



**KOSOVA
COLLEGE OF
SURGEONS**

THIRD CLINICAL CONGRESS

"Improving Quality
of Surgical Services"

CONGRESS BOOK & ABSTRACTS

OCTOBER

12-15, 2023

Prishtina, Kosova

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WELCOMING REMARKS BY THE PRESIDENT OF THE KOSOVA COLLEGE OF SURGEONS



RIFAT LATIFI, MD, FACS, FICS, FKCS

Former Minister of Health, the Republic of Kosova

President of Kosova College of Surgeons

Trauma, Critical Care and General Surgeon,

Abrazo West Campus, Goodyear, Arizona

Adjunct Professor of Surgery,

University of Arizona, Tucson, Arizona

Latifi@surgery.arizona.edu

Dear participants, international guest speakers, honorary members of Kosova College of Surgeons, colleagues, and guests,

On behalf of Kosova College of Surgeons, the newest college of surgeons in the world, welcome to the 3rd Clinical Congress taking place in the capital city of the Republic of Kosova, the beautiful Prishtina.

This congress has evolved into a beacon of knowledge, an innovation platform, and a hub for the exchange of ideas, and experience. We have gathered here from around the world to be introduced and reminded of the most significant advances in the art and science of surgery over the next two days, while on the third day we will visit the beautiful valleys and historic towns of Kosova.

The theme of this year's congress, "Improving the Quality of Surgical Services" highlights the pressing issues and how to improve the safety of all surgical services, and patient safety. We have chosen this theme because our patients are at the center of everything we do and need to do, as surgeons, and as a healthcare system. Our patients should know that we will always do only what is in their best interest and with the latest technologies and principles of surgical care. Only this way, patients will trust us, and will not seek care elsewhere and incur catastrophic expenses. It is a theme that calls us to think critically, to challenge to change the status quo and envision a future where surgical techniques and technologies continue to evolve, saving and improving lives in ways we never thought was possible.

This year's agenda is filled with a variety of sessions, symposia, world renowned international guest speakers, our fellow compatriots from the diaspora, our colleagues from the region, and members of Kosova College of Surgeons. From the keynote addresses and named lectures after our mentors and teachers, to interactive workshops, this year's congress will offer an experience that promises to not only inform but inspire. This event is also an opportunity to learn from each other, celebrate our successes and face the surgical challenges in the era of uncertainty with determination and clear vision.

But this congress is not just about what happens on the podium and what is being presented – it's about the connections we make, the collaborations that emerge and the friendships that last. It's about the sense of community that we, as surgeons, share — a community dedicated to the well-being of our patients and the advancement of our field.

I want to express my sincere gratitude to our friends and speakers from around the world, the individual authors who have selected our congress to present their scientific work and to support our college and the congress, the organizing committee, and the KCS staff, who worked tirelessly to make this congress a success.

Special thanks go to the industry, and other sponsors, for their support and partnership is crucial to provide education for surgeons, and residents.

This is the first congress that we have introduced participation in the congress with a very modest fee for our members to ensure financial sustainability of the congress. To those who have become members of Kosova College of Surgeons, thank you! This is our college, our house of surgery, and we owe it to the next generations of surgeons of Kosova to make sure that this project does not fail, we owe it to our patients.

Becoming a Fellow of Kosova College of Surgeons should be the highlight of every surgeon of Kosova.

We have started this journey together, and together we will succeed. Let us use the annual Clinical Congress of Kosova College of Surgeons as an opportunity to learn and grow professionally and become better. Let's face the challenges before us, knowing that they are steps towards progress.

Once again, we welcome you to the Third Clinical Congress of the Kosova College of Surgeons.

Thank you and let's start this amazing journey together!

Walk with us in the future and remember: Failure is Not an Option!

Rifat Latifi, MD, FACS, FKCS

President of the Kosova College of Surgeons

Key Facts

Third Clinical Congress

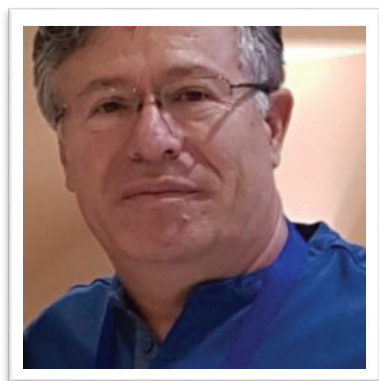
12-15 October

- KCS was established on December 3, 2018.
- The Board of Directors of Colleges of Surgeons consists of representatives of all surgical associations.
- More than 400 surgeons are members of the KCS.
- This is the Third Congress in a row, after last year's, with the participation of 111 lecturers.
- This year there are 132 lecturers with 172 presentations.
- There are 56 international Guest Speakers from: Argentina, Austria, USA, Qatar, Turkey, Italy, Israel, Bosnia and Herzegovina, Greece, Switzerland, Croatia, Slovenia, Germany, North Macedonia, France and Albania, and 76 local lecturers.
- More than 500 participants have registered in the Third Clinical Congress.
- There are 31 named lectures in 31 different surgical fields. This number will be increased in the following Congresses.
- At the Opening Ceremony of the Third Clinical Congress, 19 Honorary Members will be announced, and the Lifetime Achievement Award "Prof. Dr. Sami Haxhibeqiri" to 3 personalities.

At the Third Clinical Congress these prizes will be awarded as well:

- Award for Publication and Innovation of the year;
- "Leadership by Example" Award;
- Award for Voluntarism;
- Award "Distinguished Resident – Prof. Dr. Preveza Abrashi"
- Award for Excellent Partnership;
- Award for Distinguished Members

WELCOMING REMARKS BY THE CHAIR OF THE THIRD CLINICAL CONGRESS

**DR. OSMAN ZHURI***President Elect of Kosova College of Surgeons**Orthopedic Surgeon**Regional Hospital of Prizren**osmanzhuri@hotmail.com*

Dear colleagues,

I am more than happy and proud to write this letter in the capacity of Chairman of the Third Clinical Congress. Your presence and commitment to the field of surgery have made this congress a shining beacon of knowledge and collaboration, and I am deeply honored to chair this central gathering of surgical science.

Our two previous Congresses have served as a testament to our collective pursuit of excellence. They have been moments of inspiration, where ideas have emerged, professional connections have been strengthened and innovative research has been presented. I am confident that this year's Congress will continue this tradition and I look forward to the discussions and new discoveries that will unfold in the coming days.

The theme of the Third Clinical Congress: "Improving the Quality of Surgical Services", highlights our unwavering commitment to push the boundaries of what is achievable in the field of surgery. It challenges us to explore uncharted territories, embrace technological advances and reimagine the way we approach surgical interventions. Our ability to adapt and innovate has never been more important, especially as we face the evolving challenges of modern healthcare.

I would like to express my heartfelt gratitude to the entire dedicated team who have worked tirelessly behind the scenes to organize this Congress. Their dedication and passion are essential in ensuring the success of this event, and I commend their unwavering commitment to advancing our field.

I encourage each of you to participate actively, share your knowledge and foster new connections. The strength of our congress lies in the collective knowledge and expertise of its participants, and I have no doubt that this year's event will serve as a platform for meaningful exchange and growth.

In closing, I encourage each of you to participate actively, share your knowledge and foster new connections. Let's take this opportunity to learn from each other, inspire and shape the future of surgical practice. Together, we have the power to make a lasting impact on the lives of countless patients and redefine the boundaries of surgical excellence.

I look forward to meeting each of you at the Third Clinical Congress and to strengthen the cooperation even more!

With respect,

Osman Zhuri

Chairman of the Third Clinical Congress

Kosova College of Surgeons



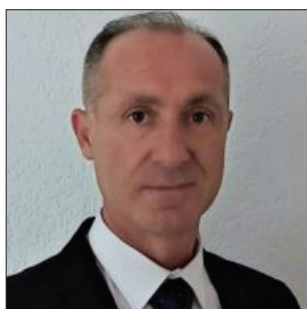
Rifat Latifi
President



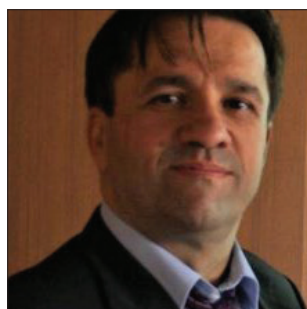
Osman Zhuri
President Elect



Gani Çeku
Director of Board



Eqrem Shala
Secretary



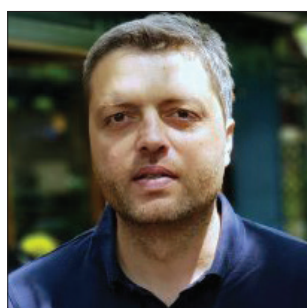
Mentor Gorani
Chair of the Organizational Committee for the Second Clinical Congress



Sadik Llullaku
Executive Director



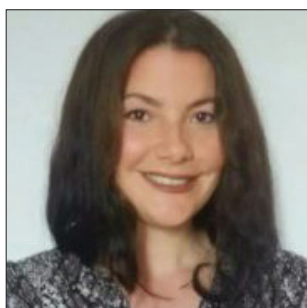
Valon Zejnullahu
Vice-President



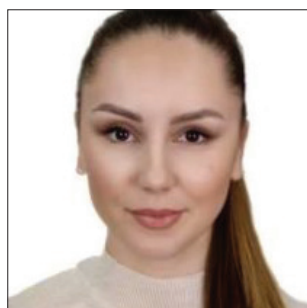
Kujtim Salihu
Director for Governmental and Governing Affairs



Lumturije Bekaj
Director for Public Relations Affairs



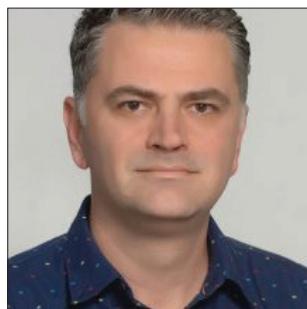
Fatjona Jahaj
Executive Administrator



Pamela Berisha
Administrative and Technical Assistant



Arben Beqiri
Vice-President for Albania



Ilir Hasani
Vice-President for
North Macedonia



Lumnije Kqiku-Biblekaj
Vice-President for Europe



Valon Baraliu
Vice-President for Europe



Mentor Ahmeti
Vice-President for USA

Congress Chair:

OSMAN ZHURI, Orthopaedic Surgeon, Regional Hospital Prizren, Kosova

Scientific Council:**Co-chairs:**

Prof. Dr. ENVER FEKAJ, General Surgeon, University Clinical Centre of Kosova, Surgery Department, Prishtina, Kosova

ASTRIT HAMZA, MD, Ph.D., General Surgeon, University Clinical Centre of Kosova, Surgery Department, Prishtina, Kosova

Members of the Scientific Council:

Ademaj Milot

Andrews Russell

Bytyqi Cen

Demaçi Shqiptar

Duçi Shkelzen

El-Menyar Ayman

Elshani Besnik

Emini Lulzim

Fekaj Enver

Grbolar Adem

Hasani Antigona

Hasbata Gazmend

Hubert Hauser

Hysenaj Qazim

Hyseni Nexhmi

Ibishi Vlora

Jaha Luan

Kqiku-Biblekaj Lumnije

Leci-Tahiri Laura

Mahmutaj Dafina

Mekaj Agon

Neziraj Alban

Nuraj Petrit

Olldashi Fatos

Salihu Naser

Shurdhiqi Shpejtim

Zatriqi Violeta

Organizational Council:**Chair:**

MENTOR GORANI, MD, MBA HM, Ophthalmologist, Eye Clinic, University Clinical Center of Kosova, Prishtina, Kosova

Members of the Organizational Council:

Shala Eqrem

Llullaku Sadik

Salihu Kujtim

Jahaj Fatjona



Scientific Program of the Third Clinical Congress Kosova College of Surgeons October 12-15, 2023

Press Opening Ceremony - Hotel Emerald, Bethoven Hall
12.10.2023 - 18⁰⁰ h

Prishtina- Hotel Emerald

Conference Hall - Beethoven

Day 1/ Friday

13.10.2023

8:00 – whole day *Registration "On Desk" in front of Beethoven*

Time	Presentati on	Topic	Name of Lecture	Speaker	Co-Authors
8:40–8:50	Live &Virtual	Introductory remarks by the President of the Kosova College of Surgeons		Rifat Latifi	

Plenary Sessions

Moderators: Lumnije Kqiku, Rifat Latifi, Alberto Ferreres

8:50-9:20	Live &Virtual	Politics and Medicine: Should Surgeons Become Politicians? A Personal perspective of a Trauma Surgeon Turned Minister		Rifat Latifi	
9:20-09:40	Live &Virtual	European research opportunities to improve research capacities in low resource countries		Lumnije Kqiku	
09:40-10:00	Live &Virtual	Ethical and legal framework for routine surgical videorecording		Alberto Ferreres	
10:00-10:20	Virtual	Artificial intelligence in medical writing and clinical methodology		Abraham Fingerhut New Honorary Fellow	
10:20-10:30		Discussion			
10:30-10:50		Coffee Break			

Trauma

Moderators: Husham Abdelrahman, Agron Dogjani, Joseph V Sakran, Mentor Ahmeti

Oral Presentation

10:50-11:10	Live & Virtual	Gun Violence in America - A Public Health Problem	Dr. Bajram Rexhepi for Combat Surgery	Joseph V Sakran New Honorary Fellow	
11:10-11:30	Live & Virtual	Current Disaster Management: What everyone should know?	Dr. Adem Ademi for Emergency Surgery	Petrit Mulaku	
11:30-11:50	Live & Virtual	Dental Traumatology: Surgical Solutions	Prof. Dr. Osman Sejfi for Maxillofac. Surgery	Lumnije Kqiku	
11:50-12:10	Live & Virtual	Non-STB training for laypersons improves the WCCI (willingness, confidence, comfort, and intervention) to provide immediate care for injured patients. Do trauma first aid Training Courses for Laypersons Improve Knowledge, Skills, and Attitudes? A Systematic Review		Husham Abdelrahman	
12:10-12:30	Live & Virtual	Epidemiology of Large-animal related injuries		Ayman El-Menyar New Honorary Fellow	
12:30-12:50	Live & Virtual	Mass Casualty Incident Preparedness		Mentor Ahmeti	Anthony Duncan, Iktesh Chahal
12:50-13:10	Live & Virtual	Evaluation of Blunt Abdominal Trauma, two years experience		Agron Dogjani New Honorary Fellow	

Quick Shot

13:35-13:40		Emergency assistance at the scene of electric shock		Isuf Bajrami	Isuf Bajrami
13:10-13:35		Discussion			
13:35-14:15	Lunch				

General Surgery and Surgical Critical Care

Moderators: Bellal Joseph, Hubert Hauser, Arben Beqiri, Enver Fekaj

Oral Presentation					
14:15-14:35	Live & Virtual	Whole blood	Dr. Hajrullah Saraçi for Critical Care Medicine	Bellal Joseph New Honorary Fellow	
14:35-14:55	Live & Virtual	Complex Abdominal Wall Reconstruction with Biologic Mesh: Operative Outcomes On 287 Patients		Rifat Latifi	David J Samson Shekhar Gogna Mathew McGuirk James Choi Kenji Okumura
14:55-15:05	Live & Virtual	Borderline pancreatic cancer: how to manage it?		Mert Erkan	Erman Aytaç Almir Miftari
15:05-15:15	Live & Virtual	True or false: Breaking myths about the pancreatic cancer	Prof. Dr. Ali Zatriqi for Surgical Oncology	Mert Erkan	Almir Miftari
15:15-15:35	Live & Virtual	Challenging cholecystitis in frail patients		Hayato Kurihara New Honorary Fellow	Matteo Maria Cimino, Matteo Porta, Paolo Negri, Diego Pettinari
15:35-15:55	Virtual	Damage control surgery for abdominal emergencies.		Hubert Hauser	
15:55-16:05		Discussion			
16:05-16:25	Coffee Break				
16:25-16:35	Live & Virtual	Emergency Admission of Liver Abscess: Risk Factors of Mortality;		Brianna Carbone	Mia Montes, Josh Simmons, Abbas Smiley, Rifat Latifi
16:35-16:55	Live & Virtual	What makes a gallbladder difficult and how to stay out of trouble?		Alberto Ferreres	
16:55-17:15	Live & Virtual	“Monster” Gallbladder! Lessons learned from more than 25 years with laparoscopic cholecystectomy!		Arben Beqiri	
17:15-17:35	Live & Virtual	Robotics in Emergency General Surgery		Joseph V Sakran New Honorary Fellow	

17:35-17:45	Live & Virtual	Delayed Operation is a Significant Risk Factor for Mortality in Patients Hospitalized with Chronic Gastrojejunal Ulcers: An Analysis of 8,525 Patients in National Inpatient Sample, 2005-2014		Manoj Goud	Abbas Smiley Maksat Idris Rifat Latifi
17:45-18:05	Live & Virtual	Quality standards and new aspects in breast cancer surgery		Hubert Hauser	
18:15-18:25		Discussion			

Conference Hall - Strauss "A" (1)

Day 1/ Friday

13.10.2023

8:00 – whole day *Registration 'On Desk' in front of Beethoven*

Time	Presentat ion	Subject	Name of Lecture	Speaker	Co-Authors
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Plastic, Reconstructive and Aesthetic surgery

Moderators: Agim Berisha, Ylber Zejnullahu

Oral Presentation

9:30-9:50	Virtual	The standardized recording of complications in the field of plastic surgery: why is it absolutely necessary		Lars-Peter Kamolz	Gerald Sendlhofer
9:50-10:10	Virtual	Improving the functional, aesthetic and social outcomes of patients suffering from severe burns: Experiences from the Burn center in Graz, Austria	Asst. Dr. Adnan Shabani for Plastic Surgery	Lars-Peter Kamolz	Christian Smolle
10:10-10:20	Live & Virtual	Reconstruction of skin defects		Agim Berisha	
10:20-10:30	Live & Virtual	Reconstruction of mid face with pectoralis flap after excision of invasiv skin cancer		Ylber Zejnullahu	
10:30-10:40		Discussion			
10:40-11:00	Coffee Break				

Orthopedics & Traumatology of the Osteomuscular System

Moderators: Cen Bytyqi, Skender Ukaj, Ilir Hasani

Oral Presentation

11:00-11:20	Virtual	Rare Complications of Total Hip Replacement	Prof. Dr. Agron Pustina for Pediatric Orthopedics	Gershon Volpin	
11:20-11:40	Live & Virtual	The power of "NOW" in Pelvic Fractures Surgery	Ass. Dr. Bedri Bakalli for Orthopedic Trauma Surgery	Ilir Hasani	
11:40-12:00	Virtual	Periprosthetic Fractures of the Femur Following Total Hip Reolacement		Gershon Volpin	
12:00-12:20	Live & Virtual	Anterior cruciate ligament reconstruction with Bone-patellar tendon-bone allograft – preliminary results		Alan Andonovski	I. Shabani B. Andonovska
12:20-12:40	Virtual	Displaced Intrarticular Fractures of the Shoulder Glenoid - including videos		Gershon Volpin	
12:40-12:50	Live & Virtual	Tretmant of Septic Arthritis sequelae		Cen Bytyqi	A. Tolaj, H. Prebreza, D. Gjigoli, N. Salihaj
12:50-13:10	Live & Virtual	Local or Spinal Anesthesia in Knee Arthroscopy		Alan Andonovski	I. Shabani B. Andonovska
13:10-13:20	Live & Virtual	Allograft transplantation and reconstruction of bones after malignant tumor resections		Rezeart Dalipi	Hasani I, Samardziski M, Jahja D, Karapandzevska S
13:20-13:30	Live & Virtual	Treatment of pseudarthrosis with intramedullary rods		Bahri Gjyshinca	
13:30-13:40	Live & Virtual	Operative treatment of pelvic obliquity		Nazmi Morina	Taulant Shatri, Skender Boshtraj, Florim Bajraktari, Sh. Berisha, V. Gashi
13:40-13:50	Live & Virtual	Analysis of Hip Ultrasonography Results in 4823 Infants - Conservative Treatment - 10 years follow-up-Retrospective Study		Skender Ukaj	

13:50-14:00	Live & Virtual	Engaged luxation of the humeroscapular joint - a diagnosis that is often mistaken		Bahri Gjyshinca	
Quick Shots					
14:00-13:05	Live & Virtual	Clinical Management of Xanthomatous Erosive Arthritis with Osteoarticular Involvement: A Case Study of Total Hip Arthroplasty and review of literature		Skender Ukaj	
14:05-14:10	Live & Virtual	Lunate and Perilunate dislocation		Imran Shaqiri	
14:10-14:20		Discussion			
14:20-14:50	Lunch				
Gynecological & Obstetric Surgery					
Moderators: Brikena Dacaj Elshani, Avdullah Taner Usta, Alban Neziri, Naser Rafuna					
Oral Presentation					
14:50-15:00	Live & Virtual	Iatrogenic injuries during Cesarian Section Delivery	Prof. Dr. Sahadete Mekuli for Gynecological & Obstetric Surgery	Sahadete Shala	Merita Krasniqi Donika Shala Taulant Hazrolli Gojart Ferati
15:00 –15:10	Live & Virtual	A Retrospective Study on the Localization and Treatment of Ectopic Pregnancies at the Gynecological and Obstetric Clinic in Kosova	Prof. Dr. Emine Gashi for Gynecological & Obstetric Surgery	Brikena Dacaj Elshani	Vlora Ibishi Astrit M. Gashi Sahadete Shala Vasuf Rexhepi Arion Elshani Gent Sopu
15:10 –15:30	Live & Virtual	Congenital Malformations of the Female Genital Tract: Diagnosis and Surgical Treatment		Alban Neziri	
15:30 –15:40	Live & Virtual	Breast Cancer And Sonomamography in The Gynecological Service		Selami Sylejmani	Sebahate Sylejmani Shala, Saime Sylejmani Leutrim Sylejmani Qëndrim Sylejmani
15:40-15:50	Live & Virtual	Robotic Gynecologic Surgery: from endometriosis to pelvic nerve		Abdullah Taner Usta	
15:50 –16:00	Live & Virtual	IOTA SR in diagnosis of ovarian cancer		Tefta Isufaj	

Poster					
16:10-16:15		Removal of endometrial polyps, early diagnosis and prevention of endometrial cancer		Aida Kumnova	Bujar Tabaku Luljeta Canhasi Agon Kumnova
16:00-16:10		Discussion			
16:10-16:30	Coffee Break				
Anesthesiology with Reanimation					
Moderators: Vedat Eljezi, Gazmend Berisha, Lulzim Emini					
Oral Presentation					
16:30-16:40	Live & Virtual	Update of diagnosis and treatement of pulmonary embolism	Ass. Dr. Shpetim Robaj for Anesthesiology	Vedat Eljezi	
16:40-17:00	Live & Virtual	Airway emergencies immediately after birth and emergency infant tracheostomy		Gazmend Berisha	
17:10-17:10		Discussion			
Conference Hall - Strauss "B" (2)					
Day 1/ Friday				13.10.2023	
8:00 – whole day Registration "On Desk" in front of Beethoven					
Time	Presentat ion	Subject	Name of Lecture	Speaker	Co-Authors
Urology					
Moderators: Arber Neziri, Shkelzen Elezaj, Bujar Frangu					
Oral Presentation					

9:50-10:00	Live & Virtual	RCC(Adenocarcinoma) and other tumors of the kidneys		Arber Neziri	
10:00-10:10	Live & Virtual	The colovesical fistula in morbus Crohn, literature review		Shkelzen Elezaj	
10:10-10:20	Live & Virtual	Urgent Urologic trauma		Arber Neziri	Çuni XH Fetahu A Nuraj P Pervorfi T Miftari I Selmani.L
10:20-10:30	Live & Virtual	Open nephron sparing surgery for T1a renal tumors: Clinical experience		Xhevdet Çuni	S. Mehmeti , A. Neziri , S. Hyseni, P. Nuraj, A. Fetahu, I. Miftari, A. Ndoj, A. Beqiri, N. Osmani, D. Kryeziu, D. Ferizi, A. Elshani, B. Frangu, L. Selmani, B. Gllareva, D. Hoxha, A. Elshani, J. Islamaj, L. Çuni, D.Muqaj, S. Gerxhaliu, D.Çuni, T. Shabani, L. Shahini
Quick Shots					
10:30-10:35	Live & Virtual	Renal Trauma		Arber Neziri	Xhevdet Çuni, Avni Fetahu, Petrit Nuraj, Sabit Mehmeti, Fahredin Veselaj, Ilir Miftari, Ardian Prenaj, Lulzim Emmini, Destan Kryeziu, Liridon Selmani
10:35-10:40	Live & Virtual	OGG1 rs2304277 gene polymorphism in bladder cancer	Prof. Dr. Xhemil Bytyçi for Urology	Bujar Frangu	
10:40-10:45	Live & Virtual	Correlatioin of the rs2279744 polymorphism in the MDM2 gene with invasiveness of bladderr carcinoma		Ardian Prenaj	

10:45-10:50	Live & Virtual	Treatment of kidney and ureteral stones with Stone Light Laser Lithotripsy		Arb Rexha	Nexhat Rexha Tobias Pottek Ardian Jusufi Shpresa Rexha Avdyl Hoxha Hekuran Zhubi Agim Hazrolli Fatos Shukriu
Poster					
11:05-11:10		Retrocaval Ureter: Report of one Cases		Halil Xhibexhiu	B.Thaci A.Hazrolli A.Rustemi F.Shukriu A.Hasani S.Kastrati
10:50-11:00		Discussion			
11:00-11:20	Coffee Break				
ORL					
Moderators: Deniz Tuna Edizer, Arsim Thaqi, Qazim Hysenaj					
Oral Presentation					
11:20-11:40	Live & Virtual	Orbital and Intracranial Complications of Acute Rhinosinusitis. My 2-week Experience from August 14 - 26 at the ENT Clinic in UCCK		Arsim Thaqi	
11:40-11:50	Live & Virtual	Cochlear Implantation	Prof. Dr. Talat Pallaska and Prof. Dr. Besim Sllamniku for ORL Surgery	Deniz Tuna Edizer	
Quick Shots					
11:50-11:55	Live & Virtual	Dilemmas of septoplasty in children		Shefazim Hulaj	
11:55-12:00		Discussion			
12:00-12:30	Lunch				
Cardiac Surgery					
Moderators: Ilirijana Haxhibeqiri, Shpejtim Shurdhiqi, Rifat Brahimaj, Ramë Alaj					

Oral Presentation					
12:30-12:50	Live & Virtual	On-pump vs Off-pump revascularization	Prof. Dr. Gazmend Shaqiri for Vascular Surgery	Ilirijana Haxhibeqiri	
12:50-13:10	Virtual	New Directions in Quality Assurance in Pediatric and Congenital Heart Surgery		George E Sarris	
13:10-13:20	Live & Virtual	Minimally Invasive Aortic Valve Surgery: One Team Experience		Selman Dumani	Ermal Likaj, Laureta Dibra, Saimir Kuci, Afred Ibrahim, Elizana Petrela, Devis Pellumbi, Alesia Mehmeti, Ali Refatllari, Arben Baboci
Poster					
13:50-13:55		Bioprosthetic Aortic Valve Dysfunction : A Case Report		Adeline Dine	Esmerilda Bulku, Jonela Burimi, Edlira Rruc, Arber Aliu, Andi Kcani
13:55-14:00		Case Presentation: The First Implantation of Aortic Valve Prosthesis "Intuity" in Our Country Short Panoramic View of the Use of these Types of Prothesis		Selman Dumani	Ermal Likaj, Laureta Dibra, Saimir Kuci, Afred Ibrahim, Elizana Petrela, Devis Pellumbi, Alesia Mehmeti, Ali Refatllari, Arben Baboci, Adeline Musliu Dine
13:20-13:50		Discussion			
13:50-14:10	Coffee Break				
Vascular Surgery					
Moderators: Girma Tefera, Hassan Al-Thani, Lulzim Vokrri, Hajriz Rudari, Laura Leci Tahiri					
Oral Presentation					
14:10-14:30	Live & Virtual	Abdominal aortic aneurysmal rupture: Risk factor and prediction	Prof. Dr. Sadri Bajraktari for Humanism and Vascular Surgery	Hassan Al-Thani New Honorary Fellow	

14:30-14:50	Live & Virtual	Current Management of Type B aortic Dissections		Girma Tefera New Honorary Fellow	
14:50-15:00		Discussion			
Conference Hall - Beethoven					
Day 2/ Saturday					14.10.2023
8:00 – whole day Registrations "On Desk" in front of Beethoven					
Time	Presentat ion	Subject	Name of Lecture	Speaker	Co-Authors
Plenary Sessions					
Moderators: Hayato Kurihara, Pierre-Alain Clavien, Peter Killcommons, Jay MacGregor					
8:30- 8:50	Virtual	Quality of Death in Surgical Practice : A 50 year Story from India	Asst. Prof. Dr. Shefqet Meha for Neurosurgery	Krishnan Ganapathy New Honorary Fellow	
8:50- 9:10	Live & Virtual	Trauma system in Europe: An Ongoing Challenge	Prof. Dr. Rifat Latifi - Advances in Trauma, Telemedicine and Technologies	Hayato Kurihara New Honorary Fellow	Matteo Porta, Matteo Maria Cimino, Diego Pettinari, Paolo Negri
9:10- 9:30	Virtual	Surgical ego: the good, the bad and the ugly		Abraham Fingerhut New Honorary Fellow	
9:30- 9:50	Live & Virtual	Quality in surgery: What does it mean?		Pierre-Alain Clavien	
9:50-10:10	Live & Virtual	Surgery Leadership Training: An Investment In Safety, Quality, and Value.		Jay MacGregor	
10:10-10:30	Live & Virtual	Perioperative Telemedicine: It has never been easier		Peter Killcommons New Honorary Fellow	

10:30-10:50	Virtual	Ethical issues in Surgical Practice in 2030- A Peep into the Future		Krishnan Ganapathy New Honorary Fellow	
10:50-11:00	Live &Virtual	Improving the quality and safety of patients: Challenges for Kosova		Qamile Morina	
11:00- 11:10		Discussion			
11:10- 11:30	Coffee Break				
Surgical and Medical Voluntarism					
Moderators: Girma Tefera, Rifat Latifi, Osman Zhuri, Russell J Andrews					
11:30- 11:50	Live &Virtual	Global Health in Surgery: Working beyond the “feel good”	The President Prof. Dr. Rifat Latifi, for Global Health	Girma Tefera New Honorary Fellow	
11:50- 12:00	Live &Virtual	Global Surgery and Surgical Voluntarism ; A Sustainable Model of Improving Access to Care	Prof. Dr. Sami Haxhibeqiri Frontiers in Surgery	Rifat Latifi	
12:00- 12:10	Live &Virtual	Voluntarism in Difficult Times of Kosova		Osman Zhuri	
12:10- 12:20	Live &Virtual	Juvenile Angiofibroma = JNA (One-week personal experience as a volunteer doctor from 06. - 10. Juni 2022 at the ENT Clinic at UCCK)		Arsim Thaqi	
12:20- 12:30	Live &Virtual	Pediatric Cardiac Surgery Mission in Kosova: The Gift of Life		Albana Krasniqi	
12:30-13:00	Lunch				
Gastro - Colorectal surgery					
Moderators: Demetrius Litwin, Kastriot Haxhirexha, Astrit Hamza					
Oral Presentation					

13:00-13:20	Live & Virtual	Nissen fundoplication and para-esophageal hernia repair; approach and technique		Demetrius Litwin	
13:20-13:40	Live & Virtual	Surgical Management of Colorectal Liver metastases - the Zurich algorithm		Perparim Limani	
13:40-13:50	Live & Virtual	Outcomes of Emergently Admitted Patients with either Intestinal Fistula, Ulceration, Perforation, Angiodysplasia, or Dieulafoy Lesion: Frailty, Age, Time to Operation, and Hospital Length of Stay as Mortality Risk Factors		Guy Elgar	Abbas Smiley, Ben Barris, Rifat Latifi
13:50-14:00	Live & Virtual	In-hospital mortality in patients emergently admitted with intestinal adhesive obstruction: An analysis of more than 115,000 patients		Akash Thaker	Abbas Smiley, Josh Simmons, Rifat Latifi
14:00-14:10	Live & Virtual	The RLQ pain in male after appendectomy		Kastriot Haxhirexha	
14:10-14:20	Live & Virtual	Treatment modalities in Rectal cancer: Neoadjuvant therapy, Surgery or watch-and-wait approach		Astrit Hamza	
14:20-14:30	Live & Virtual	Total neoadjuvant therapy – should we change our approach to locally advanced rectum cancer		Erman Aytaç	Mert Erkan, Almir Miftari
14:30-14:40	Live & Virtual	"Left Colonic Diverticulitis: A Comprehensive Review of Diagnosis and Management"		Afrim Tahiri	
14:40-14:50	Live & Virtual	Cryoablation of Cholangiocarcinoma		Iliran Laçi	Ines Mama
14:50-15:00	Live & Virtual	Benefits of Sleeve Gastrectomy as a method of treating obesity		Floren Kavaja	Agim Sharku, Edea Blyta, Dukagjin Kryeziu, Fatos Sada, Labinot Gashi, Necdet Derici, Feyzullah Ersoz, Elda Kavaja, Enida Kavaja
15:00-15:10	Live & Virtual	Low anterior syndrome: focusing on functional wellbeing after sphincter sparing surgery		Almir Miftari	Erman Aytaç, Mert Erkan
Quick Shots					

