aim to evaluate the level of quality culture implementation in healthcare institutions and to highlight existing gaps, thereby contributing to the growing body of literature on healthcare quality management.

Material and Methods: This study was conducted to assess the quality literacy levels of residents working in the General Surgery Clinic of University of Health Sciences Türkiye, Ankara Etlik City Hospital in the context of healthcare service delivery. A standardized questionnaire was administered for this purpose. In addition, five supplementary questions were incorporated into the introductory section of the survey to evaluate physicians' perspectives on quality (Tables 1 and 2). Quality literacy scores were calculated on a scale ranging from 0 to 100 based on participants' responses to the questionnaire. Furthermore, the distribution and proportions of responses to the questions assessing attitudes toward quality were analyzed.

Results: Analysis of the first five items showed that 88.1% (n=52) of residents answered "yes" and 11.9% (n=7) "no" to the question "Are quality practices necessary in healthcare?" To "Have you received training on quality practices?", 57.6% (n=34) responded "yes" and 42.4% (n=25) "no." Regarding their perspective, 69.5% (n=41) reported a positive view and 30.5% (n=18) a negative view. To "How do you define quality practices?", 59.3% (n=35) described them as a "loss of workforce," while 40.7% (n=24) considered them "necessary." Concerning primary responsibility, 45.8% (n=27) indicated physicians and 54.2% (n=32) nurses. Descriptive statistics showed a mean score of 63.09±22.71. According to the evaluation criteria, this value falls within the 50–75 range, indicating a good level on the scale.

Conclusion: Although the residents achieved high scores in quality literacy, their perception of quality practices as a source of workforce burden and as primarily a nursing responsibility may indicate that a fully institutionalized culture of quality has not yet been established.

Keywords: Health, quality

Table 1. Physicians' perspectives on quality practices

Age:	**Year of residency:**	
Are quality practices necessary in healthcare?	Yes	No
Have you received training on quality practices?	Yes	No
What is your perspective on quality practices?	Positive	Negative
How do you define quality practices?	Loss of workforce	Necessary
Who do you think holds primary responsibility for quality practices?	Physician	Nurse

Table 2. Health quality literacy scale

	Please indicate your level of agreement with the following statements by selecting the appropriate box on the right.	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
1	I can define the concept of quality.	☐	☐	☐	☐	☐
2	I am familiar with the philosophy of quality management.	☐	☐	☐	☐	☐
3	I have basic knowledge of the historical development of quality management.	☐	☐	☐	☐	☐
4	I can list the objectives of quality management.	☐	☐	☐	☐	☐
5	I can explain the concept of quality culture.	☐	☐	☐	☐	☐
6	Quality is necessary in all fields, including health, safety, production, and education.	☐	☐	☐	☐	☐
7	Quality management is necessary for employee job satisfaction.	☐	☐	☐	☐	☐
8	Quality management is necessary for service user satisfaction.	☐	☐	☐	☐	☐
9	Quality management is necessary to ensure efficiency.	☐	☐	☐	☐	☐
10	Quality management is necessary to remain competitive.	☐	☐	☐	☐	☐
11	Quality management is necessary to achieve organizational goals.	☐	☐	☐	☐	☐
12	Physical and technological resources should be considered in the design of healthcare delivery.	☐	☐	☐	☐	☐
13	Principles, rules, and procedures regarding authority and responsibility should be defined in healthcare delivery.	☐	☐	☐	☐	☐
14	The outputs of healthcare delivery should align with the institution's mission and be functional.	☐	☐	☐	☐	☐
15	A measurement and evaluation system for patient and staff satisfaction should be defined by principles and rules.	☐	☐	☐	☐	☐
16	Continuous improvement policies should be adopted in healthcare delivery.	☐	☐	☐	☐	☐
17	Healthcare professionals' participation in research processes should be supported.	☐	☐	☐	☐	☐
18	Access to healthcare administrators should be easy.	☐	☐	☐	☐	☐
19	Healthcare professionals should be adequately equipped in terms of knowledge and skills.	☐	☐	☐	☐	☐
20	Resources (physical, financial, informational, equipment, etc.) should be sufficient in quality and quantity in healthcare delivery.	☐	☐	☐	☐	☐
21	Access to healthcare services for disadvantaged individuals should be facilitated.	☐	☐	☐	☐	☐
22	Institutional facilities and infrastructure should be adequate in quality and quantity.	☐	☐	☐	☐	☐
23	I can take part in communication activities within quality management.	☐	☐	☐	☐	☐
24	I am inclined toward teamwork.	☐	☐	☐	☐	☐
25	I can associate quality culture with organizational culture.	☐	☐	☐	☐	☐
26	I can design the technological infrastructure of a quality management system.	☐	☐	☐	☐	☐
27	I believe I can contribute effectively to managerial activities.	☐	☐	☐	☐	☐
28	I can participate in international quality management activities.	☐	☐	☐	☐	☐
29	I can develop strategies and policies to compete with other institutions.	☐	☐	☐	☐	☐
30	I can develop new perspectives on quality management.	☐	☐	☐	☐	☐

[P-607]

The role of preoperative laboratory parameters in predicting complicated acute appendicitis: A single-center experience

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Objective: Acute appendicitis is one of the most common causes of acute abdomen requiring emergency surgical intervention. Delayed diagnosis may lead to the development of complicated forms such as gangrenous or perforated appendicitis, resulting in increased morbidity. Early prediction of complicated acute appendicitis is therefore essential for determining appropriate surgical timing and optimizing perioperative management. Although computed tomography has high diagnostic accuracy, its use may be limited by radiation exposure and accessibility. Recently, simple and readily available preoperative laboratory parameters have been suggested as useful tools for predicting disease severity and complicated appendicitis. This study aimed to evaluate the role of preoperative laboratory parameters in predicting complicated acute appendicitis.

Material and Methods: This single-center retrospective study included patients who underwent surgery for acute appendicitis between September 16, 2025, and January 8, 2026. Demographic characteristics, preoperative laboratory parameters, and pathological findings were reviewed retrospectively. Patients with incomplete data were excluded from the statistical analysis. Based on pathological evaluation, patients were classified as having complicated appendicitis (gangrenous, perforated, or plastron appendicitis) or uncomplicated appendicitis. Preoperative white blood cell count (WBC), C-reactive protein (CRP), albumin levels, and neutrophil-to-lymphocyte ratio (NLR) were compared between the groups. Statistical analyses were performed using appropriate tests according to data distribution. A p-value of <0.05 was considered statistically significant.

Results: A total of 99 patients were included in the final analysis. Preoperative WBC and CRP levels were significantly higher in the complicated appendicitis group compared with the uncomplicated group ($p=0.024$ and $p=0.035$, respectively). No statistically significant differences were observed between the groups in terms of albumin levels or NLR ($p>0.05$).

Conclusion: Preoperative laboratory parameters, particularly WBC count and CRP levels, may be useful in predicting complicated disease in patients with acute appendicitis. The integration of these readily available markers with clinical assessment may contribute to improved risk stratification and optimization of surgical decision-making.

Keywords: Acute appendicitis, complicated appendicitis, inflammatory markers

[P-608]

Laser ablation for pilonidal sinus: Initial experience from a single center

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Objective: Pilonidal sinus disease (PSD) is a chronic condition involving hair ingrowth and infection in the sacrococcygeal region, primarily affecting young adults. It significantly impacts quality of life due to pain, discomfort, and recurrent infections. Traditional surgical methods often require extensive excisions and prolonged healing, whereas laser ablation has emerged as a minimally invasive alternative. Laser ablation destroys sinus tract inner surfaces using laser energy, offering less tissue damage, shorter recovery, and reduced postoperative pain. Initial success rates range from 73–94%, but long-term (≥60 months) recurrence rates may reach 14-36%, potentially higher than excision techniques like the Karydakis flap. This study evaluates laser ablation effectiveness and spinal anesthesia advantages in a single-center experience. Spinal anesthesia enhances muscle relaxation, improves operative field control, aids postoperative pain management, and increases patient comfort. It also offers fewer complications and shorter hospital stays compared to general anesthesia. This study focuses on the role of spinal anesthesia in laser ablation procedures.

Material and Methods: In this single-center retrospective study, outcomes of 42 patients undergoing laser ablation for PSD between January 2023 and October 2024 were analyzed. All procedures used spinal anesthesia. Demographic data, clinical characteristics, operative details, complication rates, recurrence rates, and pain scores were recorded.

