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Message from the Board

It is with great honour that we present the **SURGICON 2026 Book of Abstracts**, a culmination of efforts made by passionate individuals towards the future of surgery.

SURGICON aims to bring together the brightest minds in surgery, unveiling groundbreaking research, innovative procedures and surgical advancements, while sharing their ideas with their fellow peers.

We extend our gratitude to the esteemed people involved in the making of **SURGICON 2026** for their invaluable contributions, and we trust that this book will serve as a source of inspiration and knowledge for everybody.

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TABLE OF CONTENTS

Oral Presentation 6

GIANT URETHRAL CALCULUS COMPLICATED BY URETHROCUTANEOUS FISTULA: A CASE PRESENTATION 7

ENDOVASCULAR OR OPEN REPAIR? RETHINKING AORTIC ARCH ANEURYSM SURGERY: SYSTEMATIC REVIEW 8

ENDOSCOPIC VACUUM THERAPY FOR GASTRIC CONDUIT LEAK FOLLOWING MCKEOWN ESOPHAGECTOMY: A CASE REPORT 9

GIANT ABDOMINAL SARCOMA REQUIRING MULTIVISCERAL EN BLOC RESECTION: A CASE PRESENTATION OF A 19.3-KG RETROPERITONEAL TUMOR 10

POSTOPERATIVE URINARY FUNCTIONAL OUTCOMES AFTER NERVE-SPARING SURGERY FOR DEEP INFILTRATING ENDOMETRIOSIS: A SYSTEMATIC REVIEW 11

360° RETINECTOMY FOR COMPLEX RETINAL DETACHMENT FOLLOWING TRAUMATIC POSTERIOR LENS DISLOCATION IN CONGENITAL GLAUCOMA: A CASE REPORT 12

PROPELLER FLAP RECONSTRUCTION OF POST-RADIOTHERAPY TRACHEOSTOMY DEFECT IN LARYNGEAL MALIGNANCY 13

REINFORCED VERSUS CLASSICAL (UNSUPPORTED) ROSS PROCEDURE IN ADULTS: A SYSTEMATIC REVIEW OF AUTOGRAFT DURABILITY 14

DISTAL RADIUS RECONSTRUCTION WITH PROXIMAL FIBULAR AUTOGRAFT FOLLOWING GIANT CELL TUMOR RESECTION: A CASE REPORT 16

LEARNING CURVES AND SKILL ACQUISITION IN LAPAROSCOPIC SUTURING AMONG NOVICES: A PROSPECTIVE INTERVENTIONAL STUDY 17

BILATERAL MIDDLE CEREBRAL ARTERY ANEURYSMS IN AN 8-YEAR-OLD CHILD WITH SEVERE AORTIC COARCTATION: A CHALLENGING ENDOVASCULAR CASE 18

WHEN IMMUNOTHERAPY COMES BEFORE SURGERY: COMPLETE PATHOLOGICAL RESPONSE IN DMMR COLON CANCER 19

LAPAROSCOPIC PANCREATICODUODENECTOMY FOR PANCREATIC HEAD MALIGNANCY: A CASE REPORT 20

OVERCOMING DIMENSIONS: TRANSPARIETAL RESECTION OF A GIANT INTRAVENTRICULAR MENINGIOMA 21

FROM TECHNIQUE TO TOPOGRAPHY: RETHINKING CONSERVATIVE SURGERY IN PLACENTA ACCRETA SPECTRUM – A LITERATURE REVIEW 22

Poster Competition 24

FROM DIAGNOSTIC DILEMMA TO DEFINITIVE SURGERY: ROBOTIC-ASSISTED MANAGEMENT OF URACHAL MUCINOUS ADENOCARCINOMA 25

A DUAL THREAT: VERMIAN PILOCYTIC ASTROCYTOMA COMPROMISING SIGHT AND SURVIVAL 26

THE HIDDEN COST OF A FALL: SECONDARY PSOAS ABSCESS IN A HEMIPLEGIC PATIENT 27

LIFE-THREATENING GASTROINTESTINAL BLEEDING FROM AN ILEAL GIST: A CASE PRESENTATION 28

ENCAPSULATED INTRAMUSCULAR LIPOMA OF THE TRAPEZIUS: A SURGICAL CASE REPORT 29

MANAGEMENT OF DIALYSIS ACCESS-ASSOCIATED STEAL SYNDROME PRESENTING WITH FOREARM PHLEGMON AND WET DIGITAL GANGRENE IN A CHRONIC HEMODIALYSIS PATIENT: A CASE REPORT 30

MULTIFOCAL PYOMYOSITIS WITH ACUTE END-ORGAN COMPLICATIONS: A CASE REPORT 31

NERVE-SPARING RETROPERITONEAL DISSECTION TECHNIQUES IN DEEP ENDOMETRIOSIS SURGERY: AN OBSERVATIONAL SYSTEMATIC REVIEW 32

SURGICAL MODALITIES, NEUROLOGICAL RECOVERY AND SURVIVAL IN TRAUMATIC ATLANTO-OCCIPITAL DISLOCATION: AN OBSERVATIONAL SYSTEMATIC REVIEW 33

STAGED MULTIDISCIPLINARY SALVAGE OF A SEVERELY INJURED UPPER EXTREMITY IN A POLYTRAUMA PATIENT: A CASE REPORT **34**

GIANT ANGIOLEIOMYOMA OF THE HAND: A 25-YEAR JOURNEY **36**

POSTERIOR DECOMPRESSION AND CERVICOTHORACIC STABILIZATION FOR A T1 METASTATIC LESION: A CASE PRESENTATION **37**

LAPAROSCOPIC MANAGEMENT OF ACUTE TRAUMATIC DIAPHRAGMATIC RUPTURE WITH GASTRIC AND OMENTAL HERNIATION FOLLOWING A PENETRATING THORACOABDOMINAL STAB WOUND **38**

RETHINKING COCHLEAR IMPLANTATION: EXOSCOPY VS. MICROSCOPY **39**

SURGICAL MANAGEMENT OF CHEMORESISTANT STAGE IV CHORIOCARCINOMA IN A MULTIPAROUS YOUNG PATIENT **40**

PERFORATED LIPOMATOUS TUMOR: A RARE CAUSE OF SHORT BOWEL SYNDROME **41**

REDEFINING AMPUTATION THROUGH SURGICAL TIMING: ACUTE PROPHYLACTIC VERSUS SECONDARY SALVAGE TARGETED MUSCLE REINNERVATION – A SYSTEMATIC REVIEW **42**

TRAUMATIC ARTERIOVENOUS FISTULA OF THE SUPERFICIAL TEMPORAL ARTERY: A RARE CLINICAL ENTITY AND REVIEW OF SURGICAL MANAGEMENT **43**

SUPERNUMERARY TESTIS OR TUMOR? A DIAGNOSTIC PUZZLE ALONG THE SPERMATIC CORD **44**

LIFETIME MANAGEMENT AND DURABILITY OUTCOMES IN TRANSCATHETER VERSUS SURGICAL AORTIC VALVE REPLACEMENT FOR LOW-RISK AND YOUNG PATIENTS: A SYSTEMATIC REVIEW OF INTERVENTIONAL TRIALS **45**

ROUTINE DRAINAGE VERSUS NO DRAINAGE IN ELECTIVE LAPAROSCOPIC CHOLECYSTECTOMY: AN INTERVENTIONAL REVIEW **46**

FATAL HEPATIC HYDATID CYST RUPTURE INTO THE INFERIOR VENA CAVA WITH RIGHT ATRIAL EXTENSION AND MASSIVE PULMONARY EMBOLISM— A CASE PRESENTATION **47**

UNMASKING A RARE ADRENAL TUMOR: MULTIMODAL DIAGNOSIS AND ROBOT-ASSISTED MANAGEMENT OF PHEOCHROMOCYTOMA **48**

THE N0 PARADOX: AGGRESSIVE GASTRIC ADENOCARCINOMA BEYOND NODAL STATUS **50**

LATERAL MALLEOLAR CHEMICAL BURN TREATED WITH PRP **51**

GRACILIS MUSCLE TRANSPOSITION FOR PEDIATRIC CONGENITAL ANAL SPHINCTER AGENESIS: CASE REPORT **52**

SURGICAL CHALLENGES IN THE MANAGEMENT OF A THALAMO-MESENCEPHALIC LESION **53**

FROM BENIGN PYLORIC STENOSIS TO JEJUNO-COLIC FISTULA: A RARE CASCADE OF RECURRENT ANASTOMOTIC COMPLICATIONS AFTER LAPAROSCOPIC ROUX-EN-Y GASTRIC RESECTION **54**

WHAT IS HIDDEN BEHIND THIS HEMATOMA? A COMPLETE RESECTION OF A RUPTURED GRADE IV SPETZLER-MARTIN AVM **55**

SURGICAL MANAGEMENT OF A CHALLENGING BRAINSTEM PILOCYTIC ASTROCYTOMA IN A PEDIATRIC PATIENT: A CASE PRESENTATION **56**

DELAYED CYTOREDUCTIVE NEPHRECTOMY AFTER IMMUNOTHERAPY IN METASTATIC CLEAR-CELL RENAL CELL CARCINOMA **57**

CUSHING'S CONUNDRUM: TRANSSPHENOIDAL SURGERY VERSUS OSILODROSTAT - A SYSTEMATIC REVIEW **58**

Debate Competition **60**

PRESERVING ANATOMICAL INTEGRITY AND PSYCHOLOGICAL WELL-BEING IN PATIENT CARE: ADDRESSING THE IMPACT OF SOCIAL MEDIA ON AESTHETIC SURGERY **61**

PERFECT FOR WHOM? PATIENT SATISFACTION AS THE GUIDING STANDARD IN SOCIAL MEDIA-DRIVEN AESTHETIC PROCEDURES **62**



ORAL PRESENTATION

GIANT URETHRAL CALCULUS COMPLICATED BY URETHROCUTANEOUS FISTULA: A CASE PRESENTATION

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Introduction

Urethral calculi account for less than 1% of urinary tract stones and are often associated with underlying urethral abnormalities. We report an exceptionally rare giant urethral calculus complicated by urethrocutaneous fistula and presenting as a perineoscrotal mass, highlighting the diagnostic challenge and importance of recognizing the underlying structural pathology for definitive surgical management.

Case Presentation

A 63 year old male presented with a longstanding, remarkably hard perineoscrotal mass that he perceived as a “third testicle.” Fifteen years earlier, he had undergone surgery for urethral stricture and urinary lithiasis. Despite the substantial stone burden, he continued voiding through the external urethral meatus while simultaneously passing urine through a visible urethrocutaneous fistula, requiring seated voiding. Examination revealed a hard perineoscrotal mass with a fistulous opening. The unusual presentation prompted consideration of testicular or paratesticular pathology and other calcified soft-tissue lesions; however, urinary drainage through the fistula suggested a urethral origin. Plain kidney–ureter–bladder radiography demonstrated a large calcified mass projected over the scrotal region. Retrograde urethrography delineated the affected urethral segment and fistulous communication, confirming a giant urethral calculus within a diverticular segment. Given the calculus size and associated urethral abnormality, open surgery was performed in lithotomy position. A perineoscrotal approach with urethrotomy permitted intact extraction of an approximately 200-g calculus. The diverticular segment was tailored and the urethra reconstructed over a transurethral Foley catheter. The catheter was removed approximately 10 days postoperatively, with restoration of urethral voiding, sustained closure of the urethrocutaneous fistula, and no reported complications.

Conclusion

Urethral lithiasis, although uncommon, should remain an important diagnostic consideration in patients presenting with a hard perineal mass, particularly with underlying urethral pathology. This case emphasizes that successful management extends beyond stone extraction to recognition and correction of the associated structural abnormality, aiming to restore function and reduce recurrence.

Keywords

giant urethral calculus; urethrocutaneous fistula; urethral diverticulum; urethrolithiasis; urethral reconstruction

ENDOVASCULAR OR OPEN REPAIR? RETHINKING AORTIC ARCH ANEURYSM SURGERY: SYSTEMATIC REVIEW

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Introduction

Aortic arch(AoA) aneurysm is a rare condition with high fatal risk due to fast enlargement and rupture. Although open surgical repair(OSR) remains the preferred treatment, endovascular repair is often used in high-risk patients. This study aims to compare the clinical outcomes of endovascular repair and OSR.

Materials & Methods

PubMed and ScienceDirect were searched for studies published in the last 10 years using phrases such as: "TEVAR", "OSR", "AoA aneurysm". Studies with n>80 evaluating adults undergoing endovascular surgery vs OSR and reporting: duration of intensive care and total hospital stay, stroke and reintervention rate or mortality were included. Excluded articles were studies focusing on prior AoA surgeries and overlapping. PRISMA guidelines were followed. A narrative synthesis was performed rather than a pooled meta-analysis given clinical and methodological heterogeneity across included studies. Risk of bias was assessed using Newcastle-Ottawa Scale.

Results

A total of 6,688 patients were identified in 11 articles(11 cohort studies) out of 25 initially selected by abstract. Time in intensive care unit and total hospital stay was shorter in endovascular patients (Yoshitake 2017: 1.0 vs 3.0 days and 10.5 vs 22 days; both P<0.001). However, endovascular repair was associated with higher stroke rates in zones 0/1 (Oishi 2024: 10.0% vs 5.8%, P<0.001), and higher reintervention rates (Song 2023: 93% vs 80%, P=0.04), driven primarily by endoleak-related complications. Mortality was comparable between groups(Oishi 2024, n=2,116: 2.2% (OSR) vs 2.7%(endovascular)). Most included studies showed a moderate risk of bias, primarily driven by confounding by indication.

Conclusion

Open surgery remains the primary treatment for AoA aneurysms, with endovascular repair feasible in selected cases. All studies were observational, with heterogeneous group definitions, variable follow-up, and substantial risk of bias , as endovascular surgery was preferentially offered to older, higher-risk patients.

Keywords

aortic arch, aneurysm, endovascular surgery, open surgical repair

ENDOSCOPIC VACUUM THERAPY FOR GASTRIC CONDUIT LEAK FOLLOWING MCKEOWN ESOPHAGECTOMY: A CASE REPORT

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Introduction

Gastric conduit ischemia is a serious complication after esophagectomy that may progress to necrosis and perforation. Early recognition and treatment are essential to prevent progression to mediastinitis and sepsis. We report a case of gastric conduit ischemia with a localized defect following McKeown esophagectomy, successfully managed with endoscopic vacuum therapy.

Case Presentation

A 70-year-old man with ischemic heart disease, type 2 diabetes mellitus, and COPD was diagnosed with adenocarcinoma of the esophagogastric junction (Siewert I/II), staged cT3N1M0. After neoadjuvant chemotherapy with partial metabolic response, he underwent minimally invasive McKeown esophagectomy with two-field lymphadenectomy.