15:10-15:15	Live &Virtual	Stercoral colitis due to spinal cord injury		Skender Telaku	Arbër Veliu, Bahri Gashi, Qëndrim Zenelaj, Jeton Bytyqi, Edmond Islamaj, Bajraktari Burim, Telaku Mimoza
15:15-15:20	Live &Virtual	Nomenclature, classification and grading of thyroid tumors: what's new in the 2022 WHO classification?		Rine Limani	Labinota Kondirolli, Brikenë Blakaj, Drita Miftari
15:20-15:30		Discussion			
15:10-15:30	Coffee Break				
Laparoscopic Surgical Interventions					
Moderators: Demetrius Litwin, Rexhep Selmani, Kushtrim Shala					
Oral Presentation					
15:30-15:50	Live &Virtual	Laparoscopic hernia repair vs open hernia repair	Prof Dr. Salih Krasniqi for Laparoscopic Pioneers Surgery	Demetrius Litwin	Gazi Rashid
15:50-16:10	Live &Virtual	My 20 years of experience in the treatment of colon cancer with laparoscopy and in particular with SILS-Laparoscopy	Prof. Dr. Samedin Haxhijaha for Endoscopic Surgery	Kushtrim Shala	
16:10-16:30	Live &Virtual	Early versus delayed laparoscopic cholecystectomy for acute cholecystitis; predictive factors for conversion	Prof. Dr. Ymer Aliu for Minimal Invasive Surgery	Rexhep Selmani	Nikola Jankulovski, Svetozar Antovic, Qemal Rushiti, Fesih Shehu, Fatjona Mislimi, Gent Bilalli, Marija Atanasova, Arijan Selmani
Quick Shots					
16:30-16:35	Live &Virtual	A case report of laparoscopic treatment of hydatid disease of the liver in a 13- year-old child compering with literature.		Senol Tahir	Jovanovska Frosina, Mustafaova Alma, Bundovska Marija, Panik Katarina, Ambardzieva Martina, Markov Petar
16:35-16:45		Discussion			

Breast Surgery

Moderators: Dafina Ademi Islami, Bedri Osmani

16:45-16:55	Live & Virtual	Trends in Surgical Management of Breast Cancer – an article review	Prof. Dr. Muhamed Guguli for Breast Surgery	Bedri Osmani	
16:55-17:15	Virtual	Neoadjuvant treatments for breast cancer and their role in breast conserving surgery: A multi-disciplinary Approach		Mary D. Chamberlain	
17:15-17:35	Virtual	Current strategies for breast reconstruction after mastectomy.		Jose Castro	
17:35-17:45	Live & Virtual	Metabolic Syndrome and Molecular Subtypes of Breast Cancer in Kosova		Dafina Ademi Islami	
17:45-17:00	Live & Virtual	The role of interleukin-7 serum level as biological marker in breast cancer: a cross-sectional, observational, and analytical study		Faton Sermahaj	

Poster

17:15-17:20		Papillary intracystic carcinoma of the male breast. Case report		Shqiptar Demaçi	Dafina Ademi Islami
17:00-17:15		Discussion			

20:00

Gala Dinner

Conference Hall - Strauss "B" (2)

Day 2/ Saturday

14.10.2023

8:00 – whole day Registrations "On Desk" in front of Beethoven

Time	Presentat ion	Subject	Name of Lecture	Speaker	Co-Authors
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Maxillofacial Surgery

Moderators: Mërgime Prekazi Loxha, Osman Sejfiija, Lumnije Kqiku

10:20-10:40	Live &Virtual	Cleft lip and palate treatment:our experiance	Prof. Dr. Jashar Dula for Maxillofacial Surgery	Mërgime Prekazi Loxha	
10:40-10:50	Live &Virtual	The role and contribution of maxillofacial surgery during the war in Kosova (1998-1999)		Osman Sejfi	
10:50-11:00	Live &Virtual	MRONJ: New Problem from an Old Disease		Shkelzen Ibishi	
11:00-11:10	Live &Virtual	Neck Management of oral squamous cell carcinoma		Alban Olluri	
11:00-11:10	Live &Virtual	Surgical Treatment of Pleomorphic Adenoma of the Parotid Gland, Evaluation of Postoperative Facial Nerve Morbidity		Nedim Kasami	
11:10-11:20		Discussion			
11:20-11:40	Lunch				
Thoracic Surgery					
Moderators: Tomaz Stupnik, Nexhati Jakupi, Fadil Gradica, Shqiptar Demaçi					
Oral Presentation					
11:40-12:00	Live &Virtual	Chest Wall Stabilization	Prof. Dr. Muharrem Gashi for Thoracic Surgery	Mentor Ahmeti	Anthony Duncan, Ikttesh Chahal
12:00-12:20	Live &Virtual	Competency in VATS major pulmonary resections	Prof. Dr. Safet Beqiri for Lung Cancer Surgery	Tomaz Stupnik	
12:20-12:30	Live &Virtual	Elderly Patients With Pulmonary Insufficiency Following Trauma Admission Have 20 Percent Mortality Rate		Victoria Afolayan	Abbas Smiley, Rifat Latifi
12:30-12:50	Live &Virtual	Challenges in Video-Assisted Thoracic Surgery Education		Tomaz Stupnik	
12:50-13:00	Live &Virtual	VATS vs open thoracotomy in patients with spontaneous pneumothorax – where do we stand?		Nexhati Jakupi	

13:00-13:10	Live & Virtual	BRAF (V600E) Mutation in Papillary Thyroid Carcinoma		Ilir Vela	Igor Dzikovski, Risto Colanceski, Asaf Abdurahmani, Slavica Kostadinova Kunovska, Magdalena Bogdanovska Todorovska
13:10-13:20	Live & Virtual	Typical pulmonary ACTH secreting carcinoid tumor in a young male		Fadil Gradica	Eliza Kastrati, Elona Xhardo, Lutfi Lisha, Kleon Gradica, Daniela Xhemalaj, Ardita Koxhaj, Alma Cani, Fahri Kokici, Rushan Muhameti
Poster					
13:55-14:00		Intrathoracic gossypiboma after cardiac surgery. Case report		Shqiptar Demaçi	Dafina Ademi Islami
13:20-13:45		Discussion			
13:45-14:30	Coffee Break				
Neurosurgery					
Moderators: Besnik Elshani, Fatos Ollidashi, Bellal Joseph, Valon Baraliu					
Oral Presentation					
14:30 –14:50	Live & Virtual	Surgical Stabilization of Craniocervical Junction and Upper Cervical Spine	Prof. Dr. Shaban Hasi for Neurosurgery	Fatos Ollidashi New Honorary Fellow	
14:50 –15:10	Live & Virtual	Discovery of the Mechanisms and Biosignatures Underlying Rapid-Acting Treatment in Neuropsychiatry: Lessons Learned from Ketamine Discovery in Treatment-Resistant Mood Disorders	Prof. Dr. Musa Haxhiu for Scientific Research	Bashkim Kadriu	
15:10 –15:30	Live & Virtual	Brain Injury Guidelines for management of ICH		Bellal Joseph New Honorary Fellow	
15:30–15:50	Live & Virtual	Efficient Surgery/Neurosurgery: Cutting Costs and Cutting Time Without Cutting Corners		Russell J Andrews	

15:50 –16:10	Live & Virtual	Initial serum phosphate level in patients with spinal injury		Ayman El-Menyar New Honorary Fellow	
16:10 –16:30	Live & Virtual	State of the Art Management of Dural Lesions		Valon Baraliu	
16:30 –16:50	Live & Virtual	How to avoid and to cope with bleeding in lumbar spinal surgery - A survey of most advanced techniques		Michael Pfeiffer	Frederick Meyer zu Schwabedissen, Valon Baraliu
16:50 –17:10	Live & Virtual	Comorbidity of polyneuropathy and lumbar spinal stenosis		Michael Pfeiffer	S. Hennigfeld
17:10 –17:20	Live & Virtual	The role of endoscopy in Neurosurgery		Artur Xhumari	Artid Lame, Gramoz Brace, Myfit Saraci, Klit Pilika, Thoma Kalefi
17:20 –17:30	Live & Virtual	Cauda Equine Syndrome		Armend Agolli	
Poster					
17:40-17:45		Case report: The vestibular schwannoma		Art Deva	
17:30 –17:40		Discussion			
20:00	Gala Dinner				
Conference Hall - Strauss " A" (1)					
Day 2 / Saturday			14.10.2023		
Time	Presentat ion	Subject	Name of Lecture	Speaker	Co-Authors
Ophtalmology					
Moderators:		Gurkan Erdogan, Nilüfer Yalçındağ, Bekim Tateshi, Ilir Arapi, Naser Salihu			

Oral Presentation

POSTERIOR SEGMENT SESSION

9:00-9:20	Live & Virtual	Minimally Invasive Surgical Approach for Complicated Vitreoretinal Diseases	Dr. Xheladin Doda in Ophtalmology	Gurkan Erdogan	
9:20-9:40	Live & Virtual	Behcet uveitis: Distinctive features and current therapeutic approach		Nilüfer Yalçındağ	
09:40-10:00	Live & Virtual	Screening for Retinopathy of Prematurity in premature Babies Born in North Macedonia – 15 Years Results (2008-2023)		Bekim Tateshi	
10:00-10:10	Live & Virtual	Autofluorescence imaging of the ocular fundus		Ilir Arapi	Matilda Islamaj, Ledia Dine, Julinda Jaho
10:10-10:20	Live & Virtual	Anti-vascular endothelial growth factor therapy in non age related degenerative macular neovascularization		Valvita Reçi	
10:20-10:50		Discussion			
10:50-11:10	Coffee Break				
	Satellite Symposium - Roche, Real Life Experience with Vabysmo				
11:10-11:20	Live & Virtual	Opening remarks		Naser Salihu	
11:20-11:40	Live & Virtual	Starting with the power of two		Arijeta Grezda	
11:40-12:00	Live & Virtual	Real Life Experience with Vabysmo		Damir Bosnar	
12:00-12:10	Live & Virtual	Closing remarks		Naser Salihu	
12:10-12:40	Lunch				

ANTERIOR SEGMENT SESSION

Moderators: Huban Atilla, Arjeta Grezda, Ilir Osmani, Belinda Pustina, Qëndresë L

12:40-13:00	Live & Virtual	Congenital cataracts; What has changed?	Prof. Dr. Qamil Haxhia for Leadership in Ophthalmology	Huban Atilla	
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13:00-13:10	Live & Virtual	Pseudoexfoliation in cataract surgery		Arijeta Grezda	Erindi Murati
13:10-13:20	Live & Virtual	Open Globe Injuries: Review of evaluation, management, and surgical pearls		Ilir Osmani	Kristina Sisarica, Sumeja Kasami
13:20-13:30	Live & Virtual	Our experience in keratoconus patients treated with Cross-Linking		Belinda Pustina	Suzana Buçinca, Mentor Gorani, Fjolla Bokshi, Lisa Qurdina
13:30-13:40	Live & Virtual	Comparision Of The Effects Of Different Multifocal Lenses On Visual Acuity And Patient Satisfaction After Cataract Surgery		Ilir Osmani	Vesna Dimovska Jordanova, Natasa Trpevska Sekerinov
13:40-13:50	Live & Virtual	Is there a need for prophylactic measures in anti VEGF-therapy to prevent secondary GON		Qëndresë Daka	Esma Shehu
13:50-14:00	Live & Virtual	General Overview on Post Covid 19 , Diabetes mellitus and Diabetic Retinopathy , statistics, tretment options - Retrospective study Jan.2022 - Jan 2023		Nora Burda	
14:20-14:40	Lunch				
14:00-14:05	Live & Virtual	The effect of hyperglycemia on intraocular pressure in patients with type 1 diabetes		Agon Rrusta	
14:05-14:15		Discussion			
	OCULOPLASTIC SESSION				
Moderators: Kelmend Spahiu, Naser Salihu, Orhan Kubati, Valvita Reçi, Mentor Gorani					
14:15-14:25	Live & Virtual	Pterygium surgery with limbo-conjunctival autograph, without sutures (with adhesive fibrin), impact on recurrences and pain		Orhan Kubati	Mirlinda Kubati Ajeti, Artan Ukshini, Shend Ajeti
14:25-14:35	Live & Virtual	Retraction of the lower lid		Kelmend Spahiu	
14:35-14:45	Live & Virtual	Unilateral infiltration of the optic nerve and orbit revealing relapse of an acute lymphoblastic leukemia		Valvita Reçi	

14:45-14:55	Live & Virtual	Orbital cavernous hemangiomas		Naser Salihu	Yllke Salihu, Mentor Gorani
15:05-15:10	Poster				
	Live & Virtual	CYCLIC ESOTROPIA: Case report		Era Tateshi	Bekim Tateshi
14:55-15:05		Discussion			
15:05-15:25	Coffee Break				
Pediatric Surgery					
Moderators: Gani Çeku, Emir Haxhija, Hysni Jashari, Dëfrim Koçinaj					
Oral Presentation					
15:25-15:45	Live & Virtual	Laparoscopic Pyloromyotomy for Hypertrophic Pyloric Stenosis in Children: does it Improve the Quality of Surgical Services?	Prof. Dr. Hajredin Ukelli & Ass. Prof. Faik Kafexholli for	Emir Haxhija	Besiana P. Beqo
15:45-16:05	Virtual	Laparoscopic pyeloplasty: Tips, tricks, and pitfalls;		Baran Tokar	
16:05-16:25	Virtual	How to Implement Artificial Intelligence Studies in Pediatric Surgery		Baran Tokar	
16:25-16:35	Live & Virtual	Gastroduodenal Duplication in a 3-month child		Nexhmi Hyseni	Izber Ademaj, Breta Kotorri, Guri Hyseni
16:35-16:45	Live & Virtual	Strangulation Of The Abdominal Organs In Previously Not Diagnosed Diaphragmatic Hernias – 2 Case Presentations		Hysni Jashari	Sadik Llullaku, Salih Grajçevci, Baton Kelmendi, Alban Rushiti, Diana Avdyli
16:45-16:55	Live & Virtual	Congenital Megaprepuce: Case reports of single stage surgery and Outcomes		Arta Syla	Kujtim Ukëperaj, Isber Ademaj, Arta Syla
16:55-17:05	Live & Virtual	Lymphatic Malformation in Children		Gani Çeku	

17:05-17:15	Live & Virtual	Clarifying the dilemmas of hypospadias classification		Dëfrim Kocinaj	Lazar Todorovic, Antigona Hasani, Ardian Shefkiu, Gani Çeku, Sejdi Statovci
17:15-17:25	Live & Virtual	Congenital Colonic Stenosis: A rare cases of intestinal obstruction		Arta Sylja	Kujtim Ukëperaj, Isber Ademaj, Arta Sylja
Poster					
17:35-17:40	Live & Virtual	Congenital kidney diseases in children are most common reason of Chronic Kidney Disease		Valbona Stavileci	Agon Kumnova Aida Kumnova
17:25-17:35		Discussion			
20:00	Gala Dinner				

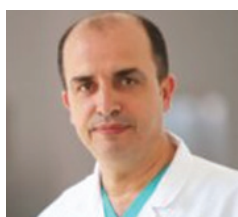
THURSDAY OCTOBER 12



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THURSDAY OCTOBER 12

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THURSDAY OCTOBER 12

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Professor of Ophthalmology, Istanbul University

Chief of the Surgery Pavilion, Regional Hospital Center "Dr. Xhafer Kongoli", Elbasan

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GuangCi Laureate Professor, Gastrointestinal Surgery Unit of Ruijin Hospital

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Professor at the Collège des Médecins des Hôpitaux de Paris

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Martin Gluck Endowed Professor of Surgery

Chief of General Surgery & Chief of Division of Trauma, Critical Care, Burns & Emergency Surgery

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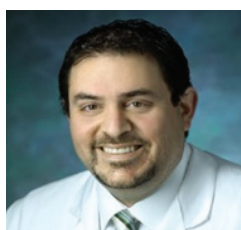
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Medical Director of the Operation Giving Back Program, American College of Surgeons

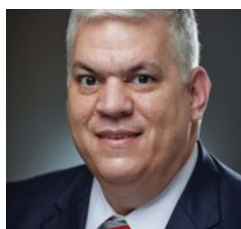
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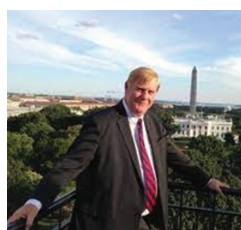
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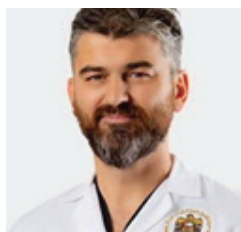
FRIDAY- SATURDAY, OCTOBER 12-13



Dr. Bajram Rexhepi for Combat Surgery | Gun Violence in America - A Public Health Problem

10:50-11:10, Beethoven Conference Room

Lecturer: Joseph V Sakran, MD, MPA, MPH



Dr. Adem Ademi for Emergency Surgery | Current Disaster Management: What everyone should know?

11:10-11:30, Beethoven Conference Room

Lecturer: Dr. Petrit Mulaku, MD, MSc



Prof. Dr. Osman Sejfi for Maxillofacial Surgery | Dental Traumatology: Surgical Solutions

11:30-11:50, Beethoven Conference Room

Lecturer: Lumnije Kqiku MD, DDS, Ph.D.



Dr. Hajrullah Saraçi for Critical Care Medicine | Whole blood

14:15-14:35, Beethoven Conference Room

Lecturer: Bellal Joseph, MD, FACS



Prof. Dr. Ali Zatriqi for Surgical Oncology | True or false: Breaking Myths about the Pancreatic Cancer

15:05-15:15, Beethoven Conference Room

Lecturer: Prof. Dr. Mert Erkan



Asst. Dr. Adnan Shabani for Plastic Surgery | The Standardized Recording of Complications in the field of Plastic Surgery: Why is it absolutely necessary?

09:50-10:10, Strauss A (1) Conference Room

Lecturer: Lars-Peter Kamolz, MD

FRIDAY - OCTOBER 12



Prof. Dr. Agron Pustina for Pediatric Orthopedics | Rare Complications of Total Hip Replacement

11:00-11:20, Strauss A (1) Conference Room

Lecturer: Prof. Dr. Gershon Volpin



Asst. Dr. Bedri Bakalli for Orthopedic Trauma Surgery | The Power of "NOW" in Pelvic Fractures Surgery

11:20-11:40, Strauss A (1) Conference Room

Lecturer: Prof. Dr. Ilir Hasani



Prof. Dr. Emine Gashi for Gynecological & Obstetric Surgery | A Retrospective Study on the Localization and Treatment of Ectopic Pregnancies at the Gynecological and Obstetric Clinic in Kosova

15:00-15:10, Strauss A (1) Conference Room

Lecturer: Prof. Asst. Dr. Brikene Dacaj Elshani



Prof. Dr. Sehadate Mekuli for Gynecological & Obstetric Surgery | Iatrogenic Injuries during Cesarean Section Delivery

14:50-15:00, Strauss A (1) Conference Room

Lecturer: Dr. Sahadete Shala



Asst. Dr. Shpetim Robaj for Anesthesiology | Update of Diagnosis and Treatment of Pulmonary Embolism

16:30-16:40, Strauss A (1) Conference Room

Lecturer: Vedat Eljezi, MD, Ph.D



Prof. Dr. Xhemil Bytyçi for Urology | OGG1 rs2304277 Gene Polymorphism in Bladder Cancer

10:35-10:45, Strauss B (2) Conference Room

Lecturer: Bujar Frangu, MD

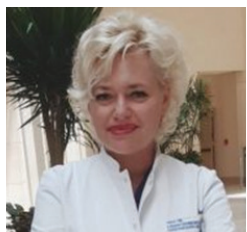
SATURDAY - OCTOBER 13



Prof. Dr. Talat Pallaska & Prof. Dr. Besim Sllamniku for ORL Surgery | Cochlear Implantation

11:40-11:40, Strauss B (2) Conference Room

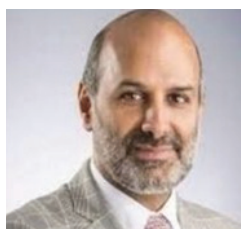
Lecturer: Deniz Tuna Edizer, MD, Assoc. Prof, MSc



Prof. Dr. Gazmend Shaqiri for Vascular Surgery | On-pump vs Off-pump Revascularization

12:30-12:50, Strauss "B" Conference Room

Lecturer: Prof. Dr. Ilirijana Haxhibeqiri – Karabdić



Prof. Dr. Sadri Bajraktari for Humanism and Vascular Surgery | Abdominal Aortic Aneurysmal Rupture: Risk Factor and Prediction

14:10-14:30, Strauss B (2) Conference Room

Lecturer: Hassan Al Thani, MD, FACS, MBA, MBBch, CABS, FRCSI/C



Asst. Prof. Dr. Shefqet Meha for Neurosurgery | Quality of Death in Surgical Practice: A 50 year Story from India

08:30-08:50, Beethoven Conference Room

Lecturer: Krishnan Ganapthy, M Ch (Neurokirurgji) FACS FICS FAMS Ph.D



Prof. Dr. Rifat Latifi – Advances in Trauma, Telemedicine and Technologies | Trauma System in Europe: An Ongoing Challenge

08:50-09:10, Beethoven Conference Room

Lecturer: Hayato Kurihara, MD, FACS, FEBS



The President, Prof. Dr. Rifat Latifi, for Global Health | Global Health in Surgery: Working beyond the "feel good"

11:30-11:50, Beethoven Conference Room

Lecturer: Dr. Girma Tefera

SATURDAY - OCTOBER 13



Prof. Dr. Sami Haxhibeqiri: Frontiers in Surgery | Global Surgery and Surgical Voluntarism; A Sustainable Model of Improving Access to Care

11:50-12:00, Beethoven Conference Room

Lecturer: Rifat Latifi, MD, FACS, FICS, FKCS



Prof. Dr. Salih Krasniqi for Laparoscopic Pioneers in Surgery | Laparoscopic hernia repair vs open hernia repair

15:30-15:50, Beethoven Conference Room

Lecturer: Demetrius E.M. Litwin, MD, MBA, FRCSC, FICS, FACS



Prof. Dr. Samedin Haxhijaha for Endoscopic Surgery | 20 years of experience in the treatment of colon cancer with laparoscopy and in particular with SILS-Laparoscopy

15:50-16:10, Beethoven Conference Room

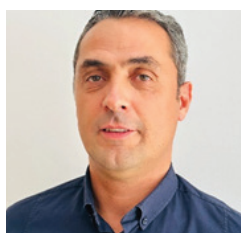
Lecturer: Kushtrim Shala, Dr. med.



Prof. Dr. Ymer Aliu for Minimal Invasive Surgery | Early versus delayed laparoscopic cholecystectomy for acute cholecystitis; predictive factors for conversion

16:10-16:30, Beethoven Conference Room

Lecturer: Prof. Dr. Rexhep Selmani



Prof. Dr. Muhamed Guguli | Trends in Surgical Management of Breast Cancer— an article review

16:45-16:55, Beethoven Conference Room

Lecturer: Dr. Bedri Osmani



Prof. Dr. Jashar Dula for Maxillofacial Surgery | Cleft lip and palate treatment: our experience

10:20-11:50, Strauss B (2) Conference Room

Lecturer: Prof. Dr. Mergime Prekazi Loxha

SATURDAY - OCTOBER 13

**Prof. Dr. Muharrem Gashi for Thoracic Surgery** | Chest Wall Stabilization

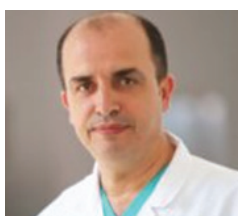
12:20-12:40, Strauss B (2) Conference Room

Lecturer: Mentor Ahmeti, MD, FACS

**Prof. Dr. Safet Beqiri for Lung Cancer** | Competency in VATS major pulmonary resections

12:40-13:00, Beethoven Conference Room

Lecturer: Tomaz Stupnik, MD, PhD

**Prof. Dr. Shaban Hasi for Neurosurgery** | Surgical Stabilization of Craniocervical Junction and Upper Cervical Spine

14:35-14:55, Strauss B (2) Conference Room

Lecturer: Prof. Dr. Fatos Ollashi

**Prof. Dr. Musa Haxhiu for Scientific Research** | Discovery of the Mechanisms and Biosignatures Underlying Rapid-Acting Treatment in Neuropsychiatry: Lessons Learned from Ketamine Discovery in Treatment-Resistant Mood Disorders

14:55-15:15, Strauss B (2) Conference Room

Lecturer: Dr. Bashkim Kadriu

**Dr. Xheladin Deda in Ophthalmology** | Minimally Invasive Surgical Approach for Complicated Vitreoretinal Diseases

09:00-09:20, Strauss A (1) Conference Room

Lecturer: Prof. Dr. Gürkan Erdoğan

**Prof. Dr. Qamil Haxhija for Leadership in Ophthalmology** | Congenital Cataracts: What has changed?

12:40-13:00, Strauss A (1) Conference Room

Lecturer: Huban Atilla, MD, FEBO

**Prof. Dr. Hajredin Ukelli & Asst. Prof. Faik Kafexholli for Pediatric Surgery** | Laparoscopic Pyloromyotomy for Hypertrophic Pyloric Stenosis in Children: does it improve the Quality of Surgical Services?

15:25-15:45, Strauss A (1) Conference Room

Lecturer: Emir Haxhija, MD, PhD, FEBPS

THIRD CLINICAL CONGRESS AWARDS

**LIFETIME ACHIEVEING AWARD “PROF.DR. SAMI HAXHIBEIQIRI”****Arben Gjata** | Prof. Dr.

General Surgeon

Rector, University of Medicine

Albania

**LIFETIME ACHIEVEING AWARD “PROF.DR. SAMI HAXHIBEIQIRI”****Hasim Saliu** | Prof. Dr.

Vascular Surgeon

North Macedoina

**LIFETIME ACHIEVEING AWARD “PROF.DR. SAMI HAXHIBEIQIRI”****Isuf Dedushaj** | Prof. Dr.

Doctor, epidemiologist, university professor, and doctor of medical sciences

Kosova

**LEADERSHIP BY EXAMPLE AWARD****Mentor Ahmeti** | MD, FACS

Vice-President of the Kosova College of Surgeons for USA

Chief of Trauma Service Line, Sanford Level One Trauma Center

Director of Advanced Trauma Life Support Course

USA

**DISTINGUISHED RESIDENT “PROF. DR. PREVEZA ABRASHI” AWARD****Dr. Dile Rrusta**

Resident, Plastic, Reconstructive and Aesthetic Surgery

EXCELLENT PARTNERSHIP AWARD**Sanfod Medical Center Fargo, North Dakota****Sanford World Clinic**

THIRD CLINICAL CONGRESS AWARDS

EXCELLENT PARTNERSHIP AWARD**International Virtual E-Hospital****VOLUNTARISM AWARD****Prof. Dr. Arsim Thaqi**

ENT Surgeon

**DISTINGUISHED MEMBER OF THE KOSOVA COLLEGE OF SURGEONS****Prof. Dr. Antigone Hasani**

Anesthesiologist

**DISTINGUISHED MEMBER OF THE KOSOVA COLLEGE OF SURGEONS****Prof. Asst. Dr. Brikene Dacaj Elshani**

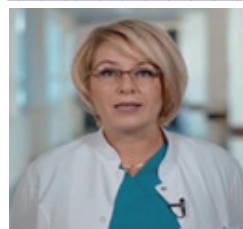
Gynecologist and Obstetrician

**DISTINGUISHED MEMBER OF THE KOSOVA COLLEGE OF SURGEONS****Prof. Dr. Ismet Shaqiri**

Abdominal Surgeon

**DISTINGUISHED MEMBER OF THE KOSOVA COLLEGE OF SURGEONS****Prof. Dr. Shqiptar Demaçi**

Thoracic Surgeon

**DISTINGUISHED MEMBER OF THE KOSOVA COLLEGE OF SURGEONS****Prof. Dr. Vlore Ibishi**

Gynecologist and Obstetrician

THIRD CLINICAL CONGRESS AWARDS

**PUBLICATION AND INOVATION OF THE YEAR AWARD****Qëndresë Daka** / Prof. Asoc.

Professor at the Faculty of Medicine, University of Pristina and ophthalmologists at the Eye Clinic, University Clinical Center of Kosova.

Kosova

FRIDAY - OCTOBER 12



Politics and Medicine: Should Surgeons Become Politicians?

A Personal Perspective of Trauma Surgeons

Turned Minister of Health?

Rifat Latifi, MD, FACS, FKCS, FICS

Former Minister of Health, the Republic of Kosova

President of Kosova College of Surgeons

Trauma, Critical Care and General Surgeon,

Abrazo West Campus, Goodyear, Arizona

Adjunct Professor of Surgery,

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Background: Physicians and surgeons as elite segment of any society over the history of the world have had major impact in their communities, region and countries they lived, and some have had major impact world-wide. Many doctors around the world serve as legislators, or as presidents or prime ministers of their countries. November 16, 2021, unexpected I became a Minister of Health of Republic of Kosova, as non-politician Minister. Less than a year later I resigned from the position, after I submitted the strategy and concepts of transformation of healthcare of Kosova. The objective of this paper is to review the experience/results of a short-term role in politics, and lessons learned.

Methodology: This is a retrospective review of prospectively collected data and findings of the state of healthcare in Kosova, while Minister. To study healthcare of Kosova we used: 1) A structured interviews with stakeholders, and a written survey with directors of each clinical discipline; 2) A review of patients treated outside of the public healthcare system (2019-August 2022); and 3) Review of reports on hospital infrastructure; and other opinions and materials available on healthcare system.

Results: Based on the analysis and reports, the need for a seven-pillar platform was identified (Table 1), along with 12 centers of excellence (Table 2), and major reforms of residency program. Establishing new advance clinical fellowships was proposed and initiated (Table 3).

Conclusion: Even in a short-term involvement as Minister of Health, one can gain enough understanding regarding the state of the country's healthcare system to devise strategies for its transformation. Surgeons, and other physician experts should get involved in politics and be at the table. Nevertheless, one must understand that not being part of the political party, you are the loneliest man in the planet and may not get the support you need to do the job.

FRIDAY - OCTOBER 12



Ethical and Legal Framework for Routine Surgical Video-recording
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FKCS (Hon.), ASGBI (Hon.), FRCSEd (Ad Hom.), MAMSE
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The first recorded anesthesia and probably the first surgical procedure was done in 1899 in Buenos Aires. Film-maker Eugene Py recorded Professor Alejandro Posadas at the University of Buenos Aires hospital's garden performing a thoracic hydatid cyst operation. Initially all the OR were open to the eyes of the public, but later on they transformed themselves into closed units, where 40% to 60% of all medical errors occur.

Video capture of the surgical activity has several implications, which include, among others, the following:

- Accountability of the surgical activity
- Performance assessment
- Quality improvement
- Patient safety
- Consequences due to the Hawthorne effect
- Ethical and legal consequences

It should be duly recognized that the dissemination of laparoscopic and endoscopic surgery favored the recording of the procedures. A distinction should be done between the recording of individual procedures with academic and/or documentation purposes and a full OR recording (eg Blackbox[®], developed at the University of Toronto), since each one poses different threats and benefits.

When confronted to this topic, every surgeon should bear in mind not only the regulations regarding the privacy of personal data but also the use and dissemination of the registered activities. Some of the goals of the surgical video-recording include: clinical care, use as registry, aid for surgical training, simulation and teaching, tool for quality improvement and research, not to mention machine learning and AI.

Video recording also serves means of assessing technical skills, like ease of tissue handling, tissue exposure, instrument handling, efficiency of time and motion and flow of the operation. Some of the contextual issues which play a major role in the legal and ethical implications of video-recording are represented by: the estrangement between the patient and the public, what really happens in the OR, a decreased confidence in health care institutions, demand for transparency, increased accountability of OR activity and patients' empowerment.

Ethical implications of surgical video-recording are not governed by a set of rules and are not punishable by law, meanwhile the medico-legal implications are based on a set of rules and are punishable by law if not adhered by. The stakeholders at risk are represented by the patient, the surgeon, the team, the institution and the society as a whole and all the involved parties should consider the risks, the benefits and the potential harm.

In a 1995 position paper, the International Committee of Medical Journal Editors determined that creation of an audiovisual record without any possibility of patient identification does not require consent. The guidelines of the HIPAA consider that while avoiding identification, a laparoscopic surgery video does not compromise privacy.

When the video is included in the operative note and thus in the electronic record, it may serve purposes of medico-legal impact, which may be used as a method of proof. Different regulations will impact in the following facts: who owns and who controls the video. A particular situation is represented by the live transmission of a surgical procedure, which is not favored by the American College of Surgeons.

FRIDAY - OCTOBER 12



Artificial Intelligence and Medical Writing: where are we going?

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Artificial intelligence has made enormous inroads in medicine and is being developed and used in many specialties. Explainable artificial intelligence (EAI), defined as a compilation of algorithms that improve on traditional machine learning techniques by providing the evidence behind predictions. For example, imaging techniques can be programmed such that when an image contains evidence of acute inflammation, an XAI system will indicate what and where that evidence is (e.g., gallbladder, hepatocystic triangle) and warn the surgeons of possible intraoperative events (potential bleeding or danger to essential structures (e.g. bile duct) that enhance their clinical judgement, thus potentially helping to avoid complications. By anticipating and avoiding adverse events (bleeding, difficulty in identifying essential structures, operative times will decrease and this should improve patient outcomes.