Results: The mean patient age was 28.5±7.2 years (range: 18-45). Of the patients, 33 (78.6%) were male, and 9 (21.4%) were female. Mean operative time was 25±8.5 minutes. Complications included abscess (2 patients), hematoma (1 patient), and seroma (8 patients). Two seroma cases required debridement and open surgery, while spontaneous resolution occurred in approximately 28 days for others. No recurrences were observed. Mean hospital stay was 1 day, return to daily activities was 3 days, and mean satisfaction level (VAS scale) was 8.5. Postoperative pain scores (VAS) were significantly lower than preoperative scores.

Conclusion: Laser ablation is a minimally invasive, effective, and safe treatment for PSD. Further research is needed on long-term recurrence rates and factors such as obesity and multiple sinus tracts.

Keywords: Laser ablation, minimally invasive surgery, pilonidal sinus

Table 1.

Parameter	Results
Mean age	28.5±7.2 years (18-45)
Gender distribution	33 male (78.6%), 9 female (21.4%)
Sinus types	Type 1: 18 patients, type 2: 24 patients
Mean operative time	25±8.5 minutes
Complications	2 abscesses, 1 hematoma, 8 seromas (2 requiring debridement and open pilonidal sinus surgery)
Recurrence rate	0
Mean hospital stay duration	1 day
Mean return to daily activities duration	3 days
Mean satisfaction level (VAS)	8.5
Postoperative mean pain score (mean ± SD)	2.1±1.5 (0-5)

SD: Standard deviation, VAS: Visual analog scale.

Figure 1. Laser application in pilonidal sinus.

Figure 2. Mechanical brushing to eliminate debris after laser treatment.

[P-609]

A rare condition after parathyroid cancer surgery: Persistent hypocalcemia following hypercalcemia

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Objective: Parathyroid cancer accounts for less than 1% of primary hyperparathyroidism cases. It is a rare endocrine pathology. Most patients present with markedly elevated serum calcium (Ca) and parathyroid hormone (PTH). Surgery is the gold standard treatment. Definitive diagnosis is by histopathology. Although Ca and PTH generally normalize after surgery, persistent or recurrent hypercalcemia—or persistent hypocalcemia—may develop. We aimed to draw attention to this rare entity by presenting our patient who developed persistent hypocalcemia following parathyroid cancer surgery.

Material and Methods: An 89-year-old male patient presenting to the neurology department with forgetfulness and dizziness was referred to the endocrinology outpatient clinic after labs revealed serum Ca 11.3 mg/dL. The patient was diagnosed with primary hyperparathyroidism and referred to our department for surgical management. During the operation, multiple nodules were observed in both thyroid lobes, as well as a soft tissue mass at the mid-upper level of the left thyroid lobe, whose borders could not be clearly distinguished from the thyroid (invasion) (Figure 1). An incisional biopsy specimen was obtained from this area and evaluated by frozen section, which reported oncocytic cells invading the thyroid. Thereupon, a bilateral total thyroidectomy with right central lymph node dissection was performed en bloc, including the aforementioned soft tissue mass.

Results: The patient's preoperative serum Ca was 12.3 mg/dL and PTH was 263 pg/mL. Neck ultrasonography showed bilateral isoechoic solid nodules (largest 2 cm in the left lobe) and a 18×14 mm irregular nodular lesion in the posterior mid-portion of the left lobe (parathyroid lesion). Parathyroid scintigraphy demonstrated focal uptake in the upper pole of the left thyroid lobe, consistent with hyperfunctioning parathyroid tissue. En bloc left superior parathyroidectomy and bilateral total thyroidectomy were performed. Postoperative Ca and PTH levels on day 1, month 1, and month 6 were 7.3 mg/dL and <1 pg/mL; 8 mg/dL and 23 pg/mL; and 8.1 mg/dL and 22 pg/mL, respectively. The patient was discharged on postoperative day 4 with oral Ca and vitamin D (1000 mg/880 IU) three times daily. Pathology revealed "parathyroid carcinoma infiltrating the thyroid" (Figure 2). He remains under close endocrinology follow-up, and the Ca dose was reduced to twice daily at month 6.

Conclusion: Parathyroid carcinoma is a rare endocrine malignancy diagnosed definitively by histopathology. Imaging findings and markedly elevated serum Ca and PTH levels may raise suspicion. Although these levels usually normalize postoperatively, hungry bone syndrome and persistent hypocalcemia may rarely occur. Close multidisciplinary follow-up is recommended.

Keywords: Carcinoma, hypercalcemia, parathyroid

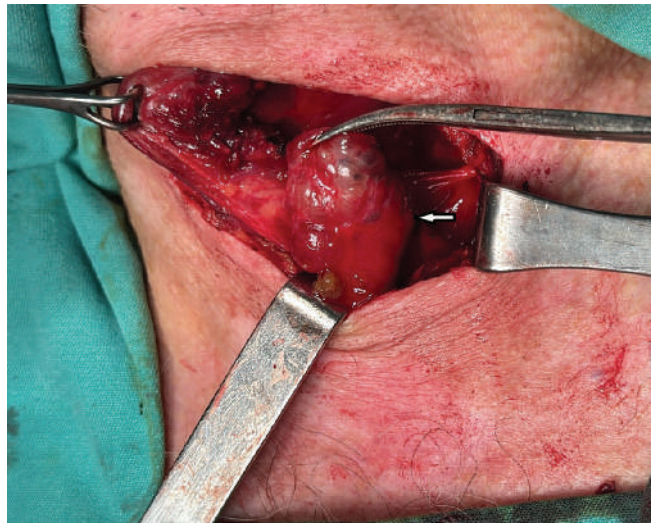

Figure 1. The lesion (marked with the white arrow) cannot be clearly distinguished from the left lobe of the thyroid.

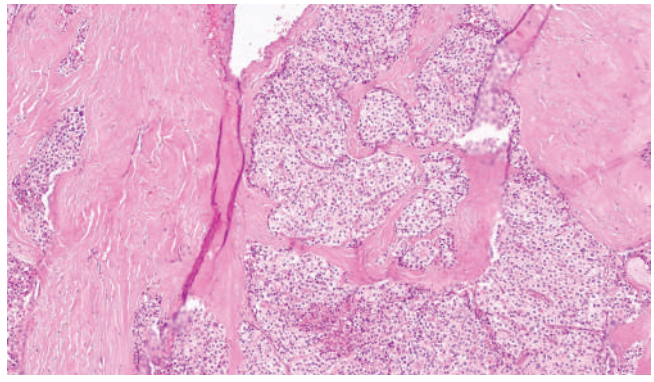

Figure 2. H&E ×100; A rare condition following parathyroid cancer surgery; from hypercalcemia to persistent hypocalcemia.vv

[P-615]

Inflammatory breast cancer: A single-center experience

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Objective: This retrospective study included a total of 24 patients diagnosed with inflammatory breast cancer (IBC) between 2023 and 2025 who underwent surgical treatment following neoadjuvant chemotherapy (NAC). The patients' demographic characteristics, tumor biology, response to neoadjuvant therapy, type of surgical intervention, axillary surgical approach, and pathological response rates were examined. Pathological complete response (pCR) was defined as the absence of invasive tumor in both the primary tumor site and the axilla. Disease course and survival data were evaluated retrospectively.

Material and Methods: Patients diagnosed with IBC between 2023 and 2025 were included in this retrospective study. Demographic data, clinical and pathological features, treatments administered, disease progression, recurrence, metastasis status, and survival data were retrieved from patient medical records. Overall survival and progression-free survival were analyzed using the Kaplan-Meier method. Data were evaluated using descriptive statistics.

Results: All patients received trimodality therapy consisting of surgery and adjuvant radiotherapy after NAC. pCR was achieved in 6 patients (25%). In the axillary evaluation, node negativity was detected in 62.5% of the patients. Among the 16 patients who underwent Sentinel Lymph Node Biopsy (SLNB), 8 (50%) were found to be axilla-negative. It was observed that axillary involvement rates were lower in patients who achieved pCR. Local recurrence in the axilla was observed in one patient, and brain metastasis was detected in another patient during the first postoperative year.

Conclusion: Trimodality therapy provides significant pathological response rates in patients with IBC. The 25% pCR rate obtained in our series is consistent with the literature and supports the efficacy of neoadjuvant therapy. The high rates of axillary node negativity support current discussions in the literature suggesting that axillary surgery may be limited in selected patients. The axillary approach in IBC may be re-evaluated, subject to confirmation by larger series.