On postoperative day 5, purulent exudate was drained from the cervical incision at bedside. CT with oral contrast demonstrated contrast extravasation extending toward the cervical incision with an associated apical collection. Upper gastrointestinal endoscopy showed an intact esophagogastric anastomosis but revealed an ulcerated defect with purulent drainage 3 cm distal to the anastomosis, in continuation with the gastric conduit staple line, consistent with focal gastric conduit ischemia causing localized disruption and leakage. Three sessions of Eso-SPONGE therapy combined with broad-spectrum antibiotic and antifungal resulted in complete healing. A residual mediastinal collection was drained under ultrasound guidance at bedside. After a prolonged but favorable postoperative course, the patient was discharged 34 days after surgery.

Conclusion

Early recognition of gastric conduit ischemia and disruption is crucial to prevent serious morbidity and mortality. In this case, endoscopy allowed identification of the defect, while vacuum therapy provided continuous local drainage and promoted granulation and tissue healing. A multidisciplinary approach with early endoscopic treatment, combined with adequate drainage and antimicrobial therapy, can effectively control contamination, prevent progression to mediastinitis and sepsis, and potentially avoid surgical reintervention in selected patients with localized gastric conduit defects.

Keywords
Gastric conduit leak, McKeown esophagectomy, serious complication

GIANT ABDOMINAL SARCOMA REQUIRING MULTIVISCERAL EN BLOC RESECTION: A CASE PRESENTATION OF A 19.3-KG RETROPERITONEAL TUMOR

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Introduction

Retroperitoneal sarcomas may remain clinically silent until reaching extreme dimensions, making complete resection technically demanding. In giant tumors, apparent adhesions may represent true infiltration, and organ-preserving dissection can compromise oncological margins. We report a 19.3-kg retroperitoneal sarcoma requiring en bloc multivisceral resection.

Case Presentation

Patient Information and Timeline: A 71-year-old man presented with progressive abdominal distension, early satiety, impaired mobility, and significant weight loss. Following multidisciplinary assessment and preoperative optimization, surgery with curative intent was planned. Clinical Findings: Examination revealed massive abdominal distension caused by a tumor occupying most of the abdominal cavity, with marked visceral displacement and functional impairment.

Diagnostic Assessment: Contrast-enhanced computed tomography demonstrated a massive intra-abdominal/retroperitoneal tumor with substantial displacement and suspected involvement of the right colon and right kidney. No distant metastases were identified. Therapeutic Intervention: Exploratory laparotomy confirmed a giant retroperitoneal tumor with firm, inseparable involvement of the right colon and kidney. To avoid tumor fragmentation and preserve oncological radicality, en bloc resection of the tumor was performed, comprising right hemicolectomy and radical nephrectomy. Renal pedicle and ileocolic vascular control was safely achieved, and intestinal continuity was restored by primary ileocolic anastomosis. The specimen weighed approximately 19.3 kg.

Follow-Up and Outcomes: Postoperative intensive care monitoring was required, followed by favorable recovery without severe complications (Clavien–Dindo ≥III). The patient was discharged in stable condition.

Conclusion

Giant retroperitoneal sarcomas involving adjacent organs require meticulous planning and multidisciplinary management. Separating firmly adherent organs may cause tumor rupture or compromise margins; therefore, en bloc multivisceral resection may be necessary for complete oncological excision. Although a single case cannot establish superiority of an aggressive strategy, this case demonstrates that extreme tumor size alone should not preclude potentially curative surgery when complete resection is technically feasible in appropriately selected patients at centers.

Keywords

giant retroperitoneal sarcoma; abdominal sarcoma; multivisceral resection; en bloc resection; surgical oncology; case presentation

POSTOPERATIVE URINARY FUNCTIONAL OUTCOMES AFTER NERVE-SPARING SURGERY FOR DEEP INFILTRATING ENDOMETRIOSIS: A SYSTEMATIC REVIEW

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Introduction

Deep infiltrating endometriosis (DIE) surgery carries a substantial risk of postoperative urinary dysfunction due to potential injury of the pelvic autonomic nerves. Nerve-sparing techniques have been developed to preserve bladder function while maintaining complete disease excision. This systematic review aimed to evaluate postoperative urinary outcomes following nerve-sparing surgery for DIE.

Materials & Methods

A systematic search of PubMed/MEDLINE was performed for studies published between 2004 and August 2026 using combinations of terms related to deep infiltrating endometriosis, nerve-sparing surgery, urinary dysfunction and voiding outcomes. Original human studies reporting postoperative urinary outcomes after nerve-sparing surgery were included. Reviews, case reports, technical reports, studies without postoperative urinary outcomes and studies not evaluating a defined nerve-sparing approach were excluded. Data extraction and study selection were performed systematically. Methodological quality and risk of bias were assessed using design-specific Joanna Briggs Institute (JBI) critical appraisal tools. Due to methodological heterogeneity, a narrative synthesis was undertaken.

Results

Eleven studies involving 959 patients fulfilled the eligibility criteria. Comparative studies suggested improved postoperative urinary recovery following nerve-sparing surgery. Systematic nerve-sparing was associated with lower postoperative self-catheterization re-

quirements (0% vs 12.9%), while another prospective comparison demonstrated earlier recovery of spontaneous voiding (3.0 vs 12.5 days; p<0.01). Mean self-catheterization duration was also shorter following nerve-sparing surgery (39.8 vs 121.1 days; p<0.001). Across the included studies, urinary outcomes were assessed using postoperative retention, catheterization requirements, time to spontaneous voiding, residual urine, uroflowmetry and validated urinary-function questionnaires. Observational cohorts generally reported preserved urinary function or low rates of persistent bladder dysfunction. However, most studies were non-randomized and varied in surgical technique, follow-up and outcome assessment, limiting direct comparison and precluding quantitative pooling.

Conclusion

Current evidence suggests that nerve-sparing surgery is associated with improved postoperative urinary recovery following surgery for deep infiltrating endometriosis, particularly through reduced catheterization requirements and earlier return of spontaneous voiding. However, predominantly observational evidence and methodological heterogeneity limit the certainty of these findings. Prospective comparative studies using standardized urinary outcomes are required.

Keywords

deep infiltrating endometriosis; nerve-sparing surgery; urinary dysfunction; voiding dysfunction; pelvic autonomic nerves

360° RETINECTOMY FOR COMPLEX RETINAL DETACHMENT FOLLOWING TRAUMATIC POSTERIOR LENS DISLOCATION IN CONGENITAL GLAUCOMA: A CASE REPORT

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Introduction

Congenital glaucoma predisposes to lens dislocation and retinal detachment secondary to chronic zonular weakness. These vitreoretinal conditions are challenging, particularly in eyes with pre-existing structural abnormalities. The risk is further increased by ocular trauma.

Case Presentation

A 16-year-old boy presented to the clinic with blunt ocular trauma accompanied by a dislocated lens and retinal detachment in the left eye. His medical history was notable for congenital glaucoma, which was surgically managed with bilateral trabeculectomy. His left visual acuity (VOS) at the moment of admission was limited to hand movements. The right eye was already severely compromised with a visual acuity (VOD) of 0 and an at-

rophic globe. Ocular ultrasonography revealed a microspherophakic lens measuring approximately 7 mm in diameter, posteriorly dislocated into the vitreous cavity and associated with retinal detachment. Lens extraction and posterior vitrectomy were performed. Extensive and complex retinal traction was identified intraoperatively, precluding adequate retinal reattachment. Therefore, a 360° retinectomy was undertaken, followed by silicone oil tamponade and 360° endolaser photocoagulation. Postoperatively, the retina remained attached, with VOS improving to 1/50 +6,00 D correction under silicone oil. Six months later, the silicone oil was extracted with VOS being 0.1. Fundus examination revealed almost complete optic disc cupping and an attached retina extending to the edges of the retinectomy, surrounded by circumferential laser retinopexy. Additionally, glaucoma treatment was continued with 2 drops of dorzolamide/timolol ophthalmic solution per day.

Conclusion

This case highlights the rare association between congenital glaucoma, underlying microspherophakia, and trauma, which caused lens dislocation and retinal detachment. It emphasises the technical complexity of surgical management, requiring vitrectomy, 360° retinectomy and endolaser photocoagulation. Despite severe preoperative visual impairment and extensive retinal pathology, anatomical retinal reattachment and meaningful visual recovery were achieved.

Keywords

congenital glaucoma; retinal detachment; 360° retinectomy

PROPELLER FLAP RECONSTRUCTION OF POST-RADIOTHERAPY TRACHEOSTOMY DEFECT IN LARYNGEAL MALIGNANCY

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Introduction

Tracheostomy is a life-saving surgical procedure used to secure the airway in patients with advanced laryngeal malignancies. Following oncological treatment, definitive closure of the tracheostomy may remain challenging due to radiation-induced tissue damage. This case report presents a novel muscle-sparing approach that uses a propeller flap for post-radiotherapy tracheostomy closure, enabling restoration of tissue continuity while minimizing donor-site morbidity and functional limitations.

Case Presentation

A 62-year-old male patient, with a one-year history of progressive respiratory insufficiency, was admitted to the ER with acute exacerbation and worsening of symptoms. An urgent supra-isthmic tracheostomy was performed to restore airway patency. CT revealed an extensive mass involving the vocal cords with significant laryngeal narrowing. Histopathological examination confirmed the diagnosis of malignancy. The patient underwent radiotherapy, with favorable oncological outcomes. A primary closure of the tracheostomy site was attempted, but due to radiation-induced tissue damage, subsequent reopening of the defect occurred. Given the persistent cutaneous and tracheal sequelae, a reconstructive approach was chosen to restore all affected planes using well-vascularized, non-irradiated tissue. Tracheostomy closure was therefore achieved using an island fasciocutaneous propeller flap based on internal mammary artery perforators. The distal skin paddle was sutured into the tracheal lumen to reconstruct the cartilaginous defect, followed by a de-epithelialized segment positioned subcutaneously, with the remaining flap covering the cutaneous defect. The following month, a fistulous complication developed, causing subcutaneous emphysema under the flap area, which was managed with debridement and deep sutures. The patient maintained a favorable clinical course, consistent with the intended treatment goals.

Conclusion

The propeller flap technique provides a versatile, muscle-sparing approach to post-radiotherapy tracheostomy closure, restoring tissue continuity while minimizing the risk of airway compromise. This tailored reconstructive strategy offers a promising alternative to conventional surgical treatments, bridging the gap between reliable reconstruction, functional restoration and good aesthetic appearance.

Keywords

Propeller flap, tracheostomy closure, laryngeal malignancy, radiotherapy

REINFORCED VERSUS CLASSICAL (UNSUPPORTED) ROSS PROCEDURE IN ADULTS: A SYSTEMATIC REVIEW OF AUTOGRAFT DURABILITY

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Introduction

Progressive pulmonary autograft dilatation threatens long-term durability after the Ross procedure. Reinforcement aims to stabilize the neo-aortic root, but its benefit over the classical unsupported technique remains uncertain. We assessed whether reinforcement improves autograft durability and outcomes in adults.

Materials & Methods

PubMed, Scopus, and CENTRAL were searched from inception to September 8, 2026. Longitudinal comparative cohorts restricted to adults (≥18 years), or reporting separately extractable adult data, comparing reinforced/supported with unsupported Ross procedures were eligible. Mixed-age inseparable cohorts, physiologic studies, non-comparative series, experimental studies, reviews, and overlapping reports were excluded. Primary outcomes were autograft reintervention/reoperation and neo-aortic regurgitation; secondary outcomes were root dilatation and survival. Owing to heterogeneity, findings were synthesized narratively. Risk of bias was assessed using ROBINS-I.

Results

Five non-overlapping cohorts (n=1,955) were included: Charitos 2009 (n=1,335), Al-Rashidi 2010 (n=26), Starnes 2023 (n=129), Van Hoof 2024 (n=173), and Abeln 2025 (n=292). Charitos 2009 reported reoperation rates of 12.9% for unsupported versus 2.3% for reinforced root replacement (P<0.001), with greater regurgitation progression without reinforcement. Al-Rashidi 2010 found no significant neo-root enlargement after Dacron support at 47-month median follow-up, unlike conventional Ross. Starnes 2023 found lower 10-year autograft reintervention with inclusion support (4.0% vs 26.8%; subhazard ratio 0.28, 95% CI 0.08–0.91; P=0.035). Abeln 2025 reported 10-year freedom from autograft reoperation of 94% with versus 81% without support (P<0.001). Conversely, Van Hoof 2024 found no reduction in reintervention with support (HR 1.18, 95% CI 0.50–2.90; P=0.72). Overall ROBINS-I risk of bias was serious, driven mainly by confounding and era effects.

Conclusion

Reinforcement was associated with fewer autograft reinterventions in several adult cohorts and reduced root dilatation in some studies, but findings were not uniform. Non-randomized designs and heterogeneous techniques limit causal inference; a survival advantage remains unproven. Prospective multicentre comparisons with standardized techniques and long-term follow-up are needed.

Keywords

Ross procedure; pulmonary autograft; autograft reinforcement; aortic root dilatation; autograft reoperation.

DISTAL RADIUS RECONSTRUCTION WITH PROXIMAL FIBULAR AUTOGRAFT FOLLOWING GIANT CELL TUMOR RESECTION: A CASE REPORT

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Introduction

Giant cell tumor of bone (GCT) is a rare, locally aggressive, osteolytic neoplasm usually arising in the epiphyseal region of long bones, with the distal radius being the third most common site. Given the complex anatomy of the wrist joint, en bloc oncologic resection often leads to severe carpal instability, subluxation, and functional deficit. Reconstructing the resulting bone defect requires solutions that ensure both joint stability and functional preservation.

Case Presentation

A 32-year-old male presented with persistent left wrist pain over the previous six months, with no relief to conservative treatment. Imaging and histopathological examination confirmed a Campanacci Grade III GCT of the distal radius. The patient underwent en bloc resection of a 6.5 cm radial segment, followed by reconstruction using an ipsilateral non-vascularized proximal fibular autograft fixed with a titanium LC-DCP plate. To enhance distal radioulnar joint stability, the distal oblique bundle (DOB) was reconstructed using an autologous palmaris longus graft. Knee stability was restored by reattaching the lateral collateral ligament and biceps femoris. Postoperatively, the patient exhibited transient common peroneal neuropraxia, which improved under structured physiotherapy, and minimal dorsal carpal subluxation. At nine-month follow-up, solid consolidation was achieved, and the Musculoskeletal Tumor Society (MSTS) score improved progressively from 30.0% at one month to 80.0%. Forearm rotation was relatively preserved, achieving 68.8% pronation and 81.3% supination compared to the contralateral side.

Conclusion

Combining a proximal fibular autograft with distal oblique bundle ligamentous reconstruction represents an effective, motion-preserving alternative to wrist arthrodesis or endoprosthetic replacement in young adults. Careful common peroneal nerve handling and prompt stability management are essential to ensure favorable functional outcomes.

Keywords

Giant Cell Tumor, Distal Radius, Proximal Fibular Autograft, Distal Oblique Bundle

LEARNING CURVES AND SKILL ACQUISITION IN LAPAROSCOPIC SUTURING AMONG NOVICES: A PROSPECTIVE INTERVENTIONAL STUDY

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Introduction

Minimally invasive surgery demands advanced psychomotor skills, with laparoscopic suturing representing a critical milestone. This prospective interventional study aims to evaluate and quantify the learning curves, skill acquisition trajectories, and competency thresholds of surgical novices during standardized simulation training.