AI in medical writing does not work exactly in the same way. The mechanisms behind AI medical writing stems from recognizing and then inserting pre-contracted sentences that were used in other publications because of standardized and characteristic logics from large amounts of text, data bases, and other (not always controlled) sources of information. While AI can undoubtedly perform well to structure an introduction, material and methods, constructing a discussion worthy of publication in a high-reputed scientific journal remains task only humans can do. One must not forget that the system relies only on the probability of the critical appraisal process necessary as gleaned from the literature: the determination of the probability remains unknown (frequency of citations? ranking of journals? Or some combination thereof? Likewise, the medical writing sequences (phrase, sentences) are sorted out in some similar (but unknown) way, and once again, only human minds can determine whether the sequences make sense in the context of the paper being composed.

Ethical problems remain unresolved: the definition of authorship is well codified internationally; AI cannot be an author by itself. Moreover, there is the problem in determining the veracity and accountability of the scientific publication; who is responsible for the Intellectual property? Who is responsible for the legal responsibility?

Another problem might be that AI tools will encourage unskilled or inadequately prepared non-physician medical writers to widen their scope of work and professional efforts, without the necessary interaction with the physicians necessary for writing successful and academically correct papers.

FRIDAY - OCTOBER 12

Current Disaster Management: What everyone should know?***Dr. Petrit Mulaku******Emergency Physician, ADSCC, Abu Dhabi, UAE******petrit.mulaku@hotmail.com******Named Lecture: Dr. Adem Ademi for Emergency Surgery***

In today's world, hospitals play a crucial role in mitigating the impact of external disasters and providing essential healthcare services during crisis situations. This presentation aims to highlight the significance of external disaster management in hospitals and the key strategies employed to ensure an effective response and build resilience.

The presentation begins by giving the definition of external disaster, the nature and scope of external disasters, such as natural disasters (earthquakes, massive fires, floodings etc.), man-made accidents (plane crash, massive traffic accidents, industrial accidents), or pandemics. It emphasizes the unique challenges faced by hospitals when dealing with these events, including overwhelming patient influx, resource shortages, infrastructure damage and coordination with external stakeholders.

Next, the presentation discusses the principles and components of effective external disaster management in hospitals. It emphasizes the importance of pre-disaster planning, including risk assessment, development of emergency response plans and training of staff. It also discusses the importance of communication channels between response teams, hospitals and other important stakeholders like government agencies, police, firefighters etc.

Then the presentation focuses in the core elements of hospital preparedness, focusing on critical aspects like the activation of external disaster code, triage protocols, resource allocation, staff mobilization, patient evacuation strategies etc. It emphasizes the need for interdepartmental and interdisciplinary collaboration and coordination. It highlights the importance of technology and information systems in external disaster management.

Furthermore, it discusses when the external disaster code should be deactivated and post-disaster recovery plan in order to return the hospital to pre-disaster operational state. It also focuses on the importance of continuous improvement through post-event evaluations, simulation exercises and knowledge sharing among hospitals and relevant stakeholders.

In summary, this presentation aims to provide healthcare workers, administrators and policymakers with valuable insights into the essential elements of external disaster management in hospitals. It stresses in the importance of having written policy and contingency plan that provides the basis of organized, structured and integrated hospital response to external disasters that can strike any time and any place.

FRIDAY - OCTOBER 12



Dental Trauma Injuries: Surgical Solutions

*Lumnije Kqiku MD, DDS, PhD and Kurt Alois Ebeleseder MD, DDS, PhD
Department of Dental Medicine and Oral Health, Division of Preventive
an Operative Dentistry, Endodontics, Periodontology,
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Named Lecture: Prof. Dr. Osman Sejjfija for Maxillofacial Surgery

Traumatic dental injuries of permanent teeth occur frequently in children and young adults.

The most commonly used classification system for dental trauma is Andreasen's classification and is applied to both primary and permanent teeth.

Managing dental trauma is based on proper diagnosis of the type of injury, treatment techniques also for immature teeth, prospective treatment planning and follow up.

Avulsion, Extrusion, Intrusion, Lateral luxation and alveolar process fractures are the most serious injuries in the permanent dentition, and need a prompt and correct emergency management.

Soft-tissue of the face and oral cavity are frequently seen in traumatic dental injuries. These types of wounds can be scarifying for patients and suturing of lip lacerations should be carried out after intraoral injuries of urgent character have been treated. Otherwise it may be difficult to enter the oral cavity once edema has started to develop.

The most common procedures employed in managing dental trauma include: endodontic, surgical and orthodontic treatment.

In this lecture, the surgical treatment of avulsion, intrusion, lateral luxation, alveolar process fractures, crown root fractures and lacerations of the oral mucosa, gingiva and lip will be presented.

The aim is to improve the knowledge on initial dental trauma treatment.

FRIDAY - OCTOBER 12



Non-STB training for laypersons improves the WCCI (willingness, confidence, comfort, and intervention) to provide immediate care for injured patients.

Do trauma first aid Training Courses for Laypersons Improve Knowledge, Skills, and Attitudes?

A Systematic Review

Husham Abdelrahman, Rafael Consunji, Ahammed Mekkodathil,

Ayman El-Menyar, Sandro Rizoli, Hassan Al-Thani

Presenting Author: Husham Abdelrahman

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Background: Trauma is the leading cause of death worldwide among young and 4th overall. Most of death toll happen in developing countries with poor resources particularly prehospital care systems. Many of these deaths are preventable with relatively simple trauma first aid involving air way management, stop the bleed and proper spine motion restriction and rapid transportation.

WHO identified layperson first responders training as crucial step in establishing trauma system. To impact the associated high mortality and morbidity large section of public need to be trained.

Aim: We conducted a systematic review to analyze the impact of training on willingness, confidence, comfort, intervention as well as the outcomes (Mortality and physiologic scores on admission).

Method: PubMed and Google Scholar databases were used to identify relevant peer-reviewed research articles describing laypersons' training from December 1, 2013, to October 31, 2022. In addition, a hand search of article references was undertaken

Results: Our database searches yielded 2,893 unique papers. We retained 33 articles for full-text review, resulting in 16 eligible papers. The most reported findings included the feasibility of short training in knowledge and skill acquisition and a willingness to assist in first aid of injured patients in sub-Saharan Africa (eight studies). Six studies were from the USA; four papers reported layperson stopping the bleeding tourniquet application; two papers focused on Somalian minorities and high-risk, underserved areas; one from a middle-income country (Guatemala) in South America. Nine studies reported statistically significant improvements in willingness, confidence, comfort, and likelihood to safely respond to a trauma scene and try to control a bleeding patient with a tourniquet. Six studies reported substantial reductions in the retention of knowledge and skills after a few months (3-9 months). Few studies followed incidence reports to follow on utilization of knowledge and skills acquired during training in the follow-up period. No study report on

Conclusion: blunt trauma first aid courses for laypersons are feasible and significantly improve knowledge, skill, confidence, and willingness to intervene for injured patients. The evaluation of clinically relevant patient outcomes is needed to strengthen further the evidence behind the recommendations for the more widespread adoption of these courses and establish a communication network (Trauma system).

FRIDAY - OCTOBER 12



Epidemiology of Large-Animal Related Injuries

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Background: Large animal-related injuries are under-represented public health problem worldwide. This study aimed to explore the epidemiology and patterns of the large animal-related injuries including the horse and camel-related injuries (HCRI).

Methods: It was a retrospective analysis of all patients who admitted with a large animal injury. Data included patient's demographics, mechanism of injury, anatomical location and severity of injury, and hospital outcomes over four years.

Results: There were 273 hospitalized patients with HCRI representing 1.3% of the total trauma admissions. Of these, 145 (53.1%) and 128 (46.9%) were horse (HRI) and camel-related injuries (CRI) respectively. It affected mainly age group of 20-29 yrs and 88% were males. Patients with HRIs were younger (27.5 ± 11 yrs) than CRIs (34 ± 13.5 yrs). Injuries to the extremities were the most common (62% vs 40%), followed by the head injury (25.5% vs 31%) among the HRIs and CRIs, respectively. Falling off the animal followed by getting kicked by the HCRI were the common mechanism of injury. There were four fatalities (1.5%), all due to brain injury.

Conclusion: HCRI predominantly affect young adult males in Qatar and may involve serious injuries, exhibit distinct injury patterns, however, it is associated with low mortality. Preventive measures need to be strictly implemented.

FRIDAY - OCTOBER 13

**Mass Casualty Incident Preparedness*****Mentor Ahmeti^{1,2}, Anthony J. Duncan¹,******Ikttesh K. Chahal¹******¹University of North Dakota School of Medicine and Health Sciences,
Department of Surgery 1919 N Elm Street, Fargo, ND 58102, USA******²Sanford Medical Center Fargo, Department of Trauma,
Department of Surgery******5225 23rd Ave S, Fargo, ND 58104, USA******Principal Contact & Presenting Author: Mentor Ahmeti,******mentorahmeti@hotmail.com***

Background: Rib fractures contribute to 248,000 annual emergency department visits in the United States. In recent years, surgical stabilization of rib fractures has gained popularity due to research indicating its benefits across various patient populations.

Data Sources: Data for this study were collected from PubMed and Google Scholar. Keywords such as “Rib” or “Chest,” combined with terms “Fixation,” “ORIF” (open reduction and internal fixation), “Stabilization,” “Plating,” or “Management,” were employed.

Conclusions: Although there is some variability in the data regarding the outcomes of rib fixation, studies advocating for early rib fixation demonstrate significant benefits in terms of reduced hospital and ICU length of stay, as well as decreased duration of ventilation.

FRIDAY - OCTOBER 12

Evaluation of Blunt Abdominal Trauma, two years experience***Agron Dogjani^{1,2}, Kastriot Haxhirexha³, Arben Gjata¹, Kastriot Subashi²******¹ Department of Surgery, University of Medicine, Tirana, Albania,******² Department of Surgery, University Hospital of Trauma, Tirana, Albania,******³ The State University of Tetovo, Republic of North Macedonia******agrondogjani@yahoo.com***

Introduction: Blunt abdominal trauma is a leading cause of morbidity and mortality among all age groups. Identification of serious intra-abdominal pathology is often challenging; many injuries may not manifest during the initial assessment and treatment period.

Material and methods: The study is in units center performed within the time period December 2017 to December 2019. In our study included 240 patients who were presented in UHT, in Tirana, Albania.

Analysis of data: To see the relationship between two variables the correlation coefficient was used to Kendal's tau. The data were presented through tables and charts of different types. Was considered significant p values <0.05 (or 5%)....

Results: Through the coefficient of correlation of Kendal's seen that there is a difference statistically significant between the mode of transport and the state of patient in admission ($r = 0199$, $n = 240$, $p = 0.001$), type of trauma and tactic of treatment ($r = 0301$, $n = 254$, $p < 0.001$), ISS and complications ($n = 240$, $p < 0.001$), ISS and form of treatment ($r = 0318$, $n = 240$, $p < 0.001$), between the ISS and *hospital stay* ($r = 0279$, $n = 240$, $p < 0.001$) ...

Conclusions: The results of trauma treatment have a close relation; hemodynamically status, age, mechanism of trauma, time of presentation to hospital...

Keywords: blunt abdominal trauma, intra-abdominal injury, hemodynamically status

FRIDAY - OCTOBER 12



Emergency Assistance at the Scene of Electric Shock

Isuf Bajrami

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Intro: The electric shock can cause burns in to the skin and deep tissue, including muscles and nerves. The electric shock throws the victim away, he can also suffer mechanical injuries. The Electric shock can lead to the cardiac arrhythmias and cardiopulmonary arrest.

Assessment: be aware of your safety, the safety of the patient and the scene.

Evaluate ABCDE

Patients exposed to a high voltage source should always be taken to the hospital. If, after exposure to electrical voltage in the home or low voltage source, the patient is asymptomatic without injury and has a normal initial 12-lead ECG, no routine is needed to transport to the hospital.

Experiences of prehospital treatment

The medical team's first priority on the part of the physician is to break contact between the patient and the power source by turning off the power (eg turning off the breaker or switch, or unplugging the device). The Safety of pre-hospital emergency medical team and care is absolute priority. If the high voltage lines are suspected, to avoid shocking the rescuer, no attempt should be made to free the patient until the power has been disconnected.

Contemporary methods of treatment

Defibrillator is mandatory.

- handle ABCD
- immobilize neck rings when there is a risk of injury
- give oxygen
- pave the way iv.
- monitor blood oxygen saturation
- constantly monitor the heart rate
- record 12-channel ECG
- treat burns and mechanical injuries
- everything you observe, measure and do must be documented

Conclusions: assessment the safety of the event location. Treat cardiac arrest according to the usual procedure. Despite seemingly minor injuries, severe tissue damage is possible. Exposure to household voltage does not necessarily require hospital treatment.

Keywords: electric shock, location, treatment, evaluation

FRIDAY - OCTOBER 12



**The Reemerging Role of Whole Blood in Modern Trauma Care:
Is Whole Greater Than the Sum of Its Parts?**

Bellal Joseph, MD, FACS

Martin Gluck Endowed Professor of Surgery

Chief of General Surgery & Chief of Division of Trauma,

Critical Care, Burns & Emergency Surgery

University of Arizona

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Named Lecture: Dr. Hajrullah Saraçi for Critical Care Medicine

Hemorrhage is the leading cause of potentially preventable deaths in both military and civilian trauma patients. Early hemorrhage control and resuscitation with blood products have been shown to improve survival in hemorrhaging trauma patients. While the use of balanced component therapy continues to be the standard of care for resuscitation, whole blood transfusion in adjunct to component therapy is increasingly becoming the modality of choice for resuscitation of civilian trauma patients across the United States.

Whole blood resuscitation offers several advantages including higher hematocrit, platelet and factor concentrations, lower additive volumes, and faster times to balanced transfusion of equivalent volumes of red blood cells, plasma, and platelets, making it logistically easier to administer. Multiple retrospective and prospective studies have shown that whole blood in adjunct to component therapy is associated with improved outcomes in trauma patients. Multiple prospective trials are currently under progress evaluating the impact of pre-hospital and in-hospital transfusion of whole blood in trauma patients.

Despite increasing evidence on the role of whole blood in resuscitation, the overall use of whole blood remains low. There has been a recent upward trend in the number and proportion of trauma centers using whole blood. Civilian practice management guidelines are yet to formally offer recommendations on the role of whole blood in resuscitation.

This session will focus on the current evidence, ongoing trials, indications, adjuncts, benefits, and risks of whole blood transfusion in the resuscitation of hemorrhaging trauma patients.

FRIDAY - OCTOBER 12



Complex Abdominal Wall Reconstruction with Biologic Mesh:

Operative Outcomes on 287 Patients

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Mathew McGuirk², James Choi², Kenji Okumura²*

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Introduction: Complex abdominal wall defects (CAWD) requiring complex abdominal wall repair (CAWR) represent an important clinical and technical surgical challenge in the presence of significant comorbidities. While often life changing procedure, which can improve significantly patients wellbeing and self-image, CAWR may be associated with major peri and post adverse outcomes. We aimed to report the results on a large patient population and identify independent outcome predictors.

Methods: All patients who underwent CAWR with biologic mesh between January 2016 and November 2021 at the tertiary academic center were studied using univariable and multivariable regressions. In addition, we updated our previous systematic and metanalysis on the subject.

Results: We studied 287 patients with a mean age of 59.1 ± 13.4 years, of whom 45.3% were female. The mean BMI was 32.4 ± 8.3 kg/sq m. 36.6% of patients were operated for recurrent incisional/ventral hernia. Perioperative complications in aggregate were observed in 38.7%. The most frequent specific adverse outcomes were surgical site infection (22.6%), reoperation (20.9%), seroma (10.1%) and wound necrosis (9.4%). Mean hospital length of stay was 17.7 ± 22.4 days. During the median follow-up of two years, recurrence hernia rate was 3.5 %, similar to deaths within 90 days that occurred in 3.5% patients. On multivariable regression, the most consistent independent predictors of adverse outcomes were emergency operation requiring damage control laparotomy, extensive lysis of adhesions, obesity, contaminated CDC wound class, loss of abdominal domain, and delayed wound closure.

Conclusions: This study is among the largest series on outcomes after CAWR with biologic mesh. Our estimates of most outcomes are near the midpoint or below compared to other large centers-specific estimates, however, recurrence rate at two years was very low at 3.5 %. High risk patients such as those that require damage control laparotomy during the emergency operation, fistula take-down, intestinal resection, lysis of adhesions, have BMI > 35kg/m², and have CDC wound class III/IV have higher rates of perioperative complications, including need for reoperation and increased hospital length of stay.

FRIDAY - OCTOBER 12

**Borderline Pancreatic Cancer: How to manage it?***Erman Aytaç**Almir Miftari**Acibadem University Hospital – Atakent**Halkalı Merkez Mah. Turgut Özal Bulvarı**16 Küçükçekmece İstanbul***Presenting Author: Mert Erkan*****mert.erkana@acibadem.com******Tel No: 02124044549******+905301017277***

Pancreatic adenocarcinoma is one of the most aggressive forms of cancer and is estimated to become the second leading cause of cancer-related deaths in the World by 2030. Surgical resection is the only treatment option that has potential for long-term survival and cure. At the initially diagnosis only 20% of the patients are resectable and the 20 – 25% are borderline resectable. For those patients with the resectable disease, the five-year survival is only 20%. Prognosis is highly dependent on a margin status, and the total gross excision and histologically negative margins (R0 resection) are associated with the best outcomes. Borderline resectable pancreatic cancer is a specific group of patients that require detailed focus. Many groups have proposed definitions, however there is not yet a universally accepted definition of borderline resectable pancreatic cancer. In general, borderline resectable pancreatic cancer is neither clearly resectable nor clearly unresectable. Borderline resectable group of patients usually have vascular involvement and are generally accepted as inoperable in most centers and receive palliative chemotherapy. However, with the help of an effective neoadjuvant treatment, such as FOLFIRINOX, they can become operable. Problem that occurs after neoadjuvant treatment is that fibrous tissue develops around the vessels and makes it impossible to radiologically categorize them as an operable cancer. In such case exploration with artery first approach should be considered and according to the intraoperative findings artery and vein resection and reconstruction should be performed. This patient should be consulted during multidisciplinary meetings in a high volume centers specialized in treating complex pancreatic cancers.

Questions:**1. What is true regarding pancreatic cancer?**

- Every patient with pancreatic cancer is operable
- Curative rate with only surgery is about 70%.
- The best way of treatment is radical chemotherapy
- Borderline resectable pancreatic cancer is neither clearly resectable nor clearly unresectable
- Patient presenting with jaundice are operable

2. What is true regarding pancreatic cancer?

- At the initially diagnosis approximately 3% of the patients are resectable
- At the initially diagnosis 20 – 25% are borderline resectable
- Borderline resectable cancer are cancer with liver metastasis
- All the statements are true
- Borderline resectable cancer are cancer with lung metastasis

1.d 2. b

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True or False: Breaking Myths about the Pancreatic Cancer

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Pancreatic cancer (PC) is one of the deadliest cancers with an increasing incidence. Pancreatic cancer is encountered more frequently as the average life span increases. It will rise to the 2nd rank in cancer-related deaths by 2030. At this point, it is absolutely necessary to mention the wrongs that are known to be correct.

1. False: Every PC causes jaundice.
Fact: Only cancers located in the head of the pancreas that block the biliary tract cause jaundice.
2. False: Every PC causes pain.
Fact: Almost half of the patients do not complain about pain initially.
3. False: Every pancreatic tumor is malignant.
Fact: Some of the pancreatic masses are benign.
4. False: It is impossible to cure pancreatic cancer.
Fact: With surgery and effective chemotherapy, 5-year survival rate can exceed 40%.
5. False: PC spreads when operated.
Fact: The only way to cure PC permanently is the combination of effective surgical treatment and chemo/radiotherapy.
6. False: Surgery is the only effective treatment.
Fact: Although surgery alone provides clinical benefit, it is insufficient to render the patient disease-free without accompanying chemotherapy.
7. False: Non-surgical treatment of PC is possible.
Fact: It is still not possible to cure PC without surgical treatment.
8. False: It is not possible to diagnose PC at an early stage.
Fact: Thanks to improved diagnostic methods and identification of risk groups, it is possible to detect cancer at an early stage at individuals at risk.
9. False: Patient cannot live without pancreas.
Fact: Patients who use insulin and enzyme supplements regularly, can live a normal quality of life without the pancreas.
10. False: Patients with PC should avoid consuming sugar and fat.
Fact: To prevent cancer related cachexia, Adequate carbohydrate and fat intake should be continued by adjusting the dose of the insulin and enzyme supplements.

Self-Assessment Questions and answers

1. What is **false** regarding the pancreatic cancer?
 - a) Surgery alone is insufficient to render the patient disease-free.
 - b) Every patient with the pancreatic cancer presents with jaundice
 - c) Thanks to improved diagnostic methods, it is possible to detect cancer at an early stage.
 - d) With surgery and effective chemotherapy, 5-year survival rate can exceed 40%
 - e) Almost half of the patients do not complain about pain initially

2. What is **true** regarding the pancreatic cancer?
 - a) Every patient with the pancreatic cancer has an abdominal pain initially
 - b) Patients with the pancreatic cancer can be treated only by surgery
 - c) There is no place for chemoradiotherapy when treating patients with pancreatic cancer
 - d) Patients with pancreatic cancer in tail can cause jaundice
 - e) Patients can live without pancreas with the help of the insulin and enzyme supplements

Answers:

1- b;

2- e

FRIDAY - OCTOBER 12

**Challenging Cholecystitis in Frail Patients***Hayato Kurihara, Matteo Maria Cimino,
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Acute cholecystitis (AC) is the most performed abdominal surgical procedure in Europe and gold standard treatment is represented by laparoscopic cholecystectomy (LC). However, due to the ageing society and the growth of immune-compromised population with multiple comorbidities and extensive use of anticoagulants, surgery may expose patients to high perioperative risks. Frailty plays a pivotal role in surgical decision-making process, but there is no consensus on its assessment and a multidisciplinary approach might be useful to quantify patients' risk and to identify a tailored surgical or alternative approach. Although index cholecystectomy is probably the best option in most cases, there is a subset of patients who might benefit from alternative strategies that might be considered as a "bridge to surgery" techniques such as percutaneous gallbladder drainage (PT-GBD), endoscopic trans-papillary gallbladder drainage (ET-GBD) and endoscopic ultrasound guided gallbladder drainage (EUS-GBD). Among these techniques the recent introduction of lumen apposing metallic stents (LAMS) that might be deployed in the inflamed gallbladder under EUS guidance through the duodenum or stomach might be considered even a definitive treatment in patients unsuitable for surgery, but this method is available only in high specialized centers and, although promising the results need to be validated on larger volume of patients. In conclusion the strategy and decision making should be based on severity of disease context, patients' physiology and mostly, local resources context; a "one size fits all" approach should be avoided in such population that would benefit from a stepwise and multidisciplinary pathway. This population might tolerate acute disease first insult, but not a second insult due to a complication as bile duct injury and the use of intraoperative indocyanine green fluorescence should be used whenever possible.

FRIDAY - OCTOBER 12



Emergency Admission of Liver Abscess: Risk Factors of Mortality

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Background: Despite relatively low rates, liver abscesses, or puss filled pockets in the liver, are a growing concern for healthcare providers and hospitals. Specifically, in untreated patients, morbidity and mortality rates are on the rise. Additionally, due to the liver's central location in the abdomen, lack of agency and action in liver abscess cases can lead to spreading complications in adjacent organs. A better understanding of the comorbidities and other various risk factors could improve hospital efficiency and patient outcome for those involved in this patient population. This study was undertaken in order to determine the underlying risk factors which may impact the mortality of patients who present with liver abscesses.

Methods: This retrospective study analyzed data from the National Inpatient Sample for patients who were admitted with a primary diagnosis of abscess of the liver from 2005 to 2014. Numerous factors of interest were utilized to stratify the data in order to determine risk factors associated in in-hospital mortality using statistical tests, including a multivariable generalized additive model (GAM).

Results: A total of 1,665 patients were admitted with the primary diagnosis of liver abscess. The mean and median age were both 58 years. Males and White race accounted for the majority of the patients admitted (57.5% and 64%, respectively). Overall mortality rate was 1.7%. GAM revealed older female patients, patients managed with operation and those hospitalized for more than three weeks had higher odds of mortality. OR (95%CI) for age, female gender and operation were 1.07 (1.03, 1.10), 3.99 (1.56, 9.68), and 3.99 (1.71, 9.31), respectively (Table 1). The estimated degree of freedom for hospital length of stay was 4.66 (P=0.01) which indicated a significant, non-linear association between mortality and hospital length of stay with the highest odds of mortality for patients hospitalized more than three weeks (Figure 1). Comorbidities that were flagged as possible risk factors included coagulopathy, diabetes (chronic complications), liver disease, and solid tumor (Table 1).

Conclusion: The odds of mortality rate in patients with liver abscesses was 4 times higher in women than in men, and also it increased by 7% for every year increase in age. The odds of mortality increased significantly after three weeks of hospitalization. The odds of mortality were 4 times higher in those who underwent operative treatment as compared to those treated non-surgically.

Key Words: Liver Abscess, In-hospital mortality, Age, Hospital length of stay, Operation

Table 1. Associations between mortality and various factors in patients admitted with a primary diagnosis of liver abscess, analyzed by multivariable generalized additive model. Mortality was the dependent variable.

Patient Characteristics, N=1,559	OR (95%CI)	P
No Operation	3.99 (1.71, 9.31)	0.001
Age, Years	1.07 (1.03, 1.10)	0.001
Female Sex	3.99 (1.56, 9.68)	0.003
Coagulopathy	4.16 (1.40, 12.30)	0.01
Diabetes, Chronic Complications	10.24 (2.87, 36.58)	0.001
Liver Disease	17.48 (1.73, 176.38)	0.015
Solid Tumor	6.51 (2.43, 17.42)	0.001
Hospital Length of Stay, Days	EDF = 4.66	0.01
Race	Removed	
Income Quartile		
Insurance	Via	
Hospital Location		
Invasive Diagnostic Procedure	Backward	
Drug Abuse		
All Other Associated Comorbidities	Elimination	

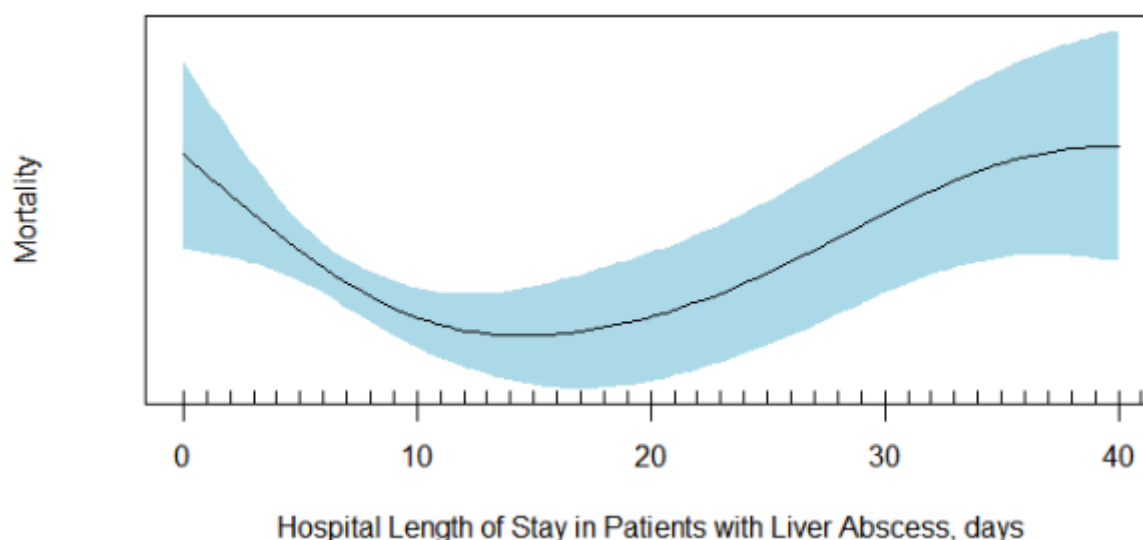


Figure 1. Association of in-hospital mortality and hospital length of stay in patients admitted with a primary diagnosis of liver abscess in NIS database, 2005-2014, according to generalized additive model (GAM). The estimated degree of freedom of 4.66 ($P=0.01$) indicated a significant, non-linear association between in-hospital mortality and hospital length of stay after adjusting for age, gender, race, income quartile, health care insurance, hospital location and comorbidities. The odds of mortality increased significantly after three weeks of hospitalization. Age, sex, operation status and several comorbidities were also significantly associated with in-hospital mortality in multivariable GAM regression.

FRIDAY - OCTOBER 12



Damage Control Surgery for Abdominal Emergencies

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About 30-40% of trauma-related deaths are caused by uncontrolled hemorrhage (Duchesne JC et al. The Journal of Trauma: Injury, Infection and Critical Care, 2010). Many of these deaths could be avoided by high quality and standardized damage control surgery. This means a rapid termination of the surgical intervention after controlling the life-threatening bleeding and contamination. By this technique, the patient is stabilized for clinicians to reverse the physiologic effects of the injury. According to the surgeon a multidisciplinary team consisting of anesthesiologists, intensive care physicians, blood specialists, respiratory therapists, specialized nurses and others are necessary to ensure adequate stabilization of the patient.

Indications for damage control surgery are: hemodynamic instability, systolic pressure for more than 60 min < 90mm Hg, temperature < 34°C, coagulopathy, metabolic acidosis (pH < 7.2, base excess > 5 and worsening), serum lactate > 5mmol/l, more than 10 units of blood required. Furthermore, if definitive repair is not possible, major venous injuries (e.g. injuries of retro-hepatic vena cava, great hepatic veins, trauma of pelvis veins), grade VI liver trauma, concomitant injuries like heavily bleeding pelvis fractures, as well as long operating times and suboptimal responses to resuscitation.

Damage control surgery can be divided into three phases: 1) emergency laparotomy phase, 2) ICU resuscitation phase, 3) definitive reconstruction phase.

Ad1) Controlling hemorrhage, contamination control, abdominal packing and closure of the abdominal cavity by using a temporary closure system dominate this phase.

Ad2) Step 2 is characterized by correction of factors like acidosis, coagulopathy, hypothermia by a multidisciplinary team.

Ad3) This phase occurs when the intensive care team has succeeded in stabilizing the patient and balancing the physiological deviations. The optimal time for definitive repair and closure of the abdominal wall depends on the severity and extent of the injury. In general, this is possible after 24-48 hours.

Although the application of the concept of damage control has greatly reduced mortality in severe abdominal trauma, it is also associated with complications like increased incidence of intra-abdominal abscesses (50-80%), development of entero-atmospheric fistulas (2-25%) and abdominal compartment syndrome (10-40%), especially if the emergency laparotomy is not performed carefully or correctly. Postoperative fascia dehiscence is also described in up to 25% after damage control surgery.

FRIDAY - OCTOBER 12



**Delayed Operation is a Significant Risk Factor for Mortality in Patients Hospitalized with Chronic Gastrojejunal Ulcers:
An Analysis of 8,525 Patients in National Inpatient Sample, 2005-2014**

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Background: Our study identified risk factors for mortality in patients emergently admitted with gastrojejunal ulcers.

Methods: A National Inpatient Sample-based retrospective cohort study from 2005-2014 was conducted on patients undergoing emergency admission for chronic gastrojejunal ulcers. Demographics, clinical data, and outcomes were collected. Multivariable logistic regression model was applied to find the risk factors of mortality in operative and non-operative patients.

Results: A total of 8,525 patients with a diagnosis of chronic gastrojejunal ulcer were included in this study and divided into an adult cohort with patients ages 18-64 (n=6,005) and an elderly cohort ages 65+ (n = 2,520). 62% of adult and 44.7% of elderly patients were female. The elderly mortality rate was 1.9% vs. 0.5% in the adult group. There was no significant difference in mortality between males and females. 50.9% of adult and 50.0% of elderly patients underwent operation (Table 1). Non-operative patients were more likely to have had an invasive diagnostic procedure performed in both the adult and elderly groups (89.9% and 90.0%, respectively) (Table 2). In operative patients, time to operation was associated with increased mortality in both the adult and elderly groups (OR=1.195, $P<0.001$ vs. OR=1.060, $P<0.035$, respectively). In adult patients undergoing operation, age was associated with mortality (OR=1.054, $P<0.041$, Table 1). In elderly patients not undergoing operation, invasive diagnostic procedure was found to be associated with reduced mortality (OR=0.189, $P<0.009$, Table 2).

Conclusion: Use of invasive diagnostic procedures and early operation of patients requiring surgery are key to improving outcomes in patients with chronic gastrojejunal ulcers.

Key Words: Chronic gastrojejunal ulcer, in-hospital mortality, age, time to operation

Table 1. Backward logistic regression analysis to evaluate the associations between mortality and different factors in emergency admitted patients with the primary diagnosis of chronic gastrojejunal ulcer and undergoing an operation. Mortality was the dependent variable. NIS 2005-2014.