Keyword: Inflammatory breast cancer

Table 1. Clinical outcomes and pathological responses

Characteristic/finding	n	Percentage (%)
Pathological complete response (pCR)	6	25.0%
Axillary status		
Overall node negativity	15	62.5%
Sentinel lymph node biopsy (SLNB) performed	16	66.7%
Negative SLNB (among SLNB group)	8	50.0%
Recurrence and metastasis		
Local axillary recurrence	1	4.2%
Brain metastasis (1st year)	1	4.2%

n=24.

[P-616]

Fournier gangrene in a tertiary surgical center: Patterns of microbiology, antibiotic resistance, and risk stratification

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Objective: Fournier gangrene represents one of the most fulminant soft-tissue infections, originating in the perineal and genital regions and spreading rapidly along fascial planes. Identifying causative microorganisms and their antimicrobial susceptibility is essential to guide empirical therapy and improve outcomes.

Material and Methods: This retrospective study was conducted at University of Health Sciences Türkiye, Ankara Etlik City Hospital, General Surgery Clinic between October 2022 and May 2025. Of 59 operated patients, 30 with complete clinical and microbiological data and available wound cultures were included. Demographic features, microbiological profiles, antibiotic susceptibility, and fournier's gangrene severity index (FGSI) scores were analyzed.

Results: The mean age was 59.2 years (range: 45-84), with male predominance (56.7%). Nearly half of the patients were aged 50-59 years (46.7%). Wound cultures demonstrated monomicrobial growth in 50.0%, polymicrobial in 26.7%, and no growth in 23.3% (Figure 1). *Escherichia coli* was the most common pathogen (52.9%), followed by *Klebsiella pneumoniae* (8.8%), while anaerobes were rarely isolated. Resistance rates reached 41.4% in Gram-positive and 38.3% in Gram-negative organisms. Amikacin (100%) and carbapenems (>80%) exhibited the highest susceptibility, whereas fluoroquinolones and aminopenicillins showed resistance above 40% (Figure 2). Based on FGSI, 93.3% of patients were classified as low risk (FGSI <9) and 6.7% as high risk (FGSI ≥9).

Conclusion: *E. coli* was the predominant pathogen in Fournier gangrene, accompanied by considerable resistance to widely used antibiotics. Aminoglycosides and carbapenems remain the most reliable empirical options. Although most patients presented with low FGSI scores, the presence of resistant isolates emphasizes the need for region-specific antibiotic stewardship and comprehensive multidisciplinary management.

Keywords: Fournier gangrene, necrotizing fasciitis, microbiology, antibiotic resistance, empirical therapy

CATEGORY	MICROORGANISM	N	%
GENERAL CLASSIFICATION	Monomicrobial	15	50.0
	Polymicrobial	8	26.7
	No growth	7	23.3
AEROBIC / FACULTATIVE ANAEROBIC	**Gram-positive**		
	Staphylococcus aureus	1	2.9
	Streptococcus pneumoniae	2	5.9
	Streptococcus anginosus	2	5.9
	Streptococcus constellatus	1	2.9
	Enterococcus faecium	2	5.9
	Corynebacterium amycolatum	1	2.9
	Gram-negative		
	Escherichia coli	18	52.9
	Klebsiella pneumoniae	3	8.8
	Proteus mirabilis	1	2.9
	Pseudomonas aeruginosa	1	2.9
ANAEROBIC (OBLIGATE / PREDOMINANT)	**Gram-positive**		
	Actinomyces naeslundii	1	2.9
	Schaalia turicensis	1	2.9
	Gram-negative	—	0.0

Figure 1.

Antibiotic	*Tested (n)*	*Susceptible (n, %)*	*Resistant (n, %)*
Amikacin	12	12 (100.0)	0 (0.0)
Teicoplanin	1	1 (100.0)	0 (0.0)
Penicillin G	1	1 (100.0)	0 (0.0)
Clindamycin	1	1 (100.0)	0 (0.0)
Gentamicin	19	16 (84.2)	2 (10.5)
Imipenem	12	10 (83.3)	2 (16.7)
Meropenem	10	8 (80.0)	2 (20.0)
Ceftazidime	17	13 (76.5)	4 (23.5)
Ertapenem	7	5 (71.4)	2 (28.6)
Trimethoprim–Sulfamethoxazole	15	10 (66.7)	5 (33.3)
Piperacillin–Tazobactam	15	10 (66.7)	5 (33.3)
Ceftolozane–Tazobactam	3	2 (66.7)	1 (33.3)
Tigecycline	3	2 (66.7)	1 (33.3)
Cefuroxime	19	11 (57.9)	8 (42.1)
Levofloxacin	14	8 (57.1)	6 (42.9)
Ceftriaxone	18	10 (55.6)	8 (44.4)
Cefepime	13	7 (53.8)	6 (46.2)
Ciprofloxacin	16	8 (50.0)	8 (50.0)
Amoxicillin–Clavulanate	14	7 (50.0)	7 (50.0)
Vancomycin	2	1 (50.0)	1 (50.0)
Colistin	2	1 (50.0)	1 (50.0)
Cefazolin	18	8 (44.4)	10 (55.6)
Ampicillin–Sulbactam	15	6 (40.0)	9 (60.0)
Ceftazidime–Avibactam	3	1 (33.3)	2 (66.7)
Ampicillin	19	6 (31.6)	13 (68.4)
Tetracycline	0	0 (0.0)	0 (0.0)
Erythromycin	0	0 (0.0)	0 (0.0)
Oxacillin	1	0 (0.0)	1 (100.0)

Figure 2.

[P-619]

An overlooked risk factor for anastomotic leakage in colorectal surgery: Vascular calcifications and mesenteric artery stenosis

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Objective: Anastomotic leakage (AL) is one of the most serious complications following colorectal surgery, significantly increasing postoperative morbidity and mortality. Although adequate tissue perfusion is essential for anastomotic healing, reliable and easily accessible preoperative risk predictors remain limited. Mesenteric artery stenosis and vascular calcifications detectable on routine preoperative computed tomography (CT) imaging are potential factors that may impair anastomotic perfusion but are often overlooked in clinical practice. The aim of this systematic review and meta-analysis was to evaluate the association between vascular pathologies assessed on preoperative CT and the risk of clinically relevant anastomotic leakage.

Material and Methods: This study was conducted as a systematic review and meta-analysis in accordance with PRISMA guidelines. Observational studies evaluating mesenteric artery stenosis (inferior and/or superior mesenteric artery) and abdominal aortic or aortoiliac calcification on preoperative CT imaging, and reporting anastomotic leakage after colorectal surgery, were included. Only clinically relevant anastomotic leaks classified as Grade B or C according to the International Study Group of Rectal Cancer (ISREC) were analyzed. Effect estimates were extracted as odds ratios (ORs) with 95% confidence intervals, and pooled using a random-effects model due to inter-study heterogeneity. Methodological quality was assessed using the Newcastle-Ottawa scale. PRISMA flow diagram illustrating the identification, screening, eligibility assessment, and inclusion of studies evaluating vascular calcification and anastomotic leakage following colorectal surgery.

Results: Seven observational studies involving more than 3.000 patients were included in the analysis. Mesenteric artery stenosis was significantly associated with an increased risk of anastomotic leakage. Inferior mesenteric artery stenosis was associated with more than a twofold increase in the risk of anastomotic leakage. Although superior mesenteric artery stenosis was evaluated in a smaller number of studies, the available data indicated a strong association with increased leakage risk. The presence of abdominal aortic and aortoiliac calcification was also significantly associated with a higher risk of anastomotic leakage. In studies using the Aortic Calcification Index, increased calcification burden was identified as an independent risk factor for anastomotic leakage. Despite methodological heterogeneity, the direction of effect was consistent across studies.

Conclusion: Mesenteric artery stenosis and vascular calcifications detected on preoperative CT imaging are associated with an increased risk of clinically relevant anastomotic leakage following colorectal surgery. Systematic evaluation of vascular structures on routine preoperative imaging may enhance risk stratification and support surgical decision-making. This approach may facilitate individualized surgical strategies, particularly in patients at high risk for anastomotic leakage.