Materials & Methods

This single-center prospective interventional study was conducted in a surgical simulation laboratory from August 3, 2026, to August 21, 2026. Inclusion criteria comprised fourth- to sixth-year medical students and junior residents without prior laparoscopic experience. Exclusion criteria included previous formal training, box-trainer exposure, or upper-extremity musculoskeletal impairments. Participants completed a standardized curriculum involving consecutive repetitions on a physical box-trainer. Outcome measures included task execution time, error rated, and procedural complications such as suture breakage. Statistical analysis employed descriptive statistics, repeated-measures ANOVA, and cumulative sum (CUSUM) analysis to assess performance evolution, with adjustments for baseline manual dexterity to minimize confounding and performance bias.

Results

Of 25 assessed candidates, 15 eligible participants met all criteria and completed the protocol (demographics: age 22-28, 9 females, 6 males). CUSUM analysis indicated that novices required an average of 15 to 35 repetitions to progress beyond the initial learning phase and attain intermediate competency. Mean execution time decreased from 145.2 ± 22.1 to 48.5 ± 9.4 seconds ($p < 0.05$). Subgroup analysis demonstrated that resident participants achieved significantly steeper learning curves and shorter completion times compared to medical students ($p < 0.05$).

The study's limitations include its single-center design, limited sample size, and use of a simulative environment, which may restrict clinical generalizability and introduce minor observation bias. Future multi-center studies with larger cohorts and correlation to intraoperative clinical performance are necessary to validate these learning curves.

Conclusion

Structured simulation training substantially reduces the initial learning curve for surgical novices. The integration of objective assessment tools and defined repetition thresholds facilitated safer skill transfer to the operating room.

Keywords
Laparoscopic suturing, Learning curve, Training

BILATERAL MIDDLE CEREBRAL ARTERY ANEURYSMS IN AN 8-YEAR-OLD CHILD WITH SEVERE AORTIC COARCTATION: A CHALLENGING ENDOVASCULAR CASE

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Introduction

Intracranial aneurysms are abnormal dilatations of cerebral arteries that carry a risk of rupture and intracranial hemorrhage. They are exceptionally rare in children and differ from adult aneurysms in etiology, morphology, and associated vascular abnormalities. Coarctation of the aorta, a congenital narrowing of the aorta, has been associated with cerebrovascular pathology, including intracranial aneurysms, although this association is rarely encountered in childhood.

Case Presentation

We present a pediatric case of ruptured middle cerebral artery aneurysm in which a previously undiagnosed severe aortic coarctation significantly influenced the endovascular strategy. The apparently healthy 8-year-old boy developed sudden loss of consciousness while running. Computed tomography demonstrated subarachnoid hemorrhage, predominantly within the left Sylvian fissure. CT angiography revealed bilateral middle cerebral artery (MCA) bifurcation aneurysms, including an approximately 5-mm left MCA aneurysm considered responsible for the hemorrhage and a smaller contralateral aneurysm.

Emergency cerebral angiography and endovascular treatment were indicated. The guiding catheter could be advanced only to the lower aortic arch, where angiography demonstrated severe aortic coarctation preventing safe catheterization of the left internal carotid artery. Consequently, the procedure was converted to a right brachial approach. Due to the complex neck configuration, the ruptured left MCA aneurysm was treated by stent-assisted coiling using two Neuroform Atlas stents and detachable coils, achieving satisfactory aneurysm occlusion.

The immediate clinical and CT evolution was favorable. On the third post-procedural day, the patient developed aphasia and right upper-limb paresis. CT and MRI demonstrated cerebral vasospasm associated with occlusion of a frontal branch of the left MCA. Intensive care treatment for vasospasm was instituted, followed by progressive neurological improvement.

Conclusion

This case illustrates the unusual association of bilateral intracranial aneurysms, aneurysmal subarachnoid hemorrhage, and previously undiagnosed severe aortic coarctation in a young child. Beyond its rarity, the case highlights how congenital extracranial vascular abnormalities may profoundly modify neuroendovascular access and treatment strategy.

Keywords

pediatric intracranial aneurysm; middle cerebral artery; subarachnoid hemorrhage; coarctation of the aorta; stent-assisted coiling ; vasospasm.

WHEN IMMUNOTHERAPY COMES BEFORE SURGERY: COMPLETE PATHOLOGICAL RESPONSE IN DMMR COLON CANCER

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Introduction

Colon malignancies can be classified into two types based on the status of the mismatch repair (MMR) system and the associated genomic instability: dMMR (mismatch repair deficient) and pMMR (mismatch repair proficient), highlighting distinct biological behaviors and therapeutic vulnerabilities. Locally advanced dMMR tumors often present surgical challenges. The sensitivity of dMMR phenotypes to immune checkpoint blockade has shifted the therapeutic paradigm, offering the potential for significant downstaging and improved surgical outcomes.

Case Presentation

A 27-year-old woman presented to the Regional Institute of Oncology Iași with severe chronic iron-deficiency anemia (Hb 4.5 g/dL) and occult gastrointestinal bleeding. CT and endoscopic biopsy revealed a stenosing adenocarcinoma of the ascending colon involving the ileocecal valve and appendix, staged as T4N2M0. Given her young age and family history of colorectal cancer, Lynch syndrome was investigated and subsequently confirmed. Immunohistochemical analysis demonstrated loss of MLH1 and PMS2 nuclear expression, consistent with a dMMR/MSI-H profile. Following multidisciplinary evaluation, neoadjuvant immunotherapy with pembrolizumab (9 cycles) was initiated. Post-treatment CT imaging demonstrated partial tumor regression, after which the patient underwent an open right hemicolectomy with ileotransverse anastomosis. Postoperative recovery was uneventful, with no surgical complications, and the patient was discharged in good clinical condition. Histopathological examination of the surgical specimen revealed

a complete pathological response (ypT0N0), with no residual viable tumor cells. At 12-month postoperative follow-up, the patient remains disease-free, with no signs of recurrence.

Conclusion

This case highlights the potential of neoadjuvant immunotherapy to reshape treatment sequencing in locally advanced dMMR colon cancer. As the first documented case of this approach at the Regional Institute of Oncology Iași, complete pathological response after surgery supports integrating systemic and surgical treatment. Further studies are warranted to define its therapeutic role.

Keywords

Neoadjuvant immunotherapy, Lynch syndrome, dMMR/MSI-H, colon cancer, right hemicolectomy

LAPAROSCOPIC PANCREATICODUODENECTOMY FOR PANCREATIC HEAD MALIGNANCY: A CASE REPORT

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Introduction

Pancreaticoduodenectomy represents the cornerstone treatment for pancreatic head malignancies, but it is associated with significant surgical trauma. The implementation of laparoscopic pancreaticoduodenectomy (LPD) represents a major advancement in minimally invasive HPB surgery, offering benefits such as reduced tissue trauma, decreased postoperative pain and faster recovery. However, LPD remains technically demanding and its feasibility in elderly patients is still widely discussed. This case highlights the successful application of LPD in a 76-year-old female patient.

Case Presentation

A 76-year-old female with a history of osteoporosis, recurrent pancreatitis, and a previously identified pancreatic head mass presented for specialized surgical management. On admission, she presented with jaundice and dehydration, but was hemodynamically stable. Preoperative thoraco-abdominal CT revealed marked intrahepatic bile duct ectasia, a common bile duct dilated to 23 mm with an in-situ stent, and a main pancreatic duct dilated up to 14 mm. The patient underwent laparoscopic pancreaticoduodenectomy under general anesthesia. Reconstruction was performed using pancreaticogastrostomy, end-to-side hepaticojejunostomy and side-to-side gastrojejunostomy, followed by multiple peritoneal drain placements. Postoperatively, a control chest X-ray identified a right-sided pneumothorax, which was successfully treated with tube thoracostomy and

completely resolved within two days. The patient showed favorable overall recovery with early resumption of bowel motility and digestive tolerance and was discharged on post-operative day 14 in good clinical condition, afebrile.

Conclusion

This case demonstrates that laparoscopic pancreaticoduodenectomy is a safe and feasible approach for pancreatic head tumors in elderly patients, as reduced surgical trauma enhances physiological resilience and prompt management of perioperative complications ensures favorable outcomes.

Keywords

laparoscopic pancreaticoduodenectomy, pancreatic head tumor, minimally invasive surgery

OVERCOMING DIMENSIONS: TRANSPARIETAL RESECTION OF A GIANT INTRAVENTRICULAR MENINGIOMA

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Introduction

Meningiomas account for half of benign primary central nervous system tumours, yet lateral ventricle variants are exceedingly rare. Originating from choroid plexus arachnoid cells, they represent just 1% of cases and predominantly affect females. This case report highlights the successful surgical management of a giant intraventricular meningioma, emphasising the operative challenges of its massive volume and complex anatomical localisation.

Case Presentation

A 73-year-old female patient presented with a one-year history of progressive left-sided hemiparesis. Neurological examination revealed a conscious patient (GCS 15) with left hemiparesis (grade 4/5) and a positive left Babinski sign, without intracranial hypertension. Brain MRI identified a voluminous lesion in the right lateral ventricle measuring approximately 66/60/44 mm (transverse/anteroposterior/craniocaudal). The multilobulated mass exhibited heterogeneous gadolinium enhancement, restricted diffusion and calcification, causing a 10 mm leftward midline shift and significant mass effect on the mesencephalon. A right transparietal approach was selected to preserve the underlying white matter tracts. The procedure involved a parietal craniotomy, allowing for complete macroscopic tumour resection, followed by the replacement of the bone flap and placement of a surgical drain. Perioperative medical management included corticosteroids, osmo-

therapy, antiepileptics and thromboembolic prophylaxis. Histopathology confirmed a WHO Grade 1 meningothelial meningioma without mitotic activity. Serial computed tomography scans showed marked reduction of the initial 19 mm pneumocephalus and 19 × 12 mm haemorrhage, with the 9.5 mm midline shift improving to 9.4 mm. Under treatment, the neurological evolution remained favourable, with uncomplicated wound healing.

Conclusion

This case demonstrates that a patient-centered surgical approach and rigorous perioperative management can yield highly favourable outcomes for deep-seated lesions, despite formidable tumour dimensions. Although limited by the short-term follow-up inherent to single-case reports, it brings valuable clinical evidence to the literature.

Keywords

intraventricular meningioma, transparietal approach, meningothelial cells, lateral ventricle tumour

FROM TECHNIQUE TO TOPOGRAPHY: RETHINKING CONSERVATIVE SURGERY IN PLACENTA ACCRETA SPECTRUM – A LITERATURE REVIEW

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Introduction

The management of placenta accreta spectrum (PAS) traditionally relied on cesarean hysterectomy. Increasing evidence supports conservative, uterus-preserving surgery in selected patients and recent advances in surgical techniques have expanded its use. This review evaluates reported outcomes, surgical strategies and anatomical factors influencing successful uterine preservation, assessing their potential to support individualized, anatomy-driven management.

Materials & Methods

The review was conducted using PubMed. Studies from 2019 to 2026 were identified using keywords including "placenta accreta spectrum", "conservative surgery" and "uterus-preserving surgery". Articles were selected for inclusion if they were peer-reviewed and reported on conservative surgical management, patient selection, perioperative outcomes or uterine preservation in PAS. Exclusion criteria included reviews, meta-analyses, editorials, non-peer-reviewed content and articles published outside the temporal frame. Data synthesis focused on surgical strategies, anatomical characteristics, uterine preservation and hemorrhagic outcomes.

Results

From the 57 initially identified articles, 11 with data on 1,632 participants were selected. Uterine preservation rates ranged from approximately 80% to 90%. Techniques included resective-reconstructive surgery, one-step conservative surgery, MOSCUS, stepwise approaches and compression sutures. A cohort of 452 patients undergoing resective-reconstructive surgery achieved 81% uterine preservation rate in type 1 disease, with median blood loss of 500 mL. One-step conservative surgery showed blood loss comparable to hysterectomy (1,740 vs. 1,500 mL), while MOSCUS achieved 88.9% preservation with reduced blood loss but higher infection rates. Surgical feasibility was heavily affected by factors such as placental topography, depth, lateral extension, vascular involvement and parametrial invasion. Primary limitations include single-database retrieval, potential publication bias and substantial heterogeneity among reported surgical classifications.

Conclusion

Current evidence demonstrates that conservative surgery can be feasible for selected PAS patients. While outcomes are promising, significant anatomical and methodological heterogeneity remains. Future research should aim to validate anatomy-based algorithms to assess feasibility and guide personalized surgical approaches.

Keywords

PAS; conservative surgery; uterine preservation



POSTER PRESENTATION

FROM DIAGNOSTIC DILEMMA TO DEFINITIVE SURGERY: ROBOTIC-ASSISTED MANAGEMENT OF URACHAL MUCINOUS ADENOCARCINOMA

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Introduction

Urachal adenocarcinoma is an exceptionally rare genitourinary malignancy, accounting for less than 1% of bladder cancers. Due to its non-specific early presentation, delayed diagnosis is common. This report highlights a successful multimodal diagnostic approach and complete surgical management of urachal adenocarcinoma, contributing valuable insights into surgical decision-making and post-operative monitoring.

Case Presentation

A 73-year-old woman, former smoker who had stopped 10 years earlier, presented in March 2024 with recurrent gross hematuria and urinary urgency.

Physical examination was non-contributory, with an unremarkable bimanual pelvic examination.

Ultrasonography and thoraco-abdomino-pelvic CT scans revealed a 5 cm bladder dome mass and a concomitant 5 cm right adnexal lesion. TURBT under hexaminolevulinate fluorescence revealed colloid/mucinous adenocarcinoma. Exploratory laparoscopy with right salpingo-oophorectomy demonstrated a benign papillary serous cystadenoma, while upper and lower gastrointestinal endoscopy excluded a primary gastrointestinal neoplasm. FDG PET-CT showed no evidence of distant metastatic disease.

In April 2024, the patient underwent robotic-assisted anterior pelvic exenteration with bilateral pelvic lymphadenectomy, omphalectomy, complete urachal resection, and open Bricker ileal conduit urinary diversion. Histopathology confirmed mucinous colloid-type urachal adenocarcinoma, staged pT3N0 (0/11), R0.

Postoperative recovery was uneventful. A parastomal hernia was managed with mesh in February 2025. At 2-year follow-up in May 2026, renal function remained preserved (eGFR 77 mL/min) with no local or distant disease recurrence.

Conclusion

Robotic radical pelvectomy paired with Bricker conduit diversion offers optimal oncological control for locally advanced urachal carcinomas. While limited as a single-case experience without generalizability to larger populations, this case underscores the pivotal role of thorough multidisciplinary evaluation in differentiating primary urachal malignancies from gynecological or colorectal metastases, achieving durable recurrence-free survival.