	Adults with Operation		Elderly with Operation	
	N=2,767	P	N=1,144	P
	OR (95% CI)		OR (95% CI)	
Time to Operation, Days	1.195 (1.102, 1.295)	<0.001	1.060 (1.004, 1.119)	0.035
Modified Frailty Index Score	1.564 (1.074, 2.279)	0.020	Removed Via Backward Elimination	
Age, Years	1.054 (1.002, 1.109)	0.041		
Sex, Female				
Invasive Diagnostic Procedure				
Type of Gastrojejunal Ulcer	Removed Via			
Race	Backward			
Income Quartile	Elimination			
Insurance				
Hospital Location				

Table 2. Backward logistic regression analysis to evaluate the associations between mortality and different factors in emergency admitted patients with the primary diagnosis of chronic gastrojejunal ulcer and not undergoing an operation. Mortality was the dependent variable. NIS 2005-2014.

	Adult, Non-Operation		Elderly, Non-Operation	
	N=2,947	P	N=1,260	P
	OR (95% CI)		OR (95% CI)	
Invasive Diagnostic Procedure	0.295 (0.059, 1.476)	0.1	0.189 (0.055, 0.656)	0.009
Age, Years	1.077 (0.989, 1.172)	0.090	Removed Via Backward Elimination	
Modified Frailty Index Score				
Type of Gastrojejunal Ulcer				
Hospital Length of Stay, Days	Removed Via			
Sex, Female	Backward			
Race	Elimination			
Income Quartile				
Insurance				
Hospital Location				

FRIDAY - OCTOBER 12



What makes a Gallbladder difficult and how to stay out of trouble?

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The gold standard for the treatment of symptomatic cholelithiasis is laparoscopic cholecystectomy (LC) via the traditional 4-trocars approach. Nonetheless, there are a number of conditions, situations, and circumstances that can increase the difficulty of the procedure and, hence, the risks associated with its performance. Among the latter, bile duct injury (BDI) is a huge concern of laparoscopic cholecystectomy, resulting in significant morbidity and mortality. Prevention of BDI should be systematically performed when confronted with a difficult cholecystectomy. The “difficult gallbladder” is a scenario in which a cholecystectomy turns into an increased surgical risk compared with standard cholecystectomy. The procedure may be difficult due to processes that either obscure normal biliary anatomy (such as acute or chronic inflammation) or operative exposure (obesity or adhesions caused by prior upper abdominal surgery).

So, when confronted with a difficult cholecystectomy, the surgeon has a must: to turn the operation into a safe cholecystectomy, which can mean conversion (to an open procedure), cholecystostomy, or partial/ subtotal cholecystectomy. The surgeon should understand that he/ she needs to rely on damage control, to prevent more serious complications if choosing to advance and progress to a complete cholecystectomy.

The difficulty in performing a laparoscopic cholecystectomy may be linked to the following factors:

- The procedure in itself. the characteristics of the procedure, patient factors (such as obesity, coronary artery disease, pulmonary restrictions), instrumentation and technical resources, and backup and the surgeon, who may be more or less experienced and more or less capable when confronting a difficult situation.
- The anatomy. Refers to potential aberrant ductal and arterial anatomy, a prominent liver, an intrahepatic or left-sided gallbladder, all factors very difficult to acknowledge in the preoperative stage.
- The disease affecting the gallbladder. Lastly, there are chances to find the following conditions: a fibrosed and contracted gallbladder, acute or relapsed cholecystitis, a xantogranulomatous cholecystitis, or even an unexpected gallbladder carcinoma.

The management of a patient undergoing a laparoscopic cholecystectomy (LC) may be exposed to the occurrence of errors. These errors may occur in three different stages, which allow a better understanding and problem-solving approach: in the preoperative stage, in the intraoperative stage or in the postoperative period.

The following situations are associated with a higher chance of a difficult cholecystectomy: acute cholecystitis (more than 5 days of onset), previous cholecystitis episode, male sex, obesity, cirrhosis, sclero-atrophic, gallbladder, thick walls (>5 mm), previous signs of canalicular dwelling (clinical and laboratory).

The five steps of a laparoscopic cholecystectomy are: 1) access to the abdomen, 2) gallbladder exposure, 3) dissection of the cystic artery and duct, 4) gallbladder ectomy and 5) gallbladder extraction. In each of these steps the acting surgeon may encounter difficulties. The issue of whether or not an intraoperative cholangiogram (IOC) prevents the occurrence of a bile duct injury is controversial, but there is no doubt the intraoperative cholangiogram is very useful in the intraoperative recognition of a bile duct injury.

BDI still remains a relatively infrequent event (<1 every 200 to 400 cases), although it represents a leading source of medical malpractice litigation claims against surgeons. The repair of such an injury is often complex and usually requires several endoscopic and interventional radiology procedures and surgeries. Major CBD injury has a substantial and definitive impact of quality of life, functional status, and survival.

From the perspective of human factors and systems safety the accident analysis of BDI offers the following findings: the BDI usually follows a definitive sequence, the severity of injury depends upon the step in which the error is identified and when the surgeon stops the procedure, in severe injuries, the CBD is cut and divided twice, with the site of injury close to the liver hilum. In most situations, the root cause is the misidentification of the distal CBD as the cystic duct. Visual perception during the operation should be considered as a form of heuristics rules of thumb that assist in performing complex tasks and in making the mental construction represented by the vision of the surgeon and the whole team.

The factors leading to injury include the following: the patient and the disease, the environment, the procedure and human factors. In accordance, the prevention of BDI should be founded on the development of strategies for building a safe working system, including the described steps: patient selection, environment control, design of error-proof procedures and a detailed training program for young surgeons under supervision.

The primary goal of a laparoscopic cholecystectomy in the treatment of symptomatic cholelithiasis is the safe remotion of the gallbladder and the absence of common bile duct injury.

FRIDAY - OCTOBER 13



Quality Standards and New Aspects in Breast Cancer Surgery

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Quality in breast surgery can be achieved by defining and controlling standards. Standards in breast surgery ensure not only quality in diagnosis and treatment, but also safety for patients and treating physicians as well as reproducibility and comparability of results. These quality standards must be open to all and also represent a driver for innovation in the diagnosis and treatment of breast cancer.

The first standardization of breast cancer surgery with a form of quality control was performed by Rotter/Halsted in 1894. Performing standardized radical resection of the entire breast including pectoral muscles and excision of the axilla, they were able to reduce the local recurrence rate of breast cancer from initially over 90% to 6% (1889 - 1894, n = 50). Even though their theory of breast cancer as a local disease as well as their surgical technique has been disproved today by the work of B. Fisher U. Veronesi and others, a first quality standard in breast cancer treatment was achieved as a result.

Today, breast cancer is considered to be a systemic disease from the very beginning of its development, and it can spread through the bloodstream at a very early stage of its development. Local recurrence and survival rates as well as treatment modalities are significantly influenced by tumor biology in addition to tumor size. Nowadays, breast cancer is considered to be a heterogeneous disease entity. Therefore, the preoperative biopsy represents an essential quality criterion for the adequate therapy of breast carcinoma. In addition to the histopathological analysis of the tumor, at least the determination of the hormone receptor status as well as HER-2-neu and KI-67 are indispensable. Once all imaging findings, histology and tumor biology markers are available, an interdisciplinary discussion in the tumor board is a decisive quality criterion. Another important quality criterion is the number of operated cases. Breast carcinomas should only be treated in certified breast cancer centers with at least 100 breast carcinomas per center in a year and 30 cases per surgeon. In order to be allowed to exist as a center, numerous other parameters defined by the certification commission are checked annually. Schoffer O et al were able to show that the survival chances of cancer patients treated in such certified centers are increased by up to 26%.

FRIDAY - OCTOBER 12



The Standardized Recording of Complications in the Field of Plastic Surgery: Why is it Absolutely Necessary?

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Standardizing the recording of complications in the field of plastic surgery is of paramount importance, as it brings numerous advantages and enhances patient safety and the quality of care provided. In this presentation, we will delve into the reasons why standardized complication recording is critically necessary.

- **Patient Safety Comes First:**

Plastic surgery encompasses a variety of aesthetic and reconstructive procedures aimed at improving the appearance and functionality of the body. While the vast majority of these interventions are successful and safe, there is always a certain risk of complications. Standardized recording allows potential complications to be identified early, leading to the implementation of adequate measures to ensure patient safety.

- **Improving Treatment Quality:**

By recording complications, surgeons and medical personnel can gather crucial information on procedures or techniques that carry a higher risk of complications. This allows for the identification and promotion of established practices in the treatment. As a result, improvements in treatment quality can be achieved, leading to better outcomes for patients.

- **Promoting Evidence-Based Medicine:**

Standardized complication recording contributes to fostering a data-driven approach in plastic surgery. Collecting comprehensive data on complications enables surgeons and researchers to develop evidence-based guidelines and best practices. This helps in making medical decisions based on reliable data, thereby enhancing patient care.

- **Advancing Research and Education:**

Systematically recording complications serves as a valuable source for research in plastic surgery. By analyzing large datasets, trends and risk factors can be identified, prompting further investigation through studies. Additionally, sharing and exchanging this data facilitate better education for surgeons and medical staff.

- **Creating Comparability and Transparency:**

Standardized complication recording establishes comparability between different surgical facilities and enables a transparent evaluation of their outcomes. Patients can make informed decisions about where they want to undergo treatment, while outstanding facilities can be recognized for their achievements.

- **Incorporating Patient and Ethical Considerations:**

Recording complications should not only be viewed from a medical standpoint but should also consider ethical aspects. Patients should actively participate in the process and be informed about potential risks and complications. Standardization helps foster transparency and respects patient autonomy.

In conclusion, standardized complication recording in the field of plastic surgery is undeniably essential to ensure patient safety, improve treatment quality, promote evidence-based medicine, advance research and education, create comparability and transparency, and consider patient autonomy and ethical principles. It is a shared responsibility of surgeons, medical personnel, facilities, and health authorities to support and implement this crucial step to enhance plastic surgery and provide patients with the best possible care.

FRIDAY - OCTOBER 12



Improving the Functional, Aesthetic and Social Outcomes of Patients Suffering from Severe Burns: Experiences from the Burn Center in Graz, Austria

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Severe burn injuries have historically presented significant challenges for patients, both physically and emotionally. However, over the past decades, remarkable progress has been made in enhancing the functional, aesthetic, and social outcomes for individuals suffering from severe burn injuries. This presentation explores the key factors contributing to these advancements.

- **Medical Advancements and Specialized Burn Care:**

One of the primary reasons for the improved outcomes is the advancement of medical techniques and specialized burn care. Modern burn centers are equipped with state-of-the-art facilities and staffed by experienced professionals who follow evidence-based protocols. These centers provide multidisciplinary care, including skilled surgeons, physiotherapists, occupational therapists, and psychologists, all working together to optimize the healing process and overall recovery.

- **Improved Surgical Techniques and Technology:**

Advancements in surgical techniques, such as skin grafting and tissue reconstruction, have played a pivotal role in improving both functional and aesthetic outcomes. The development of innovative wound management and scar treatment modalities has resulted in better wound healing, reduced scarring, and enhanced mobility for burn survivors.

- **Early Intervention and Rehabilitation:**

The shift towards early intervention and aggressive rehabilitation has significantly contributed to positive outcomes. Prompt medical attention, early wound closure, and starting rehabilitation as soon as possible after the injury have shown to enhance physical functioning and minimize complications.

- **Psychosocial Support and Mental Health Care:**

Recognizing the psychological impact of severe burn injuries, more emphasis is now placed on psychosocial support and mental health care for patients and their families. Mental health professionals play a crucial role in assisting individuals in coping with the emotional challenges, addressing body image concerns, and fostering social reintegration.

- **Research and Innovation:**

Ongoing research and continuous innovation have been key drivers in improving outcomes for burn survivors. Scientific discoveries in areas like tissue engineering, regenerative medicine, and pain management have opened up new possibilities for enhancing functional and aesthetic recovery.

- **Patient-Centered Approach:**

A patient-centered approach to care has gained prominence in recent years. Medical professionals take into account the individual needs, preferences, and goals of each patient, tailoring treatment plans accordingly. This approach ensures that the care provided is not only medically effective but also aligned with the patient's values and aspirations.

- **Community and Peer Support:**

Social support from family, friends, and peers has proven to be instrumental in the rehabilitation and social reintegration of burn survivors. Community-based support groups and online platforms provide a sense of belonging and understanding, fostering resilience and self-acceptance.

In conclusion, the functional, aesthetic, and social outcomes for severe burn survivors have significantly improved over the last few decades due to a combination of factors. Advancements in medical care, surgical techniques, early intervention, rehabilitation, psychosocial support, research, patient-centered care, and community involvement have all contributed to this transformative journey of progress. As medical knowledge continues to evolve, we can remain optimistic that the journey towards improved outcomes for burn survivors will continue, offering hope and a better quality of life for those who have faced these challenges.

FRIDAY - OCTOBER 12

Reconstruction of Skin Defects

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Skin Defects is followed by injury of skin, under skin, muscular and skeletal tissues or the group of anatomical structures of the body. Unfortunately accept these partial loss of tissues sometimes the traumas end with amputated extremity, high level of morbidity and invalidity and sometimes can be fatal. Posttraumatic reconstruction of the skin defects can be performed by knowing the mechanism of the wound or defect creation and by careful planning for better functional and aesthetic outcome.

To achieve these outcomes we need to have:

Good connection between the well trained and equipped professionals (surgeons),

The health condition of the patient and its motivation for the cooperation, and

Institutional support accompanied by god medical devises.

We are going to present some specific cases in the last decade in our Clinic.

Keywords: Skin, Defects and Reconstruction.

SATURDAY - OCTOBER 13



Reconstruction of Midface with Pectoralis Mayor Flap after Excision of Advanced Skin Cancer

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Intruduction: Patient 74 old. Male gender. Lack of education. Controled high blood pressure. Presenting inva-sive wide spread skin kancer affecting left half of face auricular temporal region with local metastasis in neck. Patient has developed this cancer for 2 years but havent got treted due to fear and hasiation to be operated.

Material and methods: The extensive radical excision of cancer is performed exposing part of temporal bone as well zygomatic arch, external auditory canal, arch of mandibulary bone and facial nerve facial artery were in-volved. In addition the left side neck disection was performed. Pectoralis mayor muscle harvesting After relising from humeral insertion sternocostal and only living uper clavicular part based on thoracoacromial artery. The flap was covered by STSG from the thigh. Also the pectoralis muscul in the level of external meatus was opened and the angulus of the mouth was inforced to zygomatic arch with palmaris longus tendon graft due to facial nerve lose.

Discusion: Similar cases are rare to face due to operation in much early stages wen the cancer is smaller end les invasive. So curativ outcome is imposible due to local and distant metastasis and the region limitation for radical operativ aproach. Paliative care is nesesary in order to improve the quality of of life and extend the survival of patient. Many other techniques and reconstructive options were possible many regarding free flaps.

Conclusion: The pectoralis flap in our patient is performed succesfully. No ICU care needed. Recovery very fast.

FRIDAY - OCTOBER 12

**The Power of “NOW” In Pelvic Fractures Surgery*****Ilir Hasani, MD******ilirku@yahoo.com*****Named Lecture: Ass. Dr. Bedri Bakalli for Orthopaedic Trauma Surgery**

Pelvic fractures historically are associated with serious complications. Malgagnie has emphasized the importance of pelvic classification to distinguish the life-threatening pelvic injuries, from the others. The golden German hours or platinum minutes are important in bleeding pelvic fractures.

Pelvic fractures are a consequence of devastating blunt or penetrating injuries. Major injuries to soft tissue and pelvic bones affect homeostasis, and if not controlled in a timely fashion may lead to death.

Immediate surgical and supportive non-surgical action with damage control and homeostasis resuscitation is mandatory. Several techniques have been established to ensure timely hemostasis, including mechanical or intervention vascular intervention. These actions are typical representations of every trauma surgeon's dream “to save a life” by intervening as early as possible, but once major visceral abdominal injuries have been addressed. Close communication between trauma general surgeons and orthopedic trauma surgeons is crucial.

All this should be done “now”. There is no, more powerful weapon to fight death than the power of “now” in pelvic trauma surgery.

FRIDAY - OCTOBER 12

Anterior Cruciate Ligament Reconstruction with Bone-Patellar Tendon-Bone Allograft – Preliminary Results***A. Andonovski, I. Shabani, B. Andonovska******University Clinic for Traumatology, Orthopedic Surgery,
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Although there are different surgical techniques for Anterior cruciate ligament (ACL) reconstruction there is no single technique that could be described as a golden standard, because all of them have advantages and disadvantages. Techniques that use Bone-patellar tendon-bone (BTB) autograft give better graft incorporation and good postoperative knee stability but they also give anterior knee pain, kneeling problems and knee extension deficit. In surgical techniques that use Hamstring tendons graft lengthening and rupture, knee instability, donor site morbidity and knee flexion deficit could be seen. That is why ACL reconstruction with allograft became popular in the last time. BTB allograft for ACL reconstruction gives good graft incorporation and good knee stability without donor site morbidity, kneeling problems, anterior knee pain and knee flexion and extension deficit. The surgery can be performed faster and more simple. On the University clinic for orthopedic surgery in Skopje nine ACL reconstructions with BTB allograft were performed in the period from February 2022 to December 2022. Allograft was obtained from brain dead donors and prepared according to the special protocol for preparation. The purpose of our study was to report the preliminary results in these patients after ACL reconstruction with BTB allograft.

FRIDAY - OCTOBER 12



Treatment of Septic Arthritis Sequelae

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Introduction: Septic arthritis of the hip joint in childhood is a bacterial infection of the synovium and subsequently of all the structures within the joint and has multiple sequelae and may result in severe disability. The purpose of this study was to present results of treatment of sequelae of septic arthritis of the hip in children.

Material and Methods: Twelve hips in twelve children age from 2 to 22 years suffering septic arthritis sequelae in infancy were followed from 50 to 150 months. Five were male subjects, and 7 female. We evaluated the history, clinical findings and radiographs of all children who had been treated at the Orthopaedic University Hospital in Prishtina between 1999 and 2019 for septic arthritis of the hip. All patients were treated operatively: 2 with Pelvic support osteotomy for abduction insufficiency in combination with lengthening of the femur and valgus corrective osteotomy, 4 hips with valgisation corrective osteotomy, 6 with Total Hip replacement because of painful joint degeneration.

Results: Final results of treatment include: range of motion, presence or absence pain, joint stability, limb-length discrepancy were assessed, Trendelenburg sign, and Harris hip score. Remodelling of the femoral head, hip stability, and arthritic changes in the hip were evaluated radiographically. Three hips had mild pain in sports activities. Final results showed average limb length discrepancy was about

1.5 cm. At the time of last follow-up, the Harris Hip Score (HHS) showed excellent functional outcome in six cases (50%) treated with Total Hip Replacement, good in 6 cases (60%), and was no poor functional outcome. Trendelenburg sign become negative in all but two patients.

Conclusion: Operative treatment of sequelae of neonatal septic arthritis of the hip can successfully correct a Trendelenburg gait and restore knee alignment and correct lower-extremity length discrepancy. Total Hip Replacement in patients with sequelae of septic arthritis after the age of 18 years is the best choice with excellent functional outcome according Harris Hip Score.

FRIDAY - OCTOBER 12



Local or Spinal Anesthesia in Knee Arthroscopy

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Introduction: Arthroscopy of the knee can be performed under local, regional (spinal or epidural) or general anesthesia. The aim of our study was to assess the efficacy, safety and complications of two anesthetic techniques including local and spinal anesthesia.

Patients and methods: In the study were included 310 patients in whom knee arthroscopy was performed under local (LA group= 210) or spinal (SA group = 100) anesthesia. LA group received portal injection (10 mL Lidocaine with Adrenaline) and intra-articular injection (10 mL Bupivacaine with Adrenaline and Morphine). SA group received 0.5% Bupivacaine 5 mg/mL. In all patients was performed knee arthroscopy on the University clinic for orthopedic surgery on Skopje in the period from June 2021 to December 2022. The following parameters were assessed: intraoperative pain (VAS score: 0 = no pain, 10 = extreme pain), surgical operating conditions, patient satisfaction score (1 = very satisfied, 4 = very unsatisfied), postoperative analgesia, and time to discharge.

Results: Pain throughout the procedure was more common in LA than in SA group (20% vs 5%). Only two patients in SA group required conversion to general anesthesia. 93% of patients from LA group and 80% of patients from SA group were either satisfied or very satisfied with their anesthesia. The mean postoperative stay was significantly shorter in LA than in SA group (3 hours vs 30 hours). 75 % of the patients from LA group were discharged from the hospital within first 3 hours from the procedure. The need of postoperative analgesia was higher in SA group compared with LA group (70% vs 20%). The rate of complications differed significantly between LA and SA groups. Postoperative knee hemarthrosis was more common in patients from SA group than in those from LA group (35% vs 5%).

Conclusion: Local anesthesia for knee arthroscopy is a simple, reliable, and safe alternative to spinal anesthesia and should be preferred in most of the cases.

Keywords: knee arthroscopy, local anesthesia, spinal anesthesia, results.

FRIDAY - OCTOBER 12



Allograft Transplantation and Reconstruction of Bones

after Malignant Tumor Resections

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Introduction: Reconstruction surgery after excision of musculoskeletal tumors has advanced greatly in the last few decades. Allografts have proven useful in the reconstruction of bone defects after tumor resection.

Case presentation: This report presents four cases with malignant or aggressive bone tumors treated surgically with wide resection of the bone tumor and reconstruction of the bone defect with frozen cadaveric allograft. Case 1 represents a patient with angiosarcoma of distal left tibia. This patient was treated with wide resection of 6 cm long tibial diaphysis segment. The defect was reconstructed with intercalary tibial bone allograft and was fixed with two locking plates. Case 2 is a patient with aggressive giant cell tumor of right radial bone. Distal radius with 7 cm length, including distal radial articular surface was resected due to joint invasion and fibular cadaveric graft was used. Radiocarpal joint arthrodesis was performed. Case 3 represents a patient with Ewing sarcoma of the proximal part of the right femur invading the intertrochanteric region and proximal diaphysis was treated with resection of proximal femur, application of femoral diaphysis allograft and hip joint endoprosthesis. The forth case is a patient with Ewing sarcoma of the right femur. Resection of 24 cm of femur diaphysis segment was done. The defect was reconstructed with two intercalary femoral diaphysis allograft and fixed with intramedullary nail.

Conclusion: Bone tumors should be diagnosed and treated in referral centers by a multidisciplinary team including pathologists, radiologists, orthopedic surgeons and oncologists. There is no prevention. Early diagnosis and adequate treatment are only hope for good outcome. Biological reconstructions with bone allografts are very useful after resection of certain malignant extremity bone tumors. The surgical techniques and method of treatment presented in this report will allow a better functional outcome and quality of life of treated patients.

Keywords: allograft, malignant tumor, resection, bone.

FRIDAY - OCTOBER 12



Treatment of Long Bone Pseudarthrosis through Intramedullary Method

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Long bone pseudarthrosis refers to the non-union or failed bone healing after a fracture, presenting significant challenges in orthopedic practice. This research paper focuses on exploring the effectiveness of the intramedullary method as a treatment approach for long bone pseudarthrosis. The objective is to evaluate the clinical outcomes and efficacy of intramedullary interventions in promoting successful bone union and functional recovery.

The study conducted a comprehensive literature review to identify relevant publications and clinical studies involving the intramedullary treatment of long bone pseudarthrosis. Key aspects, including patient characteristics, fracture location, surgical techniques, and outcomes, were analyzed. Moreover, various factors affecting the success of intramedullary fixation, such as implant selection, bone grafting, and adjuvant therapies, were assessed.

The findings demonstrate that the intramedullary method offers several advantages over traditional treatment approaches. It provides stable fixation, promotes mechanical stability, and stimulates bone healing through compression and improved load transmission. Additionally, intramedullary fixation techniques allow for early mobilization and reduce the risk of infection compared to external fixation methods. Furthermore, the use of autologous or allograft bone grafts and adjuvant therapies, such as growth factors or biologics, have shown promising results in enhancing osseous union.

While the intramedullary method exhibits considerable potential, this paper acknowledges the importance of personalized treatment plans tailored to individual patients' specific needs. Factors such as patient age, fracture type, and associated comorbidities should be considered when determining the most appropriate treatment strategy. Additionally, future research should focus on optimizing implant designs and materials, refining surgical techniques, and exploring novel adjunctive therapies to further improve clinical outcomes.

In conclusion, this research paper highlights the efficacy of the intramedullary method in the treatment of long bone pseudarthrosis. With its ability to provide stable fixation, promote bone healing, and facilitate early mobilization, this approach holds significant promise in achieving successful bone union and restoring functionality. Further advancements in technique and research will continue to enhance the outcomes and contribute to the evolution of intramedullary treatment for long bone pseudarthrosis.

FRIDAY - OCTOBER 12

**Operative Treatment of Pelvis Obliquity***Nazmi Morina, Taulant Shatri, Skender Boshtraj,**Florim Bajraktari, Sh. Berisha, V.Gashi**Orthopaedic Department of General Hospital**Peja, Kosova**Presenting Author: Nazmi Morina**nazmimorina@yahoo.com*

Introduction: Pelvic obliquity is a rare condition within our population characterized by an asymmetrical alignment of the pelvis. It occurs when one side of the pelvis is higher or lower than the other, resulting in an imbalance of the body's posture due to leg length discrepancy. Several contributing factors may include muscular imbalances, structural abnormalities (such as scoliosis or leg length inequality), and trauma.

Objectives: In this paper, we aim to elucidate the true cause of pelvic obliquity, which we believe is associated with fibrous tissue changes in the hip capsule. This condition is further exacerbated by the thickening and shortening of the iliotibial tract or vice versa. Notably, we did not find any contractures in the abductor muscles on the dropped side of the pelvis.

Methodology: We treated three patients with previously intractable hip issues. Our success story began with the treatment of abduction contracture in both hips of a young girl who had a fixed pelvis without spinal tilting to accommodate the true range of abduction contracture. We performed a Howorth procedure, releasing all abductor muscles and conducting a superior capsulotomy of the hip joint. Additionally, elongation of the iliotibial tract in the trochanter and supracondylar region was necessary.

Results: The outcomes were excellent, requiring minimal physical therapy. The patients were able to walk with crutches within six weeks. Only one patient needed a revision for coxa saltans in the left hip.

Discussion: When pelvic obliquity is not attributed to spasticity, a fixed spine, or other causes of leg length discrepancy following thorough clinical examination, operative treatment emerges as the sole viable option for successful management of pelvic obliquity across all age groups.

Key words: pelvis, obliquity, inequality, contracture

FRIDAY - OCTOBER 12



Analysis of Hip Ultrasonography Results in 4823 Infants - Conservative Treatment - 10 years follow-up-Retrospective Study

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Introduction: As one of the most common skeletal anomalies, developmental dysplasia of the hip (DDH) is characterized by a wide range of pathologies, from mild weakening of the ligaments in the hip to complete luxation. DDH alters the biomechanics of the hip, overloading the articular cartilage and leading to early osteoarthritis. DDH is a developmental disorder that results in various abnormalities in the building structures of the hip.

Methods: Analysis of cases examined with ultrasound of the hip in children up to 1 year of age, respectively of cases with hip luxation and their correlation with sex and time of examination.

Results: The study conducted was a retrospective cohort study. Initially, a protocol was requested from the office, from which only cases in which the hip was examined were included, while cases with other pathologies were excluded. There were a total of 4823 hip examinations that were entered into the database in Excel, tables and charts were presented and annotated using the pivot table.

Conclusions: Of the total number of cases examined, 48% were women and 52% were men. DDH was diagnosed in 27.6% of women, while it was so in 19.5% of men. The control mostly took place after the first month of the child's birth.

FRIDAY - OCTOBER 12



Common Misdiagnosis of Humero-Scapular Angranted Fracture Luxations

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Humero-scapular angranted fracture luxations represent a complex and challenging orthopedic condition frequently encountered in clinical practice. This research paper aims to identify and examine the common misdiagnoses associated with humero-scapular angranted fracture luxations, highlighting the potential pitfalls in accurate diagnosis and treatment.

A comprehensive review of the existing literature was conducted to identify relevant studies and case reports pertaining to humero-scapular angranted fracture luxations. The analysis focused on evaluating the various misdiagnosis patterns, including misinterpretation of radiographic imaging, failure to recognize associated injuries, and misidentification of fracture patterns.

The findings indicate that misdiagnosis of humero-scapular angranted fracture luxations is a prevalent issue in clinical settings. Radiographic misinterpretation, often resulting from the complexity of fracture patterns and overlapping anatomical structures, is a frequent source of misdiagnosis. Failure to recognize associated injuries, such as neurovascular compromise or concomitant rotator cuff tears, further contributes to diagnostic errors. Additionally, the subtle nature of certain fracture patterns, particularly in cases of partial dislocations or subtle humeral head fractures, may lead to missed diagnoses.

To address these challenges, this research paper emphasizes the importance of a thorough clinical assessment, including a detailed history, physical examination, and appropriate imaging techniques. Advanced imaging modalities, such as computed tomography (CT) or magnetic resonance imaging (MRI), may provide valuable insights for accurate diagnosis and treatment planning. Furthermore, close collaboration between orthopedic surgeons, radiologists, and other healthcare professionals is crucial in improving diagnostic accuracy and preventing misdiagnosis.

Awareness of the common misdiagnoses associated with humero-scapular angranted fracture luxations is essential for clinicians to enhance their diagnostic acumen and avoid potential pitfalls. By emphasizing the need for careful evaluation of radiographic images, comprehensive clinical assessments, and interdisciplinary collaboration, this paper seeks to improve the overall accuracy of diagnosis and subsequent management of humero-scapular angranted fracture luxations.

In conclusion, this research paper sheds light on the common misdiagnoses encountered in cases of humero-scapular angranted fracture luxations. By understanding the challenges and potential pitfalls, healthcare providers can enhance their diagnostic skills, implement appropriate imaging techniques, and foster collaborative approaches to ensure accurate identification and effective treatment of these complex injuries. Continued research and awareness are crucial to minimizing misdiagnoses and improving patient outcomes in cases of humero-scapular angranted fracture luxations.

FRIDAY - OCTOBER 12



**Clinical Management of Xanthomatous Erosive
Arthritis with Osteoarticular Involvement:
A Case Study of Total Hip Arthroplasty and Review of Literature**

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Xanthomatous erosive arthritis is an exceedingly rare disorder categorized under benign non-Langerhans cell histiocytosis, characterized by its infrequent association with osteoarticular lesions.

This case report presents a unique instance of xanthoma erosive arthritis involving the hip joint, where total hip arthroplasty (THA) was performed as an intervention.

The diagnostic criteria for this condition encompass a comprehensive assessment, including physical examination findings, pathological analysis, and abnormal laboratory test results.

Moreover, a compelling link exists between xanthomatous erosive arthritis and plasma cell dyscrasias as well as lymphoproliferative disorders, though cases necessitating joint replacement have scarcely been documented in the literature.

This report chronicles the clinical journey of a patient who underwent left total hip replacement for xanthomatous erosive arthritis, underscoring the importance of individualized treatment approaches in managing this exceedingly rare and enigmatic disease.

FRIDAY - OCTOBER 12

**Perilunate and Lunate dislocation***Imran Shaqiri**Daut Mustafa Hospital, Department of Orthopedics,**Prizren*

Perilunate and lunate dislocations usually result from a fall on an outstretched hand or occur in a motor vehicle crash. Incidence is rare < 1 per 100,000 injuries annually.

Isolated lunate dislocations represent a rare subsection of perilunate dislocations which are often undiagnosed due to the rest of the carpus remaining aligned. Diagnosis requires careful evaluation of plain radiographs, indicated by disruptions of Gilula's arc, lunocapitate overlap on posteroanterior radiographs and spilling teacup sign, increased radiolunate angle on lateral radiographs (DISI, VISI). Treatment requires urgent closed versus open reduction and stabilization, to prevent complications, nerve damage, carpal instability, avascular necrosis of lunate and arthritis.

FRIDAY - OCTOBER 12

Iatrogenic Injuries during C-Section Delivery***Sahadete Shala, Merita Krasniqi, Donika Shala, Taulant Hazrolli, Gojart Ferati******Obstetric and Gynecologic Clinic of the University Clinical Center of Kosova******Presenting Author: Sahadete Shala******drsahadete@gmail.com*****Named Lecture: Prof. Dr. Sehadete Mekuli
for Gynecological & Obstetric Surgery**

Objective: There is well –known relationship between iatrogenic injuries and C-section delivery.

The aim of this study was to evaluate the postpartum C-Section patient with iatrogenic bladder injuries (Lae-seio iatrogenica vesica urinaria)during C-Section delivery case at post-op early period and clinical significance of sign and symptoms after first day of C-Section delivery, role of conservative management in reducing associated morbidity .

Method: We choose a case report study of postpartum C-Section delivery with bladder iatrogenic laceration diagnosed between January and October 2023 at the Obstetric and Gynecologic Clinic of the University Clinical Center of Kosovo from the total 2278 of C-Section delivery , during this time only 4 patient were investigated for bladder injury based on their signs and symptoms, only 1 of them were diagnosed with the diagnose above during this time.

Results: Between January –October 2023, from 2278 patients referred to our clinic postpartum C-Section delivery unit ,3 patients were investigated for bladder injury at intraoperative of C-Section delivery . One patient diagnosed at post-op early period based on the clinical symptoms after consultation by urologist request.