Keywords: Anastomotic leak, arterial occlusive diseases, colorectal surgery, mesenteric arteries, vascular calcification

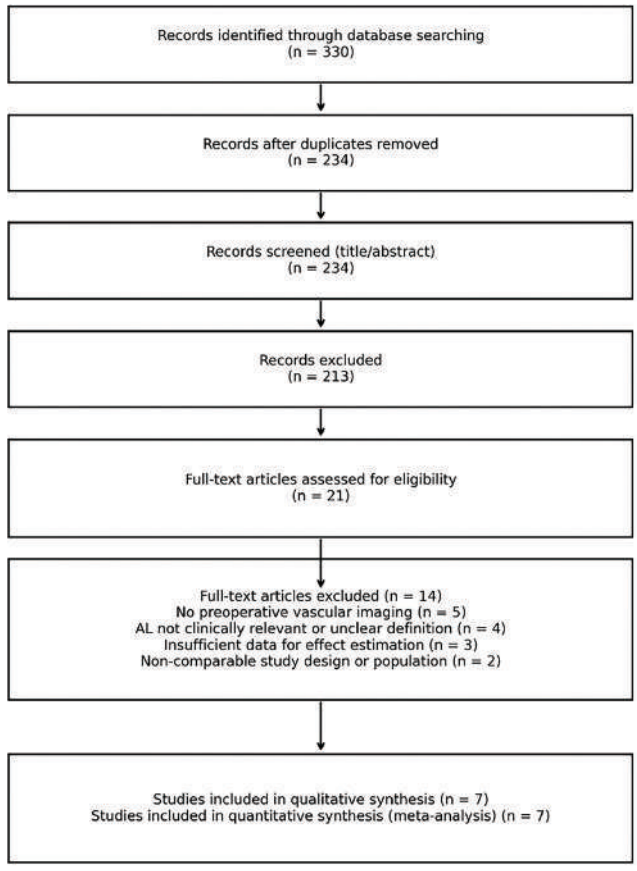

Figure 1. PRISMA flow diagram.

AL: Anastomotic leakage.

Table 1. Characteristics of studies included in the meta-analysis

First author (year)	Country	Study design	Sample size (AL / total)	Type of surgery	Anastomotic location	Vascular assessment (CT)	Exposure definition	AL definition	Effect estimate
Komen (2011)	Netherlands	Retrospective cohort	11/122	Colorectal resection	Colon/rectum	Aortoiliac calcium scoring	Aortoiliac calcium score	Clinical AL	OR 1.23 (95% CI 1.01-1.49)
Eveno (2016)	France	Prospective cohort	6/60	Left-sided colorectal surgery	Colon/rectum	Abdominal aortic calcification score	Aortic calcification score	Clinical AL	OR 1.31 (95% CI 1.08-1.59)
Shen (2019)	China	Retrospective cohort	33/423	Anterior resection for rectal cancer	Rectum	Aortic Calcification Index (ACI)	ACI (continuous)	ISREC Grade B-C	OR 2.39 (95% CI 1.05-5.44)
Morita (2021)	Japan	Retrospective cohort	16/98	Laparoscopic colorectal surgery	Colon/rectum	Aortic calcification volume	Calcification volume (%)	Clinical AL	OR 1.09 per 1% increase
Arron (2022)	Netherlands	Retrospective cohort	76/1273	Left-sided colon and rectal cancer surgery	Colon/rectum	Mesenteric artery evaluation	IMA stenosis ≥70%	Clinical AL	Narratively reported significant association (no extractable OR)
Harmankaya (2024)	Netherlands	Case–control	130/757	Colorectal resection	Colon/rectum	Mesenteric artery stenosis	IMA ≥50%, SMA ≥50%	ISREC Grade B-C	IMA: OR 2.11 (1.11-3.63); SMA: OR 5.91 (2.78-12.60)
Turhan (2025)	Türkiye	Retrospective cohort	9/151	Colorectal cancer surgery	Colon/rectum	Abdominal aortic calcification	Aortic calcification >50%	Clinical AL	OR 10.38 (95% CI 1.24-92.12)

AL: Anastomotic leakage, CT: Computed tomography, IMA: Inferior mesenteric artery, SMA: Superior mesenteric artery, ISREC: International Study Group of Rectal Cancer, OR: Odds ratio, CI: Confidence interval.

[P-621]

A rare pathology in patients operated with a pre-diagnosis of acute appendicitis: Analysis of our cases of appendiceal endometriosis

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Objective: Appendiceal endometriosis is a rare pathology, particularly observed in women of reproductive age, which frequently mimics the clinical presentation of acute appendicitis. Preoperative diagnosis is often not feasible, and the definitive diagnosis is established through histopathological examination. In this study, we aimed to evaluate the clinical, radiological, and histopathological characteristics of cases operated with a preliminary diagnosis of acute appendicitis and subsequently diagnosed with appendiceal endometriosis based on pathology results.

Material and Methods: Ten female patients who underwent surgery with a preliminary diagnosis of acute appendicitis and were histopathologically diagnosed with appendiceal endometriosis at our clinic between October 2022 and October 2025 were retrospectively reviewed. Demographic data, presenting complaints, imaging findings, intraoperative observations, and histopathological results were analyzed.

Results: The mean age of the patients was 37.1 years (range: 21-57). All cases presented with right lower quadrant pain; anorexia and nausea were recorded as the most common associated symptoms. In imaging studies, findings consistent with acute appendicitis were observed in the majority of cases, while pelvic inflammatory disease or cystic lesions were additionally detected in two cases. Histopathological examination identified endometriosis foci in all cases, and ER, PR, and CD10 positivity was determined immunohistochemically. In the majority of cases, significant inflammatory changes accompanying acute appendicitis and edema in the periappendiceal adipose tissue were observed.

Conclusion: Appendiceal endometriosis, although rare, is a significant pathology that can clinically mimic acute appendicitis in women of reproductive age and is often indistinguishable during the preoperative period. Especially in the presence of accompanying pelvic inflammatory findings or suspected gynecological pathology, keeping it in mind for the differential diagnosis of acute appendicitis may reduce unnecessary diagnostic delays and potential recurrent admissions. Careful histopathological evaluation of the appendectomy specimen, and confirmation with immunohistochemical markers such as ER, PR, and CD10 when necessary, is of critical importance for a definitive diagnosis and for guiding the management of the potential associated endometriosis burden. Therefore, adopting a standardized assessment approach between surgical and pathology teams will strengthen clinical management.

Keywords: Endometriosis, acute appendicitis, abdominal pain, histopathology, appendiceal endometriosis, immunohistochemistry

Table 1. Common characteristics of appendiceal endometriosis cases

Özellik	Bulgular
Toplam olgu sayısı	10
Yaş aralığı (yıl)	21–57 (ort. 37,1)
Cinsiyet	Haliyle kadın
Başvuru şikâyeti	En sık sağ alt kadran ağrısı; eşlik eden bulantı/iştahsızlık yaygın
Görüntüleme	Çoğunda akut apandisit lehine bulgular; 2 olguda ek pelvik inflamasyon/kistik lezyon
Operasyon tipi	6 laparoskopik, 4 açık apendektomi (1'i ek salpenjektomi)
Histopatoloji	Tümünde endometriozis odağı, çoğunda eşlik eden inflamatuvar değişiklikler
İmmünohistokimya	ER(+), PR(+) ve CD10(+) pozitifliği yaygın
Ortak klinik mesaj	Akut apandisit ön tanısıyla opere edilen reprodüktif çağ kadınlarda, jinekolojik bulgular eşlik ediyorsa endometriozis akılda tutulmalı

Table 2. Comparison of appendiceal endometriosis cases with the current literature

Çalışma	Yıl	Olgu Sayısı (n)	Ortalama Yaş	Klinik Sunum	Preop Tanı	Histopatoloji	İmmünohistokimya	Öne Çıkan Mesaj
Uohara ve ark.	2018	7	35	Akut apandisit benzeri karın ağrısı	Çoğunlukla akut apandisit	Appendiks duvarında endometriozis	ER(+), PR(+), CD10(+)	Appendiks endometriozisi akut apandisiti klinik olarak taklit eder
Slesser ve ark.	2013	9	34	Sağ alt kadran ağrısı, bulantı	Preop tanı zor	Endometriozis + inflamasyon	Belirtilmemiş	Reprodüktif çağ kadınlarda ayırıcı tanıda mutlaka düşünülmeli
Gunes ve ark.	2016	5	38	Akut batın	Yanlışlıkla akut apandisit	Submukozal endometriozis	ER(+), PR(+)	Kesin tanı yalnızca histopatoloji ile konur
Emre ve ark.	2013	6	36	Apandisit kliniği	Preop tanı yok	Endometriozis odağı	CD10(+)	Jinekolojik eşlik eden patolojiler uyarıcı olabilir
Machado ve ark. (derleme)	2020	140+	30–40	%70 akut apandisit benzeri	Çok nadiren preop	Çoğu serozal/submukozal	ER/PR/CD10 yaygın	Nadir ama klinik önemi yüksek bir patoloji
Bizim Çalışmamız	**2025**	**10**	**37,1**	**Tüm olgularda sağ alt kadran ağrısı**	**Tamamı akut apandisit ön tanısı**	**Tümünde endometriozis + inflamasyon**	**ER(+), PR(+), CD10(+)**	**Pelvik/jinekolojik bulgular tanı ihtimalini artırabilir; histopatoloji kritiktir**