Keywords
Urachal adenocarcinoma; Robotic surgery; Pelvic exenteration; Bladder dome mass;

A DUAL THREAT: VERMIAN PILOCYTIC ASTROCYTOMA COMPROMISING SIGHT AND SURVIVAL

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Introduction

Pilocytic astrocytoma is a slow-growing glioma with generally favorable outcomes. In the posterior fossa, however, it may cause obstructive hydrocephalus and brainstem compression. Severe visual impairment from raised intracranial pressure is rarely reported. This case illustrates the unusual coexistence of profound bilateral visual impairment and life-threatening medulla oblongata compression.

Case Presentation

We present the case of a 22-year-old woman with several months of diffuse headache, two months of progressive bilateral visual deterioration, one month of dizziness and balance impairment, and recent vomiting. Ophthalmological examination identified bilateral papilledema and severe visual impairment. Brain MRI revealed a 38 × 44 × 60 mm mixed solid-cystic, predominantly vermian mass extending into the fourth ventricle, causing active obstructive hydrocephalus and medulla oblongata compression. The development of vomiting and cardiac rhythm disturbances, in the setting of medullary compression, indicated an imminent risk of life-threatening deterioration and required emergency neurosurgical intervention. External ventricular drainage was followed by subtotal microsurgical resection through a median suboccipital approach, achieving brainstem decompression. Histopathological examination established the diagnosis of pilocytic astrocytoma with pilomyxoid areas, IDH1-wildtype. The postoperative course was complicated by cerebrospinal fluid leakage, meningitis, and recurrent hydrocephalus, requiring antimicrobial therapy and repeated external ventricular drainage. After infection control, a ventriculoperitoneal shunt was placed for definitive cerebrospinal fluid diversion. Ventricular decompression and resolution of papilledema were achieved; however, severe bilateral visual loss persisted, with subsequent ophthalmological examination confirming bilateral optic atrophy.

Conclusion

This case highlights the dual threat of a large vermian pilocytic astrocytoma: life-threatening medullary compression requiring emergency neurosurgical intervention and profound visual impairment associated with obstructive hydrocephalus. Early recognition of brainstem compromise and intracranial hypertension is essential for preventing critical neurological deterioration and preserving neurological and visual function.

Keywords

pilocytic astrocytoma; hydrocephalus; optic atrophy

THE HIDDEN COST OF A FALL: SECONDARY PSOAS ABSCESS IN A HEMIPLEGIC PATIENT

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Introduction

Iliopsoas abscess is rare, with a worldwide incidence estimated at approximately 3.9-12 cases per year, likely underestimated given improved imaging detection. Most abscesses are primary and caused by Staphylococcus aureus; progression from a traumatic hematoma to a secondary abscess is extremely rare and carries higher mortality. We report a case in which a hemiplegia-related fall caused a psoas hematoma that became infected and was managed with a rarely reported laparoscopic approach.

Case Presentation

A 67-year-old male with known right hemiplegia fell from his bed due to his neurological deficit, sustaining trauma to the lower limb and hip. Two days later, he presented with right lower-limb pain and difficulty ambulating. Contrast-enhanced CT revealed a large multiloculated collection (115x90x160 mm) within the psoas muscle, displacing the ipsilateral kidney anteriorly by approximately 65 mm, without fracture. Laboratory studies showed marked leukocytosis and elevated CRP, consistent with infection superimposed on the hematoma. Rather than the more conventional percutaneous catheter drainage, the patient underwent laparoscopic drainage of the retroperitoneal abscess, combined with a two-week course of intravenous ceftriaxone and metronidazole. Cultures identified Escherichia coli. Drain output averaged 400 mL of purulent fluid daily for two weeks, then progressively decreased over an additional month. Inflammatory markers normalized, and the patient was discharged healed after approximately six weeks of hospitalization.

Conclusion

This case highlights an underreported mechanism for secondary psoas abscess formation: a hemiplegia-related fall causing a hematoma infected with E. coli. Management via laparoscopic drainage, a technique rarely reported compared with the standard percutaneous approach, achieved a good outcome despite a prolonged drainage course, underscoring both an unusual etiology and an uncommon but effective surgical strategy.

Keywords

Psoas abscess; Iliopsoas hematoma; Hemiplegia; Laparoscopic drainage

LIFE-THREATENING GASTROINTESTINAL BLEEDING FROM AN ILEAL GIST: A CASE PRESENTATION

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Introduction

Gastrointestinal stromal tumors (GISTs) are mesenchymal neoplasms that predominantly affect older adults. Although gastrointestinal bleeding is a recognized presentation of GIST due to ulceration of the overlying mucosa, massive hemorrhage causing hemodynamic instability is uncommon and may pose major diagnostic and therapeutic challenges. We present a young adult with an actively bleeding ileal GIST requiring emergency surgical management.

Case Presentation

A previously healthy 36-year-old man presented with syncope, melena, and hypovolemic shock (heart rate, 110 bpm; blood pressure, 90/60 mmHg). Initial laboratory testing revealed a hemoglobin level of 4.3 g/dL. Emergency esophagogastroduodenoscopy failed to identify the bleeding source. Contrast-enhanced computed tomography revealed a 58 × 48 mm hypervascular small-bowel mass with central necrosis, with GIST and neuroendocrine tumor considered in the differential diagnosis. Following resuscitation with intravenous fluids and blood products, emergency exploratory laparotomy identified an actively bleeding ileal mass without evidence of metastatic disease. Segmental ileal resection with primary side-to-side ileo-ileal anastomosis was performed. Histopathological and immunohistochemical examination demonstrated a spindle-cell GIST with overlying mucosal ulceration, strong CD117 and focal CD34 expression, and a low mitotic rate of 2 mitoses/5 mm^2. The tumor was classified as pT3N0 and completely resected (R0). The postoperative course was uneventful, and the patient was discharged on postoperative day 8. At the 3-month follow-up, the patient remained asymptomatic and in good clinical condition.

Conclusion

This case highlights the potential for an ileal GIST to present with life-threatening gastrointestinal hemorrhage and the diagnostic challenge of localizing bleeding after nondiagnostic upper endoscopy. In this instance, early contrast-enhanced CT successfully localized the occult lesion, allowing emergency surgical exploration to provide definitive hemorrhage control and complete oncologic resection.

Keywords

Ileal GIST; Gastrointestinal hemorrhage; Hypovolemic shock; Small-bowel tumor; Emergency surgery.

ENCAPSULATED INTRAMUSCULAR LIPOMA OF THE TRAPEZIUS: A SURGICAL CASE REPORT

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Introduction

Lipomas are common benign tumors of mature adipose tissue, most frequently located in the subcutaneous tissue. Intramuscular lipomas are uncommon, accounting for less than 1% of all lipomas, and arise within skeletal muscle, where their deep position may create diagnostic and surgical challenges. We present a case of an encapsulated intramuscular lipoma in the trapezius muscle, highlighting its unusual clinical presentation and the surgical challenges encountered during excision.

Case Presentation

A 63-year-old woman presented with several years of tension and stiffness in the left scapular region, associated with a palpable swelling. Physical examination revealed a firm, elastic mass measuring approximately 7 x 5 cm, located 2 cm below the inferior angle of the left scapula. Its firm consistency and deep location raised suspicion of a deep soft-tissue lesion. Defining the margins of the lesion proved challenging because it varied in size and clinical prominence with changes in patient position and muscle tension. MRI demonstrated a deep fatty lesion within the trapezius muscle. Under local anesthesia, an elliptical excision of the overlying skin and subcutaneous tissue initially revealed only a bulging muscle, with no visible adipose tissue. A limited muscular incision was therefore performed, allowing the encapsulated lipoma to be delivered by manual compression and carefully dissected from the surrounding muscle fibers. The resulting muscular defect was repaired with sutures. Histopathological examination confirmed a benign lipoma. The postoperative course was uncomplicated, with satisfactory wound healing and no evidence of functional impairment.

Conclusion

This case demonstrated the surgical challenges posed by an encapsulated intramuscular lipoma of the trapezius, including difficult clinical localization and the need for direct muscular access during excision. Accurate preoperative imaging, thorough physical examination, and careful surgical planning are essential for appropriate management and safe dissection of an intramuscular lipoma.

Keywords

encapsulated intramuscular lipoma; trapezius muscle; surgical excision

MANAGEMENT OF DIALYSIS ACCESS-ASSOCIATED STEAL SYNDROME PRESENTING WITH FOREARM PHLEGMON AND WET DIGITAL GANGRENE IN A CHRONIC HEMODIALYSIS PATIENT: A CASE REPORT

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Introduction

Arteriovenous fistula (AVF) represents the preferred vascular access for end-stage renal disease (ESRD) patients on chronic hemodialysis. However, while arterial steal syndrome originates from AVF creation that can severely compromise distal perfusion, underlying comorbidities such as diabetes, chronic kidney disease (CKD) and calciphylaxis further increase the risk of critical ischemia and infections. This case highlights the pathophysiological complexity of severe upper-limb ischemia secondary to arterial steal in an immunocompromised patient, which precipitated an extensive necrotizing infection (Parona space phlegmon).

Case Presentation

A 58-year-old diabetic male with ESRD on chronic hemodialysis presented with sepsis, extensive left hand and forearm edema, erythema and crepitus. Clinical examination revealed purulent discharge from previous 4th-5th digit amputation stumps, gangrene of the 4th digit stump, secondary camptodactyly (digits 1-3) with paroxysmal pain on passive extension and prolonged capillary refill time (5 s). Imaging confirmed a Parona space phlegmon and calciphylaxis-related vascular calcifications. Steal syndrome was confirmed using a pulse oximeter on the thumb, showing immediate recovery of the distal pulse wave upon manual AVF compression. Management followed a staged approach: temporary femoral catheter placement (until resolution of the septic state to allow future placement of a permanent tunneled catheter), surgical AVF ablation via venous ligation, carpal tunnel decompression with proximal extension down to the Parona space for drainage of purulent collections, epimysiotomy of forearm flexor muscles, muscle necrec-

tomy and amputation stump revision. Serial extensive debridements followed over subsequent days. Targeted antibiotics, negative pressure wound therapy (VAC) and split-thickness skin grafting (STSG) achieved full graft take, sepsis resolution and discharge.

Conclusion

Early recognition of arterial steal syndrome and severe necrotizing infection in hemodialysis patients with calciphylaxis is vital. Emergency decompressive and evacuative intervention, AVF ligation, serial debridements and advanced wound closure (VAC and STSG) are crucial for limb salvage.

Keywords

arterial steal syndrome; end-stage renal disease; Parona space phlegmon; calciphylaxis.

MULTIFOCAL PYOMYOSITIS WITH ACUTE END-ORGAN COMPLICATIONS: A CASE REPORT

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Introduction

Pyomyositis is a rare primary purulent infection of skeletal muscle, historically prevalent in tropical climates but increasingly recognized in temperate zones. Because robust vascularity and intact fascial compartments physiologically protect striated muscle against hematogenous seeding, bacterial colonization typically requires microtrauma, local ischemia, or immune dysfunction. This report highlights the pathogenesis, anatomical challenges, and multisystem management of extensive, multifocal pyomyositis in a 40 years host with non-specific clinical manifestations.

Case Presentation

We report the case of a 40-year-old male presenting to the emergency department with severe right forearm pain. Cardiovascular risk factors included obesity, undiagnosed diabetes mellitus, and active smoking. Clinical examination showed tender, indurated areas with positive fluctuation in the right forearm, raising suspicion of an intramuscular abscess, accompanied by significantly elevated inflammatory markers. Emergent surgical drainage and decompression were performed. Subsequently, escalating right thigh pain prompted a soft-tissue ultrasound, which initially suggested a deep hematoma; emergent surgical exploration revealed an additional intramuscular abscess. The disease progressed to multifocal lower-limb and gluteal collections requiring serial surgical debridements and continuous vacuum-assisted closure (VAC) therapy. Complications included

septic shock, vancomycin-induced KDIGO 3 acute kidney injury, hypertensive crises, and right fronto-parietal watershed infarctions secondary to intracranial/carotid stenoses, presenting as left faciobrachial hemiparesis. Following intensive multidisciplinary management, the patient was discharged in an improved clinical condition, with surgical wounds progressively healing, scheduled for elective delayed reconstructive coverage.

Conclusion

Pyomyositis should be considered in the differential diagnosis of patients presenting with localized muscle pain or swelling, even in temperate regions and in the absence of classical risk factors : recent muscle trauma or injury, HIV/AIDS infection, malignancy, malnutrition, intravenous drugs and tropical climate. Early imagining and microbiological evaluation are essential for establishing the diagnosis and initiating appropriate treatment.

Keywords

pyomyositis; intramuscular abscess; vacuum-assisted closure therapy; multidisciplinary management.

NERVE-SPARING RETROPERITONEAL DISSECTION TECHNIQUES IN DEEP ENDOMETRIOSIS SURGERY: AN OBSERVATIONAL SYSTEMATIC REVIEW

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Introduction

Deep infiltrating endometriosis (DIE) invades the presacral and pararectal retroperitoneal spaces, placing the inferior hypogastric plexus and pelvic splanchnic nerves at risk during excision. Nerve-sparing technique opens these planes to identify and preserve the autonomic fibers before dissecting the nodule. This review examines how dissection extent across parametrectomy, bowel disc excision and robotic techniques relates to postoperative urinary function in DIE surgery.

Materials & Methods

A systematic search was conducted across PubMed and Scopus for peer-reviewed studies published between 2020 and 2025. Search terms included "deep infiltrating endometriosis", "nerve-sparing", "radical resection" and "retroperitoneal dissection". Laparoscopic or robotic series reporting postoperative urinary or complication outcomes with a defined denominator were eligible. Case reports, secondary reviews and non-English publications

were excluded. Overlapping cohorts were counted once at the larger denominator. Comparative cohorts were appraised with the Newcastle-Ottawa Scale, single-arm series with the JBI checklist.

Results

Of 40 records identified (3 duplicates removed), 37 were screened and 16 assessed as full text, yielding 10 unique primary studies (11 published articles; 2 sharing one cohort) covering 1,166 patients: five comparative/graded-exposure cohorts, five single-arm series. Risk of bias was low in 8 studies and moderate in 2; none was high risk. Self-catheterisation favoured systematic nerve-sparing over partial dissection (0% vs. 12.9%). A graded cohort of 151 women showed catheterisation risk falling from 23.1% at 8 weeks to 7.7% at 8 months despite full contralateral preservation. Voiding dysfunction ranged 0–8.7%; post-void residual was abnormal in 17.7% with normal preoperative urodynamics. Grade ≥III complications ranged 0–13.3%. Bladder outcomes tracks completeness of autonomic preservation rather than the surgical label used.

Conclusion

Nerve-sparing dissection adds no major morbidity and improves catheterisation rates without abolishing postoperative voiding change. Evidence is limited by retrospective, non-randomised designs and heterogeneous outcomes. A matched comparison is needed to confirm and quantify the benefit.