Conclusion: Early diagnosis and therapy may prevent complications and loss of organs that may lead to morbidity and mortality.

Key words: Bladder injury, iatrogenic diseases, early injury laceration

FRIDAY - OCTOBER 12



A Retrospective Study on the Localization and Treatment of Ectopic Pregnancies at the Gynecological and Obstetric Clinic in Kosova

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Introduction: An ectopic pregnancy is a medical condition where a fertilized egg implants and starts to develop outside the uterus. In an ectopic pregnancy, the fertilized egg is stuck and begins to develop in the Fallopian tube or other locations like the cervix, ovary, or abdominal cavity. As the fertilized egg grows, it can cause the Fallopian tube to rupture or other complications that may lead to severe pain, internal bleeding, and, if left untreated, a life-threatening situation. Early diagnosis and adequate medical intervention are crucial for the treatment of an ectopic pregnancy. Amenorrhea, abdominal pain, vaginal bleeding, and shoulder pain are all common signs and symptoms of an ectopic pregnancy. The diagnosis is generally made by combining symptoms, physical examination, and medical imaging (such as ultrasound). The treatment options available include drug treatment or surgery to remove it, depending on the patient's condition and the age of the ectopic pregnancy. To protect the woman's health from life-threatening situations, it is important to manage ectopic pregnancies promptly.

Aim: The objective of this research was to determine the location and treatment of ectopic pregnancies at the Gynaecological and Obstetric Clinic in Kosova.

Material and Method: Between January and December 2022, the study was conducted in Obstetrics and Gynecology Clinical, Faculty of Medicine, University of Pristine, Kosova. The study population is composed of women who were hospitalized in the operational unit at the Gynecological and Obstetric Clinic. Medical history cards were used to obtain the information, including age, marital status, occupation, and pregnancy status. The collection of data by qualified medical personnel was preceded by obtaining every woman's informed consent.

Result: The Clinic of Gynecology and Obstetrics recorded 91 cases of ectopic pregnancy between January and December 2022. The average age of women was 22% for the age group between 18 and 25 years old, 35% for the age group between 26 and 35 years old, and 43% for those over 40 years old. Diagnosis of ectopic pregnancy based on gestational age: 0-5 week's gestation was 19%, 6-10 weeks gestation was 32%, and 11 weeks gestation

was more than 43%. The location of ectopic pregnancy was 86% tubal, 9% ovary, 4% pregnancy scar, and 1% cervical. Out of the 91 cases, 71 were surgically treated, 12 were expected (serial follow-up of -hCG values), and eight were medically treated with methotrexate. Of a total of 71 cases that were treated surgically, 13 patients had a laparoscopy, and 58 had a laparotomy; 60 women had salpingectomy, nine women had adnexectomy, and two cases had ovule evacuated.

Conclusion: In conclusion, ectopic pregnancies are a medical condition in which a fertilized egg implants and begins to develop outside the uterus. This condition is not viable and can result in significant health risks, such as internal bleeding and life-threatening complications. Effective management of ectopic pregnancies requires early diagnosis and adequate medical intervention. It's crucial to know the implantation location, signs and symptoms, early diagnosis, and appropriate treatment in advance.

Keywords: Ectopic Pregnancies; localization; treatment; surgically; Kosova

FRIDAY - OCTOBER 12



Congenital Malformations of the Female Genital Tract: Diagnosis and Surgical Treatment

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Female genital malformations or Müllerian anomalies are anatomic disorders affecting the female reproductive tract and the woman's health, leading to a variety of physical symptoms, findings, and reproductive outcomes. Patients with obstructive Müllerian anomalies generally present in adolescence with pain associated with the obstruction of menstrual outflow; thus, these disorders are frequently managed surgically. Because most gynecologists will care for women with Müllerian anomalies, an understanding of the usual presentation, evaluation, management, and reproductive health impact of these anatomic disorders is essential.

Currently, a wide range of non-invasive diagnostic procedures are available enriching the opportunity to accurately detect the anatomical status of the female genital tract, as well as a new objective and comprehensive classification system with well-described classes and sub-classes. However, accurate diagnosis of congenital anomalies remains a clinical challenge because of the drawbacks of the previous classification systems and the non-systematic use of diagnostic methods with varying accuracy.

Patients with suspected complex anomalies, defined as anomalies resulting from disturbances in more than one stage of normal embryological development and having as a result anatomical deviations in more than one organ of the female genital tract, should be evaluated as follows: Abdominal and/or transrectal 3D ultrasound in a pre-defined and systematic manner where the shape and the deviations from normal cervical and uterine anatomy should be recorded and documented. MRI: Evaluation of the results is recommended to be performed by an imaging expert in collaboration with an experienced gynecologist. Hysteroscopy and Laparoscopy: These techniques should be offered by clinicians (endoscopic reproductive) and surgeons with experience in the management of complex female genital anomalies in special centers after a thorough non-invasive evaluation.

The aim of this lecture is to evaluate clinically relevant classification systems and to discuss which is more suitable for the accurate, clear, and simple related to clinical management of congenital female genital anomalies. Furthermore, to evaluate methods of surgical management as a part of mission of Kosova College of Surgeons to improve education and increase the quality of surgical care in Kosova.

FRIDAY - OCTOBER 12



Breast Cancer and Sonomammography in the Gynecological Service

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Introduction: The breast (mammary) is a paired organ located in the chest area (regio mammaria) in the front of the thoracic cage (regio antethoracalis) and is part of the external genitalia. It is made up of glandular mammary ((*glandulae mammariae*)) and the connective tissue or stroma. Like any organ of the body, the breasts can be involved in various pathological processes, for which it is the duty of the gynecologist to check up the breasts during the gynecological visit. The best method for breast control has been shown to be sonomammography. The data obtained during the sonomammographic visit should be reported on the basis of the ACR BI-RADS system (*American College of Radiology Breast Imaging Reporting and Data System*), developed by the American College of Radiology since 1993, for the purpose of clarification. -interpretation and facilitation-communication between doctors. This classification has experienced five editions of renewal, the last one in February 2014, and in addition to the US, it has entered into routine use in many countries of the world. According to this classification, imaging findings are classified into 7 categories: **BI-RADS 0 - 6**. Of the countries around, Croatia is among the first countries which since 2006, during the national program for areas for early detection of breast cancer, interpreting the results of imaging diagnostic methods has applied the BI-RADS classification.

Purpose: to analyze and evaluate the accuracy of categorization of sonomammographic results according to the criteria used for BI-RADS, and pathological changes in the breasts in the gynecological service.

Material and methods: In the period 01.01.2006 - 31.12.2022 in the GINEKOS Polyclinic in Prizren were performed a total of 3560 sonomammography visits, of which 3551 for women and 9 visits for men. The most common reason for coming for a sonomammographic visit was the palpation of breast changes by the patient or doctor at 2390 (67.13%). The sonographic findings are categorized according to the relevant BI-RADS criteria for sonomammography. Each change is described using these features and is classified into categories 0 through 6, according to BI-RADS. BI-RADS categorization and biopsy results were compared in 249 cases. The data were collected and analyzed with a special computer program Win Acta Medicus, Zagreb Croatia, version 2.0.0.

Results: In 401 (12.40%) BI-RADS 1, 2339 (65.70%) BI-RADS 2, 514 (14.44%) BI-RADS 3, in 98 (2.75%)

BI-RADS 4, 180 (5.06%) BI-RADS 5 and in 14 cases or 0.39% BI-RADS 6. Comparison of BI-RADS classification results and pathohistological results were analyzed in 249 cases. In 91 cases classified as BI-RADS 2, the pathohistological result in 90 (98.90%) indicated for benign process, 1 (1.10%) for malignant process. In 51 cases categorized as BI-RADS 3, in 49 (96.08%) indicated for benign process, 2 (3.92%) for malignant process. In 15 cases classified as BI-RADS 4, 12 (80.0%) cases, the pathohistological result indicated for malignancy, in 3 cases (20.0%) for benign process. In 90 cases categorized as BI-RADS 5, 89 (98.89%) of the cases, the pathohistological result indicated for malignant process and only in 1 case or 1.11% for benign process. BI-RADS categorization classification and average age of patients has given the following results: BI-RADS 1 - 37 years, BI-RADS 2 - 38 years, BI-RADS 3 - 42 years, BI-RADS 4 - 45 years, BI-RADS 5 - 52 years. And BI-RADS 6 - 53 years.

Conclusion: Evaluation of findings during sonomammography based on the criteria used for BI-RADS of breast sonomammography, has high accuracy, compared to pathohistological results

Keywords: breast, sonomammography, categorization of results according to BI-RADS, pathohistology.

Concordance Between BI-RADS® Assessment Categories and Management Recommendations.

ULTRASOUND	Assessment	Management	Likelihood of Cancer
	Category 0: Incomplete — Need Additional Imaging Evaluation	Recall for additional imaging	N/A
	Category 1: Negative	Routine screening	Essentially 0% likelihood of malignancy
	Category 2: Benign	Routine screening	Essentially 0% likelihood of malignancy
	Category 3: Probably Benign	Short-interval (6-month) follow-up or continued surveillance	> 0% but ≤ 2% likelihood of malignancy
	Category 4: Suspicious	Tissue diagnosis	> 2% but < 95% likelihood of malignancy
	Category 4A: <i>Low suspicion</i> for malignancy		> 2% to ≤ 10% likelihood of malignancy
	Category 4B: <i>Moderate suspicion</i> for malignancy		> 10% to ≤ 50% likelihood of malignancy
	Category 4C: <i>High suspicion</i> for malignancy		> 50% to < 95% likelihood of malignancy
	Category 5: Highly Suggestive of Malignancy	Tissue diagnosis	≥ 95% likelihood of malignancy
	Category 6: Known Biopsy-Proven Malignancy	Surgical excision when clinically appropriate	N/A

FRIDAY - OCTOBER 12

IOTA Simple Rules in early Diagnosis of Ovarian Cancer***Tefta Isufaj Haliti******Clinic of Obstetrics and Gynecology, University Clinical Centre of Kosova,******Prishtina, Kosova******Faculty of Medicine, University of Prishtina,******Prishtina, Kosova******tisufaj@hotmail.com***

Objective: To explore if International Ovarian Tumour Analysis (IOTA) Simple Rules with Ca 125 would enhance the diagnostic performance for early detection of ovarian malignancies by comparison with histopathologic diagnosis of adnexal masses.

Method: A prospective cross-sectional analysis of a cohort of women with adnexal masses scheduled for surgery was conducted to evaluate the early detection of ovarian cancer by comparing ultrasonographic criteria of IOTA Simple Rules with histopathologic diagnosis after the surgical intervention. ROC (receiver operating characteristic) curve analysis of suspected adnexal tumours was calculated in 226 women admitted for surgery to Gynaecology and Obstetrics clinic within University Clinical Center of Kosovo (UCCCK)

Setting: This study was performed from June 2020 to June 2022 in the UCCCK, which is a public tertiary health care center in Prishtina, Kosovo.

Participants: 226 women aged 16-80 with suspicious adnexal masses that were referred for surgery.

Outcome measures: Primary outcome was the diagnostic accuracy of the combination of adnexal mass biomarkers and IOTA Simple Rules.

Results: IOTA Simple Rules increased the diagnostic performance of classifying adnexal masses. The AUCs (Area Under the Curve) for IOTA Simple Rules in discriminating benign from malignant or borderline adnexal masses was 0.929 (95% CI, 0.888–0.971). Analyses of multi-measure arms determined the combination of CA125 + IOTA to be related with the largest ROC sensitivity (AUC = 0.969).

Conclusions: We found that a combination of IOTA Simple Rules and CA125 showed the best diagnostic performance in categorising the adnexal masses. Study findings prompt additional research on reliable predictors of malignancy with the aim of refining best practices of clinical decision making in ovarian cancer cases.

FRIDAY - OCTOBER 12

**Removal of Endometrial Polyps, Early Diagnosis and Prevention of Endometrial Ca***Aida Kumnova, Bujar Tabaku, Luljeta Canhasi, Agon Kumnova**Presenting Author: Aida Kumnova**aidakumnova@hotmail.com*

Background: Endometrial polyps are frequent cause of bleeding in women. Rarely, a complex or atypical hyperplasia is identified within a polyp in a biopsy or polypectomy specimen.

Objective: Evaluation of the contribution of hysteroscopy in the treatment of endometrial polyps. Evaluation of the risk of recurrence of endometrial polyps, also detection of endometrial malignancy in early stages.

Material and method: The selected patients are from the age of 20 years and older who are diagnosed with endometrial polyps. The examinations of the patients were done with GE expert E6 conventional 3D ultrasound and the endometrial polyps were observed.

Measurement: this study included 100 patients who were diagnosed with endometrial polyp from the age of 20 years or more.

Results: From the histopathological results we can conclude that 58% of endometrial polyps are functional polyps, 9.5% are atrophic polyps, 4.7% are hyperplastic polyps, 3.1% simplex glandular hyperplasia of the endometrium, 3.1% complex hyperplasia of the endometrium, 14.2% endocervical polyps, 3.1% uterine adenomyoma and 3.1% endometrial carcinoma.

Discussion: Endometrial polyps are a pathology that appears in the fertile age based on the statistics that have been processed in our paper, they are not the frequency of high-risk pathologies. The risk of endometriosis is about 3.1%.

Key words: endometrial polyp, hysteroscopy, biopsy, carcinoma.

FRIDAY - OCTOBER 12

**Update of diagnosis and treatment of pulmonary embolism***Vedat Eljezi**University Hospital Center Gabriel Montpied**Département of Anesthesiology and Intensive Care**Division of Cardio Vascular Surgery**58, Rue Montalembert**63003 Clermont Ferrand**France**Email: veljezi@chu-clermontferrand.fr***Named Lecture: Ass. Dr. Shpetim Robaj for Anesthesiology**

Pulmonary embolism is a frequent disease with an annual incidence of 40-120 per 100,000 inhabitants. It is a disease with a high mortality rate of 14% (in hospital) and 20% in 90 days. There are many risk factors for pulmonary embolism. Acute right ventricular failure resulting from an acute increase in pressure in the right ventricle and profound hypoxemia are considered the main causes of death. High-risk pulmonary embolism is defined by hemodynamic instability and includes the following clinical forms such as cardiac arrest, obstructive shock, and persistent hypotension. The clinical presentation is quite diverse with non-specific clinical signs and symptoms. The diagnosis of pulmonary embolism is made through the assessment of clinical probability, D-Dimer dosing and imaging techniques. Among the most used clinical predictors are the PERC system, Wells, and the revised Geneva system. Dosing of D-Dimers has a very good negative predictive value of over 95%. Computed tomographic pulmonary angiography is the diagnostic imaging method of choice with 83% sensitivity and 93% specificity. Treatment of pulmonary embolism depends on the clinical conditions and hemodynamic stability. Patients with hemodynamic instability and shock require a bedside transthoracic echocardiography urgently. These patients should be treated with systemic thrombolysis in the absence of contraindications. In case of contraindication, they should benefit from percutaneous or surgical thrombectomy. Supportive treatment also consists of adequate resuscitation with inotropes, vasopressors, adequate oxygenation. In cases with hemodynamic stability, treatment consists of efficient anticoagulation and other general measures. Anticoagulation of pulmonary embolism should last at least three months.

FRIDAY - OCTOBER 12



Airway Emergencies Immediately After Birth and Emergency Infant Tracheostomy

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Airway obstruction in infants may be part of a syndromic condition or an isolated finding. Significant airway obstruction due to severe micrognathia and/or other anatomical features are seen in neonates with congenital syndromes such as CHARGE syndrome, Treacher Collins, Goldenhars and Pierre Robin syndrome. Critical airway obstruction might also be found in neonates with Down syndrome, Laryngomalacia/Tracheomalacia, Vallecular cyst, Vocal cord palsy (primary condition, associated with hydrocephalus), and Laryngeal web. Specific airway-related diagnoses mandate a customized approach to neonatal resuscitation. Another group of conditions that are not directly associated with specific airway diagnoses have implications for airway management in the delivery room, especially conditions wherein the role of bag-mask ventilation is limited and immediate tracheal intubation is recommended for example, oesophageal atresia, and congenital diaphragmatic hernia. The need for emergency tracheostomy arises when resuscitating a neonate or when trying to secure the airway of a neonate which you cannot ventilate and cannot intubate. Establishing a front of neck airway in infants <2 kg or <36 weeks post-menstrual age can be difficult due to the neonatal airway anatomy, especially the short neck and relatively thick anterior neck tissues. Suboptimal conditions and the added stress and time pressure in an unexpected difficult airway situation, are likely to reduce the chances of success even in trained hands. The infant trachea can be difficult to identify when performing the procedure because of the trachea being extremely soft, pliable, and laterally mobile. Proper patient positioning and meticulous dissection technique are therefore critical. Stay sutures are placed to achieve tube replacement if accidental decannulation occurs in the early postoperative period. An infant tracheostomy carries higher complication and mortality rates compared to tracheostomy in adults.

FRIDAY - OCTOBER 12



RCC (Adenocarcinoma) and other tumors of the kidneys

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Renal cell cancer represents 2-3% of all cancers, with the highest incidence in Western countries. During the last two decades the incidence of RCC increased by about 2%, worldwide and in Europe. Incidence varies globally, with the highest rates in developed countries such as North America and Europe and the lowest in Asia and Africa.

In 2012, there were approximately 84,400 new cases of RCC and 34,700 kidney cancer-related deaths in the European Union.

There is a male to female predominance of 1.5:1, with a peak incidence between 60 and 70 years of age.

Etiological factors include smoking, obesity and hypertension [14].

Other risk factors: higher or lower RCC include, occupational exposure to specific carcinogens, acetaminophen and non-steroidal anti-inflammatory drugs, hybrid vegetables, nephrolithiasis and viral hepatitis [15], however, data from the literature are still inconclusive

The purpose of study: Determination the stage of tumor according to the EAU for the Surgery of RCC, determination of criteria in Imaging: criteria for radiographic evaluation of renal tumors, the role of computerized tomography with contrast - illustrations, operative management of kidney tumors, Surgical management - operative approaches and the presentation of complications.

Results: evaluation of our cases in the treatment of renal cell carcinoma in recent years, some cases treated in our clinic recently... during the pandemic.

Conclusions: RCC represent, serious urological disease and are often a big challenge for urologists.

Keywords: Renal Cell Carcinoma, Radical Nephrectomy, Renoraphia, Nephron sparing surgery.

FRIDAY - OCTOBER 12

The Colovesical Fistula in Morbus Crohn, Literature Review***Shkelzen Elezaj at al.******Head of the urologic department******General Hospital in Peja******Mother Theresa n.n.******shkelzenelezaj@yahoo.com***

Introduction: Colovesical fistula is not a common condition. It is the pathological communication between the colon and urinary bladder. The main reason for the formation of the colovesical fistula is an intestinal disease occurring within the intestinal loop adjacent to the bladder resulting in the formation of abnormal communication.

Case presentation: We report a case of an 89-year-old man complaining of abdominal pain, fatigue, oliguria, hematuria, pneumaturia, and fecal content inside a urinary drainage bag.; Abdominal echo showed splenomegaly, both kidneys smaller in size with signs of chronic pyelonephritis, urinary bladder with dense content; In cystoscopy on the upper left wall of bladder present was bullous edema and a hole with a diameter around 8-10mm; Cystography contrast is passable from urinary bladder into the colon. After investigations, we performed surgical preparation between the sigmoid colon and the dome of the bladder continuing with partial cystectomy, whereas the bladder wall defect was repaired by simple closure. The colon defect was treated by segmental resection. Due to the advanced age, malnutrition, and poor health condition of the patient colostomy was performed. The patient is doing well after the operation, shows no evidence of fistula recurrence, and is asymptomatic at four months of follow-up.

Discussion: Colovesical fistula is a rare complication of Crohn's disease. It has been reported to occur in 2-5% of patients with Crohn's disease. Segmental resection of the sigmoid colon and closure of bladder wall defect is the treatment of choice for colovesical fistula.

Conclusion: In summary, colovesical fistula diagnosis is complex, requiring proper investigation through good anamnesis, cystoscopy, retrograde cystography, CT scan, and colonoscopy are crucial to confirm the diagnosis. Based on the publications of the other authors, the treatment of entero-colovesical fistulas is eminently surgical and associated with low rates of recurrence, while nonoperative management has been advocated for patients unfit for surgery, with mild symptoms or those who decline surgical indication.

Keywords: Colovesical fistula; Crohn's disease; Pneumaturia

FRIDAY - OCTOBER 12



Urgent Urologic trauma

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Introduction & Objectives: Introduction & Objectives: Renal trauma occur in 1-5% of all trauma. The kidney is the most frequently attacked organ in the urinary and abdominal trauma.

M: F ratio= 3:1. Kidney trauma may risk the patient's life but most of the kidney injuries can be treated in a conservative manner. Within abdominal trauma 2% of injuries belongs to the bladder. Because of the location, ureter participate in 1% of urinary tract trauma. Analysis of urinary tract injury during the period January 2010 - January 2020. Analysis of the nature of the injury and therapeutic methods undertaken

Material & Methods: Operating protocol is used from Emergency Center in Pristina for the period January 2010 - January 2020. Retrospective method of analysis of patients operated during this period of time has been used.

Results: During this period of time in the operating room have been surgically treated 140 cases of urinary tract trauma.

55 cases of kidney injury have been in 30 cases of kidney injury sutura of kidney is applied, while in 25 cases nefrektomia, 10 patients with rupture of kidney have died in the operating room (intraoperacionem)

Bladder injuries - Rupture of the bladder are encountered in 25 cases or 17.85% of the cases is applied suture of the bladder the transurethral catheter is applied.

Retroperitoneal hematoma are explored in 35 patients or 25% of the cases.

Urethra injuries in 15 patients or 10.7% of cases, rupture of posterior urethra where catheterization is applied.

Injuries of Ureter and Renal Vennes with 5 cases or 3.5% of all cases.

Conclusions: Rupture of kidney are most common urologic Trauma emergencies, found in 39.2% of cases, or 55 cases in our material. Main risk comes from the rupture of the kidney, so in 10 cases patients have died in the operating table.

Rupture of bladder occurs in 25 cases or 17.85% of urologic trauma, the suture of bladder is applied and trans-urethral catheterization.

Retroperitoneal hematoma occur in 35 patients or 25% of all cases.

Rupture of the posterior urethra encountered in 15 patients or 10.57% of cases.

Renal vein and ureter injuries are very rare with those found in our material in 5 cases to each other or in the 3.57 of all cases

FRIDAY - OCTOBER 12



Open Nephron Sparing Surgery for T1a Renal Tumors: Clinical Experience

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Aims: While in Western Europe nephron sparing surgery has become standard treatment for small renal masses, in countries like Kosovo, the experience is much more limited. We aimed at reporting our initial experience in managing small renal masses with nephron sparing surgery (NSS).

Materials and Methods: This is a retrospective study of patients who underwent Open Partial Nephrectomy (OPN) at our Clinic of Urology, between January 2010 and December 2022.

Results: Of 215 patients with renal tumors, 34 underwent OPN. 12 (35%) were female and 22 (65%) were male. The mean kidney tumor size was 3.2 cm (range 3.1-4.0). The patients median age was 46 years (age 24-61). The indications were elective in 29 cases and relative is 5 cases. There were no intra-operative complications and the post-operative complications were minimal. After a median follow-up of 34 months (range 24-41) there were no local recurrences or late complications.

Discussion: Well recognized modern guidelines on the treatment of small renal masses indicate the use of nephron sparing surgery. Our urological community needs to implement these guidelines and our urologists need to be provided with the necessary teaching of this more and more emerging treatment strategy.

Conclusions: Patients with small renal masses that are amenable for a technically and oncologically safe partial nephrectomy, even in presence of a normal contralateral kidney, should undergo nephron sparing surgery that we showed to be feasible and to provide excellent tumor control.

FRIDAY - OCTOBER 12



Renal Trauma

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Introduction: Epidemiology, etiology and pathophysiology. Renal trauma is present in up to 5% of all trauma cases [26].

It is more common in young men and has a general population incidence of 4.9 per 100,000 inhabitants [27].

Prevalence is higher in urban settings. The most frequently used classification system is that of AAST (American Association for the Surgery of Trauma).

The purpose of study: Determination of the degree of injury according to the American Society for the Surgery of Trauma (AAST), the degree of kidney damage, determination of criteria in Imaging: criteria for radiographic evaluation of kidney injuries - the role of computerized tomography with contrast - illustrations, determination of the degree of kidney injury. Criteria for non-operative and operative management of kidney injuries.

Surgical management - operative approaches. Presentation of complications.

Results: evaluation of our cases in the treatment of renal trauma in recent months, some cases treated in our clinic recently... during the pandemic.

Conclusions: renal traumas represent acute urological emergencies, and are often a big challenge for urologists.

Keywords: UCCK-Prishtina, Renal trauma, Renal rupture, Nephrectomy, Renoraphia.

FRIDAY - OCTOBER 12

**OGG1 rs2304277 Gene Polymorphism in Bladder Cancer*****Bujar Frangu¹, A.Prenaj¹, S.Panov³, J.Janculev², S. Saidi²******¹University Clinical Center of Kosova, Clinic of Urology, Pristina,******²Ss. Cyril and Methodius University in Skopje · Clinic of Urology******³Faculty of Natural Sciences, Ss. Cyril & Methodius University, Skopje******Presenting Author: Bujar Frangu:******bujarfrangu@gmail.com*****Named Lecture: Prof. Dr. Xhemil Bytyqi for Urology**

Bladder cancer is the 7th most common cancer in men, while it is the 10th most common in both sexes. Genetic instability caused by DNA damage plays a key role in the molecular etiopathogenesis of bladder cancer. Metabolites of carcinogens and genotoxic agents are excreted in urine, resulting in direct exposure of urothelial cell DNA to these compounds. Although cells have a variety of mechanisms for repairing damaged DNA, polymorphisms in genes responsible for DNA repair can reduce their functionality and contribute to genetic instability and the risk of malignant transformation.

Preliminary data obtained from bladder cancer samples are presented, of which 33 with low histological differentiation and 16 with high grade. The rs2304277 polymorphism in the OGG1 gene was analyzed from blood leukocytes using real-time PCR. Statistical analyzes were used to determine the association between pathological data and genetic testing results.

The results showed that the homozygous GG genotype is more present in patients with high-grade tumors (43.75%) than in those with low-grade cancers (18.18%). Therefore, GG genotype carriers have 6,417 times greater probability of developing higher grade tumors than AA genotype carriers and this difference is statistically significant ($p=0.039$).

Key words: urothelial bladder cancer, rs2304277 polymorphism, OGG1

FRIDAY - OCTOBER 12



Correlation of the rs2279744 Polymorphism in the MDM2 Gene with Invasiveness of Bladder Carcinoma

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Urothelial bladder cancer is the 10th most common cancer worldwide with an incidence of 549,000 new cases per year. Transurethral resection (TUR) is a diagnostic method that is a gold standard for histopathological verification of the tumor. This procedure is curative in most non-invasive muscle cancers that account for almost 75% of primary tumors. The remaining nearly 25% are muscle invasive tumors that are treated with radical cystoprostatectomy. In the last 20 years, a large amount of evidence has accumulated about gene changes implicated in the development of urothelial cancer and its phenotype.

The rs2279744 polymorphism in the MDM2 gene was determined from blood samples.

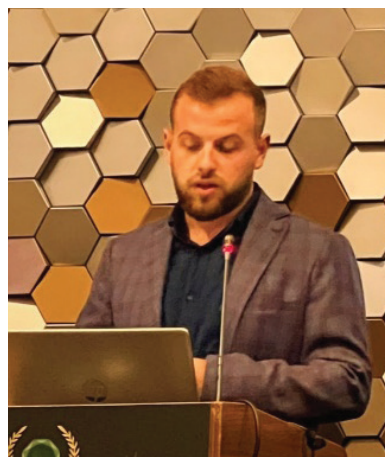
Statistical analyzes were used to identify the correlation of relevant clinical and histopathological data with the molecular-genetic results from the patients.

Preliminary data indicate the existence of a genetic association of the rs2279744 polymorphism in the MDM2 gene with the invasiveness of bladder cancer.

The frequency of the heterozygous TG genotype is statistically significantly ($p < 0.05$) higher in patients who have muscle-invasive bladder tumors, i.e. stage $\geq pT2$.

Key words: urothelial bladder cancer, rs2279744 gene polymorphism, MDM2

FRIDAY - OCTOBER 12



Treatment of Kidney and Ureteral Stones with Stone Light Laser Lithotripsy

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Introduction: Stone disease affects approximately 8-10% of the global population, making it a prevalent health issue. Laser lithotripsy, performed through a ureteroscope in the urinary tract, is increasingly utilized worldwide for stone management. This study aims to evaluate the efficiency and safety of Stone Light Laser Lithotripsy in treating kidney and ureteral stones while addressing associated procedural challenges. Laser lithotripsy is a minimally invasive technique. Surgical management depends on many factors, including the availability of different technologies. We started in October 2013 with stone laser lithotripsy from AMS 10 Watt. Since 2020 we have upgraded with Medilas H Solvo 35 Watts from Dornier.

Objective: To assess the effectiveness and safety treatment of stone light laser lithotripsy in the kidney and ureter including the problems encountered during this procedure.

Materials & Methods: In this study from October 2013 till September 2023, there were 266 patients treated. The age of the patients was 9-77 years. Males 149 while Females 107.

A pre-op examination was done with CT intravenous urography. The stones harness was assessed through the measurement of Hounsfield Units (HU) these ranged from 800-2670 HU.

The duration of time for procedure was 8-120 minutes. All patients had spinal anesthesia performed. 2 hours before the procedure Ceftriaxone was given. The patients were discharged 5 hours after the intervention, where they were subjected to antibiotic therapy for 5 days at home.

There have been six cases with impacted stones in the subpyeloureteric junction, which were partially crushed, where a double j was then placed on the same day, and the cases were continued with two more RIRS sessions.

In cases where we cannot enter directly with URS, double J is placed for 2-4 weeks.

In cases where the infection was present with temperature and fever, a double J was placed - it was treated with antibiotics and after four weeks, stone laser crushing was performed.

Results: All patients underwent successful stone fragmentation with one to three RIRS sessions. Frequent postoperative monitoring via ultrasound and native RTG revealed no major or minor complications. These results affirm the efficacy and safety of holmium laser lithotripsy for treating urinary stones in diverse patient populations.

Conclusions: Stone Light Laser Lithotripsy is gaining prominence, particularly in cases of hard stones. RIRS is the preferred method in our practice. The rise in infections presents future challenges due to antibiotic resistance, warranting further medical attention.

The treatment is quick and effective and the patient goes home the same day.

Patients with diabetes and hypertension who have or have had infections or urinary tract infections in the past should be more careful from developing severe infections after the intervention.

Keywords: urolithiasis, stone management, laser lithotripsy, kidney stones, ureteral stones

FRIDAY - OCTOBER 12

**Retrocaval Ureter: Report of one Cases***Halil Xhibexhiu, B. Thaci, A.Hazrolli, A.Rustemi, F.Shukriu,**A.Hasani, S.Kastrati**General Hospital "Prim. Dr. Daut Mustafa" - Prizren**Presenting Author: Halil Xhibexhiu;**halili001@hotmail.com*

Retrocaval ureter (RCU) is a rare congenital anomaly in which the ureter passes posterior to the inferior vena cava (IVC).

We present one cases of retrocaval ureter which were successfully managed at the General Hospital in Prizren.

Case 1. A 39-year-old man presented with a history of dull right flank pain of 1 years duration. Physical examination and basic laboratory investigations performed on her were normal. Abdominal ultrasound showed right hydronephrosis and urografia I.V and a retrograde right ureteropyelogram (RPG) showed right hydroureteronephrosis with an "S" shaped proximal ureter. A diagnosis of retrocaval ureter was made and confirmed at surgery.

Conclusion. Retrocaval ureter is a rare congenital anomaly that is now increasingly being reported. Surgical treatment of symptomatic cases successfully relieves symptoms.

FRIDAY - OCTOBER 12



**Orbital and Intracranial Complications in
Patients with Acute Rhinosinusitis
(Two-week personal experience from 14.- 26.
August 2023 at the ENT Clinic at UCCK)**

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With antibiotic treatment, the incidence of complications of acute sinusitis has been significantly reduced. Complications are rare, but still very dangerous.

Orbital infections from sinusitis, if not diagnosed or treated inadequately, can result in ptosis, diplopia, and even blindness.

The incidence of orbital complications is around 5.8% of patients with acute rhinosinusitis

Orbital complications from rhinosinusitis were classified according to Chandler's Classification several decades ago, and this classification is based on the type of inflammation and the severity of the clinical presentation.

It is not unusual for orbital and intracranial complications to occur simultaneously in the same patient.

The risk is approximately (15-20%) for the spread of infection in intracranial structures such as meningitis, encephalitis or abscess. Even today, a mortality of 0-19% and morbidity of 8-33% must be reckoned with.

The decision for surgical intervention is largely based on clinical factors such as ptosis and weakening of vision or neurological deficits.

Preoperative planning also includes diagnostics with CT (with contrast) and MRI.

Appropriate interdisciplinary consultation with pediatrics (infectious disease), radiologists, ophthalmologists, neurologists and neurosurgeons is key.