[P-622]

EUS-guided RFA treatment may be an alternative for small liver metastasis: A case report

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Objective: The liver is the most frequent site for colorectal cancer metastasis, and various management options exist for these patients. While surgical resection is the curative standard for resectable metastases, ablation techniques have emerged as a significant alternative in selected cases. Guidelines recommend ablation for small lesions (<3 cm). In this way, ablation serves as an alternative approach that may protect the patient from major surgery and its associated risks. Radiofrequency ablation (RFA) is a widely utilized method among these techniques. Although RFA is commonly performed percutaneously, EUS-guided application for pancreatic, adrenal, and liver lesions is considered as a safe alternative. This method can be considered an effective treatment option for metastatic liver lesions, as well as primary hepatobiliary malignancies. Here we share our experience with EUS-guided RFA for a metastatic liver focus that showed regression after systemic therapy.

Material and Methods: A 65-year-old-male presented with abdominal pain and difficulty in defecation. Examinations revealed 28 cm rectosigmoid lesion circumferentially narrowing the lumen. Biopsy confirmed adenocarcinoma. Contrast-enhanced CT detected wall thickening in the rectosigmoid region, suspicious pericolic lymph nodes, and 21x17mm metastatic lesion in liver segments 8 and 4a (cT3N2bM1a) (Figure 1). No pulmonary metastases were observed. Systemic therapy was initiated. After 6 cycles of FOLFIRINOX + bevacizumab, imaging showed near-complete regression in the liver and partial regression in the primary mass. The multidisciplinary tumor board planned primary tumor resection and RFA for the liver lesion.

Results: In the patient scheduled for laparoscopic low anterior resection (LAR) and intraoperative RFA, the liver lesion—undetected on preoperative USG—was localized with difficulty using intraoperative laparoscopic USG. However, since the posterior right lobe lesion was technically unsuitable for percutaneous or laparoscopic intervention, ablation was postponed to the postoperative period. The LAR procedure was completed without complications. Postoperative pathology reported adenocarcinoma, ypT3N1bMx, Grade 2. On the 6th postoperative day, the patient underwent ablation with RFA at 50W for 10 seconds on an 11x10 mm hypoechoic lesion observed in liver segment 8 via transgastric EUS guidance (Figure 2). The patient was discharged on day 7 without complications. After completing a total of 12 cycles of adjuvant FOLFIRINOX treatment, capecitabine + bevacizumab was initiated as maintenance therapy.

Conclusion: EUS-assisted RFA is a valuable alternative for liver metastases that could not be reached intraoperatively due to anatomical locations. As in this case, when percutaneous or intraoperative ablation is unfeasible, postoperative EUS-RFA may be a viable treatment option.

Keywords: Colorectal cancer, colorectal cancer liver metastasis, endoscopic ultrasound (EUS), radiofrequency ablation (RFA)

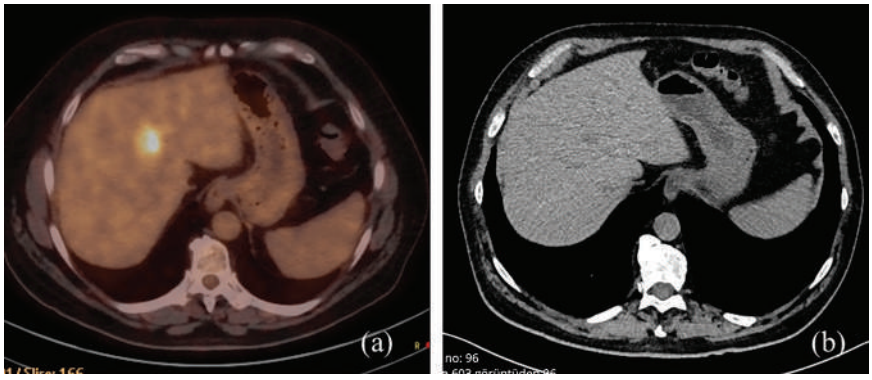

Figure 1. Liver metastasis observed in the mid-treatment PET-CT scan (a) and the lesion that is difficult to distinguish in the post-treatment sectional imaging (b).

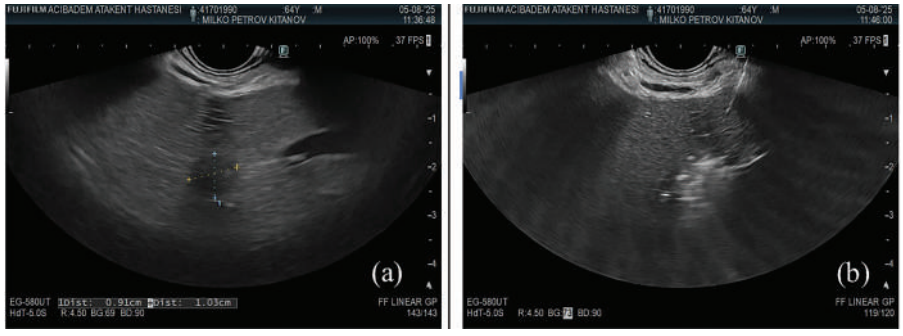

Figure 2. Anatomical localization of the lesion via EUS (a) and the RF ablation procedure performed through a transgastric approach (b).

[P-623]

Bibliometric analysis of the Turkish publications on the inflammatory bowel disease surgery

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Objective: Inflammatory bowel disease (IBD), which includes ulcerative colitis and Crohn's disease, frequently requires surgical intervention due to complications or the ineffectiveness of medical therapy during disease course. Recently, Türkiye has become a notable contributor to the global literature on IBD surgery; however, a comprehensive analysis of the characteristics and impact of these publications is lacking. This study aims to systematically explore the publication trends, research focus, and institutional contributions of Turkish authors in the field of IBD surgery.

Material and Methods: A bibliometric analysis was conducted using data extracted from the Scopus database, specifically targeting publications related to IBD surgery with at least one author affiliated with a Turkish institution. The dataset comprised detailed metadata, including author names, full affiliations, article titles, publication years, document types, keywords, citation counts and journal information. Data cleaning and preprocessing were performed in Python, involving the normalization of author and institution names and the extraction of pertinent keywords.

Results: The analysis revealed that the majority of Turkish-authored publications on IBD surgery were original research articles, with "inflammatory bowel disease," "ulcerative colitis," and "Crohn's disease" being the most common keywords. The annual publication output has steadily increased, indicating growing research activity. The most productive authors were affiliated with major academic centers in Türkiye, particularly İstanbul and Ankara. Institutional analysis indicated that Turkish universities and departments of gastroenterology and general surgery were the primary contributors to this research. Collaboration networks demonstrated both strong intra-national and notable international partnerships, especially with the United Kingdom and Italy. Research topics have extended beyond surgical techniques to encompass management, pregnancy, colonoscopy, and comorbid conditions such as familial Mediterranean fever.

Conclusion: This bibliometric study provides a detailed characterization of Turkish contributions to the literature on IBD surgery. The findings underscore Türkiye's prominent and expanding role in this field, the diversity of research topics, and the significance of national and international collaboration. These insights can inform future research strategies and foster advancements in IBD surgery.

Keywords: Crohns disease, inflammatory bowel disease, Turkish, ulcerative colitis

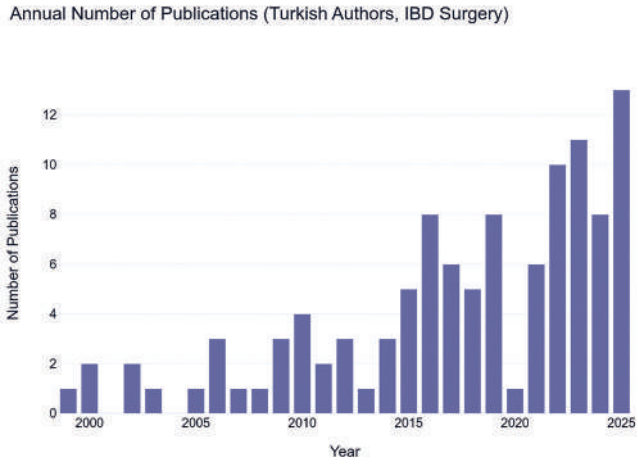

Figure 1. Annual number of publications.