Keywords

deep infiltrating endometriosis; nerve-sparing surgery; retroperitoneal dissection; parametrectomy; urinary dysfunction

SURGICAL MODALITIES, NEUROLOGICAL RECOVERY AND SURVIVAL IN TRAUMATIC ATLANTO-OCCIPITAL DISLOCATION: AN OBSERVATIONAL SYSTEMATIC REVIEW

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Introduction

Traumatic atlanto-occipital dislocation (AOD) carries high mortality from osteoligamentous disruption and brainstem stretching. While posterior occipitocervical fusion (OCF) is definitive, controversy persists regarding intervention timing (<72 hours vs. delayed), screw-rod systems versus wiring constructs and managing concomitant atlanto-axial dislocation (AAD). This review evaluates surgical techniques, timing, ASIA neurological recovery and construct safety in acute craniocervical disruptions.

Materials & Methods

PubMed, Scopus and ScienceDirect were queried (1986–2026) for traumatic AOD, posterior instrumentation and functional outcomes. Inclusion criteria comprised observational cohorts reporting acute traumatic AOD treated via posterior rigid fixation or definitive external orthoses with verified survival and neurological follow-up. Non-traumatic etiologies, subaxial injuries and non-English texts were excluded. Data were synthesized via qualitative thematic and quantitative pooling analyses; risk of bias was appraised using the Newcastle-Ottawa Scale.

Results

Across 24 included studies encompassing 397 surgical patients, Traynelis Type II distraction carried the highest baseline complete neurological deficit (68.4% vs. Types I/III, $p = 0.004$). Overall survival reached 84.6%, strongly favoring intervention within <72 hours over delayed surgery or non-operative orthoses (88.9% vs. 51.4%, $p < 0.001$). Concomitant AOD/AAD required caudal extension (C0–C3/C4) against rotational shear. Screw-rod instrumentation favored osseous fusion over sublaminar wiring (96.2% vs. 73.2%, $p = 0.002$) and enhanced functional recovery (≥1 ASIA grade improvement: 45.3% vs. 23.6%, $p = 0.008$) with fewer construct failures (3.3% vs. 17.9%, $p = 0.003$). Pediatric cohorts showed heightened distraction vulnerability (61.2% vs. 38.4%, $p = 0.012$). Definitive external immobilization yielded >40% nonunion. Primary limitations include high risk of bias from retrospective designs, small sample sizes and resuscitation protocol heterogeneity.

Conclusion

Early rigid screw-rod OCF (<72 hours) significantly improves osseous fusion, ASIA neurological conversion and survival in traumatic craniocervical dislocations over non-rigid techniques. Non-operative orthoses should remain restricted to temporary perioperative bridging.

Keywords

Atlanto-occipital dislocation, Atlanto-axial dislocation, Occipitocervical fusion, Screw-rod construct, ASIA grade

STAGED MULTIDISCIPLINARY SALVAGE OF A SEVERELY INJURED UPPER EXTREMITY IN A POLYTRAUMA PATIENT: A CASE REPORT

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Introduction

Severe upper extremity trauma combining vascular, neural, musculoskeletal and soft tissue injuries presents a challenging limb salvage decision in polytrauma. The Mangled Extremity Severity Score (MESS) has limited predictive reliability for upper extremity salvage. The Mangled Upper Extremity Score (MUES) was developed specifically for these injuries. We report limb preservation despite high injury severity scores.

Case Presentation

A 47-year-old man sustained a contaminated, approximately 20-cm anterior left proximal forearm and antecubital laceration following a road traffic accident, with open elbow dislocation, complete brachial artery transection, median and radial nerve injuries and flexor and extensor compartment muscle disruption. Concurrent conditions included traumatic brain injury, thoracic trauma with a left rib fracture, hemorrhagic and traumatic shock with anemia, rhabdomyolysis and mixed acidosis.

Initial assessment included cranial and thoracoabdominopelvic computed tomography, CT angiography and eFAST. Primary wound closure and brachial artery ligation preceded transfer with the patient intubated. On arrival, MESS was 11 and MUES was 7. Amputation was initially planned, but clinical reevaluation led to attempted limb salvage.

Plastic, vascular and orthopedic surgeons performed exploration, debridement and elbow reduction and stabilization with K-wires and cerclage, followed by brachial artery reconstruction using an ipsilateral great saphenous vein graft. Further exploration four days later included assessment of the ulnar neurovascular bundle, median and radial nerve reconstruction using bilateral sural nerve grafts, biceps tendon repair and reconstruction of both radial wrist extensors. Negative pressure wound therapy followed, with subsequent dressing changes and microbiological sampling. Complete wound closure was achieved using a split-thickness skin graft. The limb was preserved, with a favorable local and systemic clinical course.

Conclusion

Anatomical preservation supports the decision to attempt salvage in this patient despite MESS 11 and MUES 7. This case illustrates the importance of interpreting both scores alongside clinical findings and reconstructive feasibility. Follow-up is required to assess neurological recovery and functional benefit.

Keywords

Limb salvage; Mangled upper extremity; Brachial artery injury; Peripheral nerve reconstruction; Injury severity scores.

GIANT ANGIOLEIOMYOMA OF THE HAND: A 25-YEAR JOURNEY

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Introduction

Angioleiomyoma is a rare benign perivascular tumor arising from the smooth muscle layer of blood vessels, typically presenting as a small, slow-growing, well-circumscribed lesion. We present an unusual case of a voluminous hand angioleiomyoma with a 25-year history, intimately associated with the radial collateral digital artery of the index finger.

Case Presentation

A 47-year-old male patient presented electively for surgical treatment of a voluminous subcutaneous mass of the left hand, progressively enlarging for 25 years and becoming invalidating due to its size and location. The lesion had been investigated by MRI 20 years earlier in Germany, but no treatment was undertaken. Preoperative ultrasonography revealed a well-defined, heterogeneous, predominantly hypoechoic 55 mm mass at the thenar eminence, with arterial and venous Doppler signals and numerous intralesional vessels. Incisional biopsy suggested a benign mesenchymal tumor consistent with angioleiomyoma. Definitive excision was performed under locoregional anesthesia. Following skin incision, meticulous circumferential dissection was performed, with preservation of the surrounding noble anatomical structures. Intraoperatively, the tumor was found to intimately incorporate the radial collateral digital artery of the index finger, arising from the princeps pollicis artery. Due to the intimate vascular involvement and inability to safely separate the vessel from the tumor, the involved arterial branch was carefully isolated, proximally ligated, and divided, preserving the patency of the princeps pollicis artery. The tumor was completely excised en bloc and submitted for histopathological examination. Soft-tissue coverage was achieved using four triangular transposition skin flaps. Given the tumor's considerable size and location, it had caused significant functional impairment. Following excision and reconstruction, full range of motion of the thumb and index was restored immediately postoperatively, with an uneventful recovery.

Conclusion

This case demonstrates that invalidating giant hand angioleiomyoma can be successfully managed with meticulous surgery, restoring function and achieving an excellent outcome.

Keywords

Angioleiomyoma, Giant tumor, Hand surgery

POSTERIOR DECOMPRESSION AND CERVICOTHORACIC STABILIZATION FOR A T1 METASTATIC LESION: A CASE PRESENTATION

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Introduction

The spine is a frequent site for dissemination from adenocarcinomas, facilitated by its high vascularity and lymphatic drainage. While thoraco-lumbar metastases predominate in the existing literature, cases at the cervicothoracic junction remain underdocumented. Therefore, our case of a T1 vertebral-body tumor illustrates the diagnostic and therapeutic considerations specific to this challenging region and highlights the necessity of a sensible and systematic approach in the management of oncologic spine patients.

Case Presentation

A 72-year-old female patient with a 5-year history of bronchopulmonary neoplasm (treated with chemotherapy) presented with a 2-month history of progressive sensory deficits. Neurological examination upon admission revealed right-sided hemibody hypoesthesia, indicating compression of the long ascending tracts, otherwise neurologically intact.

Spinal MRI demonstrated a lytic tumoral formation within the T1 vertebral body causing posterior medullary compression and partial invasion of the right T1 pedicle, while sparing the adjacent C7-T1 and T1-T2 intervertebral discs, characteristic metastatic features. The lesion was causing high instability, raising the need for surgical intervention.

Under general anesthesia and radiological guidance, a C4-T3 midline incision was performed, followed by bilateral skeletonization. A T1-T2 laminectomy achieved dorsal decompression, while a right transpedicular approach allowed for the subtotal ablation of the tumor. To ensure a balanced distribution of forces given the compromised anterior column, a long-segment posterior spinal fusion was executed from C4 to T3, combining cervical and thoracic systems.

Immediately post-operation, the patient was transferred to the ICU. A cervicothoracic CT scan confirmed optimal hardware placement with no signs of hemorrhage. The ward progress was highly favorable under anti-DVT prophylaxis.

Conclusion

In oncological cases of spinal tumors, the main priority of the neurosurgeon is mechanical stabilization and immediate neural decompression, while creating a safe margin for adjuvant radiotherapy. In our particular case, a key challenge represented the necessity of adaptation to both cervical and thoracal vertebral architecture, therefore connecting two

different fixation systems and accounting for region-specific anatomical relations. Our approach proved effective, resulting in restoration of neurological function and reduced morbidity for the patient.

Keywords

Spine, Metastasis, Skeletonization, Neurosurgery

LAPAROSCOPIC MANAGEMENT OF ACUTE TRAUMATIC DIAPHRAGMATIC RUPTURE WITH GASTRIC AND OMENTAL HERNIATION FOLLOWING A PENETRATING THORACOABDOMINAL STAB WOUND

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Introduction

Traumatic diaphragmatic injury is an uncommon but potentially serious consequence of penetrating thoracoabdominal trauma. Diagnosis can be challenging, since patients may remain hemodynamically stable with minimal abdominal findings, and Computed tomography (CT) may fail to detect every diaphragmatic lesion. Missed injuries may later cause life-threatening complications. We report the case of a diaphragmatic rupture with gastric and greater omental herniation following a stab wound, successfully treated laparoscopically.

Case Presentation

A 39-year-old man presented to the emergency department approximately eight hours after an assault with a knife that caused multiple stab wounds, including a 5-cm deep left basithoracic wound at the ninth intercostal space. He was conscious and hemodynamically and respiratorily stable (heart rate 76 beats/min, respiratory rate 16 breaths/min, temperature 36.9 °C), with a soft abdomen and no peritoneal signs. Laboratory tests on admission were unremarkable (hemoglobin 15.3 g/dl, WBC 13,760/mm3 , PLT 250,000/mm3, and CRP 0.2 mg/L). Thoracoabdominopelvic CT demonstrated a small left pneumothorax, moderate-to-large hemothorax, pulmonary contusion, pneumomediastinum, pneumoperitoneum, and findings interpreted as large hemoperitoneum with an AAST grade III splenic injury, without active contrast extravasation. Exploratory laparoscopy showed no significant hemoperitoneum but revealed a 5-cm left diaphragmatic defect with herniation of the stomach and greater omentum into the left hemithorax. The viscera were reduced; the stomach was intact and viable. The defect was primarily sutured laparoscopically, a 24-Fr left chest tube was placed, and a left subphrenic drain was inserted.

The postoperative course was uneventful: extubation occurred three hours after surgery, oral feeding resumed on postoperative day 1, drains were removed on day 3, and the patient was discharged on day 4.

Conclusion

Penetrating diaphragmatic injuries can be difficult to detect clinically and radiologically. This case also illustrates clinically important radiology–operative discordance. In appropriately selected patients, laparoscopy is a valuable diagnostic and therapeutic strategy allowing visualization and definitive diaphragmatic repair.

Keywords

Laparoscopy, Thoracoabdominal trauma, Stab wound, Diaphragmatic rupture

RETHINKING COCHLEAR IMPLANTATION: EXOSCOPY VS. MICROSCOPY

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Introduction

Cochlear implantation (CI) restores hearing through an electronic implant. Exoscopes offer an alternative to conventional surgical microscopes, with potential benefits in visualization, ergonomics, and surgical performance. This systematic review evaluates outcomes of exoscope-assisted versus microscope-assisted CI.

Materials & Methods

PubMed, Google Scholar, and ScienceDirect were searched for studies published since 2021 using the keywords “exoscope,” “surgical microscope,” and “cochlear implant.” Articles evaluating exoscope-assisted and microscope-assisted CI were included, focusing on operative time, anatomical visualization, ergonomics, surgical performance, and educational utility. Studies unrelated to CI or exoscopy, non-human studies, duplicates, and reviews were excluded. PRISMA guidelines were used for data synthesis. Risk of bias was not assessed.

Results

Of 16 studies, 10 met the criteria, encompassing 352 adult and pediatric patients across cohort, case-control, and case series studies. Crimi et al. indicated better ergonomics with exoscopy (RULA: 1.38±0.49 vs. 3.45±0.91; $p<0.001$) and enhanced round-window visualization. Tao et al. reported longer adjustment times with the exoscope (9.7 vs. 4.8 min; $p<0.001$), accounting for 11.6±5.4% vs. 6.8±1.8% of cCST ($p<0.001$), while microscopy provided superior visualization of anatomical landmarks. Ogata et al. observed greater resident participation in mastoidectomy with exoscopy (28.6% vs. 8.6%; $p=0.0417$), suggesting educational benefits. In pediatric CI, Zhang et al. reported faster facial recess opening ($p=0.033$), indicating improved surgical performance, while Keane et al. confirmed feasibility.

Conclusion

Overall, exoscopy is a feasible CI alternative, offering ergonomic, educational, and selected surgical advantages, while microscopy remains preferable for anatomical visualization and depth perception. Larger comparative studies are required to determine the clinical effectiveness and long-term role of exoscopy.

Keywords

"exoscope," "surgical microscope," "cochlear implant"

SURGICAL MANAGEMENT OF CHEMORESISTANT STAGE IV CHORIOCARCINOMA IN A MULTIPAROUS YOUNG PATIENT

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Introduction

Gestational trophoblastic neoplasia (GTN), specifically choriocarcinoma, is a highly aggressive but typically chemosensitive malignancy. However, high-risk cases that develop chemoresistance present significant therapeutic challenges. The risk and complexity of management are further increased in patients with extreme multiparity and metastatic spread. Choriocarcinoma is a rare condition, occurring in roughly 1 in 40,000 pregnancies.

Case Presentation

A 33-year-old female patient with a history of 11 pregnancies and 11 deliveries presented with abnormal vaginal bleeding and pelvic pain. Histopathological examination following a uterine curettage confirmed choriocarcinoma. Imaging revealed a primary uterine tumor and bilateral pulmonary metastases, alongside a baseline serum β-hCG of 25,881 mIU/mL. The case was classified as high-risk, stage IV FIGO (WHO score 8). First-line systemic chemotherapy was initiated with 3 cycles of the EMA/CO regimen. Due to chemoresistance, evidenced by a rising β-hCG under treatment from 199 mIU/mL to 547 mIU/mL, the regimen was escalated to 5 cycles of EMA/EP. After 8 cycles, β-hCG normalized (1 mIU/mL). While follow-up PET-CT imaging showed complete resolution of the pulmonary metastases, it revealed persistent metabolically active uterine disease and suspicious pelvic lymph nodes. In accordance with the patient's wishes and socio-economic status, surgical intervention was performed to achieve complete regional resection, consisting of a total hysterectomy with bilateral adnexectomy and bilateral pelvic lymphadenectomy, targeting the iliac and obturator nodes. Notably, the final histopathological examination of the resected tissues revealed no residual viable tumor, confirming a complete pathological response to the chemotherapy. The postoperative recovery was uneventful.