Orbital decompression of subperiosteal abscess should be performed by an experienced surgeon with the endoscopic endonasal technique. This operative technique is performed as a modern procedure in our country.

FRIDAY - OCTOBER 12

**Cochlear Implantation*****Deniz Tuna Edizer, MD, Assoc Prof, MSc******Acibadem University, Medical Faculty,******Department of Ear, Nose and Throat Diseases*****Named Lecture: Prof. Dr. Talat Pallaska &
Prof. Dr. Besim Sllamniku for ORL Surgery**

Cochlear implantation is a surgical procedure used for patients with severe to profound hearing loss. Generally, a cochlear implant device consists of an inner and an outer part. Inner part is surgically implanted and converts incoming sound signals to electrical signals that stimulate the auditory nerve. The candidate patient must have a functional auditory nerve as well as a sufficiently developed cochlea to house the electrode chain of the cochlear implant. Both preoperative and postoperative education is mandatory. Audiological, radiological, linguistic and psychological evaluations along with a neurootological examination should be performed in decision making. The indications, basic surgical steps and complications of the cochlear implantation is discussed.

FRIDAY - OCTOBER 12

**Septoplasty in children, problem or solution?**

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Introduction: Nasal septum deviation in childhood is not a rare occurrence. 2-12% of children are thought to be born with nasal septum deviation. Therefore, there's a need for surgical correction, depending on the severity of the deviation. The preferred age for such surgical intervention is 14 and older, however in specific cases even earlier, starting from age 6, though appropriate procedures have to be followed. That means the growth centers of the nose have to be kept intact.

Aim: Knowing that surgical intervention in nasal septum in pediatric patients has been contradictory, it seemed appropriate to research the results of such interventions all over the world, and compare them to our work over 4 years in the General Hospital of Prizren.

Methodology: Statistical. There has been shown the data of children who have underwent septoplasty in General Hospital of Prizren in the 4-year period 2016-2019.

Results: The total number of operated children over 4 years is 95. Of those, 39 males and 56 females. There are 19 surgical interventions on children under 14, and 76 on those aged 15-18. Only 5 children under 10 have been operated on, which can be understood as reluctance to do the procedure on younger children. Of all these cases, 11 have needed revision surgery and there has been 1 septum perforation.

Conclusion: Functional results have been satisfactory in 87.4% of cases. There have been no cases of postoperative deformations of the nose or the face.

FRIDAY - OCTOBER 12

**On-pump vs Off-pump Revascularization***Ilirijana Haxhibeqiri – Karabdic**ilirijanahk@yahoo.com***Named Lecture: Prof. Dr. Gazmend Shaqiri for Vascular Surgery**

Background: Coronary artery disease (CAD) is a major public health issue and a leading cause of death globally. It is one of the most common indications for surgical intervention. There are a lot of different techniques, including CABG, which consists of two approaches: sternotomy and mini-thoracotomy. Different techniques have been developed to improve surgical outcomes, including the use of machine for extracorporeal circulation (on-pump) or without it (off-pump).

Methods: In period between 2022 – 2023, we performed CABG operation in 80 patients. CABG was performed either on- pump or off-pump.

Results: The results have shown advantages and disadvantages of one or another type of CABG. We were comparing the duration of surgical procedure, time on mechanical ventilation, drainage volume, neurological incidents, time to discharge, indication for repeat revascularization and mortality between two groups.

Conclusion: The choice of surgical technique should be based on individual patient factors, including comorbidities and surgical risks. It is important to say that OPCABG is more challenging than ONCABG, and it is very important that OPCABG is done by skilled, experienced and confident surgeon, which contributes to better outcome and survival.

Keywords: coronary disease, off-pump coronary artery bypass, on-pump coronary artery bypass, coronary artery bypass grafting

FRIDAY - OCTOBER 12



Quality Benchmarking in Congenital Heart Surgery A Novel Artificial Intelligence – based On-line Platform

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Background. Assessment of value in health care is based on the ratio of quality and cost. Focusing on the known Donabedian three aspects of quality (structure, process, and outcome), outcome measurement is an essential prerequisite to improvement. In congenital heart surgery, this requires recording of detailed surgical outcome data in large organized databases, which must fulfil specific requirements: use of standardized common nomenclature, a mechanism for ensuring data veracity, accuracy, and completeness, and, of course, provision of facilities for case risk stratification, risk adjustment, and benchmarking. These requirements have been satisfied by The European Congenital Heart Surgeons Association (ECHSA) Congenital Database, which, over more than 25 years, has continued to accumulate data (already on more than 350,000 congenital cardiac procedures), while fully respecting patient, center and surgeon anonymity (certified GDPR compliance), and has also evolved ever more powerful analytical facilities. The ECHSA Database, in close collaboration with the USA based STS Congenital Cardiac Database, has pioneered the development of risk stratification and risk – adjusted methodologies. These have included initially the consensus-based methods of the Aristotle Basic and Comprehensive Complexity Scores, and, subsequently, the data-driven EACTS-STs STAT mortality and STs Morbidity scores. These scores have been extensively used along classical medical statistical techniques in the evaluation of pediatric cardiac surgical outcomes with numerous scientific publications on both sides of the Atlantic.

However, we have come to realize that the classical medical statistical techniques have several shortcomings: These include the erroneous assumption of the existence of linear interactions between potential risk factors, as well as the increased vulnerability to human bias, in addition to their being cumbersome and time-consuming.

To circumvent these limitations, the ECHSA Database, in collaboration with the expert Artificial Intelligence (AI) Team of Professor Dimitris Bertsimas at the Massachusetts Institute of Technology (MIT) in the USA, has developed the unique Machine-Learning (ML)-based methodology of Optimal Classification Trees (OCTs) to analyse congenital heart surgery data. Major advantages of this novel methodology include that it is free of any assumptions that risk factors interact in a linear fashion, that it is completely mathematical and therefore as free of human bias as possible, and that, unlike other AI-based methods, it is far from a “black-box” method, on the contrary, it is readily understandable and transparent to the clinician.

As reported in previous publications, using the ECHSA Congenital Database data, we have demonstrated that our OCT ML-based methodology can a) accurately predict risk after Congenital Heart Surgery (CHS) and b) assess case-mix-adjusted performance after the subset of congenital procedures known as the “benchmark procedure groups”.

These include both commonly performed operations (such as VSD closure, coarctation repair, or Tetralogy of Fallot repair) and also more challenging procedures (arterial switch or Norwood operations), which are generally deemed to collectively reflect the performance of congenital heart surgery programs.

We subsequently extended this methodology to provide interpretable, easily accessible, customizable and actionable detailed hospital performance analysis across all procedures, for the purpose of facilitating our participating centers' individual quality improvement programs.

Methods. The ECHSA Database data subset of 172,888 congenital cardiac surgical procedures performed in European Centers between 1989 and 2022 was analysed. OCT models (decision trees) were built predicting hospital mortality (HM) (AUC=0.866), prolonged postoperative mechanical ventilatory support time (MVST) (AUC=0.851) or length of hospital stay (LOS) (AUC=0.818), thereby establishing case-adjusted benchmarking standards reflecting the aggregated overall performance of all participating hospitals, designated as the “virtual hospital.” OCT analysis of “virtual hospital” aggregate data then yielded predicted expected outcomes (both aggregate and for risk-matched patient cohorts, as revealed by the OCT analysis) for each individual hospitals' own specific case-mix.

Results: Raw average rates were HM=4.9%, MVST =14.5%, and LOS =15.0%. Of N=146 participating Centers, in comparison with each hospital's overall case-adjusted predicted HM benchmark, 20.5% statistically (under 90% CI) overperformed and 20.5% underperformed.

An interactive on-line platform tool based on the OCT analysis automatically reveals 14 virtual hospital-specific patient cohorts, simultaneously assessing overperformance or underperformance, enabling further analysis of cohort strata in any chosen time frame.

Predicted expected outcomes (both aggregate and for risk-matched patient cohorts, as revealed by the OCT analysis) for individual hospitals' own specific case-mix, that is, the center-specific “benchmark against which the individual center should compare itself, are then compared with the corresponding actual observed outcomes for each individual hospital, calculating in each case an observed versus expected (O/E) ratio.

The results of these calculations were made available to each center in the form of a confidential center-specific report. In additional, each center can access their own confidential center-specific analysis logging into a specially designed on-line platform, which permits customization of the report by selection of various parameters such time period of analysis or depth level of analysis. Specific center feedback for the purpose of engineering possible platform improvements has been requested.

Conclusions: Participation in the ECHSA Congenital Cardiac Database provides centers with access to the unique ECHSA Database ML-based OCT benchmarking analysis, which yields automatic assessment of hospital-specific and case-adjusted performance after CHS, not only overall, but, importantly, by similar risk patient cohorts. This is an extremely powerful tool for hospital self-assessment, particularly facilitated by the user-accessible online-platform.

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FRIDAY - OCTOBER 12



Minimally Invasive Aortic Valve Surgery: One Team Experience

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Introduction: Minimally invasive approach during cardiac surgery is becoming everyday more popular. Upper hemisternotomy surgical approach was used in a series of patients underwent aortic valve and/or ascending aorta surgery.

Purpose: We are going to report the early results of one team experience in a serie of patients.

Materials and Methods: We perform about 100 cases of aortic valve surgeries per year at our institution. We used minimal invasive technique, ”J” dexter or inveted “T” hemisternotomy, in 39 patients. The data were collected from hospital follow up and presented in mean value and standard deviation. The endpoints were early mortality, perioperative complications, intraoperative and post-operative times in the respective wards and the physiological impact of the mini-incision.

Results: Our group included 39 patients, 22 males and 17 females, the mean age was 64 years old, mainly were in aortic valve stenosis. We performed minimal invasive approach in two patients with ascending aorta aneurysm. We had only one hospital death, two patient did postoperative atrial fibrillation and one patient was re-explored for bleeding and one patient did sternitis and one patients did mediastinitis that was the cause of death. Cardio-pulmonary by-pass, cross clamp, respiratory assistance, intensive care unit stay and postoperative hospital times were respectively 92.3 ± 16.6 min, 68 ± 17.3 min, 7.1 ± 3.6 hour, 40 ± 5.6 hour and 8.3 ± 9 days. No patient had patient- prosthesis mismatch. Patients were more satisfied comparatively with the patients that have performed standard sternotomy.

Conclusions: The minimal invasive technique can be safely performed during aortic valve surgery and it is a reproducible technique.

FRIDAY - OCTOBER 12



Bioprosthetic Aortic Valve Dysfunction: A Case Report

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Bioprosthetic valve dysfunction (BVD) and bioprosthetic valve failure (BVF) may be caused by structural or nonstructural valve dysfunction, thrombosis, or endocarditis [1]. Both surgical and transcatheter bioprosthetic valves have limited durability because of structural valve deterioration.

Bioprosthetic valve thrombosis (BPVT) is a rare entity associated with high morbidity and mortality [2]. Bioprosthetic valve thrombosis (BPVT) can coexist with other forms of prosthesis dysfunction, such as endocarditis or pannus formation, and has a wide spectrum of clinical presentations [3]. Echocardiography plays a major role in the diagnosis and differentiation of bioprosthetic valve thrombosis (BPVT) from other forms of valve dysfunction.

We present the case of a 77-year-old male with dysfunction of the biological prosthesis in the aorta (thrombus in the prosthesis). The patient underwent aortic valve replacement (AVR) IN 2017 due to sever stenosis of native valve after bacterial endocarditis. He had also other concomitant diagnosis: Left bundle branch block (LBBB), Heart failure New York Heart Association (NYHA St. II), Arterial hypertension stage II (HTA stage II), The patient was followed regularly from the first month after the operation with ultrasound, holter rhythm, and INR analysis up to 6 months. He was treated with warfarin, and after 6 months, he took acedum acetylsalicylium. Year 2020 Holter rhythms showed sinus tachycardia. The transthoracic echocardiogram (TTE) of 2020: Aortic biological prosthesis with a slightly high gradient (mean gradient 16 mmHg, max gradient 32 mmHg) Mild central reflux of the prosthesis. January 2023. The transthoracic echocardiogram (TTE) showed: Biological aortic prosthesis with a mean gradient of 55 mmHg and a max gradient of 85 mmHg Mobile hypoechoic formations. Central and eccentric reflux of the prosthesis. Echocardiography played an important role in diagnosis and guided management in both presentations.

Keywords: Bioprosthesis, Thrombosis, Endocarditis, Echocardiography

FRIDAY - OCTOBER 12



**Case Presentation: The First Implantation of
Aortic Valve Prosthesis “Intuity” in Our Country
Short Panoramic View of the Use of these Types of Prosthesis**

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Aortic valve surgery is the most important part of valvular surgery in adults. The traditional aortic valve replacement surgery (AVR) with artificial prosthesis is performed by suturing the prosthesis in all around the valvular annulus. There is more than a decade that have been introduced for clinical use “sutureless” prosthesis. These prosthesis are implanted in the aortic annulus without traditional suturing. We will introduce the first implantation of a sutureless prosthesis in a patient in our country and we will take a brief look over the latest data on the use of these types of prostheses.

Conclusion: The beginning of use these types of prostheses open a new window in the aortic valve surgery in our country.

SATURDAY - OCTOBER 13



Quality of Death in Neurosurgical Practice: A 40-year Story from India

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Named Lecture: Asst. Prof. Dr. Shefqet Meha for Neurosurgery

Background: Neurosurgeons probably encounter more deaths than most other surgical specialists **Objective:** The author over a 40-year period of active practice has personally certified over 2500 deaths in Government, Trust and Corporate tertiary care hospitals in a densely populated metro - Chennai in India. Retrospectively, the author questions, if in spite of his conservatism and obsession with Quality of Life, he should have taken proactive measures to also ensure a good Quality of Death. This communication reviews literature on Good Death and extrapolates observations and inferences to neurosurgical practice. Changes in approaches to Good Death in the COVID 19 era are also discussed, including its aftermath in the post pandemic era, the influence on lessons learnt across various socio-economic groups, with varied access to technology.

Search strategy, Data Extraction and Analysis, Intervention: This narrative “review” has no research question or specific search strategy. Data extraction, analysis and intervention are also not relevant. The article is an overview of a current topic of interest, from a neurosurgeon’s perspective, highlighting the author’s personal experience, and views.

Main Outcome is to share the extensive experience of the author highlighting take home messages from published literature.

Results, Conclusions and Relevance. The author concludes that ensuring Good Death should also fall within the domain of a surgeon’s practice. In an era of increasing depersonalization, exponential deployment of technology and social media, this message of ensuring a good quality of death is particularly relevant.

Key words: Good Death, Good Death AND Neurosurgical Practice, Quality of Death

SATURDAY - OCTOBER 13



Trauma System in Europe: An Ongoing Challenge

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**Named Lecture: Prof. Dr. Rifat Latifi –
Advances in Trauma, Telemedicine and Technologies**

Adequate trauma care is strictly linked to an organized trauma system, but in several European countries a mature and effective trauma system has not been formalized yet. Although in Europe trauma is still the leading cause of death in younger age groups and different scientific societies have stressed this need, a pan-European government participation is still lacking; the result is that quality improvement, verification programs and trauma data collections are quite patchy all across Europe. Another challenge is represented by the lack of leadership in trauma care mainly due to the hyperspecialization effect with of “organ specific surgeons” with minimal interest in trauma. Trauma care have been developed mainly in two different ways: in some countries the trauma leader is a surgeon with a specific background in orthopedics and skeletal trauma, while in the rest of EU countries is a general surgeon; both systems have multiple limitations especially due to a progressive lack of exposure to trauma which is also associated to the progressive decrease of motor vehicles accidents that came along with the WHO Road safety action plan. Thankfully, in most European countries the rate of penetrating injury is quite low when compared to US or South America data and the lack of exposure on penetrating injury is even less. Both systems, skeletal trauma or general surgeon centered, have many limitations and these different surgical communities need to focus on a broader perspective that should include damage control surgery and resuscitation, surgical critical care, postoperative assistance, and rehabilitation. The need for implementation and maturation of a dedicated trauma system in each European country should be strongly advocated and scientific societies should address this need to healthcare authorities. The present generation of surgeons might be the last generation that could act as principal stakeholder.

SATURDAY - OCTOBER 13

**Surgical Ego: the good the bad and the ugly***Abraham Fingerhut**GuangCi Laureate Professor**Shanghai Jiao Tong University School of Medicine,**Shanghai China**Medical University of Graz, Division for Surgical Research,**Graz, Austria**Co-Editor-in-Chief of Annals of Laparoscopic and Endoscopic Surgery (ALES)**abefingerhut@aol.com*

Surgical ego is often necessary for surgeons to assume the task of decision making, especially in life-threatening situations, where the patient's future depends on a decision that has to be made in a few seconds. The surgeon has to be confident that he or she knows what to do, how and when to do it, and is capable of execution of the task. Self-confidence is a necessary component of decision-making. However, surgical ego is also responsible for over-estimation of capabilities or skills that can lead to poor indications, poor execution of simple or complicated tasks necessary to treat patients, or ill-directed or misconstrued decisions. "Bad" aspects of surgical ego consist of making decisions based on ideas, concepts or reasoning handed down from generation to generation, without taking into account the evidence for or against that has been published since the genesis of the idea, concept or reasoning behind the decision under scrutiny. "Bad" aspects of surgical ego consist of persistence of bad decisions or lines of thought because of the lack of introspection, of admitting that the surgeon might be wrong or even ignores what should be done. Such behavior patterns can lead the surgeon to communication errors to other partners in health care that can lead to complications or even mortality. Ugly aspects of surgical ego are when the surgeon is arrogant or disrespectful to juniors or sometimes even patients. Ugly behavior patterns characteristic of the over-egoistic surgeon lead to insults, arguments and even physical aggressions that are reprimandable in the face of justice.

SATURDAY - OCTOBER 13



**Surgery Leadership Training:
An Investment in Safety, Quality, and Value**

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Background: Surgeon leadership development is frequently discussed as a method to address myriad issues from quality outcomes to physician burnout. Objective data is rarely used in the discussion of physician leadership.

Data Source: Review of the English language literature from 2010 to present.

Conclusions: While often discussed, little objective data exists to guide surgeon leadership development. An opportunity exists for the international community of surgeons to better define outcomes and guidelines for surgeon leadership development.

SATURDAY - OCTOBER 13



Ethical issues in Surgical Practice in 2030: A Peep into the Future

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Futurology is a pseudoscience where cutting edge technology of today, is extrapolated, to do some crystal ball gazing. Most surgical specialities are growing exponentially with radical transformations. The use of Artificial Intelligence (AI), robots, Augmented Reality (AR), Augmented Virtual Reality (AVR), tele mentored surgery, telesurgery and augmentative surgery is only tip of the iceberg. The practice of surgery and surgical decision making in the next decade could be totally different. New codes of conduct need to be evolved. An AI influenced Hippocratic Oath in the next decade may well be called “The Robocratic Oath”. Would *not* deploying AI be considered malpractice? Machines, like humans, can also commit errors. When AI-driven machines and robots start making critical treatment decisions or operating autonomously, who is responsible for errors, complications or patient death? There would be a need for a change in mindset from *shifting* responsibility to *sharing* responsibility. Biased or skewed data used to create AI algorithms could have major repercussions. Decision made by an AI platform could override patient autonomy if patients cannot choose for themselves. This article will give an overview of what can be expected in the coming decade for surgeons in the area of ethics.

Key words: Futurology, Surgical ethical issues AND 2030, AI AND Surgery

SATURDAY - OCTOBER 13

**Improving the quality and safety of patients:
Challenges for Kosova***Qamile Morina**qamilemorina00@gmail.com*

We are all aware that health care saves lives and has brought many benefits to society, but at the same time, it also carries significant risks for patient safety.

Until recently, medical errors were considered an inevitable part of health care. But, this approach changed in 1999, when the report on medical errors titled “To err is human” was published in Washington by the Institute of Medicine (IOM). According to that report, every year in the US from medical errors that could have been prevented, nearly 100,000 people died.

It was an alarming data and at the same time it was an initiative to improve patient safety by mobilizing the governments of countries around the world, health and educational institutions, health professionals and patients. This mobilization led to the development of a special discipline called Patient Safety.

During the improvement of safety practices, expansion of knowledge in this direction as well as learning, it has been understood that the main thing that is emphasized by the experience of others is the change of culture in our work.

A country’s patient safety culture depends on the extent to which the health system supports and promotes patient safety. It refers to individual and group values, beliefs, attitudes, competencies and behavioral patterns that determine commitment and ability to organize security programs.

And that means we have to change the approach to health care in order to make it safe, and that has proven to be a very big and difficult job. What has been learned in the last two decades is that health care is more complicated than previously thought, and trying to make it safe is much more difficult than it is thought to be.

In conclusion we must consider the fact that safety is greatly influenced by personal attitudes and our culture as well as the climate in our units or hospital and no single instrument for patient safety will work if the safety culture of a hospital is unfavorable.

FRIDAY - OCTOBER 12



Global Surgery and Surgical Volunteerism: A Sustainable Model of Improving Access to Care

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Named Lecture: Prof. Dr. Sami Haxhibeqiri – Frontiers in Surgery

Surgical volunteer missions (SVMs) have become a popular approach for reducing the burden of surgical disease (BSD) worldwide. SVM have been organized for many decades, but the published report by the Lancet Commission (LC) on Global Surgery in 2015 add more importance and weight to SVM. The LC reported that nearly 45% of the total estimated surgical cases worldwide are left un-operated each year, leaving more than 143 million people LIMICs without adequate surgical care. Nearly 2/3 the world's population do not have access to safe, affordable, and timely surgical care, with the majority being from low-income countries. Two billion people lack insufficient surgical infrastructure including lack of surgeons, tens of millions each year face catastrophic financial hardship when they are forced to pay for their own surgery and anesthesia. SVMs offer a flexible surgical care, but long-term results have not been studied, and the number of missions number or patients served is not known. SVM are organized by the NGOs, or governments, or are supported and organized by faith-based organizations. SVMs based on emergency situations (i.e., disaster-response missions), are created in an ad hoc fashion from a single institution, or are formed from an existing roster of emergency volunteers. Irrespective, the goal of SVM is to lessen BSD based on the expertise of the surgical team, and the infrastructure of the hospital, where the mission is taking place. There is a lack of data on outcomes of SVMs. The lack of international surgical practice guidelines on is another reason for lack of such data.

In this presentation of special symposium of the 3rd Clinical Congress of KCS, I will address major organizational topics that would make SVM safe and effective way of lessening the BSD.

FRIDAY - OCTOBER 12

**Juvenile Angiofibroma = JNA****(One-week personal experience as a volunteer doctor from 06. - 10. Juni 2022 at the****ENT Clinic at UCCK)***Arsim Thaqi**kosovasinuscenter@gmail.com*

JNA is a benign, highly vascularized lesion that accounts for 0.05% of all head and neck tumors and typically affects young adolescent males.

Typical symptoms for JNA are unilateral nasal obstruction and epistaxis. Proptosis or swelling of the cheek clearly indicate that the lesion has extended into the orbit or the infratemporal fossa.

Endoscopy usually shows a large, lobulated and hypervascularization mass bulging behind the tail of the middle turbinate and filling the choana.

Biopsy is not recommended, as it would expose the patient to an risk of massive hemorrhage.

Preoperative planning also includes diagnostics with CT (with contrast) and MRI.

Preoperative Embolization was introduced to decrease intraoperative bleeding and has nowadays become a standard procedure when an interventional radiologist is available.

Surgery is considered the ideal treatment for JNA. There is a general agreement that lesions involving the nasal cavity, nasopharynx, sphenoid sinus and pterygopalatine fossa can be appropriately resected through an endoscopic approach.

SATURDAY - OCTOBER 13

Laparoscopic Fundoplication and Paraesophageal Repair: Approach & Techniques

*Demetrius Litwin**Department of Surgery, University of Massachusetts**Demetrius.Litwin@umassmemorial.org*

The standard surgical repair for gastroesophageal reflux disease (GERD) is fundoplication with repair of the hiatus hernia if present.

Indications include failure of medical management, inability to take/pay for medications, complications including stricture, bleeding, asthma/aspiration pneumonia, and quality of life issues (i.e. intractable symptomatology or lifelong antireflux medication). The laparoscopic approach is safe and effective but is associated with a relatively high rate of recurrent GERD and/or hiatus hernia. Surgeons must vigilantly adhere to the principles of an appropriate workup and careful patient selection. The operative principles include reestablishment of an intraabdominal distal esophagus, precise crural closure, and creation of a “floppy” fundoplication.

The presence of paraesophageal hernias and motility disorders may require variations in technique, such as substitution of Nissen (full 360 degree) fundoplication for a Toupet (partial 270 degree) posterior fundoplication. The general principles surgeons should adhere to when evaluating patients for surgical management of GERD will be outlined. Specific technical steps will be described, with emphasis on the steps that require rigorous attention for success. Finally, the anticipated postoperative course and common complications will be briefly reviewed.

SATURDAY - OCTOBER 13

**Multimodal therapeutic strategies for colorectal cancer liver metastases***Pärparim Limani**Department of Surgery and Transplantation, University Hospital Zurich**perparim.limani@usz.ch*

Colorectal cancer (CRC) ranks as the third most prevalent cancer globally. Liver metastases occur in half of CRC patients during the course of the disease, and in the absence of treatment, the 5-year survival rate is nearly zero. Surgical resection is currently the only potential curative option, and adjuvant chemotherapy is recommended according to current guidelines, resulting in a 5-year survival rate of over 50%. Neoadjuvant systemic therapy is not recommended for cases involving simple resection, but it should be offered to patients with extensive bilobar disease. Personalized systemic treatment is crucial in converting initially non-resectable lesions into resectable ones. Both open and minimally invasive surgeries (laparoscopic or robotic) can be utilized to perform anatomical or non-anatomical resections, as well as two-stage hepatectomies. The extent of hepatic resection is limited due to the risk of postoperative liver failure, which may result from factors such as insufficient liver remnant size, inflow or outflow obstruction, or inadequate biliary drainage. Approximately 75% of patients are diagnosed with non-resectable liver metastases that cannot undergo standard upfront resection. In recent years, advancements in therapeutic approaches have revolutionized liver surgery, allowing for the conversion of primarily non-resectable metastatic disease into a resectable state. These strategies encompass both oncological and surgical therapies, often in combination. Systemic chemotherapy, immunotherapy, or selective intra-hepatic arterial infusion chemotherapy may be employed for oncological treatment, depending on the extent of the disease and mutational status. Surgical strategies frequently involve two-stage procedures using portal vein occlusion techniques such as portal vein embolization or ligation, as well as complex two-stage hepatectomies like associating liver partition and portal vein ligation for staged hepatectomy. Additional tools, such as tumor ablations (electroporation, microwave, or radiofrequency), can be utilized to achieve curative resection. The role of stereotactic radiation in treating liver metastases is not yet well-defined, as modern radiation techniques have only been introduced for a larger patient population in recent years, necessitating prospective studies with larger patient cohorts. Over the past decade, liver transplantation has gained increasing attention for selective cases of non-resectable colorectal liver metastases, with promising findings from cohort studies; however, definitive recommendations await the results of ongoing randomized controlled trials. Optimal treatment for patients with colorectal liver metastases requires the timely integration of various strategies, and all cases should be discussed in multidisciplinary team conferences. While colorectal liver metastases used to be uniformly fatal a few decades ago, it has now become amenable to curative therapies, leading to excellent quality of life in many cases. This overview focuses on the current treatment modalities for colorectal liver metastases.

SATURDAY - OCTOBER 13



Outcomes of Emergently Admitted Patients with either Intestinal Fistula, Ulceration, Perforation, Angiodysplasia, or Dieulafoy Lesion: Frailty, Age, Time to Operation, and Hospital Length of Stay as Mortality Risk Factors

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Background: International classification of diseases (ICD)-9 code of 569.8 represents a collective of highly prevalent gastrointestinal diseases including intestinal fistula, intestinal ulceration, intestinal perforation, angiodysplasia, and Dieulafoy lesions. In the United States, GI pathology accounts for greater than 135.9 billion USD in annual healthcare expenditure. The goal of this investigation is to elucidate and quantify mortality risk factors involved in patients emergently admitted with either intestinal fistula, intestinal ulceration, intestinal perforation, angiodysplasia, or Dieulafoy lesions.

Methods: The National Inpatient Sample repository was utilized to investigate elderly and adult patients emergently admitted with either intestinal fistula, intestinal ulceration, intestinal perforation, angiodysplasia, or Dieulafoy lesions (ICD-9 569.8) between 2005-2014. Relationships between mortality and all parameters of interest were determined with univariable and multivariable logistic regression models. Results collected included demographics, clinical interventions, outcomes, and comorbidities.

Results: 53,585 patients were assessed including 18,361 adults and 35,224 elderly patients who possessed an average age of 50.8 and 78.1 years, respectively. Female patients made up 51.2% of adults and 57.2% of the elderly, males accounted for 48.8% of adults and 42.8% of elderly patients. Average mortality rate observed for operated adults was 4.3%, non-operated adults was 2.5%, operated elderly was 6.6%, and non-operated elderly was 7.1%. Multivariable logistic regression analysis revealed time to operation, age, modified frailty index, intestinal ulceration, intestinal perforation, angiodysplasia, and Dieulafoy intestinal lesion were the most significant risk factors for mortality for the operative group. Every additional day of delay to operative intervention increased the risk of mortality by 3.0% and 3.5% in adult and elderly patients, respectively. Regarding age, each additional year increased the mortality odds by 3.4% in operated adults and 4.7% in operated elderly patients. Additionally, a higher modified frailty index was associated with a 40.8% and 10.4% increase in mortality odds for operatively managed adult and elderly patients, respectively. Fistula of the intestine was chosen as the reference category for comparison between the intestinal disorders. Of which, intestinal perforation was most strongly associated with mortality. Operatively managed adult and elderly patients with intestinal perforation were 3.2 times and 4.0 times

more likely to expire relative to those with intestinal fistula, respectively. The presence of intestinal ulceration was associated with reduced mortality odds by 62.0% in adults and 65.7% in elderly patients when compared to fistula. Similarly, when compared to fistula, the mortality risk decreased by 61.7% and 82.7% in adult and elderly patients with angiodysplasia, respectively. Lastly, the indication of Dieulafoy intestinal lesion was associated with an 82.4% reduced mortality odds relative to fistula in elderly patients (Table 1). In the non-operative group, the most significant mortality-associated variables were age, modified frailty index, hospital length of stay, and intestinal disorders. Regarding age, each additional year increased mortality odds by 3.6% and 4.6% in adult and elderly patients, respectively. Frailty was associated with a 38.6% increase in mortality odds in adults and 9.1% increase in mortality odds in elderly patients. Hospital length of stay was not a significant mortality factor in non-operative elderly patients, however, each additional day of hospitalization increased mortality by 1.3% in non-operative adults. Intestinal perforation displayed robust associations, increasing mortality odds by 3.0 times in adults and 3.3 times in elderly patients when compared to those with fistula. When comparing mortality odds against those with fistula, adult non-operative patients with intestinal ulceration, angiodysplasia, or Dieulafoy intestinal lesion displayed reduced mortality odds by 57.8%, 59.9%, and 83.5%, respectively. Similarly, non-operative elderly patients with intestinal ulceration, angiodysplasia, or Dieulafoy intestinal lesion displayed reduced mortality odds by 73.7%, 84.8%, and 86.5%, respectively (Table 1).

Conclusion: Patients emergently admitted for either intestinal fistula, intestinal ulceration, intestinal perforation, angiodysplasia, or Dieulafoy lesions with advanced age or frailty possessed higher mortality risk than their younger and non-frail counterparts. Delayed time to operation and prolonged hospital length of stay increase mortality odds in operatively managed and conservatively managed patients, respectively. Compared to intestinal fistula, intestinal perforation increases mortality odds, while intestinal ulceration and angiodysplasia lower mortality odds in all respective patients.

Key Words: Intestinal Fistula, Intestinal Ulceration, Intestinal Perforation, Angiodysplasia, Dieulafoy lesions, In-hospital mortality, Age, Hospital length of stay.

Table 1. Backward logistic regression analysis evaluating associations between mortality and different factors in emergently admitted operative and non-operative patients with the primary diagnosis of either intestinal fistula, intestinal ulceration, intestinal perforation, angiodysplasia, or Dieulafoy lesions (ICD-9 569.8). Mortality was the dependent variable. NIS 2005-2014.