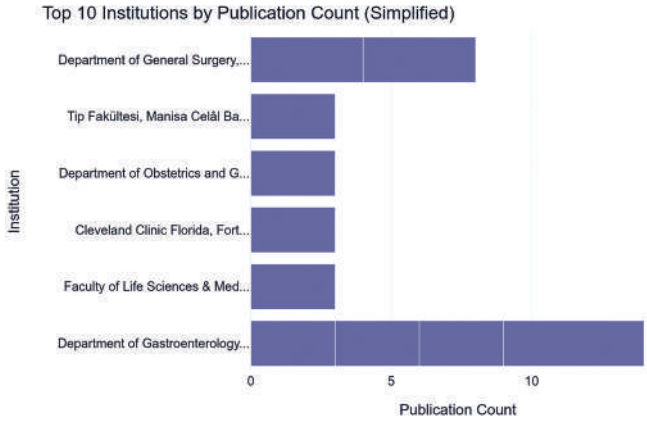

Figure 2. Top institutions.

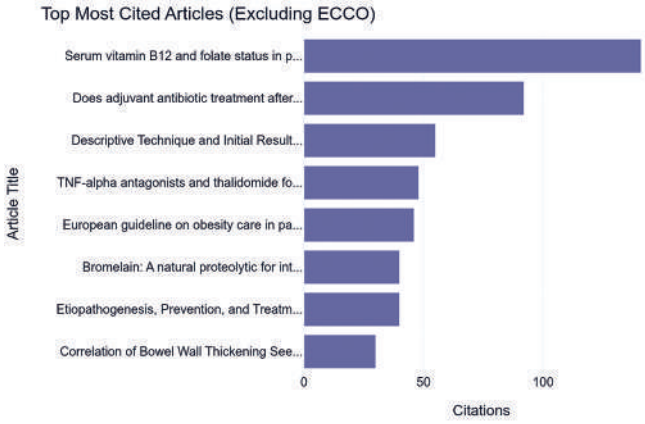

Figure 3. Most cited articles.

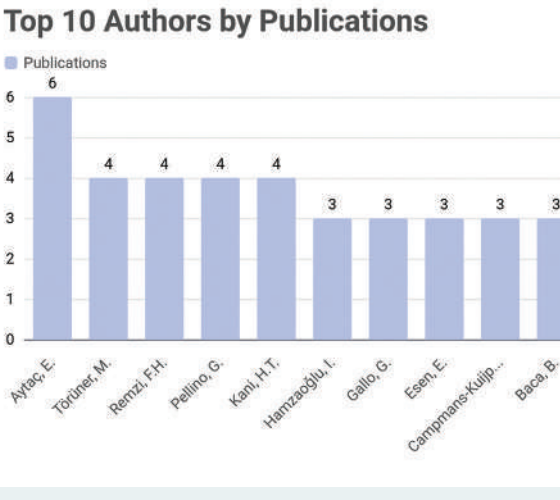

Figure 4. Top authors in the field.

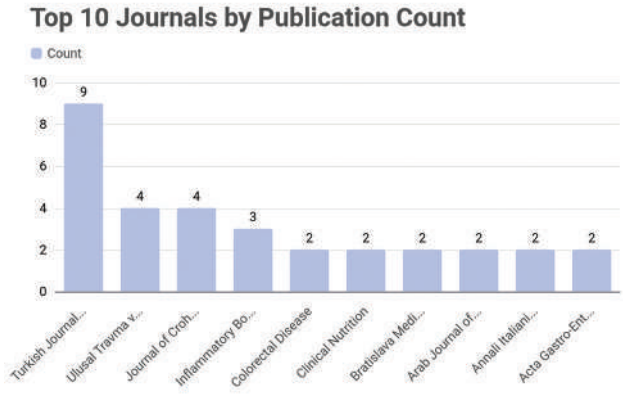

Figure 5. Top journals in the field.

[P-624]

The relationship between clinical, radiological, and laboratory findings and clinical course in Ogilvie syndrome: A single-center case series

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Objective: Acute colonic pseudo-obstruction (ogilvie syndrome) is a clinical condition that often developes under advanced age, severe comorbidities, and systemic stress. In cases of delayed diagnosis and treatment, it can lead to significant morbidity and mortality. This study aimed to evaluate the demographic characteristics, triggering factors, clinical-radiological findings, laboratory parameters, treatment approaches, and short-term clinical outcomes of patients diagnosed with ogilvie syndrome.

Material and Methods: A total of 5 patients diagnosed with ogilvie syndrome who were followed up in the general surgery clinic of etlik city hospital were included in this retrospective observational study. Demographic data, ASA score, Charlson comorbidity index categories, possible triggering factors, and medication use were recorded. Clinical presentation findings, cecum diameter measurements in radiological evaluation, and imaging findings for excluding mechanical obstruction were examined. Laboratory parameters, including serum electrolyte levels, albumin, and lactate values, were used to assess metabolic status. Treatment approaches (conservative monitoring, neostigmine administration, colonoscopic decompression, and surgical intervention), recurrence rates, and 30-day mortality were analyzed. The data were presented using descriptive statistics.

Results: A total of 5 patients with ogilvie syndrome were included. Median age was 88 (46-93), 60% male. All had high-risk profiles (ASA ≥3: 100%), distributed asa 3 (40%) and ASA 4 (60%). Charlson comorbidity index: 0 (1 patient), 4 (2 patients), 5 (2 patients). ICU/immobilization was a trigger in 20% of cases; others were in "other" category (80%). All had abdominal distention, pain, and constipation, with vomiting in 80%. Laboratory results: median WBC 10.2/mm^3, CRP 85 mg/L, lactate 2.04 mmol/L, albumin 38.6. No electrolyte disturbances. Radiological exam: median cecum diameter 10.0 cm, transverse colon 7.5 cm; mechanical obstruction excluded. Conservative treatment in 40%, decompression tubes in 80%, colonoscopic decompression in 20%, surgery in 20%. 60% responded in 24 hours. No recurrence at 72 hours or 7 days. 30-day mortality 60%.

Conclusion: This study confirms that ogilvie syndrome occurs in elderly patients with high comorbidity, but can also present with severe clinical course without classic triggering factors like electrolyte imbalances. Systematic exclusion of mechanical obstruction, careful evaluation of cecum diameter, and interpretation with clinical presentation were decisive in diagnosis and treatment. Laboratory parameters such as albumin and lactate reflected disease severity and systemic stress. Treatment approaches were individualized, and while no recurrence was found, the high mortality rate was more related to the heavy comorbidity burden than ogilvie syndrome itself. These findings support the importance of early diagnosis, close monitoring, and a comprehensive approach with clinical, radiological, and laboratory data.

Keywords: Acute colonic pseudo-obstruction, cecal diameter, colonoscopic decompression, comorbidity, Ogilvie syndrome

Table 1. Clinical characteristics and presenting findings

TABL O1. DEMOGRAFİK VE KLİNİK RİSK ÖZELLİKLERİ (N = 5)

PARAMETRE	DEĞER
YAŞ, YIL – MEDYAN(MİN–MAKS)	88 (46–93)
ERKEK, N (%)	3 (60)
KADIN, N (%)	2 (40)
ASA 3, N (%)	2 (40)
ASA 4, N (%)	3 (60)
ASA ≥3, N (%)	5 (100)
CHARLSON KOMORBİDİTE İNDEKSİ (SINIF), N (%)	
0	1 (20)
4	2 (40)
5	2 (40)

TABL O2. TETİKLEYİCİ FAKTÖRLER, İLAÇ KULLANIMI VE KLİNİK BAŞVURU BULGULARI

A. TETİKLEYİCİ FAKTÖRLER

FAKTÖR	N (%)
POSTOPERATİF	0
TRAVMA	0
SEPSİS / ENTEKSİYON	0
DOĞUM / SEZARYEN	0
ICU / İMMOBİLİZASYON	1 (20)
DİĞER	4 (80)

B. İLAÇ KULLANIMI

İLAÇ	N (%)
OPİOİD	0
ANTİKOLİNERJİK	0
SEDATİF / ANTİPSİKOTİK	2 (40)

C. KLİNİK BAŞVURU BULGULARI

BULGU	N (%)
ABDOMİNAL DİSTANSİYON	5 (100)
ABDOMİNAL AĞRI	5 (100)
BULANTI	5 (100)
KUSMA	5 (100)
DEFEKASYON YOKLUĞU	5 (100)
GAZ ÇIKARAMAMA	5 (100)