Conclusion

This case illustrates the therapeutic complexity of high-risk, stage IV choriocarcinoma. While systemic chemotherapy remains the primary treatment for GTN, the emergence of chemoresistance requires rapid clinical adaptation. This case highlights that surgical intervention, such as radical hysterectomy, can be part of the treatment sequence for high-risk choriocarcinoma, contributing to loco-regional disease control without compromising overall oncologic outcomes.

Keywords

choriocarcinoma; gestational trophoblastic neoplasia; chemoresistance

PERFORATED LIPOMATOUS TUMOR: A RARE CAUSE OF SHORT BOWEL SYNDROME

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Introduction

Small bowel lipomas develop from mature fat cells within the submucosa, a layer retaining mesenchymal fat deposits from early gut development. Most stay silent for years, occasionally causing obstruction or intussusception once large enough. Perforation is unusual and rarely reported. We describe such a case, in which a jejunal lipoma triggered a far more challenging complication: short bowel syndrome.

Case Presentation

A 71-year-old man presented with diffuse abdominal pain, nausea, and repeated vomiting. CT showed free air, a thickened jejunal loop, and a 54 × 37 mm intraluminal mass beside a fluid-and-gas collection. Emergency laparotomy revealed purulent peritonitis from a perforated jejunal mass. Segmental enterectomy was performed with a double-barrel ileostomy. Histopathology confirmed a perforated lipomatous tumor. Postoperatively, short bowel syndrome was associated with a high-output ileostomy, causing major fluid and electrolyte losses and contributing to acute kidney injury. On readmission, the patient also developed a urinary tract infection caused by a pan-drug-resistant organism. Treatment included fluid and electrolyte repletion, targeted antimicrobial therapy, and parenteral nutrition. Once stabilized, he underwent adhesiolysis, ileostomy takedown, and side-to-side entero-enteral anastomosis. Postoperative recovery was favorable, with return of bowel transit and satisfactory wound healing. He was discharged with supportive care measures and scheduled follow-up.

Conclusion

This case illustrates how an uncommon jejunal lipomatous tumor can trigger a severe chain of complications extending far beyond the initial surgical emergency. The key lesson is that successful surgery is only the beginning. Careful control of stoma losses, renal function, infection and nutrition is essential to preserve quality of life and prepare the patient for safe restoration of intestinal continuity.

Keywords

lipomatous tumor; bowel perforation; short bowel syndrome; ileostomy; drug-resistant infection

REDEFINING AMPUTATION THROUGH SURGICAL TIMING: ACUTE PROPHYLACTIC VERSUS SECONDARY SALVAGE TARGETED MUSCLE REINNERVATION – A SYSTEMATIC REVIEW

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Introduction

Traditional amputation has long been viewed as a purely ablative procedure, leaving transected nerves without targets, which frequently causes symptomatic neuromas and debilitating phantom limb pain (PLP). Targeted Muscle Reinnervation (TMR) addresses this by microsurgically connecting severed nerves to motor branches of denervated muscles. This transforms amputation into an active reconstructive procedure, preventing nerve complications. This systematic review evaluates TMR based on surgical timing, comparing the efficacy of acute (prophylactic) versus secondary (salvage) applications in major amputations.

Materials & Methods

We searched PubMed, Embase, and the Cochrane Library September 2020–August 2026) using: ("Targeted Muscle Reinnervation" OR "TMR") AND ("acute" OR "prophylactic") AND ("secondary" OR "delayed") AND "amputation". Inclusion criteria: English-language comparative studies evaluating acute versus secondary TMR in major amputees with quantitative pain data. Exclusion criteria: non-comparative series and animal models. Data were narratively synthesized by aggregating validated pain scores, neuroma incidence rates, and postoperative medication reliance.

Results

From 63 initially analyzed records, 11 articles including 355 participants were selected. The direction of effect strongly favors acute TMR, which upgrades primary amputation to a functional reconstruction. Aggregated pain scores (VAS/NRS) revealed early TMR patients averaged ~1.75/10, compared to ~5.65/10 in the secondary salvage group. Notably, delayed TMR patients were 30 times more likely to develop symptomatic neuromas. Furthermore,

62% of acute TMR patients reported complete absence of PLP. Long-term reliance on neuropathic modulators was significantly lower (33% vs. 71%). Immediate application physically prevents central pain sensitization. Risk of bias was low-to-moderate, primarily due to surgical blinding limitations. Literature limitations include heterogeneous surgical approaches, varying follow-up periods, and subjective pain metrics.

Conclusion

Acute prophylactic TMR yields superior antalgic outcomes compared to secondary revision. Integrating this microsurgical technique alongside primary amputation revolutionizes the procedure, effectively preventing neuromas at their source and redefining functional recovery.

Keywords

Targeted Muscle Reinnervation; Phantom Limb Pain; Neuroma; Prophylactic Amputation.

TRAUMATIC ARTERIOVENOUS FISTULA OF THE SUPERFICIAL TEMPORAL ARTERY: A RARE CLINICAL ENTITY AND REVIEW OF SURGICAL MANAGEMENT

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Introduction

Superficial temporal artery pseudoaneurysms and fistulas are rare clinical entities, with approximately 200 cases reported globally . While primarily associated with closed craniocerebral trauma, these lesions can occasionally arise as iatrogenic complications following surgical revascularization or pterional craniotomies.

Case Presentation

We present the case of a 47 year old male with a history of chronic alcoholism and recurrent head trauma who was admitted with a persistent, pulsating headache and left-sided tinnitus. Notably, two years prior, he sustained blunt trauma to the left temporal region from a pitchfork handle. Three months post-injury, he developed a pulsatile temporal mass with a distinct systolo-diastolic bruit. Over the following year, the lesion progressed, causing significant engorgement of the local epicranial vascular network and an increasingly distressing murmur.Approximately one year post-injury, the patient observed a progressive engorgement of the left temporal epicranial vascular network, characterized by abnormally dilated vessels, alongside an exacerbation of the systolo-diastolic murmur, which became increasingly distressing. Brain CT imaging ruled out intracranial pathology

but showed dilation of the left superficial temporal artery. Color Doppler ultrasonography confirmed a high-turbulence, systolo-diastolic flow with both superficial and deep venous drainage. Computed Tomography Angiography (CTA) with 3D reconstructions and digital subtraction angiography (DSA) were subsequently performed.

The surgical procedure was performed under general anesthesia. It involved the microsurgical dissection of the superficial temporal artery (STA), electrocoagulation of the recruited feeder vessels, and resection of the vascular mass. Histopathological examination of the resected specimen revealed arterial and venous fragments, alongside arterialized venous structures. The postoperative course was uneventful.

Conclusion

A post-traumatic pulsatile mass in the temporozygomatic region warrants high clinical suspicion for a superficial temporal arteriovenous fistula. While Doppler ultrasonography confirms the diagnosis, CTA and DSA are mandatory for detailed anatomical localization and surgical planning. Although direct surgical resection remains definitively curative, minimally invasive endovascular approaches, such as coil embolization, represent increasingly viable modern alternatives.

Keywords

arteriovenous fistula, superficial temporal artery, pseudoaneurysm

SUPERNUMERARY TESTIS OR TUMOR? A DIAGNOSTIC PUZZLE ALONG THE SPERMATIC CORD

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Introduction

Supernumerary testis is a rare congenital anomaly, often associated with ectopia or cryptorchidism, that can remain clinically silent for years while mimicking a retroperitoneal neoplastic or vascular lesion on imaging. This case is notable for the markedly delayed diagnosis of an ectopic supernumerary testis, ultimately identified only after progressive degenerative change, hemorrhage, necrosis, and the incidental discovery of a benign mesenchymal tumor at the spermatic cord.

Case Presentation

A 56 year-old male with longstanding hypertension and multiple comorbidities was incidentally found in 2022 to have an aneurysmal dilation of the right spermatic vascular bundle on pelvic CT, in the context of an abdominal CT lesion initially suspicious for pancreatic neoplasm; this was later excluded by echoendoscopy. No further imaging or follow-up occurred until 2025, when the patient presented with a urinary tract infection and

was found on CT to have a right retroperitoneal mass with hematoma and suspected active arterial bleeding. Ultrasound demonstrated a heterogeneous, partly necrotic mass vascularized by the testicular artery, raising suspicion of an ectopic supernumerary testis. Surgery was recommended but postponed at the patient's request. Over the following months, the mass enlarged and became increasingly heterogeneous, accompanied by hemiscrotal and lumbar pain poorly responsive to anti-inflammatories. In December , 2025, right orchiectomy of both the scrotal and ectopic supernumerary testes was performed via an inguinal approach. Histopathology showed testicular atrophy with chronic inflammation and a paratesticular benign mesenchymal proliferation (myxoid stroma, bland spindle cells, prominent vasculature, mast cells, MDM2-negative), with areas of ischemic necrosis and recent hemorrhage.

Conclusion

Ectopic supernumerary testis should be considered in the differential of retroperitoneal masses near the spermatic vascular bundle, particularly when vascularization traces to the testicular artery. Delayed surgical management risks hemorrhagic and necrotic complications.

Keywords

supernumerary testis; testicular ectopia; retroperitoneal mass; mesenchymal tumor; cryptorchidism

LIFETIME MANAGEMENT AND DURABILITY OUTCOMES IN TRANSCATHETER VERSUS SURGICAL AORTIC VALVE REPLACEMENT FOR LOW-RISK AND YOUNG PATIENTS: A SYSTEMATIC REVIEW OF INTERVENTIONAL TRIALS

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Introduction

Transcatheter aortic-valve implantation (TAVI) is the elected therapy in patients with severe, symptomatic aortic stenosis who are at high, or prohibitive risk for surgical aortic-valve replacement (SAVR). TAVI has started to gain ground among cases involving lower-risk or younger patients, but certain aspects-durability beyond 10 years, conduction disturbances, and repeat interventions-remain contentious compared to SAVR. The purpose of this study is to evaluate the mid-to-long-term outcomes and lifetime procedural sequelae of TAVI versus SAVR in low-risk and young adult patients.

Materials & Methods

Following PRISMA guidelines, PubMed, EMBASE, and Cochrane Central were searched (January 2020–March 2025) using the keywords "TAVI", "SAVR", and "low risk patients". Randomized controlled trials and prospective multicenter registries reporting outcomes in low-risk (STS-PROM <4%) or younger (<75 years) patients with ≥1-year follow-up were included. Studies exclusively enrolling fragile or inoperable cohorts and single-arm registries lacking a surgical comparator were excluded. Bias risk was not evaluated.

Results

Out of 15 articles found 12 were selected, including >18,500 patients. At 1–2 years post intervention, TAVI demonstrated superior early recovery (PARTNER 3: 8.5% TAVI vs. 15.1% SAVR, p<0.001) and lower stroke rates (M. J. Mack et al. 2023, CI=95%). At 5 years, composite primary endpoints converged (PARTNER 3: 22.8% TAVI vs. 27.2% SAVR; p=0.21; all-cause mortality: 10.0% vs. 8.2%). TAVI achieved lower transvalvular gradients (10.7 vs. 12.8 mmHg; p<0.001) but carried significantly higher permanent pacemaker rates (Evolut Low Risk: 27.3% vs. 8.9%; Forrest JK et al. 2024) and paravalvular regurgitation. Surgical explant of failed TAVI showed a 30-day mortality of 13.1% in EXPLANT-TAVR, whereas TAV-in-TAV exhibited elevated risks of coronary obstruction (Bapat VN et al. 2021).

Conclusion

While TAVI offers excellent early hemodynamic performance, its survival benefit over SAVR attenuates by 5 years. Given higher pacemaker dependency and substantial explant hazards, primary SAVR remains favoured in young patients within a structured lifetime management strategy.

Keywords

Transcatheter Aortic Valve Implantation, Surgical Aortic Valve Replacement, Low Surgical Risk, Lifetime Management

ROUTINE DRAINAGE VERSUS NO DRAINAGE IN ELECTIVE LAPAROSCOPIC CHOLECYSTECTOMY: AN INTERVENTIONAL REVIEW

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Introduction

Prophylactic abdominal drainage during elective laparoscopic cholecystectomy (LC) remains widely debated despite minimally invasive advances. This literature review evaluates the clinical efficacy, safety, and recovery outcomes of routine drainage versus non-drainage in elective LC for benign gallbladder disease.

Materials & Methods

PubMed and PubMed Central were searched for peer-reviewed articles published between 2014 and 2025 using keywords "laparoscopic cholecystectomy", "drain", "drainage", and "no drainage". Interventional randomized controlled trials (RCTs) and comparative cohorts on adult elective LC for uncomplicated benign disease were included. Emergency procedures, conversions to laparotomy, and malignancies were excluded. Data were synthesized using mean differences (MD) and risk ratios (RR). Risk of bias was appraised via Cochrane RoB 2 and the Newcastle-Ottawa Scale.

Results

Ten studies comprising 4,685 patients were analyzed (5 RCTs, 1 meta-analysis of 21 RCTs, and 4 comparative cohorts). RCTs exhibited low-to-moderate risk of bias, while observational studies demonstrated high methodological quality following covariate adjustment. Direction of effect consistently favoured non-drainage across primary outcomes. Non-drainage significantly reduced operative duration (MD: -5.69 min; $p = 0.005$), 24-hour visual analog pain (MD: -1.07; $p < 0.001$), analgesic demand ($p < 0.01$), and hospital stay (MD: -0.47 days; $p = 0.005$). Drains doubled surgical site infection rates (4.8% vs. 2.2%; RR: 1.97; $p = 0.02$). Subhepatic fluid collections (8.1% vs. 7.0%; $p = 0.54$), bile leaks ($p = 0.32$), and mortality ($p = 0.50$) showed no significant differences. Study limitations include variation in drain types and subjective discharge criteria.

Conclusion

Routine drainage in elective LC offers no diagnostic or therapeutic benefit and increases wound infections, pain, and hospital stay. Prophylactic drains should be avoided in uncomplicated elective LC.

Keywords

Laparoscopic cholecystectomy; Abdominal drainage; Postoperative pain; Surgical site infection; Hospital stay

FATAL HEPATIC HYDATID CYST RUPTURE INTO THE INFERIOR VENA CAVA WITH RIGHT ATRIAL EXTENSION AND MASSIVE PULMONARY EMBOLISM— A CASE PRESENTATION

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Introduction

Cystic echinococcosis, caused by Echinococcus granulosus, is highly endemic in Romania, with hepatic localization accounting for approximately 75% of cases. Hydatid cysts located in the posterior segments of the liver (segments VII, VIII, and I) are in direct ana-

tomical proximity to the inferior vena cava, predisposing them to intravascular rupture, an extremely rare and life-threatening complication with few cases reported in the literature. We present a fatal case in which the anatomical position of the cyst was the critical determinant of a catastrophic cascade.