N = 9,891 OR (95% CI)		Adults Managed with Operation		Elderly Managed with Operation		Adults Managed with No Operation		Elderly Managed with No Operation	
		R ² = 0.106	N = 18,824	R ² = 0.248	N = 11,175	R ² = 0.108	N = 21,193	R ² = 0.248	
		P	OR (95% CI)	P	OR (95% CI)	P	OR (95% CI)	P	
Time to Operation, Days		1.030 (1.020, 1.039)	<0.001	1.035 (1.021, 1.048)	<0.001	Not Applicable			
Age, Years		1.034 (1.022, 1.046)	<0.001	1.047 (1.038, 1.055)	<0.001	1.036 (1.025, 1.047)	<0.001	1.046 (1.038, 1.054)	<0.001
Modified Frailty Index Score		1.408 (1.284, 1.545)	<0.001	1.104 (1.044, 1.167)	<0.001	1.386 (1.272, 1.511)	<0.001	1.091 (1.035, 1.149)	0.001
Hospital Length of Stay, Days		*				1.013 (1.009, 1.017)	<0.001	*	
Intestinal Disorders	Fistula [Ref]		<0.001		<0.001		<0.001		<0.001
	Ulceration	0.380 (0.174, 0.828)	0.015	0.343 (0.214, 0.550)	<0.001	0.422 (0.204, 0.872)	0.020	0.263 (0.168, 0.413)	<0.001
	Perforation	3.296 (2.330, 4.664)	<0.001	4.025 (3.046, 5.320)	<0.001	3.082 (2.261, 4.200)	<0.001	3.344 (2.609, 4.286)	<0.001
	Angiodysplasia	0.383 (0.231, 0.634)	<0.001	0.173 (0.126, 0.239)	<0.001	0.401 (0.249, 0.646)	<0.001	0.152 (0.113, 0.204)	<0.001
	Dieulafoy Lesions	0.180 (0.024, 1.322)	0.090	0.176 (0.080, 0.389)	<0.001	0.165 (0.023, 1.212)	0.080	0.135 (0.061, 0.295)	<0.001

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SATURDAY - OCTOBER 12

**The RLQ Pain in Male after Appendectomy*****Kastriot Haxhirexha, Roland Alili,******Aulona Haxhirexha, Teuta Emini******Clinical Hospital of Tetove******Department of General Surgery******Presenting Author: Kastriot Haxhirexha******dr.kastriot@gmail.com***

Introduction: Acute appendicitis represents one of the most frequent emergency interventions in abdominal surgery. Although the appendectomy represents an intervention that shows good post-operative results, in rare cases it can lead to the presentation of various complications which are manifested by chronic pain in the RLQ.

Aim of the study: to present a case of a patient with chronic pain localized in the RLQ after appendectomy.

Case report: A 29-year-old patient was admitted to our hospital due to chronic pain in the RLQ accompanied by intermittent temperature and tenderness during palpation of the abdomen in the right lower quadrant. In the patient's history report he refers that seven months before he had had an appendectomy procedure done in another hospital. Laboratory tests showed an increased white blood cell count (14.8), while the percentage of neutrophils was 87%. The value of CRP was 117, while D-dimers 2100. Ultrasonographic examination and abdominal CT with contrast showed a pericecal mass with a moderate amount of fluid around it. After that, a surgical intervention was performed and a segment of the small intestine, a part of the omentum and the inflamed appendicular stump were observed in the space around the cecum and adhered to it.

Conclusion: Although abdominal pain localized in the RLQ after appendectomy in males is very rare and challenging, surgeons must take into consideration that sometimes they can be the result of inflammatory processes that also come from the appendicular stump.

Key words: appendectomy, RLQ, pain, stump

SATURDAY - OCTOBER 12



**Treatment Modalities in Rectal Cancer:
Neoadjuvant Therapy, Surgery or Watch-and-Wait Approach**

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The treatment of rectal cancer depends on various factors such as the stage of the cancer, the location of the tumor and the patient's overall health. Surgical resection is the cornerstone of curative treatment for rectal adenocarcinomas achieving histologically negative margins for local excision or performing a total mesorectal excision that includes resection of local lymph nodes.

However, most patients have more deeply invasive tumors that do not meet the criteria for local excision or surgical resection. Hence, this rectal cancer patients with clinical stage T2N1M0, T3N0M0, or T3N1M0 especially those located in the lower part of the rectum, who are eligible for sphincter-sparing surgery needs preoperative chemotherapy or chemoradiotherapy for tumor downstaging!

On the other hand, about 16-27% of patients with rectal cancer who received neoadjuvant therapy especially total neoadjuvant therapy experience a clinical complete response. This patients may be considered for an initial non-operative approach watch-and-wait with an experienced multidisciplinary team.

We present the case who have been diagnosed with low rectal cancer 9 years ago. Initially, he refused surgical treatment with a definitive stoma but had only undergone chemoradiotherapy treatment. After 9 years, a surgical resection is performed with oncological free margins, without distant metastases!

In conclusion, multidisciplinary team and appropriate effective multimodality treatments must be used in every patient with rectal cancer.

Key words: Rectal cancer, neoadjuvant therapy, watch-and-wait approach

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Total Neoadjuvant Therapy – Should We Change Our Approach to Locally Advanced Rectum Cancer

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Colorectal cancer (CRC) is the third most common and second most lethal cancer. Between 5% and 10% of rectal cancer patients present with locally advanced rectal cancer (LARC). In order to downstage/downsize and improve loco-regional control in locally advanced (clinical T3–4 or N-positive) rectal cancer, neoadjuvant therapy (radiation or chemo-radiotherapy) is considered as a golden standard. The possible drawback of the neoadjuvant therapy is control of the distant metastasis. The term “total neoadjuvant therapy” (TNT) is a new model of implementing both radiation and systemic therapy before surgical resection in patients with locally advanced rectal cancer. TNT can be implemented as a two strategy regimen: induction (chemotherapy first) or consolidation (radiation first). Patient selection criteria for administration of total neoadjuvant therapy in the recent guidelines are unclear and can be tailored according to the clinical status of the patient, symptoms, and desired treatment goals. Radiation can be considered first for the symptom relief in patients presenting with tenesmus, bleeding from their cancer or offered to the patients in whom organ preservation (i.e. low anterior resection instead of abdominal perineal resection) is possible. In patients with unfavorable tumor characteristics like lymph node involvement or extramural venous invasion where the risk for an earlier micro-metastasis is higher – performing a chemotherapy first is more desirable. As with many other malignant diseases, locally advanced rectum cancer should be discussed on multidisciplinary meetings and a patient-tailored approach should be considered and tailored by both patients and physicians.

Self-Assessment Questions and answers

1. What is the difference between consolidation and induction TNT?
 - a) In consolidation regimen only chemotherapy is administered
 - b) In induction regimen only radiotherapy is performed
 - c) In induction regimen chemotherapy comes first and in consolidation regimen radiation comes first.
 - d) They are all the same and are part of neoadjuvant therapy
 - e) Consolidation therapy is used in only patient with liver metastasis due to the colorectal cancer
2. What is locally advanced rectal cancer regarding the tumor size?
 - a) It is T1 rectal cancer with liver metastasis
 - b) It is T3 or T4 rectal cancer
 - c) It is T2 rectal cancer with liver metastasis
 - d) It is T1 rectal cancer with synchronous T1 colon cancer
 - e) It is the T1 or T2 metachronous right colon cancer

Answers: 1-c; 2-b

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Left Colonic Diverticulitis: A Comprehensive Review of Diagnosis and Management

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Abstract: Left colonic diverticulitis is a common condition that presents with a range of symptoms, from mild abdominal pain to severe complications such as perforation, abscess formation, and sepsis. Diagnosis can be challenging, requiring a combination of clinical history, physical examination, laboratory tests, and imaging modalities such as CT scan and ultrasound. The differential diagnosis will also be highlighted, as other pathologies may mimic the presentation of diverticulitis. Management of left colonic diverticulitis depends on the severity of the disease, ranging from conservative treatment with antibiotics and bowel rest to surgical intervention in severe cases.

Methods: This comprehensive review will cover the pathophysiology, clinical presentation, diagnosis, and management strategies for left colonic diverticulitis. The presentation will begin with an overview of the anatomy and pathophysiology of diverticulitis, including risk factors, and the mechanisms that lead to inflammation and infection. The management of left colonic diverticulitis will be addressed, including the role of antibiotics, bowel rest, and surgical intervention. The appropriate use of antibiotics, including duration and spectrum of coverage, will be reviewed, and the indications for surgical intervention will be discussed.

Discussion: The review emphasizes the importance of a comprehensive approach to the diagnosis and management of left colonic diverticulitis. The appropriate use of diagnostic tests and imaging modalities can help identify the severity of the disease and guide management decisions. Antibiotics and bowel rest are effective in treating mild to moderate cases, while surgery is reserved for severe cases or complications. The review also highlights the importance of preventing and managing complications, which can result in significant morbidity and mortality.

Conclusion: In summary, this comprehensive review will provide clinicians with a thorough understanding of left colonic diverticulitis, including diagnosis, management, and strategies to prevent and manage complications. Clinicians will be equipped with evidence-based information to improve patient outcomes.

Key words: acute colonic diverticulitis, diverticular disease, medical management, surgical management, Hinchey classification, percutaneous drainage management, colectomy.

SATURDAY - OCTOBER 12



Cryoablation of Cholangiocarcinoma

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Cholangiocarcinoma is the most common biliary and the second most common primary hepatic malignancy. At the time of diagnosis, patients are often not surgical candidates due to tumor features or other comorbidities.

In addition, there is a very high rate of tumor recurrence after resection

With rapid advances in modern imaging, minimally invasive ablative procedures have emerged as popular alternatives to surgical removal of tumors. Cryoablation, is increasingly being used for treating various solid tumors.

In this article we present the first cryoablation procedure performed in Albania.

Key words: Cryoablation, intrahepatic cholangiocarcinoma

SATURDAY - OCTOBER 13



The Benefits of Sleeve Gastrectomy as a Method of Treating Obesity

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Introduction: Bariatric surgery is the surgical treatment for weight loss and the most effective method for achieving long-term weight loss. Laparoscopic Sleeve Gastrectomy is one of the most popular operations in modern times, which results in weight loss and relief of most of the obesity related diseases. The criteria for a patient to be a candidate for bariatric surgery are: BMI equal to 40 or greater than 35 and associated with conditions related to obesity such as hypertension, diabetes mellitus, sleep apnea, age 16-75 years, etc. According to recent studies, the benefits of Sleeve Gastrectomy surgery are weight loss, improved breathing, lower blood sugar, the ability to be more physically active, and a lower risk of death from cardiovascular disease and some cancers.

Aim of study: To identify the correlation between hypertension, lipids profile, blood sugar, and weight before and after Sleeve Gastrectomy. Certain biochemical and clinical parameters are analyzed in patients undergoing Sleeve Gastrectomy and these parameters are compared before and after the procedure. In terms of time, the improvement of these parameters should be analyzed over time, as we believe that over time in different patients we will have a variable rate of improvement in results.

Patients and Methods: The research is of Prospective Case-Control type. The study includes patients who have undergone Laparoscopic Sleeve Gastrectomy at Kavaja Hospital from the period July 2022-July 2023. This number is expected to be up to 200 patients. Patients will be classified according to gender, age, BMI.

Conclusion: Based on our clinical experience and the results of other studies, we expect to have normalization of blood sugar, blood pressure and blood lipids profile.

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Low Anterior Syndrome: Focusing On Functional

Wellbeing After Sphincter Sparing Surgery

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Low anterior resection syndrome (LARS) may occur after low anterior resection (LAR) in rectal cancers and less frequently after anterior resection in sigmoid tumors. The most frequently reported problems were incontinence (97%), increased frequency of defecation (80%), urgency of defecation (67%), difficulty in defecation (47%), inability to distinguish between gas and stool. The exact etiology of LARS remains unclear. The cause of LARS is complex and possibly multifactorial. After surgical treatment of colorectal cancer, LARS appears immediately, becomes more prominent in the first few months, and stabilizes after about 2 years. LARS may affect the patient's postoperative life in terms of general quality of life and social function. Factors such as advanced age, total mesorectal excision (TME), distance of the tumor from the anal verge, diversion stoma, and preoperative radiotherapy were found to be risk factors for LARS.

Understanding the possible risk factors for LARS can assist in surgical decision making and in post-operative anorectal rehabilitation programs. A 'LARS score' has been developed to increase the consistency of LARS reporting. The LARS score is a validated 5-item questionnaire evaluating bowel function after sphincter-sparing surgery, created by Emmertsen et al. in Denmark in 2012. The score ranges from 0 to 42, with 0-20 indicating no LARS, 21-29 minor LARS and 30-42 major LARS. Those with a score of ≥ 30 (major or severe LARS) were found to have a significant impact on their quality of life.

First-line treatment for LARS includes dietary changes. Medical therapy includes serotonin receptor antagonists, anti-diarrheals such as loperamide and atropine. Sacral nerve stimulation (SNS) significantly reduces the frequency of weekly incontinence episodes. Definitive stoma may be considered for treatment-resistant LARS lasting more than two years.

Questions:

1. What is true regarding Low anterior resection syndrome (LARS):

- a) LARS score can be used for diagnosis
- b) Carefully surgery can bring risk to 0
- c) Patient with score 0-20 are considered to have the most severe LARS
- d) The LARS score is a validated 5-item questionnaire evaluating bowel function after sphincter-sparing surgery
- e) Stoma is first step in treatment of patient with LARS

2. What is true regarding Low anterior resection syndrome (LARS):

- a. LARS occurs only after sigmoid resection
- b. Those with a score of ≥ 30 (major or severe LARS) were found to have a significant impact on their quality of life.
- c. LARS score includes age of the patient
- d. Sacral nerve stimulation (SNS) should be only performed in female patient
- e. Stoma is not an option in treating LARS

Answers

1.d 2 b

FRIDAY - OCTOBER 12



Stercoral Colitis due to Spinal Cord Injury: a Case Report

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Background: Neurogenic bowel disease dysfunction (NBD) is fecal incontinence or constipation resulting from central nervous disease or injury. One of the causes of neurogenic bowel disease is spinal cord damage. Stercoral colitis is a uncommon form of inflammatory colitis resulting from focal compression of colonic mucosal wall and vasculature by large hardened faecal material, termed faecaloma, or synonymous to a large fecalith. The purpose of this case report is to describe the potential challenges in the diagnosis and treatment of stercoral colitis.

Case presentation: Here we present a case of a 58-year-old man admitted to the clinic due to frequent bowel movements, 3-6 times a day, fatigue, and lethargy. The complaints started 3 months ago. In 2010, he was hospitalized in Orthopaedic Clinic after a traffic accident that left him paralyzed in the lower extremity (paraplegia). Suffers from HTA, urinates with a catheter. In the sacral part there is a scar from the aforementioned operation. Blood count and biochemistry were normal, CRP 11.5 mg/l; HBsAg negative, Anti HCV negative, prothrombin time 14.7%, INR, 1.095, PTT 21.0 sec. AFP 2.14 IU/ml, CA 19-9 50.15 U/ml, CA 72.4 0.875/ml, CEA 1.75 ng/ml, PSA; 0.504 ng/ml. pANCA 5.9 AU/ml; cANCA 37.9 AU/ml POSITIVE; calprotectin in feces 630 ng/kg, C difficile toxin A and B negative, occult blood in feces was positive. Urine was cloudy, albumin positive, sediment with 10-12 leukocytes and mass of bacteria. Colonoscopy was suspicious for Crohn's disease, ischemic colitis and carcinoma. The terminal ileum at endoscopy was normal. In the biopsies taken from the rectosigmoid region, there were signs of chronic inflammation, active ulceration, with architectural disorders of the crypts. These features primarily corresponded to chronic inflammatory bowel disease. CT angiography and Angio CT – DSA of visceral arteries did not reveal obvious or dynamic pathology in the aorta and visceral arteries. The patient was treated for 5 months with Fraxiparine (Nadroparinum), mesalamine suppositories, synbiotics, and laxatives. Special attention was paid to bowel emptying. In the meantime, the patient's condition began to improve. Frequent bowel movements stopped, feces began to form, and the endoscopic changes were largely resolved.

Conclusion: Doctors should be aware of the occurrence of stercoral colitis in a patient with neurogenic intestinal dysfunction, more specifically with spinal cord injury. Early and adequate detection and treatment of stercoral colitis enables us to avoid these diseases from its possible complications, especially from perforation of the colon.

Keywords: neurogenic bowel dysfunction, spinal cord injury, stercoral colitis

SATURDAY - OCTOBER 13



Thyroid Tumor Nomenclature, Classification and Grading:

What is Knew in WHO 2022 Classification?

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The World Health Organization (WHO) 2022 fifth edition of the Classification of Endocrine and Neuroendocrine tumors integrates several changes to the nomenclature and classification of neoplastic and non-neoplastic thyroid disease, that are essential for patient management. The new classification puts thyroid tumors into categories according to the cell of the origin, pathologic features, molecular classification and biological behavior. There is a major shift toward follicular cell neoplasms stratification based on molecular profiles into BRAF- like malignancies and RAS- like malignancies. Tumor size is no longer the main feature for the diagnosis of the so called papillary thyroid microcarcinomas regardless of histomorphological features. Moreover, there are shifts within subtypes in diagnostic categories and new diagnostic categories are introduced such as ‘differentiated high-grade thyroid carcinoma’ for papillary thyroid carcinomas, follicular thyroid carcinomas and oncocytic thyroid carcinomas with high grade features and poorer prognosis. A review and discussion of the main changes in the WHO 2022 fifth edition classification of Thyroid tumors and its implications in patient prognosis and management is provided.

Questions CME:

1. Which tumors enter the new category of “differentiated carcinomas with high histological grade of the thyroid” according to WHO 2022, and what are its implications for patient treatment?
2. What are WHO 2022 criteria for the histopathological classification of the so-called “papillary thyroid microcarcinoma” and what are its implications for patient prognosis?

Answers CME

1. Differentiated high-grade thyroid carcinomas are papillary, follicular and oncocytic thyroid carcinomas with high mitotic activity, ≥ 5 mitoses in 2 mm² of the microscopic field, and/or tumor necrosis. These tumors have more advanced histopathological stages and less avidity to bind to iodine than well-differentiated thyroid cancers.
2. In the new 2022 WHO classification, except for tumor size in ‘papillary thyroid microcarcinoma’ it is also required to provide additional subtype information as for tumors larger than 1 cm. A number of papillary microcarcinomas have morphological characteristics of more aggressive tumors, such as those with a “tall cell like”, “columnar” and “hobnail” appearance, and consequently.

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**Laparoscopic hernia repair vs. open hernia repair*****Demetrius Litwin, MD, Gazi Rashid, MD******Department of Surgery, University of Massachusetts******Presenting author: Demetrius Litwin, MD******Demetrius.Litwin@umassmemorial.org*****Named lecture: Prof. Dr. Salih Krasniqi for
Laparoscopic Pioneers in Surgery**

Inguinal hernias are the most common types of hernia in the United States, leading to an estimated 750,000 operations every year. Though both open and laparoscopic approaches can be used, patients who undergo the laparoscopic approach have been shown to have faster return to activity, decreased postoperative pain, and may also have fewer recurrences than those who undergo the open approach. Furthermore, there is a clear benefit in laparoscopic repair with recurrent and bilateral hernias. Despite these advantages, laparoscopic inguinal hernia repair has not been as widely accepted as we would expect.

The outcomes comparing open vs. laparoscopic will be reviewed, including benefits, drawbacks, and historical trends. Transabdominal preperitoneal (TAPP) and totally extra-peritoneal (TEP) laparoscopic surgeries will also be compared and contrasted in their anatomic approach and outcomes, though their fundamental similarities will be highlighted.

The principles of laparoscopic TAPP repair will be illustrated. Laparoscopic TAPP repair is more difficult to perform than a laparoscopic cholecystectomy and may require greater technical skill; however, adherence to strict principles outlined here will ensure low complication and recurrence rates.

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Early versus Delayed Laparoscopic Cholecystectomy for Acute Cholecystitis; Predictive Factors for Conversion

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One of the most common gastrointestinal diseases are diseases of the biliary tree that often result in high morbidity and mortality. Of particular importance is an acute cholecystitis which represents the state of emergency and the need for timely diagnosis and appropriate treatment.

The aim of the study are to identify predictive factors for conversion to open method in early compared to delayed laparoscopic cholecystectomy (LC) in patients with acute cholecystitis.

In the case study are included 139 patients total with acute cholecystitis hospitalized at our Clinic. In the case study group, 71 patients were treated with early LC from 0-7 day from the onset of symptoms, 68 patients in the control group were treated with late LC in the period of 6-12 weeks from onset of symptoms. The selection of participants was made by random sampling and according to predetermined inclusion and exclusion criteria.

There is no significant differences ($p > 0.05$) between the respondents from the two groups due to age, gender, education, place of living, past illnesses, co-morbidity and previous abdominal surgery. Significant differences was found between the two groups due to the duration of LC till/up 85 minutes (Chi-square=14,17; $p < 0.001$), applicated drainage (Chi-square=16,42; $p = 0,001$), and histopathology findings (Chi-square=9,19; $p = 0,001$).

The analysis of individual parameters for conversion into open method the study group showed that fever [$p = 0,054$, 95% CI=0,969-31,222] and CRP [$p = 0,004$, 95% CI=2,898-260,98] are significant predictors for the conversion, while temperature, leucocytes and EHO findings resulted with notsignificant greater risk of conversion.

Early LC for acute cholecystitis is safe and effective procedure, offers a definite initial hospitalization treatment and is a better option for the treatment of acute cholecystitis compared with delayed LC.

There is a significant difference in the type of predictive factors for conversion to open method between early versus late LC for acute cholecystitis.

Keywords: Acute cholecystitis, early laparoscopic cholecystectomy, predictive factors, conversion.

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A Case Report of Laparoscopic Treatment of Hydatid Disease of the Liver in a 13-year-old child

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A 13-year-old girl who had no known medical history went to our clinic complaining of stomach discomfort, fatigue, and nausea for months. Laboratory examinations, Ultrasonography and non-contrast CT scans of the abdomen were performed. The CT Scan of the abdomen revealed a large cyst measuring 120x100mm located in the 5th and 8th segments of the liver. Serological test to Echinococcus granulosus antibodies IgG was positive. The patient has no family history of this disease. Albendazole was administered 2 weeks prior to the planned term for surgery.

After preparing the patient, a laparoscopic operation was performed. The operation was performed with three ports (1x10 mm, 2x5mm), with a 5 mm optical endoscope. A supraumbilical entry was made with a 10 mm trocar Hasson technic, insufflation of CO₂, at 10 mmHg of pressure and 13L/min flow. The abdominal cavity was visually inspected, and then additional two paraumbilical 5mm trocars were inserted. The contents of the cyst were removed by suction, and the cyst was ablated. Lavage with a 20% sodium chloride solution was applied to the remaining pericyst and the surrounding region, and the resulting effluent was sucked away. The cyst was packed in a make-do endobag. The second look pericyst exploration was performed and included checking for bile leakage, followed by a partial pericystectomy was done (consisting of fenestration, omentoplication, and the insertion of a single drain into the pericyst). The endobag was removed through the 10mm port. The operation was performed in under an hour.

The drainage for the first three days was 250, 150 and 80 ml appropriately. On the 11th postoperative day, the production stopped and the abdominal drain was removed, so the patient was discharged.

Treatment with Albendazole continued for four weeks after surgery.

Regular checkups thereafter showed no abnormalities.

Conclusion: With specific precautions, laparoscopic therapy of hydatid cysts of the liver may be done safely and effectively. Surgeons must also be knowledgeable about the surgical treatment of this condition, as well as laparoscopic methods.

Keywords: Hepatic cyst, Hydatid disease, Echinococcus granulosus, Laparoscopy

SATURDAY - OCTOBER 13

**Trends in Surgical Management of Breast Cancer****– an Article Review*****Bedri Osmani¹, Nazmi Kolgeci², Driton Tolaj²***¹Thoracic Surgery Department,***University Clinical Centre of Kosova, Prishtina.******Corresponding and Presenting Author:******Bedri Osmani******bedriosmani@hotmail.com***

Breast cancer management has evolved into an evidence-based, multidisciplinary surgical specialty with a special emphasis on conservative surgery. A number of landmark trials have established lumpectomy followed by radiation as the gold standard of care for many patients. The purpose of this article is to construct a narrative overview of recent developments in the surgical management of breast cancer and how such developments have influenced surgical practice. A comprehensive literature search was performed in Pubmed. Specific keywords and different operators were used in combination with regard to surgical management. Articles were selected and reviewed based on relevance. We selected publications in the last 10 years, but did not exclude commonly cited and highly regarded earlier publications. Review articles and book chapters were also cited to provide reference on details not discussed in the academic literature. This article reviews the current evidence in the surgical management of early-stage breast cancer, discusses recent trends in surgical practice for therapeutic and prophylactic procedures, and comments on the implications and factors associated with these trends.

Keywords: Breast cancer, Lumpectomy, PubMed

FRIDAY - OCTOBER 12

**Current Strategies for Breast Reconstruction after Mastectomy*****Jose A. Castro Garcia, MD, FACS******Assistant Professor******Division Chief******Plastic and Craniofacial Surgery******Surgery Department******University Medical Center and Children's Hospital,******El Paso******Texas Tech University******El Paso******jose.castro@ttuhsc.edu***

Breast cancer continues to be the most common malignancy in women in the US, with an estimate of almost 300,000 new cases in 2023. The Women's Health and Cancer Rights Act of 1998 (WHCRA) is a US federal law protecting patients who require breast reconstruction after mastectomy. In the US, all patients who will undergo or have already had a mastectomy for breast cancer should be offered reconstruction. Reconstruction of the breast after mastectomy has evolved over the past years to minimize morbidity and maximize cosmetic, functional, and psychological outcomes. Depending on the patient's desires, anatomy, cancer staging, and perioperative medical treatment, the strategies for breast reconstruction are multiple. They should be tailored to the patient's desires following their clinical setting. Options include implant-based with or without acellular dermal matrix and autologous tissue transfers, pedicled or with microvascular anastomosis. Breast reconstruction does not end with the restoration of the breast mound. Current strategies also include reestablishing sensation in the reconstructed breast. Complications from cancer treatment, such as lymphedema, can also be managed with lymphatic-venous bypass or lymph node transfers. This overview will discuss the strategies and options for breast reconstruction to educate the audience on the current alternatives available.

SATURDAY - OCTOBER 13

**Metabolic Syndrome and Molecular Subtypes of Breast Cancer in Kosova***Dafina Ademi Islami**dafinaademi@hotmail.com*

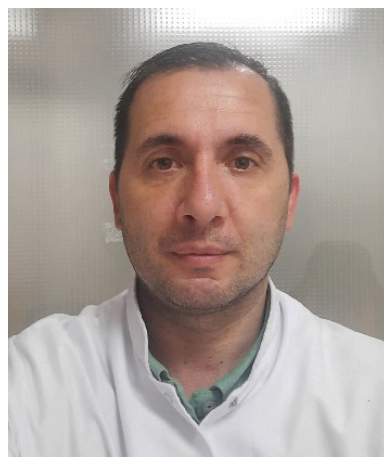
Introduction: Molecular subtypes of breast cancer have different prognoses, and Luminal A has a better prognosis compared to other molecular subtypes of breast cancer. However, whether the metabolic syndrome or specific metabolic syndrome risk factors influence the development of a particular molecular subtype remains unclear. We aimed to evaluate the association between metabolic syndrome risk factors and molecular subtypes of breast cancer among metabolic syndrome patients.

Methods: A total of 101 breast cancer patients with a mean age of 58.4 ± 8.5 years and metabolic syndrome, referred to the oncology department for treatment, were prospectively recruited, and using immunohistochemical procedures, molecular subtypes were confirmed. Clinical evaluation, parameters biochemical and anthropometric examination have been done. Logistic regression analysis was used to assess the association between risk factors and molecular subtype categories of breast cancer.

Results: In the comparison of individual risk factors of metabolic syndrome according to molecular subtypes of breast cancer, no statistical difference was found for systolic ($p = 0.33$) and diastolic blood pressure ($p = 0.17$), glucose ($p = 0.77$), triglycerides ($p = 0.62$), high-density lipoprotein ($p = 0.33$), body mass index ($p = 0.87$) and waist circumference ($p = 0.81$). A positive trend was found between high-density lipoprotein and HER2+ (OR and 95% CI: 1.42 (0.79-2.52) p -value 0.23)). No association was found for other risk factors. Furthermore, an association was found between HER2+ category and menopause (OR and 95% CI: 4.40 (1.00-19.54) p value 0.05)).

Conclusion: In breast cancer patients with metabolic syndrome, an increasing trend was observed between high-density lipoprotein and HER2+ molecular subtype, suggesting that dyslipidemia may favor the development of molecular subtypes with poor prognosis. HER2+ was associated with menopause, which may play a mediating role in further HER2+ expression.

SATURDAY - OCTOBER 13



**The Role of Interleukin-7 Serum Level as
Biological Marker in Breast Cancer:
A Cross-Sectional, Observational, and Analytical Study**

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Marina Popović², Slavica Sović³, Davor Mijatović^{3,6},
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Background: The important role that the immune system plays in malignant diseases is well known. The action of interleukin-7 (IL-7) as a cytokine has been observed in many cellular processes, both in normal cells of the immune system and in some cancer cells. The aim of this study has been to explore whether there is any elevation of interleukin-7 serum levels in early invasive breast cancer patients (EIBC) in comparison with healthy controls. In addition, the correlation between the IL-7 serum level and the histopathological characteristics of the tumor has been evaluated.

This cross-sectional, observational, and analytical study included 213 consecutive patients with EIBC and 62 healthy participants as the control group. Blood samples have been taken from patients confirmed with breast cancer by biopsy, prior to surgical intervention and other oncological treatments, as well as from healthy participants. In addition, after the surgical intervention, histopathological specimen examinations and immunohistochemistry have been performed and analyzed.

The serum level of IL-7 in EIBC patients was significantly higher than in control cases ($P < 0.001$). Patients with invasive lobular carcinoma seem to have a lower IL-7 serum level compared to other histological subtypes, and the difference has been significant ($P = 0.043$). There has been no correlation between IL-7 serum level and histopathological characteristics of the tumor, with neither age nor menopausal status of the patients.

Noting the significant increase in the IL-7 serum level in the EIBC patients as compared to the healthy control group, the use of IL-7 as a potential diagnostic indicator for BC, as well as in the follow-up of the patients after treatment, can be assumed. The lack of correlation with tumor size, lymph node metastasis, and all other histopathological characteristics of the tumor questions its use as a prognostic indicator.

SATURDAY - OCTOBER 12



Intracystic Papillary Carcinoma of Breast at Male. Case Report

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It is presented a case of a 49-year-old man with malignant intracystic tumor of the breast. Swelling in the left breast with d:3 x 4 cm in the central quadrant. After obtaining a core needle biopsy (CNB) from the intracystic change, the diagnosis of DCIS (Ductus Carcinoma in situ) is ensured. Immunohistochemistry, X-ray of the lungs, Sonography of the abdomen: no secondary lesions; Bone scintigraphy: no bone lesions, tumor markers CA15-3, CA 19-9 and CEA1 were normal. Therefore, it is treated with a modified radical mastectomy, which gives the diagnosis: Intracystic Papillary carcinoma with component of ductal invasive carcinoma with a size of 0.3 cm. In the 5 nodes found in the axillary dissection, no metastasis was found; According to TNM: pT1a pNo Mo St IA. 7-month postoperative follow-up: no recurrences. The patient is treated with antihormonal therapy Anastrasole 1mg/day.

In tumors in the mammary region of men, the possibility of malignant lesions should be kept in mind, especially in patients with a positive family history.

Key words: Male breast carcinoma

SATURDAY - OCTOBER 13



Cleft Lip and Palate Treatment: Our Experience

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Cleft lip and palate is the most frequent congenital craniofacial deformity. The clefts may affect the lip, alveolar ridge and palate and cause esthetic, functional and psychosocial disorders. They occur in the embryonic period of intrauterine life and present multifactorial etiology, with association of genetic and environmental factors.

The aim of this presentation is to show the treatment of this pathology and experience of our Department with their treatment.

Maxillofacial Surgery Department in University Hospital Center in Prishtina is involved throughout the process of diagnosis, surgical intervention of cleft lip at the age 3-6 months, surgical intervention of cleft palate at the age 13-18 months, secondary surgery at the age 5-7 years, alveoloplasty at the age 9 years, rhinoplasty and orthognatic surgery performed at the end of facial growth for the correction of maxillomandibular discrepancies, pharyngoplasty after 16 years.

FRIDAY - OCTOBER 12



**The Contribution and Role of Maxillofacial Surgery
during Captivity (1991-1999), the War In Kosova (1998-1999)
and Freedom (June 1999 Onwards)**

Osman Sejfi

Maxillofacial Surgeon

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In these very important and significant time periods (stages) of Kosovo's history, Maxillofacial Surgery with its professional activity made a special and significant contribution.

In addition to this contribution, the staff (personnel) of Maxillofacial Surgery also contributed:

1. In the organization of teaching at the Faculty of Medicine of the University of Pristina,
2. Organization of the supply of medicinal consumables and medical equipment,
3. Created relations in the field of cooperation with similar institutions in the region, Europe and the USA.

SATURDAY - OCTOBER 13



Medical Related Jaw Osteonecrosis: New Problem from an old Disease

Shkelzen Ibishi

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Osteonecrosis medicamentosa is a condition that shows as a complication after usage of medication for treating malign disease, osteoporosis etc.

Mrojn is shown up to 10 % when medication is administrated IV and 0.1 up to 0.5% in oral administrations, its shown in oral cavity specially in mandibulae.

Bisphosphonates are the main group of drugs that Couse osteonecrosis also dezimunab and anti-angiogenic agents also can cause it.

Mrojn shows by itself, but mostly after dental extraction, chronic prosthetic irritation

The first description if this complication is presented by Marks 2003.

Since then is worked on analyzing of this complication but there is still space for exploration.

We in Maxillofacial surgery clinic here in Prishtina treat this compilation from diagnosing until definitive treatment.

The objective of presentation is to inform medical staff about this condition and helping them in screening, diagnosing and treatment of Mjorn.