TABL O3. RADYOLOJİK BULGULAR VE ELEKTROLİT DURUMU

A. RADYOLOJİ KDEĞERLENDİRME

PARAMETRE	N (%)
ÇEKUM ÇAPI <10 CM	2 (40)
ÇEKUM ÇAPI 10–12 CM	2 (40)
ÇEKUM ÇAPI >12 CM	1 (20)
BT'DE MEKANİK OBSTRÜKSİYON DIŞLANDI	5 (100)
KOLONOSKOPİDE MEKANİK OBSTRÜKSİYON DIŞLANDI	5 (100)

B. ELEKTROLİT VE METABOLİK DURUM

PARAMETRE	N (%)
HİPOKALEMİ	0
HİPOMAGNEZEMİ	0
ELEKTROLİT REPLASMAN TEDAVİSİ	5 (100)
24 SAAT İÇİNDE ELEKTROLİT NORMALİZASYONU	4 (80)

TABL O4. TEDAVİ YAKLAŞIMI, NÜKS VE KLİNİK SONLANIMLAR

PARAMETRE	N (%)
KONSERVATİF TEDAVİ	2 (40)
NEOSTİGMİN TEDAVİSİ	3 (60)
KOLONOSKOPİK DEKOMPRESYON	2 (40)
CERRAHİ MÜDAHALE	1 (20)
72 SAAT İÇİNDE NÜKS	0
7 GÜN İÇİNDE NÜKS	0
30 GÜNLÜK MORTALİTE	3 (60)

Table 2. Literature comparison

TABLO 5. GÜNCEL VE GÜVENİLİR LİTERATÜR İLE BİZİM ÇALIŞMAMIZIN KARŞILAŞTIRMASI

BAŞLIK	GÜNCEL/OTORİTE LİTERATÜR (ÖZET)	BİZİM OLGU SERİSİ (N=5)	BİZİM KATKIMIZ / YORUM (ÖLÇÜLÜ)
HASTA PROFİLİ VE RİSK ZEMİNİ	ACPO (OGİLVİE) ÇOĞUNLUKLA **YAŞLI, KOMORBİD,** POSTOPERATİF/İMMOBİLİZE/YOĞUN BAKIM HASTALARINDA GÖRÜLÜR; TEMEL YAKLAŞIM "YÜKSEK RİSKLİ HASTADA ERKEN TANI".	MEDYAN YAŞ **88**; ASA 2/3 **%100**; CHARLSON **4–5** SINIFI **%80**	SERİ, LİTERATÜRDEKİ **"FRAJİL, YÜKSEK KOMORBİDİTE"** PROFİLİNİ NET DOĞRULUYOR
TANI YAKLAŞIMI: MEKANİK OBSTRÜKSİYONU DIŞLAMA	YÖNETİM ALGORİTMALARI KLİNİK + GÖRÜNTÜLEME İLE **MEKANİK TIKANIKLIĞIN DIŞLANMASINI** TEMEL ŞART KABUL EDER.	**BT İLE DIŞLAMA %100**; KOLONOSKOPİ/LE DIŞLAMA BU SERİDE **İŞARETLİ DEĞİL**	"BT İLE SİSTEMATİK DIŞLAMA" GÜÇLÜ; ENDOSKOPİ HER OLGUDA ŞART DEĞİLDİR
ÇEKUM ÇAPI VE PERFORASYON RİSKİ	PERFORASYON/İSKEMİ RİSKİ, ÖZELLİKLE **ÇEKUM ÇAPI ≥10–12 CM** VE/VEYA DİSTANSİYON SÜRESİ UZADIKÇA ARTAR; EŞİKLERDE DAHA AGRESİF YAKLAŞIM ÖNERİLİR.	ÇEKUM ÇAPI **10,0 (9,3–13,0) CM**; >12 CM **EN AZ 1 OLGU**	BİZİM VERİ, **"KRİTİK EŞİKLERE YAKLAŞAN/ÜZERİNE ÇIKAN"** OLGULARIN OLDUĞUNU GÖSTERİYOR
İLK BASAMAK TEDAVİ	REHBERLERDE İLK BASAMAK: **KONSERVATİF** (MOBİLİZASYON, NPO, NG/REKTAL TÜP, ELEKTROLİT DÜZELTME VB.). YANIT YOKSA FARMAKOLOJİK (NEOSTİGMİN) VEYA ENDOSKOPİK DEKOMPRESYON.	KONSERVATİF **%40**; **DEKOMPRESYON TÜPÜ %80**	SERİDE **"TÜP/DEKOMPRESYON"**UN YÜKSEK ORANDA KULLANILMASI, PRATİKTE KONSERVATİF PAKETİN ANA BİLEŞENİ OLARAK UYGULANMIŞ OLABİLECEĞİNİ DÜŞÜNDÜRÜYOR.
NEOSTİGMİN VS KOLONOSKOPİK DEKOMPRESYON	ASGE KILAVUZU VE YENİ DERLEMELER, KONSERVATİFE YANITSIZ OLGUDA **KOLONOSKOPİK DEKOMPRESYONUN** EN AZ NEOSTİGMİN KADAR (BAZI ÇALIŞMALARDA DAHA) ETKİLİ OLABİLECEĞİNİ; ANCAK KANIT DÜZEYİNİN SINIRLI OLDUĞUNU VURGULAR.	NEOSTİGMİN: **%0**; KOLONOSKOPİK DEKOMPRESYON: **%20**	BU, "HER MERKEZDE HER ZAMAN NEOSTİGMİN UYGULANMIYOR" GERÇEĞİNİ YANSITIR.
KOMPLİKASYONLAR (PNÖMATOZİS/SERBEST HAVA/PERFORASYON/İSKEMİ)	KOMPLİKASYON GELİŞİMİ KÖTÜ PROGNOZLA İLİŞKİLİDİR; RİSK ARTIŞI ÇEKUM ÇAPI VE KLİNİK KÖTÜLEŞME İLE PARALELDİR.	PNÖMATOZİS/SERBEST HAVA/PERFORASYON/İSKEMİ: **0**	KÜÇÜK SERİDE "MAJÖR KOMPLİKASYON YOK" BULGUSU, MORTALİTENİN **OGİLVİE DIŞI SİSTEMİK HASTA YÜKÜ** İLE İLİŞKİLİ OLABİLECEĞİ ARGÜMANINI DESTEKLER
LABORATUVAR PARAMETRELERİ (ALBUMİN, LAKTAT VB.)	KILAVUZLAR DAHA ÇOK KLİNİK-GÖRÜNTÜLEME TEMELLİDİR; ANCAK KLİNİKTE **LAKTAT ARTIŞI** DOKU HİPOPERFÜZYONU/ŞİDDET GÖSTERGESİ OLARAK DEĞERLENDİRİLİR; DÜŞÜK ALBUMİN GENEL FRAJİLİTE/İNFLAMASYON YÜKÜNÜ YANSITABİLİR.	LAKTAT MEDYAN **2,04** (MAKS **10,93**); ALBUMİN MEDYAN **38,6** (MİN **24,3**)	BİZİM SERİNİN GÜÇLÜ TARAFI: ÇEKUM ÇAPI İLE BİRLİKTE **ALBUMİN-LAKTAT GİBİ "ŞİDDET/FRAJİLİTE" GÖSTERGELERİNİ** AYNI TABLODA KAYITLAYIP KLİNİK SEYİRLE BİRLİKTE SUNMASI
YANIT, NÜKS VE MORTALİTE	NÜKS, ÖZELLİKLE ENDOSKOPİK DEKOMPRESYON SONRASI GÖRÜLEBİLİR; CİDDİ KOMORBİDİTESİ OLAN HASTALARDA MORTALİTE YÜKSEK OLABİLİR	24/5 YANIT **%60**; NÜKS **0**; 30G MORTALİTE **%60**	"NÜKS YOK AMA MORTALİTE YÜKSEK" PATERNİ OGİLVIE'NİN KENDİSİNDEN ÇOK **HASTA YÜKÜ VE SİSTEMİK KIRILGANLIK** VURGUSUNU GÜÇLENDİRİR.