Case Presentation

A 77-year-old female presented to the endocrinology department with cold intolerance, chronic fatigue, weight loss, and muscle weakness, attributed to subclinical hypothyroidism and iron deficiency anemia. Contrast-enhanced CT revealed an 80×77×70 mm hepatic cystic collection in segment VII extending through the right hepatic vein into the IVC and right atrium. Bilateral pulmonary arterial filling defects and a left lower lobe excavated infarction were also identified. The patient was emergently admitted with a diagnosis of fistulized hepatic hydatid cyst; given the critical hemodynamic status, surgery was not feasible, and she died 30 hours after admission following refractory cardiorespiratory arrest. Post-mortem examination confirmed hepatic hydatidosis with tight diaphragmatic adhesions and direct IVC involvement. Histopathological analysis identified acellular lamellar membrane within hepatic venous structures and pulmonary vasculature, with hemorrhagic necrosis, establishing massive pulmonary embolism of parasitic origin as the cause of death.

Conclusion

This case illustrates how posterior hepatic hydatid cysts, due to their proximity to the IVC, can lead to a fatal cascade of intravascular rupture, right atrial extension, and massive pulmonary embolism. The clinical and radiological presentation may mimic hepatic malignancy with pulmonary dissemination, highlighting the importance of including hydatid disease in the differential diagnosis of hepatic cystic lesions with vascular extension in endemic regions. Prompt CT evaluation and clinical awareness remain key to timely diagnosis and treatment.

Keywords

hydatid cyst, inferior vena cava, pulmonary embolism, echinococcosis, hepatic segment VII

UNMASKING A RARE ADRENAL TUMOR: MULTIMODAL DIAGNOSIS AND ROBOT-ASSISTED MANAGEMENT OF PHEOCHROMOCYTOMA

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Introduction

Pheochromocytomas are rare, catecholamine-secreting neuroendocrine tumors originating from the adrenal medulla, accounting for under 0.2% of all hypertension cases. Clinical manifestations vary widely, spanning from asymptomatic incidentalomas to life-threatening cardiovascular crises. Timely identification is imperative to mitigate severe systemic morbidity and mortality. Herein, we report a case of localized pheochromocytoma diagnosed through a multimodal approach and successfully managed via robot-assisted laparoscopic adrenalectomy.

Case Presentation

A 57-year-old woman with recently diagnosed type 2 diabetes and a history of resolved thyroiditis presented with recurrent hypertensive episodes associated with progressive weight gain, palpitations, and profuse diaphoresis. Cross-sectional imaging revealed a 2.5–3.0 cm right adrenal mass with atypical radiological features inconsistent with a benign adrenal adenoma.

Biochemical assessment demonstrated elevated plasma noradrenaline, markedly increased normetanephrine levels, together with elevated dopamine and chromogranin A concentrations, supporting the diagnosis of a functioning catecholamine-secreting tumor. Functional imaging with 18F-DOPA PET/CT showed intense and isolated uptake within the right adrenal gland, without evidence of locoregional or distant metastatic disease.

Following multidisciplinary endocrinological and surgical evaluation, the patient underwent robot-assisted right total laparoscopic adrenalectomy. The procedure was completed without intraoperative complications. Histopathological examination revealed a 28-mm encapsulated pheochromocytoma with a neuroendocrine immunophenotype, Ki-67 index <5%, and absence of necrosis, angioinvasion, capsular invasion, or other histological features associated with aggressive behavior.

The postoperative course was uneventful, with adequate pain control, early mobilization, and rapid recovery. The patient was discharged in good clinical condition, with favorable follow-up and long-term endocrinological surveillance for biochemical remission and disease recurrence.

Conclusion

Pheochromocytoma is a rare and diagnostically challenging adrenal neoplasm requiring comprehensive biochemical and functional assessment. This case highlights the value of accurate preoperative characterization and multidisciplinary management, with robot-assisted adrenalectomy achieving definitive treatment and favorable short-term outcomes.

Keywords

pheochromocytoma; adrenal tumor; robotic adrenalectomy; catecholamine-secreting tumor

THE N0 PARADOX: AGGRESSIVE GASTRIC ADENOCARCINOMA BEYOND NODAL STATUS

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Introduction

Gastric adenocarcinoma remains a formidable oncological challenge, with prognosis influenced not only by nodal status but also by histological aggressiveness and local tumor extent. While radical resection constitutes the cornerstone of curative-intent treatment, selected high-risk presentations demand a carefully integrated multimodal strategy. This case highlights the pivotal role of modern radiotherapy in complementing surgery and systemic therapy in an apparently node-negative but biologically aggressive disease.

Case Presentation

A 63-year-old man was admitted with persistent abdominal pain and weight loss, with subsequent CT and MRI revealing a circumferential gastric lesion causing significant luminal stenosis, without evidence of distant metastatic disease. Biopsy confirmed a poorly differentiated gastric adenocarcinoma, prompting curative-intent surgical management. The patient underwent subtotal proximal gastrectomy with D2 lymphadenectomy, omentectomy, Roux-en-Y gastrojejunal anastomosis and tactical cholecystectomy, achieving complete oncological resection through an extensive surgical approach. Histopathology revealed G3, pT3N0 disease, with 0/17 lymph nodes involved, L1, V0, Pn0 and R0 resection; HER2 was negative. Despite R0 resection and the absence of nodal metastases, the combination of high-grade histology, advanced local invasion and lymphatic involvement indicated a substantially higher-risk biological profile than N0 status alone would suggest. Five cycles of adjuvant FOLFOX chemotherapy were followed by adjuvant chemoradiotherapy using VMAT-DIBH, delivering 50 Gy to the tumor bed and 45 Gy to regional lymphatic areas, with concomitant capecitabine. Grade III thrombocytopenia necessitated interruption of capecitabine, while radiotherapy was completed as planned. At the latest follow-up, the patient maintains a recurrence-free status and an excellent quality of life at latest follow-up.

Conclusion

The biological behaviour of gastric adenocarcinoma may extend far beyond what nodal status reveals. Recognizing this discordance, we combined surgery with adjuvant radiotherapy in a node-negative tumour displaying aggressive histological and lymphatic features. This case introduces a new therapeutic perspective, opening a path toward biology-driven management and redefining the boundaries of curative-intent treatment.

Keywords

Gastric adenocarcinoma; pT3N0 disease; Lymphatic invasion; VMAT-DIBH.

LATERAL MALLEOLAR CHEMICAL BURN TREATED WITH PRP

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Introduction

Chemical burns can extend from the epidermis into the dermis and subcutaneous tissues, involving hypodermis, cutaneous sensory structures and local microcirculation. The lateral malleolus is particularly vulnerable because of its superficial bony prominence, limited soft-tissue coverage and proximity to tendinous, neural and vascular structures. Platelet-rich plasma (PRP) is an autologous blood-derived preparation containing increased platelet concentrations and growth factors involved in angiogenesis, fibroblast activity, cell proliferation, extracellular-matrix remodelling and revascularization. This case describes a deep chemical injury at the anatomically exposed malleolar site and the use of PRP as an adjunct to tissue regeneration.

Case Presentation

A 58-year-old woman with a history of pulmonary nodule sustained a chemical burn during a holiday in Turkey in July 2026. Dermatological examination showed a deep burn centred on the lateral malleolar region, extending through the epidermis and dermis into the hypodermal/subcutaneous compartment. The central area was necrotic, with deep brown-black, yellow-white and carbonised tissue. A deep, full-thickness chemical burn was diagnosed clinically, with associated destruction of the local cutaneous microvascular network and sensory nerve endings.

Given the extensive tissue loss, autologous PRP was used as an adjunct to wound healing. PRP was prepared from peripheral venous blood by centrifugation and administered locally. Three PRP sessions were performed. During follow-up, the yellow-white areas progressively diminished, while the purple appearance subsequently decreased. The patient is undergoing further regenerative treatment with vascular laser therapy, Alexandrite laser and mesotherapy combining PRP, hyaluronic acid and polynucleotides. No complications or adverse effects were documented; complete epithelialisation has not yet been documented.

Conclusion

This case demonstrates the difficulty of managing deep chemical burns involving the lateral malleolus because of limited soft-tissue coverage. PRP was associated with clinical improvement during follow-up; however, its contribution cannot be isolated from concomitant regenerative therapies. Longer follow-up is required to assess epithelialisation, scar maturation, vascular recovery and functional outcome.

Keywords

chemical burn; lateral malleolus; tissue necrosis; platelet-rich plasma; wound healing; angiogenesis

GRACILIS MUSCLE TRANSPOSITION FOR PEDIATRIC CONGENITAL ANAL SPHINCTER AGENESIS: CASE REPORT

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Introduction

Anal sphincter agenesis is a birth defect that occurs in an unborn child during the developing stages of pregnancy and is included in the category of congenital anorectal malformations. Commonly used as a flap in reconstructive surgery, gracilis muscle is the most superficial muscle on the medial aspect of the thigh. Gracilis muscle transposition is proven to be an efficient choice of treatment for individuals with congenital anal sphincter agenesis. The procedure does not result in normal control of defecation since the striated muscle cannot maintain a permanent contraction state. Nevertheless, an acceptable fecal control can be achieved.

Case Presentation

We present the case of a 9-year-old male at Zetta Hospital in Bucharest diagnosed with anorectal agenesis, born without the anal sphincter. The treatment consisted of the reconstruction of the internal anal sphincter using a gracilis muscle flap. An incision was made on the medial aspect of the right thigh, followed by dissection of the gracilis muscle. A counter incision was made on the right knee, then the gracilis muscle was detached, tunneled, and brought through a perianal tunnel. An incision was made on the right and left parts of the anus, creating a perianal tunnel. The muscle flap was rotated and sutured in anatomical layers. Two years later, the patient presented for revision surgery to tighten the reconstructed anal sphincter. The procedure included lateral anal sphincter incisions, dissection, identification of previously transferred gracilis tendon, and gracilis tensioning. The patient showed a favorable post-surgery evolution and is currently recovering.

Conclusion

Gracilis muscle flap transplantation provides an efficient reconstruction method for congenital anal sphincter agenesis. Secondary revision surgery through surgical retensioning is a reliable approach to maintain long-term favorable outcomes.

Keywords

Reconstructive surgery, anal sphincter agenesis, gracilis transposition, pediatric

SURGICAL CHALLENGES IN THE MANAGEMENT OF A THALAMO-MESENCEPHALIC LESION

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Introduction

Children over 10 years old and infants under 3 years old are the category most affected by central nervous system tumors. Pilocytic astrocytomas are relatively uncommon CNS tumors, with an incidence of approximately 1.03 per 100,000 children and are considered WHO grade 1 tumours and corresponding to a relatively good prognosis.

Case Presentation

A 2-year-old patient has presented over the past year and a half with gait disturbances and impaired coordination of the right hand, with symptoms of insidious onset and progressive worsening. Imaging shows a thalamo-mesencephalic tumor causing compression of the fourth ventricle, possible tissue necrosis, and irregular margins. The patient was admitted for specialized neurosurgical treatment. Surgical intervention was performed using a left paramedian frontal craniotomy through a linear paramedian coronal incision, with a transcallosal approach. Subtotal resection of the left intra-axial thalamo-mesencephalo-pontine tumor was achieved. An intraventricular drainage catheter was placed and secured, followed by layered anatomical closure. In the immediate postoperative period, worsening of the left motor deficit and left oculomotor nerve (CN III) palsy were noted. Histopathological examination later identified the tumor as a pilocytic astrocytoma. Postoperative brain CT showed a clean resection cavity with no evidence of ischemia or hemorrhage. The ventricular drain was removed on postoperative day 3 without complications. The patients postoperative course was otherwise favorable and the patient was subsequently discharged.

Conclusion

This case demonstrates that deep-seated thalamo-mesencephalic tumors in children require individualized surgical planning depending heavily on location and size. Complete surgical resection remains the treatment of choice, but in this case, subtotal resection is feasible due to high risks of morbidity associated with the large tumor extension. This approach aims to manage the pathology minimizing the use of radiotherapy in order to avoid sequelae in such a young patient.

Keywords

Pilocytic astrocytoma, Pediatric brain tumor, Transcallosal approach

FROM BENIGN PYLORIC STENOSIS TO JEJUNO-COLIC FISTULA: A RARE CASCADE OF RECURRENT ANASTOMOTIC COMPLICATIONS AFTER LAPAROSCOPIC ROUX-EN-Y GASTRIC RESECTION

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Introduction

Laparoscopic subtotal (2/3) gastric resection with Roux-en-Y gastrojejunal anastomosis is well-established for refractory ulcerative pyloric stenosis, valued for low morbidity and preservation of a functional gastric reservoir. While marginal ulceration and anastomotic stenosis are recognized long-term complications, spontaneous jejuno-colic fistula formation at a juxta-anastomotic site is exceedingly rare, with only isolated cases reported, particularly years after a complicated postoperative course.

Case Presentation

We report a 43-year-old male, a chronic smoker, with a nearly decade-long history of upper gastrointestinal surgery. In 2017 he underwent laparoscopic 2/3 gastric resection with Roux-en-Y gastrojejunal anastomosis for ulcerative pyloric stenosis with GERD, complicated postoperatively by an intraperitoneal collection requiring laparoscopic re-exploration and drainage. Five years later (2022), he presented acutely with epigastric pain and pneumoperitoneum secondary to a perforated juxta-anastomotic ulcer, managed by laparoscopic suture, adhesiolysis, and lavage-drainage. In 2026, he was readmitted with several months of persistent diarrhea and a 30 kg weight loss, diagnosed with gastrojejunal anastomotic stenosis complicated by a jejunocolic fistula involving the transverse colon, alongside a postanastomotic jejunal ulcer. Also were present adhesive syndrome, moderate anemia, and hypoalbuminemia. After nutritional, electrolyte, and anticoagulation optimization, he underwent en-bloc laparoscopic resection of the anastomosis with segmental transverse colectomy, a new Roux-en-Y gastrojejunal anastomosis, and a latero-lateral colo-colic anastomosis, with favorable postoperative recovery. Zollinger-Ellison syndrome was flagged for outpatient biochemical exclusion.

Conclusion

This case illustrates a progressive cascade of anastomotic pathology — ulceration, perforation, stenosis, and ultimately fistulization — following Roux-en-Y gastric reconstruction, unfolding over nearly a decade. It underscores the need for long-term surveillance, smoking cessation counseling, and a low threshold for reinvestigating atypical gastrointestinal symptoms in patients with prior gastric surgery.

Keywords

gastrojejunal anastomosis; Roux-en-Y reconstruction; marginal ulcer; jejuno-colic fistula; laparoscopic surgery

WHAT IS HIDDEN BEHIND THIS HEMATOMA? A COMPLETE RESECTION OF A RUPTURED GRADE IV SPETZLER-MARTIN AVM

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Introduction

Arteriovenous malformations (AVMs) represent a group of congenital malformations of blood vessels, in which the arteries and veins communicate directly, without capillaries between them. Besides two relevant treatment options (endovascular embolization and non-invasive Gamma Knife radiosurgery), classic surgical resection is the choice that offers immediate and complete healing, permanently eliminating the danger of bleeding if successfully done.

Case Presentation

A 53-year-old female patient presenting with an acute onset over several hours of jet vomiting and right hemiplegia is brought to the emergency room with a GCS of 5 and intubated. A CTA shows a left frontoparietal intraparenchymal hematoma due to a ruptured grade IV Spetzler-Martin AVM and intraventricular hemorrhage in all four ventricles. A left paramedian frontoparietal craniotomy is performed to excise the AVM and evacuate the hematoma. Postoperative angiography shows complete excision and quasi-stationary hemoventriculia. Sedation is stopped, the patient shows favorable neurological evolution (motor aphasia and a MAS score of 1 on the right hemibody) and is monitored for another 11 days. Before being sent to neurological rehabilitation with a MAS score of 2, a native control CT shows complete resorption of the hemoventriculia and disappearance of the hemorrhage in the left lobe, with a minor postinterventional subarachnoid hemorrhage in the right superior parietal lobe.

Conclusion

A ruptured AVM represents an emergency for which rapid surgical management is essential to prevent major neurological deficits. Although invasive, with a high risk of intraoperative bleeding and dependent on the surgeon's expertise, the classic resection of AVMs remains, in most cases, the gold standard as a treatment.

Keywords

ruptured AVM, craniotomy, intraventricular hemorrhage, complete resection, Spetzler-Martin

SURGICAL MANAGEMENT OF A CHALLENGING BRAINSTEM PILOCYTIC ASTROCYTOMA IN A PEDIATRIC PATIENT: A CASE PRESENTATION

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Introduction

Pilocytic astrocytoma is a slow-growing glioma classified as WHO grade 1, predominantly occurring in children and adolescents. We present a paediatric case of a challenging brainstem pilocytic astrocytoma, initially biopsied in another medical service, with definitive surgical resection subsequently reconsidered. The case highlights the feasibility and clinical outcome of definitive surgical management following reassessment of the surgical approach.

Case Presentation

A 7-year-old boy, previously diagnosed with ADHD and with a biopsied brainstem tumour histologically diagnosed as pilocytic astrocytoma, was admitted for visual and balance disturbances. Contrast-enhanced MRI showed a well-demarcated brainstem tumour, hypointense on T1-weighted images. Neurological examination revealed horizontal diplopia and a positive Romberg test, without paresis or sensory deficits; gait was possible with assistance. Macroscopic total resection of the brainstem tumour was performed through a combined supracerebellar and infracerebellar approach. Postoperatively, right oculomotor paresis developed. Native CT performed 24 hours after surgery showed a clear resection cavity, without haemorrhage or ischaemic changes. The postoperative course was favourable, with slow improvement of the oculomotor paresis. The findings, correlated with the clinical history, confirmed a WHO grade 1 pilocytic astrocytoma. At discharge, 7 days postoperatively, the patient was transferred to paediatric neurology for continuation of specialised treatment, with right oculomotor paresis in remission, bilateral ataxia, and a positive Romberg test.

Conclusion

We demonstrate that total resection is feasible in complex brainstem pilocytic astrocytomas, with macroscopic total resection achieved via a combined supracerebellar and infracerebellar approach. Brainstem lesions require experienced multidisciplinary teams, given the potential for a range of postoperative neurological deficits.

Keywords

pilocytic astrocytoma; brainstem tumour; paediatric neurosurgery; biopsy; brainstem surgery.

DELAYED CYTOREDUCTIVE NEPHRECTOMY AFTER IMMUNOTHERAPY IN METASTATIC CLEAR-CELL RENAL CELL CARCINOMA

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Introduction

Cytoreductive nephrectomy (CN) has become more selectively used in metastatic renal cell carcinoma (RCC) since the introduction of immune checkpoint inhibitors. In patients achieving durable systemic disease control, delayed CN of a progressing primary tumour may be considered. We report such a case to illustrate this evolving surgical indication.

Case Presentation

A 69-year-old man presented in December 2021 with fever, productive cough, lumbar pain, asthenia and myalgias, in the context of a paraneoplastic inflammatory syndrome without the classical RCC presentation. Imaging showed a right renal mass, pulmonary lesions, mediastinal lymphadenopathy and bilateral adrenal lesions. Renal biopsy confirmed WHO/ISUP grade 2 clear-cell RCC, while left adrenal biopsy showed inflammatory tissue without evidence of malignancy. With ECOG performance status 2 and intermediate/poor IMDC risk, nivolumab monotherapy was started and escalated to nivolumab plus ipilimumab after clinical improvement. Treatment produced a dissociated response, with near-complete regression of pulmonary and mediastinal disease but isolated progression of the renal primary, while performance status improved to ECOG 1. Immune-related hypothyroidism (TSH 178) was managed with levothyroxine without interruption of immunotherapy. Following multidisciplinary reassessment, delayed cytoreductive nephrectomy was performed. Final histopathology showed WHO/ISUP grade 3 clear-cell RCC, pT1aN0, without vascular invasion, representing an upgrade from the initial biopsy grade. An adrenal lesion was ultimately identified as a benign cortical adenoma.

Conclusion

This case illustrates the potential role of delayed cytoreductive nephrectomy for isolated progression of the renal primary in patients maintaining durable extra-renal disease control on immunotherapy, while also highlighting biopsy-to-final-pathology grade discordance and the limitations of radiological assessment of adrenal lesions.

Keywords

cytoreductive nephrectomy, clear-cell renal cell carcinoma, immunotherapy, oligoprogression, dissociated response

CUSHING'S CONUNDRUM: TRANSSPHENOIDAL SURGERY VERSUS OSILODROSTAT - A SYSTEMATIC REVIEW

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Introduction

Cushing's disease leads to chronic hypercortisolism with significant morbidity if untreated. Transsphenoidal surgery (TSS) is an intervention considered as first-line treatment while osilodrostat, an oral 11β-hydroxylase inhibitor, offers a non-invasive option by directly suppressing adrenal cortisol synthesis. This systematic review aims to compare the efficacy and clinical outcomes of transsphenoidal surgery versus osilodrostat in managing Cushing's disease.

Materials & Methods

A search was conducted on PubMed, Science Direct and Google Scholar for articles published since 2017 using keywords like 'transsphenoidal surgery', 'osilodrostat treatment', 'Cushing's disease', 'steroidogenesis inhibitor'. Only studies regarding mean urinary free cortisol levels (mUFC), remission rates, and complication rates were included. The exclusion criteria were articles including combined treatment plans, articles comparing types of transnasal surgery, that had less than 50 subjects or were published more than 10 years ago. Bias risk was not evaluated and PRISMA guidelines were used for data abstractisation.

Results

A total of 10 studies were selected out of 14 found including 4 RCTs, 4 clinical trials and 2 systematic reviews summing 940 patients. Gadelha et al. (2022) reported that 77% of osilodrostat-treated patients achieved mUFC ≤ ULN (95% CI, $P < 0.0001$). Saratziotis et al. (2024) found that postoperative mUFC decreased significantly (40.5 nmol/24 h, $P = 0.019$), indicating remission. S. Jones et al. (2022) observed remission rates of 68–91% after TSS ($P = 0.05$, 95% CI). Antonini et al. (2022) noted ≥20% pituitary tumor size reduction in 28% of osilodrostat patients after 48 weeks. Honegger et al. (2022) reported TSS-related complic-

ations including cerebrospinal fluid leakage (4.5%), meningitis (1.9%), and cardiovascular issues (1.2%) ($P < 0.05$). Gadelha et al. (2022) identified osilodrostat adverse effects such as decreased appetite (37.5%), arthralgia (35.4%), and nausea (31.3%) ($P < 0.05$).

Conclusion

TSS achieves high remission and effective tumor control, while osilodrostat reliably lowers mUFC levels with milder, yet more frequent adverse effects. Direct long-term comparative outcomes remain uncertain, warranting large-scale head-to-head trials to evaluate osilodrostat as a primary or adjunct therapy to surgery.

Keywords

'transsphenoidal surgery', 'pituitary surgery', 'Cushing's syndrome', 'hypercortisolism', 'pituitary adenoma'.


DEBATE
COMPETITION

PRESERVING ANATOMICAL INTEGRITY AND PSYCHOLOGICAL WELL-BEING IN PATIENT CARE: ADDRESSING THE IMPACT OF SOCIAL MEDIA ON AESTHETIC SURGERY

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Team A – Anatomical Perfection

Introduction

Aesthetic surgical procedures are associated with self-esteem improvement, good body image and increased life satisfaction. Social media is a growing phenomenon in today's society with a significant impact in shaping current beauty standards. Through dynamic interaction, people's body image can become altered, leading to negative feelings about their appearance. Moreover, it has a persuasive component, with a tendency to drive an individual towards considering different cosmetic procedures. An altered body image is also associated with lower postoperative satisfaction in aesthetic surgery. Thus, we consider that anatomical considerations should outweigh social media-influenced patient preferences due to the need to establish an objective standard of quality and the fact that social media can negatively impact the individual's preoperative appearance perception and postoperative satisfaction. This analysis encompasses information from articles selected from PubMed.

Argument 1

First of all, patient preferences do not equate to proper standardisation of aesthetic surgeries and the need for standardized anatomical criteria. The need for such reliable methods of assessment is highlighted by Alford JA et al. (2022). In aesthetic surgery the walk between patient satisfaction and patient care impacts the way such a surgery is seen as successful, however to better serve patients' expectations, anatomical standards help surgeons bridge the gap between patients expectation and safety limitations. Such standards may also provide appropriate clinical reasoning and justify a surgeon's refusal due to safety concerns. Furthermore,while patient satisfaction plays an important role in aesthetic surgery the physiological well being of the patient must take priority. Jeon A et al. (2025) highlights the ethical responsibility of surgeons to prioritize patient well-being, safety, and individual needs over aesthetic ideals.

Argument 2

Second of all, social media has a negative impact on one's perception of his appearance, resulting in both preoperative and postoperative dissatisfaction. Fereidouni E et al. (2025) reported positive correlations between Dysmorphic Concern Questionnaire (DCQ) scores and all Social Media Addiction (SMA) dimensions ($p < 0.001$) in candidates for elective cosmetic surgical procedures, while also identifying a significant relationship between social media addiction and BDD across all the monitored age groups except for the 18 to 25-year age group.

A relevant example on postoperative satisfaction assessment is the study conducted by Al-Dossari S. (2026). They revealed that patients that underwent upper eyelid blepharoplasty who reported strong social media influence had lower postoperative satisfaction (86%), compared to moderate influence group (96%) and minimal or no influence group (93%). Moreover, Tik Tok and Youtube videos regarding cosmetic surgical procedures showed limited information quality. Om A et al. (2021) reported that Tik Tok videos have low DISCERN scores, while Ward B et al. (2020) identified that Youtube videos display high bias. This could also be a cause for misinformation, unrealistic expectations, which should be further investigated, and highlights the importance of health literacy and medical education.

Conclusion

In conclusion, the decision to perform elective aesthetic surgical procedures should be assessed through careful analysis, with consideration to the possible psychological impact of social media on an individual, patient-doctor thorough discussions and the presentation of possible procedure outcomes, its benefits and complications. Most importantly, it should prioritize achieving optimal anatomical characteristics, thus maintaining proper functionality, and providing qualitative patient care.

Keywords

Aesthetic surgery; Anatomical standards; Patient safety; postoperative satisfaction

PERFECT FOR WHOM? PATIENT SATISFACTION AS THE GUIDING STANDARD IN SOCIAL MEDIA-DRIVEN AESTHETIC PROCEDURES

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Team B – Patient Satisfaction

Introduction

The rapid expansion of social media has fundamentally altered contemporary perceptions of beauty and increasingly influenced patients' expectations regarding aesthetic procedures. Digitally modified images, algorithm-driven trends and repetitive exposure to highly standardized facial and body features may contribute to body-image concerns

and an increasing desire to conform to homogeneous aesthetic ideals. A systematic review of 25 studies involving 13,731 participants identified an association between social-media exposure, body-image dissatisfaction and consideration of cosmetic procedures. In this context, an important question emerges: if social media can impose an unrealistic concept of aesthetic perfection, should aesthetic medicine replace it with another rigid standard-anatomical perfection? We argue that patient satisfaction, achieved through informed and medically appropriate decision-making, should represent a core outcome of aesthetic treatment.

Argument 1

Social media has created unprecedented exposure to a narrow and highly curated representation of beauty. However, the solution should not be the systematic normalization of patients according to predetermined anatomical proportions. The golden ratio (φ = 1.618) and neoclassical facial canons are frequently invoked as objective standards of facial harmony, yet the scientific evidence does not support their use as universal formulas of beauty. A systematic review found no significant universal association between the golden ratio and facial attractiveness across the evaluated populations, while another evidence-based review concluded that quantitative facial beauty remains far from being fully established. Therefore, anatomical perfection may itself become an unattainable aesthetic construct. Excessive reliance on standardized anthropometric targets risks aesthetic homogenization, potentially diminishing the very individuality that aesthetic medicine should preserve. The objective of an aesthetic procedure should not necessarily be to transform an individual toward an externally defined template, but to allow controlled enhancement of existing characteristics while preserving identity and individual variation.

Argument 2

Prioritizing patient satisfaction does not mean fulfilling every request. Aesthetic medicine must remain grounded in clinical assessment, evidence-based practice, risk–benefit analysis, realistic expectations, informed consent and shared decision-making. The appropriate goal is therefore not “giving the patient what they ask for,”but reaching a medically sound decision that integrates the patient's informed preferences with the surgeon's clinical expertise, thereby maximizing the likelihood of a satisfactory outcome. Importantly, patient satisfaction can be scientifically evaluated. The FACE-Q, a validated patient-reported outcome measure (PROM), was developed specifically for facial aesthetic patients and assesses satisfaction with appearance, psychosocial well-being, quality of life and satisfaction with treatment outcomes. Its scales have demonstrated reliability, validity and responsiveness to clinical change. Similarly, the BREAST-Q, developed and psychometrically validated in 1,950 women undergoing breast surgery, measures satisfaction with breasts and overall outcome alongside psychosocial, physical and sexual well-being. The incorporation of such PROMs into aesthetic research demonstrates that the patient's perspective is not an anecdotal endpoint but a scientifically measurable component of treatment success.

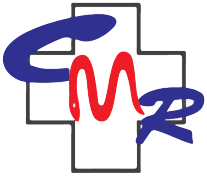
Conclusion

Anatomical parameters remain indispensable for safe planning and technical evaluation; however, they should function as clinical tools rather than universal definitions of beauty. If we criticize social media for imposing unattainable standards, we should equally question whether an inflexible concept of anatomical perfection can impose another form of standardization. Patient satisfaction does not mean abandoning medical judgment or providing every requested intervention. It means respecting autonomy through an informed, ethical and medically appropriate decision, with the aim of achieving a safe result that corresponds to the patient's realistic goals. Ultimately, aesthetic medicine should not seek to produce a universally “perfect” patient, but to preserve individuality while enabling meaningful, proportionate and medically responsible enhancement.









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