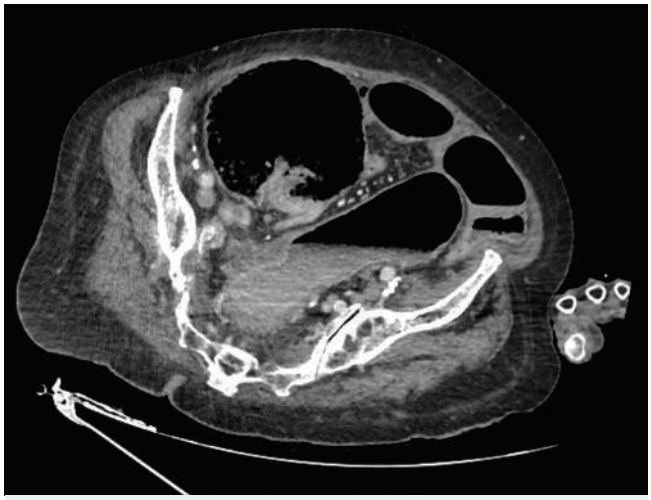

Figure 1. CT images.

Figure 2. CT images.

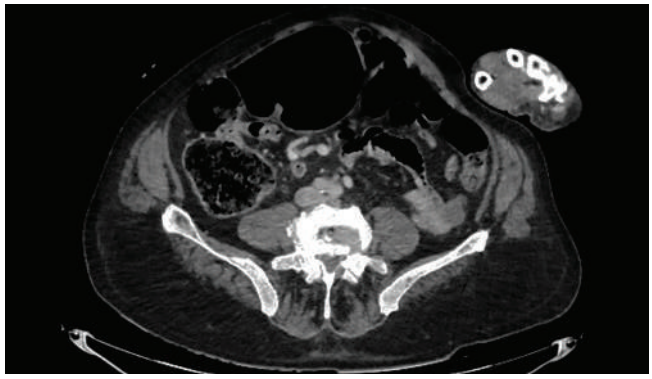

Figure 3. CT images.

[P-625]

FISSURE-CD (FISSUre in cRohn's disEase): International prospective multicentre observational study on the management and outcomes of anal fissure in Crohn's disease

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Objective: Perianal Crohn's disease research has predominantly focused on anal fistulas. However, in clinical practice, the first perianal manifestation is frequently an anal fissure. Current management strategies for Crohn's-related fissures are largely extrapolated from idiopathic fissure algorithms, despite fundamental differences in inflammatory pathobiology, tissue healing dynamics, and disease course. Existing guidelines provide safety frameworks for idiopathic fissures but offer no phenotype-driven strategy for Crohn's-associated fissures. This study aims to develop the first biology-centred, phenotype-based treatment selection model, shifting decision-making from procedure-orientated paradigms toward disease-specific stratification.

Material and Methods: This international prospective multicentre observational cohort study includes adult Crohn's disease patients diagnosed with anal fissures between June 2026 and June 2027 who meet the inclusion criteria. Patients will be followed for at least 6 months (optionally 12 months). Continuous variables will be summarised as mean ± SD or median (IQR); categorical variables as absolute and relative frequencies. Multilevel mixed-effects logistic regression and Cox frailty models will identify independent predictors, accounting for center clustering. Confounding will be addressed through prespecified adjustment and IPTW sensitivity analyses. Sample size was planned to provide ~80% power to detect a clinically meaningful difference in healing at α=0.05.

Results: The primary endpoint is clinical fissure healing rate and time following index fissure-directed treatment. Clinical healing is defined ASA documented macroscopic epithelialisation or absence of visible fissure on examination, with patient-reported pain ≤ 2/10 on the visual analogue scale (VAS) without analgesic use for ≥7 days. Resolution or minimal pain (VAS ≤ 2/10 or equivalent clinical documentation), c) No requirement for escalation within 12 weeks for medical therapy. The secondary endpoint is to evaluate symptom improvement, time to healing, treatment escalation, recurrence, and complications, HR-QoL change (IBDQ-short or EQ-5D-5L), and continence (Vaizey/Wexner score), as well as identify clinical and disease-related predictors of treatment success or failure.

Conclusion: This study aims to identify independent determinants of clinical improvement and the need for treatment escalation in anal fissures associated with Crohn's disease. Based on the findings, the goal is to develop a risk-based and phenotype-focused management algorithm for CD-related anal fissures. This will reveal the biological and clinical differences between this clinical presentation and idiopathic anal fissures; treatment strategies for patients with concomitant CD and anal fissures can be restructured according to disease activity and involvement characteristics.

Keywords: Anal fissure, clinical healing, Crohn's disease, Crohn's disease, anal fissure, idiopathic anal fissure

[P-626]

Organ transplant nursing operating room preparations

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Objective: Organ nakil ameliyatlarının en önemli özelliklerinden biri ameliyathane ortamının hazırlanması ve profesyonel bir ekip çalışmasının olmasıdır.

Material and Methods: Bu aşamada hemşirelik sanatının icra edilmesi, steril sahanın korunması önem arz etmektedir.

Results: Cerrahi sürenin etkili bir şekilde devam ettirilmesi için hemşirelik deneyimi oldukça önemlidir.

Conclusion: Bu çalışmada organ nakil ameliyathane hazırlıklarının hemşirelik bazın daki deneyimlerinden bahsedilecektir.

Keywords: Organ nakil, ameliyathane, hemşirelik

[P-627]

Can the surgery-to-resident ratio be used to determine the ideal number of residents in a general surgery training clinic? Single-center experience

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Objective: General surgery training requires significant clinical exposure for residents to acquire essential skills, knowledge, and experience. Successfully navigating the surgical learning curve and preparing for independent practice strongly depend on the volume of procedures residents actively perform. In our country, resident numbers are determined centrally; however, evaluating a clinic's educational carrying capacity objectively is crucial. Although adding residents can distribute workloads, it risks diluting the surgical cases available per resident if clinical capacity remains unchanged, ultimately compromising education quality. This study aims to examine the impact of resident numbers on surgical training quality and evaluate the surgery-to-resident ratio (SRR) as a systematic metric to determine the optimal number of residents.

Material and Methods: A retrospective analysis was conducted at the General Surgery Department of Gazi University Faculty of Medicine between 2012 and 2023. Data were evaluated across 48 three-month quarterly periods. The analysis included total surgeries under general anesthesia, appendectomies, upper endoscopies, and colonoscopies. Procedures under local anesthesia and residents serving less than three months were strictly excluded. The surgery-to-resident ratio (SRR) was calculated by dividing the total number of surgical procedures by the total number of active residents. To prevent statistical bias from the suspension of elective procedures, periods heavily affected by the COVID-19 pandemic were entirely excluded from the ideal number calculations

Results: Over the 48 periods, the resident count fluctuated between 12 and 26, averaging 18.69. As the number of residents increased, a steady, significant decline in total surgical cases per resident was observed. During the COVID-19 pandemic, total surgeries decreased significantly due to the restriction of elective cases (p=0.038). After excluding the pandemic periods, the SRR and resident totals were overlaid on a 3-axis chart. Statistical comparisons revealed that the SRR decreased significantly when the resident count exceeded 18 (p=0.032). This drop became even more pronounced when the resident count reached 21 (p=0.036). Based on these statistical intersection points and the current surgical volume, the ideal number of residents for our clinic was accurately determined to be 18.

Conclusion: Expanding the surgical resident workforce without concurrent enhancements to clinical resources—such as hospital beds and operating rooms—inevitably leads to educational inefficiencies. The SRR method provides an objective, evidence-based approach to determine the optimal number of residents, ensuring adequate case exposure. While 18 is unique to our specific institutional data, the SRR methodology can be readily adapted by other surgical training centers to maintain rigorous, high-quality surgical education standards globally.

Keywords: Surgery education, surgery-to-resident ratio, resident case exposure

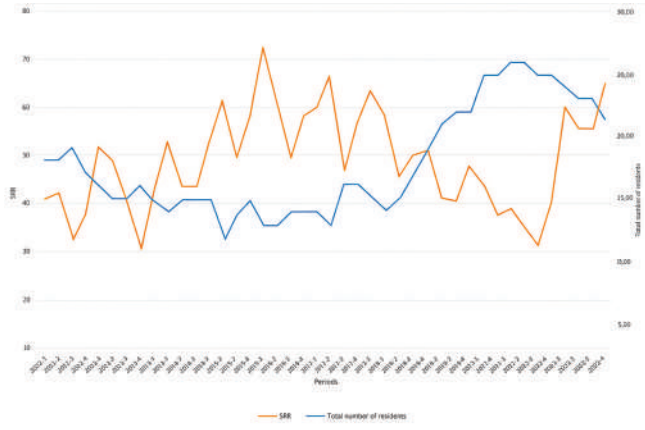

Figure 1.