Key words: Osteonecrosis, jaw, cancer

SATURDAY - OCTOBER 13

Management of the neck in Oral Squamous Cell Carcinoma*Alban Olluri, Thane Kosumi, Milot Ademaj, Leminot Salihu, Shkelzen Ibishi, Mirand Heta, Visar Ramadani**University Clinical Center, Department of Maxillofacial Surgery, Prishtina, Kosova**Presenting Author: Alban Olluri**albanolluri1983@gmail.com*

Approximately 90% of oral cell carcinomas are squamous cell carcinoma. Despite the poor prognosis, there still is a lack of attention in preventing, diagnosing and treating this neoplasm.

According to WHO, oral squamous cell carcinomas are the sixth most frequent carcinomas in men and the tenth most frequent in females. Each year four hundred and fifty thousand new cases of oral squamous cell carcinomas (OSCC) are recorded around the world. For more than one decade, neck dissection and radiotherapy were the main treatment methods for cervical metastatic OSCC. The knowledge in the biology of this tumor has enhanced so much, which led to the need for a new management protocol for neck dissection to be made. One of the main purposes of this presentation is to emphasize the role of early diagnoses of this tumor in the prognosis of this disease. Surgical therapy, radiotherapy, chemotherapy, all together or solely are treatment modalities for OSCC. Regardless of treatment method chosen, five years prognosis is very poor as a result of large tumor size at the time of diagnosis in 2/3 of patients. OSCC requires interdisciplinary treatment in which removal of tumor, relapse prevention, functional preservation of region affected are the main purposes of treatment. Lymph node metastasis is the single most prognostic determinant of OSCC. The decision to perform neck dissection is dependent on risk factors for tumor metastasis such as: tumor size, histopathology type, local infiltration, lymph node involvement.

This presentation aims to describe our experience in surgical management of neck in cases with oral cancer in our clinic.

Key words: oral carcinoma, neck dissection, regional metastasis

SATURDAY - OCTOBER 13



Surgical Treatment of Pleomorphic Adenoma of the Parotid Gland, Evaluation of Postoperative Facial Nerve Morbidity

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Pleomorphic adenoma is the most frequent benign tumor of the salivary glands. It is characterized by a tendency to recur, which is determined by the biological characteristics of the tumor as well as the mode of its treatment. Fine needle aspiration cytology for diagnosis of a parotid gland tumor is widely used. MRI is golden standard that provides information also in the deep lobe and the parapharyngeal space.

Postoperative facial palsy is associated with the mode of surgical treatment and the rate of subsequent recurrence. Among the factors of recurrence the most important are: incomplete excision, intraoperative capsule rupture and myxoid subtype.

The aims of the study were evaluation and correlations of the mode of treatment, to compare the incidence of post-operative facial morbidity, by using clinical- neurophysiological assessment of facial nerve function post-operatively.

This study includes clinical study cases of overall 77 patients with benign tumor (PA), treated at the University Clinic for maxillofacial surgery Skopje, in a period from 2016 to 2020. Enucleation, extracapsular dissection and superficial parotidectomy are the modes of treatment of the pleomorphic adenoma in this study. The values of the size and the subtype of the tumor were obtained from the pathohistological findings after the surgery, comparing the results with the preoperative assessment with CT or MRI values. Clinical assessment was based on House–Brackmann scale post-operatively and the neurophysiological diagnostic measurement which included neuroconductivity of the branches of facial nerve form. frontalis, m. orbicularis oculi and m. orbicularis oris and blink-reflex (BR), comparing the affected side with the non-affected one, performed by specialist neurologist. A descriptive and binary logistic regression analysis were performed for the variables facial nerve dysfunction, mode of treatment, tumor size, location and it's subtype. A statistically significant relationship was found between the appearance of facial paresis and mode of surgical treatment and myxoid subtype. Electroneuroconducting study and S- EMG, allows for the evaluation of face muscles reinnervation and facial nerve regeneration. Mainly grade I of H–B was recorded post-operatively in patients with small tumors. H–B scale and neuroconductivity results revealed positive correlations between the type of tumor and surgery with facial nerve function. The commonest complications after parotidectomy are temporary or permanent facial palsy and Frey's syndrome. Tumor location in the parotid superficial lobe upper area, superficial parotidectomy, size and myxoid subtype are risk factors for recurrence and can worsen facial paresis. The knowledge of these complications is relevant for patient's counseling and to achieve better long-term outcomes.

Key words: Pleomorphic adenoma, risk factors, superficial parotidectomy, facial nerve palsy, House–Brackmann scale, neuroconductivity, electromyography, Blink reflex

SATURDAY - OCTOBER 13



Chest Wall Stabilization in Trauma Patients with Rib Fractures

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The incidence of rib fractures remains high among trauma patients, serving as a significant source of morbidity and mortality. Outcomes are further impacted by the presence of a flail segment, multiple rib fractures, or patient's age. In recent years, there has been an increase in the utilization and research into chest wall stabilization. Due to heterogeneity of the rib fracture pathology, concomitant injuries and patient variability, there have been challenges to develop strict indication guidelines that can be generalized in this patient population.

We present a comprehensive review in management of rib fractures via chest wall stabilization and its impact on outcomes. Outcomes of interest include mortality rates, length of stay in the intensive care unit (ICU) and hospital, post-operative pain, and post-operative complications.

The majority of research reports a decrease in in both the ICU and hospital length of stay. Studies show decreased post-operative pain with chest wall stabilization when compared to non-operative management. Interestingly, these benefits appeared to be most prominent within 72 hours post-surgery. Although some studies show no difference in these variables, most of the data shows a non-conclusive signal that chest wall stabilization surgeries might be a viable option with positive impact on the morbidity and mortality in select patients with rib fractures.

Questions: Chest wall stabilization has been proven to not improve outcomes? T or F

Clear guidelines exist on timing of chest wall stabilization? T or F

SATURDAY - OCTOBER 13

Elderly Patients with Pulmonary Insufficiency Following Trauma Admission have 20 Percent Mortality Rate

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Background: Pulmonary insufficiency is common in elderly patients post major trauma and it is associated with major complications including high mortality. The goal of this study was to assess risk factors of in-hospital mortality for patients admitted emergently with trauma and developed pulmonary insufficiency.

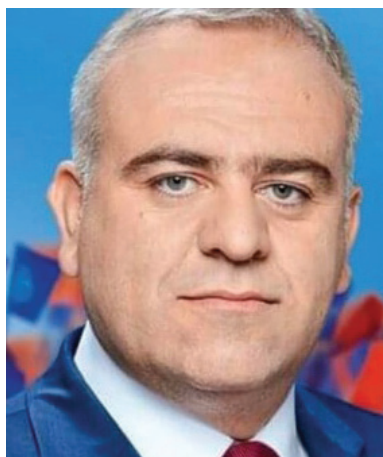
Methods: Patients who developed pulmonary insufficiency that were admitted for trauma were analyzed using the National Inpatient Sample (NIS) database, 2005-2014. Data was stratified according to sex and outcomes. The relationship between mortality and different comorbidities, demographics, and possible predictors of pulmonary insufficiency were explored using stratified analysis and multivariable logistic regression analysis.

Results: A total number of 818 elderly patients and 1392 adult patients were included in the study with the diagnosis of PI. 1288 were males and 922 were females. The mean age for adult males was 43.34 (14.03) years compared to 47.34 (12.93) years in adult females. In the elderly population, the mean age in males was 75.30 (7.18) years compared to 75.61 (7.08) years in females. Mortality rates were similar between males and females in both age groups. In the adult population, the mortality rate was 10.2% and 11.4% for males and females, respectively. In the elderly population, the mortality rate was 19.5% and 18.9% for males and females respectively. In the final regression model, bacterial infections (OR=2.39, p= 0.001), cardiac diseases (OR=3.45, p=0.001), liver diseases (OR=1.93, p=0.002), genitourinary system diseases (OR=1.48, p=0.006), traumas, burns and poisons (OR=1.91, P=0.001), cerebrovascular diseases (OR=1.63, p=0.049), fluid/electrolyte disorders (OR=1.48), neurological disorders (OR=3.16, p=0.001), and surgical operations (OR=1.58, p=0.01) were the main risk factors for mortality whereas hospital length of stay (OR=0.95, p= 0.001) was a protective factor.

Conclusion: Elderly patients admitted for trauma, who developed pulmonary insufficiency are at high risk of mortality. Surgical operations and several comorbidities were the main risk factors, whereas hospital length of stay was a protective factor.

Key Words: Pulmonary Insufficiency, Mortality, Risk factors, comorbidities, admission

SATURDAY - OCTOBER 13



VATS vs Open Thoracotomy in Patients with Spontaneous Pneumothorax – Where do We Stand?

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Introduction: Spontaneous pneumothorax (SP) can be surgically treated with two different techniques - video-assisted thoracoscopy (VATS) and conventional open thoracotomy (OT). There are controversies in the literature concerning the outcome of both procedures, despite the fact that VATS is a less invasive procedure and is better tolerated by the patients. We aim to compare both procedures in terms of perioperative and postoperative outcome, as well as cost-effectiveness.

Methods: Overall, 136 patients underwent surgery for SP at our institution, out of which 104 met the inclusion criteria and therefore were included in our study. Patients were further divided in two groups, consisting of 56 and 48 patients who underwent VATS and OT, respectively. Data were collected prospectively for 5 years and comparison of the perioperative and postoperative outcome, as well as cost-effectiveness of both procedures, was performed.

Results: The VATS group was superior to the OT with shorter duration of surgery (87.77 vs 132.92 min.; $p < 0.05$), reduced length of hospital stay (7.28 vs 9.81 days; $p < 0.05$), as well as chest drain duration (4.84 vs 5.98 days; $p < 0.05$). There was no statistically significant difference in the recurrence rate, perioperative bleeding, as well as postoperative complications. Average cost (in MKD) per patient for VATS was significantly lower when compared to the cost for open thoracotomy (92.650,14 vs 121.484,42 den; $p < 0.05$). **Conclusion:** We come to the conclusion that when certain criteria are met, VATS should be recommended as the optimal approach for SP given the current clinical, financial and cosmetic advantages. Like any other minimally-invasive procedure, VATS has an associated learning curve; once the learning curve is surpassed, any complications are less likely to be prevalent and optimum results can be observed.

SATURDAY - OCTOBER 13



BRAF (V600E) Mutation in Papillary Thyroid Carcinoma

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Introduction. BRAF has an important role in cellular proliferation, differentiation, and programmed cell death. The BRAF (V600E) gene mutation has recently been found to be present in various types of cancers. Studies on the BRAF (V600E) mutation in thyroid cancer are intensively examined in various countries, showing that the presence of the BRAF (V600E) mutation varies and ranges from 28% to 86% in papillary thyroid carcinoma. Papillary thyroid carcinoma is the most common type of endocrine malignancy, accounting for 85–90% of all thyroid cancers. However, there is a lack of sufficient studies in the Republic of Macedonia regarding the expression of the BRAF (V600E) mutation in papillary thyroid carcinoma.

Materials and methods. The study population consisted of 35 patients. The cobas4800 BRAFV600E Mutation IVD test was used for detection of mutations in the BRAF gene, which was performed on the Cobas Z 480 IVD Real-Time PCR instrument (Roche Diagnostic). The test kit included appropriate controls (wild type and mutant).

Objectives. The aim of the study was to analyze the expression of the gene mutation BRAF (V600E) in papillary thyroid carcinoma and the correlation between expression and clinicopathological characteristics.

Results. Patients with lymph node metastases had a higher risk of BRAF V600E gene mutation compared to patients without lymph node metastasis of the tumor. Greater patient age, invasion of the capsule, multifocality, and male gender were factors associated with increased expression of the BRAF V600E gene mutation.

Key words: Papillary thyroid carcinoma, expression, BRAF (V600E) mutation

SATURDAY - OCTOBER 13



Case Report: Typical Pulmonary ACTH Secreting Carcinoid Tumor in a young Male

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Introduction: Carcinoid bronchopulmonary tumors represent approximately 25% of all carcinoid tumors. Typical carcinoid tumors are the most common pulmonary neoplasia seen in young patients. These tumors can have neuroendocrine activity and certain can produce specific syndroms due to excess hormones production. Ectopic Cushing syndrome is a form of Cushing's in which a tumor outside the pituitary gland produces adrenocorticotrophic hormone (ACTH). Carcinoid and small cell tumors of the lung comprises half of its cases.

Presentation of Case: In these report, we present a case of a young adult diagnosed with a typical carcinoid tumor and a known history of Cushing syndrome.

A final diagnosis of an ectopic ACTH secreting typical lung carcinoid was deduced.

Discussion: The diagnosis was made by *CT-guided* percutaneous transthoracic needle *biopsy* and serological tests. The ectopic spot was finally detected and excised surgically through thoracotomy. After six months of follow up there was no recurrence, signs and symptoms of Cushing syndrome begin to disappear.

Conclusion: A carcinoid tumor may be considered a challenging disease especially functional neuroendocrine forms considering its infrequency and consecutive symptoms. Ectopic Cushing syndrome is a complicated medical problem when it comes to identification of the ectopic spot. The surgical treatment could be curative when the spot is determined.

Key Words: Carcinoid tumors; ectopic; Cushing

SATURDAY - OCTOBER 13

**Intrathoracic Gossypiboma after Cardiac Surgery: Case report*****Shqiptar Demaçi,^{1,2} Fitim Selimi¹******¹Department of Thoracic Surgery, University Clinical Centre of Kosova;******²University for Business and Technology (UBT), Prishtina******Presenting Author: Shqiptar Demaçi******shdemaci@hotmail.com; shqiptar.demaci@ubt-uni.net***

Introduction: Gossypiboma is a surgical complication resulting from sterile cotton material left inside cavities or anatomical regions. It increases the risk of postoperative morbidity complications, with an increase in the number of reoperations and rehospitalizations.

Case Presentation: We present the case of a 63-year-old male patient, who was admitted to our Center for an operation. According to the CT thorax, the patient had radiological signs of a unilocular left thoracic cystic lesion. He had been operated 5 years ago for an aortic valve replacement with a metal prosthesis. Given the symptoms of pain on the left side of his chest, fatigue, and slight difficulty breathing, the CT of the thorax revealed a unilocular cystic lesion in the lower lobe of the left lung.

Methods: A left thoracotomy was performed. As we prepared to remove the cystic formation, it began to secrete thick yellow pus, which aspirated. The textile material was shown (fig. 2) lackened with pus. A gauze/compress of 25 x 10 cm, (fig 3.) was left in the body of the patient after a sternotomy intervention 5 years ago.

Conclusion: This report suggests counting the gauzes before and after the surgery. In addition, we recommend marking the gauzes and compresses with a radiopaque line to reduce early and late postoperative complications.

Keywords: Thoracic gossypiboma; encapsulated empyema

SATURDAY - OCTOBER 13

**Surgical Stabilization of Craniocervical Junction and Upper Cervical Spine***Fatos Olldashi**Department Neurosurgery**University Hospital of Trauma**Tirana, Albania**fatosolldashi@gmail.com***Named Lecture: Prof. Dr. Shaban Hasi for Neurosurgery**

Introduction: The craniocervical junction (CVJ) includes the bone that forms the base of the skull, occipital bone, and the first two bones in the spine, atlas and the axis. Craniocervical junction surgery is an operation performed on the bones in the junction between the skull and the spine.

Treatment of CVJ instability is challenging field in neurosurgery and is primary indication for occipitocervical fusion. The common result is cervicomedullary neural tissue compression with development of symptoms and signs. Patients may present with progressive myelopathy, pain (neck pain, radiculopathy), lower cranial nerve dysfunction, or deformities of the craniocervical region. In this presentation we reviewed 25-year experience of clinical outcome, occipitocervical instrumentation and operative morbidity in treatment of CVJ instability and lessons we learned are discussed.

Method: Each patient underwent preoperative radiological evaluation of X-ray, CT scan and MRI of the CVJ region. Instability of the CVJ was diagnosed if atlantodental interval was shifted by more than 3 mm in dynamic X-ray and if pathologic movement with neurological symptoms (subjective and objective) were present. In patients who had severe trauma, dynamic X-ray was not performed in order to avoid pain and to prevent neurological deterioration. Treatment was chosen considering a number of different factors, including the general medical condition of the patient, the severity and location of the fracture, compression of the spinal cord, degree of instability and the neurological status. Immediately after the operation, plain cervical X-ray images showed restoration of bone alignment in every patient. Postoperative imaging studies confirmed excellent instrument fixation and no abnormal lesion related to surgery in all patients. Post-operative X-ray at 6 months did not reveal instrument loosening or breakage. Up to 12- or 24-month follow-up, plain radiographs did not show any change in instrument position when compared with the immediate post-operative radiographs. During the follow up fusion was assessed by dynamic plain radiographs.

Conclusion: The indication for fusion in CVJ instability patients, an extensive posterior instrumentation fixation procedure that sacrifices the motion of the occipital and C1-2 complex is still controversial. To determine the number of fusion level is one of the most important factors to achieve the complete fusion. Reducibility, status of posterior element and direction of surgical approach should be determined in deciding the level.

SATURDAY - OCTOBER 13



Discovery of the Mechanisms and Biosignatures Underlying Rapid-Acting Treatment in Neuropsychiatry: Lessons Learned from Ketamine Discovery in Treatment-Resistant Mood Disorders

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Named Lecture: Prof. Dr. Musa Haxhiu for Scientific Research

Glutamatergic transmission is widely implicated in neuropsychiatric disorders. The discovery of ketamine as a rapid-acting antidepressant spurred significant research to understand its underlying mechanisms of action and identify other novel compounds that may act similarly. Clinical trials with novel, rapid-acting antidepressant medications, including the glutamatergic modulator ketamine, have revolutionized our expectations of when antidepressant effects could be expected, reducing the duration from weeks or months to hours or days. This paradigm shift has instilled hope in individuals struggling with depression, particularly treatment-resistant depression.

In this lecture, we will explore the complex mechanisms of ketamine's rapid-acting antidepressant effects, including its direct and indirect actions at the N-methyl-D-aspartate (NMDA) receptors, as well as its modulation of α -amino-3-hydroxy-5-methyl-4-isoxazole propionic acid receptor (AMPA) signaling in the synapse. We will also discuss how ketamine's discovery has spurred a resurgence of interest in the field and created a blueprint for studying novel pharmaceuticals. Despite tremendous progress, challenges have arisen in investigating promising, novel, and rapid-acting (as well as non-rapid-acting) antidepressant interventions for depression. In this lecture, we will briefly assess some of these recent successes and setbacks in the field.

SATURDAY - OCTOBER 13

**From Challenge to Success: Transforming Care Through Brain Injury Guidelines***Bellal Joseph, MD, FACS**Martin Gluck Endowed Professor of Surgery**Chief of General Surgery & Chief of Division of Trauma,**Critical Care, Burns & Emergency Surgery**University of Arizona**bjoseph@arizona.edu*

Traumatic brain injury (TBI) has the highest incidence of all common neurological disorders and is associated with high morbidity and mortality. Management of TBI accounts for a large proportion of emergency surgical, neurosurgical, and critical care practice. Although a vast majority of TBIs are managed non-operatively, neurosurgical interventions are an absolute life-saving necessity when required. The Brain Injury Guidelines (BIG) were developed to guide the triage, management, and appropriate disposition of TBI patients based on patients' medical history, clinical, and radiologic findings.

The patients are classified into BIG 1, BIG 2, or BIG 3 groups according to the guidelines. The proposed management for BIG 1 is a 6-hour period of observation in the emergency department, without the need for neurosurgical consultation (NSC) or a repeat head computed tomography (RHCT) scan. For BIG 2, the plan consists of hospitalization of the injured patient, and for BIG 3, hospitalization, RHCT, and NSC are suggested. The Brain Injury Guidelines have been validated at 10 Level I and Level II trauma centers in the recently concluded AAST BIG multi-institutional trial and have been established as a safe and effective tool to guide the management of TBI by acute care surgeons while at the same time reducing hospital costs.

This session will focus on the public health burden due to TBI, changing patterns of the TBI management approach, the Brain Injury Guidelines, and the role of trauma and acute care surgeons in the management of TBI.

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Efficient Surgery/Neurosurgery: Cutting Costs and Cutting Time without Cutting Corners

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Introduction: Approximately 50% more neurosurgeons than the current 50,000 worldwide – 23,000 – are needed to provide for the unmet need, primarily in low- and middle-income countries (LMICs).¹ In Europe the average number of operations per neurosurgeon annually ranges from 56 to 300 depending on the country.² Thus increasing the productivity of “under-performing” neurosurgeons can address the unmet neurosurgical need. This is likely true also for other surgical specialties.

Methods: Limits on productivity are typically: (1) procedure-related; (2) infrastructure-related. The neurosurgeon can control the former, the latter requires interaction with other healthcare personnel (e.g. anesthesiologists, hospital administrators). The former can be addressed by education of neurosurgeons, the latter is largely site-specific (i.e. solutions addressing local “weak links”).

Results: Several procedure-related points that increase neurosurgeon productivity:

- (1) Not shaving prior to surgery (unless scalp trauma in cranial cases). This decreases the risk of infection, saves time (a) prior to surgery, (b) after surgery (no or minimal dressing required), (c) post-op – patients with hair intact feel less “disabled” and mobilize more readily.
- (2) Making incisions parallel to scalp arteries. Time applying/removing Raney clips is obviated.
- (3) Replacing many ventriculoperitoneal shunts (VPS) or ventriculoatrial shunts (VAS) with either third ventriculostomies (ETV) for obstructive hydrocephalus or lumboperitoneal shunts (LPS) for communicating hydrocephalus. Surgery time is typically shorter, with fewer complications long-term.
- (4) Limiting urinary catheter placement to lengthy cases or when otherwise essential. Both the risk of urinary tract infection and time to post-op mobilization can be reduced.
- (5) The neurosurgeon constantly assessing his/her surgical “habits” for more efficient techniques.

Infrastructure-related limits on productivity would benefit from courses by neurosurgeons who have been successful interacting with the healthcare system to improve productivity. Examples of infrastructure-related improvements from Indonesia and Pakistan are discussed.³

Conclusions: Surgeon/Neurosurgeon productivity can be enhanced through careful revision of inefficient “habits” and improved interaction with the healthcare infrastructure.

References:

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Initial Serum Phosphate Level in Patients with Spinal Injury

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Background: Electrolyte imbalance in trauma patients leading to poor outcomes such as prolonged length of stay and mortality. Phosphate imbalance in patients with spinal injury remains understudied. We aimed to evaluate the serum phosphate imbalance in spinal injury patients with concomitant head trauma.

Methods: A retrospective analysis was conducted for admitted trauma patients between June 2016 and May 2021. Data included patient's demographic, clinical characteristics, and mortality based on phosphate levels on admission. Normal phosphate level was defined as 1.12-1.45 mmol/L.

Results: A total of 272 patients with spinal and associated head injuries were included in the final analysis. Mean age of the patients was 32 years. Nearly half of the patients had cervical spine injuries. Hypophosphatemia (68%) was more common. However, mortality rate was high in patients with hyperphosphatemia. There were 14 cases with neurological deficits.

Conclusion: Hypophosphatemia in spinal injury patients with TBI is common. Imbalances in phosphate levels may also contribute to other electrolytes imbalances. However, the formula of feeding was lacking in this study. Therefore, research with larger sample sizes is necessary.

SATURDAY - OCTOBER 13



How to avoid and to Cope with Bleeding in Lumbar Spinal Surgery - A Survey of most Advanced Techniques

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Rationale of the survey: Bleeding in spinal surgery poses the greatest risk for the patient in terms of iatrogenic neurologic deficit, additional dural laceration by obstructed view of the surgical field, wound healing complications and infections, yet also a considerable additional risk for cardiopulmonary and cerebral complications. It must be avoided by all means, if possible. The most advanced technologies are rarely described altogether in the literature. Primary measures such as enhancement of hemoglobin levels prior to surgery and secondary measures as autologous transfusion of cell saver blood are often discussed separately but should both be integrated into a comprehensive algorithm for improved patient safety which will be outlined in the presentation.

Materials and Methods: From a meta-analysis of the scientific literature, nearly 40-year own experience, and industry reports we extracted all currently available (and historic) drugs and implants which may (or may rather no longer) be advisable to have at hand for immediate response in case of bleeding. The usefulness of certain pre-, intra-, and postoperative measures, and whether the use of microscopes gives significant advantages was evaluated on evidence-based grounds from the literature.

Results: Most important is a preoperative assessment of the effective bleeding risk which can be done in a standardized manner during a so-called patient blood management which mostly comprises a comprehensive anamnesis.

Preoperative autologous blood transfusion and Erythropoietin is no longer advocated, at least not for adult patients.

Intraoperatively in lumbar surgery, free suspension of the belly and slight Trendelenburg position, yet without compressing the iliac vessels, has proven beneficial. In cervical surgery the same holds true for a reverse Trendelenburg position.

Mean arterial pressure below 65 mm Hg significantly reduces bleeding but is dangerous for the nutritional supply of neural tissue, especially during manipulation.

Bipolar sealant coagulation also shows (weak) evidence in this respect.

Lysin analogues have proven blood sparing effects, if applied systematically. Their topical effect is also advocat-

ed by evidence class I studies. Only for two other passive topical agents there seems to be clear evidence for a recommendation (Tisseel/Evicel and Surgiflo/Floseal).

Aprotinin and Norarterenol found widespread use in the past due to their effectiveness and low cost, but have been abandoned due to unwanted side effects, off-label use considerations, and poor availability.

The use of a cell-saver is effective to restore a normal blood volume but it is unclear if it is more effective in preventing associated complications than allogeneic blood transfusion. Yet, it significantly reduces the use of the latter.

It was interesting to note that there is no real consensus about the effects of postoperative drainage on blood loss and complications.

Conclusions: It could be demonstrated that good recommendations for a reasonable algorithm, respecting the hopefully relative rareness of the event, particularly in comparison to the cost of the products, their usefulness, availability and potential savings as compared to treatment of specific complications can be given. This should bring forward the quality in spine surgery in the future, especially in countries with emerging facilities and capabilities in this field.

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Comorbidity of Polyneuropathy and Lumbar Spinal Stenosis*M. Pfeiffer, S. Hennigfeld**District Hospital Loerrach, Germany**Department of Spine Surgery**Presenting Author: Michael Pfeiffer**pfeiffer.privat@gmail.com*

Rationale of the study: Aim of the study presented was to evaluate for the first time the percentage of patients with and respectively without lumbar bilateral spinal canal stenosis who also exhibit signs of polyneuropathy. Additionally, a simple test battery for diagnosis of polyneuropathy in patients with such stenosis should be developed.

Materials and Methods: In the study, 70 patients with and 57 patients without MRI-proven lumbar spinal canal stenosis were compared in respect of general signs of polyneuropathy and specifically small fiber polyneuropathy. Among other methods, a matched pair design and analyses of variance were utilized.

Results: It could be demonstrated for the first time that patients with lumbar spinal stenosis have a highly significant higher incidence of polyneuropathy than those without stenosis. Their percentage with signs for small fiber polyneuropathy was also statistically elevated.

A resulting test battery to validly detect or exclude polyneuropathy in patients with lumbar stenosis just required the following three items: Achilles tendon reflexes, testing of vibration, and allodynia of the feet.

Discussion: The study elucidates the currently available scientific knowledge in the context of the aforementioned results. The latter may be seen as a clear progress for practical use in this field: It is crucial to recognize superimposed signs of polyneuropathy prior to lumbar surgery for spinal canal stenosis since the symptoms of both diseases are often similar but the impairments related to polyneuropathy often do not improve after surgery. This is important both for valid informed consent of the patient and patient satisfaction after surgery. If the symptoms of polyneuropathy are even more crippling than claudication due to stenosis, a previous nonoperative treatment of polyneuropathy may be advocated. In case of suspected polyneuropathy the situation should also be clarified by involvement of neurologists, especially for conducting electrophysiological tests, and internal physicians for detection and causal treatment or secondary prophylaxis of the underlying pathology.

Caveats particularly apply to the interpretation of the comorbidities: No interdependent causality can safely be derived from the results.

Conclusions: On the grounds of this study and the sparse previous publications it seems urgently necessary to increase efforts for detecting possible therapeutic consequences of the results presented via controlled prospective studies. Invasive validation of the results also seems mandatory, thus interdisciplinary cooperation should be fostered to allow further necessary research.

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The Role of Endoscopy in Neurosurgery

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Introduction: Endoscopy in neurosurgery, with the improvement of technology, has become an integral part in the treatment of various intracranial pathologies.

Aim: To present the current possibilities of using the endoscopic approach in neurosurgery.

Materials and methods: Review of charts, notes and operative videos during the last 5 years in a personal series of cases where endoscopy was used for the treatment of various intracranial pathologies.

Results: Endoscopy was used as the only method in the treatment of pituitary adenomas, tuberculum sellae meningioma, craniopharyngioma, simple or multicameral hydrocephalus, trigeminal neuralgia, spheno-orbital meningioma, orbital epidermoid cyst.

Endoscopy is used as a complementary method in the treatment of supra or infratentorial epidermoid cysts, facial decompression.

Conclusions: Neuroendoscopy is now an integral part of the armamentarium of neurosurgery, improving operative results. After learning this technique in training courses, continued use brings safety of use even in more challenging cases.

SATURDAY - OCTOBER 13

**Case Report: The Vestibular Schwannoma*****Sami Pnishi******Neurosurgery Department******University Clinical Center of Kosova******pnishisami@gmail.com***

In this report we present the case of a 55 years old male patient who presented with dizziness and imbalance during walking (gait disturbances), left hand tremor while holding any object and difficulty focusing objects with the left eye. The complaints started three months ago with exacerbation of the symptoms during all this time. In physical exam there was paresis of left facial nerve with right horizontal nystagmus in both eyes and hearing loss in the left ear. Patient had a positive tandem gait test, positive finger-to-nose test, positive rebound phenomenon on the left, positive Dysdiadochokinesia on the left and a positive Heel-to-shin test on the left side. Head MRI showed a large lesion in the left pontocerebellar angle, which had large cystic components and extended to the left internal acoustic canal. After the application of intravenous contrast, a dense, light, inhomogeneous imbibition of the contrast was observed. The patient was prepared and treated surgically with a retromastoid approach and the tumor was removed. A post-operative CT scan was conducted and no rest tumor was found (according to the radiologic report). After the surgery the patient improved clinically and on follow-up was presented with no dizziness, no gait disturbance, the left hand tremor was gone, nystagmus was gone, hearing was improved and a light facial nerve paresis was persistent. The vestibular schwannoma is an uncommon intracranial tumor and frequently presents with chronic hearing loss, headache, tinnitus, disequilibrium, and facial numbness. The best outcome and the best clinical improvement is after the surgical removal of the tumor.

SATURDAY - OCTOBER 13



**Minimally Invasive Surgical Approach
for Complicated Vitreoretinal Diseases**

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Video presentation of surgical 27 gauge pars plana vitrectomy – PPV.

SATURDAY - OCTOBER 13

**Behçet Uveitis: Distinctive Features and Current Therapeutic Approach**
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Behçet disease (BD) is a systemic vasculitis with unknown etiology. It is characterized by recurrent mucocutaneous lesions and major organ involvement such as ocular, neurologic, vascular and gastrointestinal manifestations. The diagnosis of BD is mainly based on clinical manifestations.

Eye involvement is characterized by chronic recurrent non-granulomatous uveitis that can affect both the anterior and posterior segments of the eye. It is more common and severe in males. Behçet uveitis is a distinct entity and can be diagnosed with ocular findings.

The most useful clues in differentiating Behçet uveitis from other uveitic entities are explosive inflammatory attacks and spontaneous resolution of acute inflammatory lesions.

Anterior segment inflammation in Behçet disease is acute and always non-granulomatous. Although the anterior uveitis is classically described as hypopyon uveitis, the majority of cases do not have a hypopyon. The hypopyon in Behçet uveitis forms and dissolves rapidly. It forms a smooth layer and shifts freely with head positioning. It is almost always associated with severe inflammation in the posterior segment

Diffuse vitritis is a constant feature of posterior segment involvement. Dense vitreous haze is found to be associated with severe retinal inflammation. As the vitreous haze starts to clear with treatment, white pearl-like precipitates may appear on the surface of the inferior peripheral retina.

Transient superficial retinal infiltrates are one of the pathognomonic findings of Behçet uveitis. There might be in any number or location. These infiltrates may or may not be accompanied by hemorrhage.

Occlusive periphlebitis is another finding of Behçet uveitis. A fern-like diffuse capillary leakage is the most common fluorescein angiography finding of Behçet uveitis. It may be the only sign of persistent inflammation during clinically quiescent periods.

There is no specific medication for treatment of Behçet disease. Traditionally, management has relied heavily on corticosteroids and conventional immunosuppressives. However, their long-term use is frequently associated with systemic side effects and insufficient control of ocular inflammation. Biologic therapies, particularly interferon alpha and TNF-alpha inhibitors like infliximab and adalimumab, have emerged as effective alternatives, offering better disease control and a more favorable safety profile.

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**Screening for Retinopathy of Prematurity in
Premature Babies Born in North Macedonia
– 15 Years Results (2008-2023)**

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Purpose: Retinopathy of prematurity (ROP) is a vasoproliferative disorder of the retina and a leading cause of visual impairment and childhood blindness worldwide. The purpose of this paper is to analyze the possibility of developing ROP and the need for treatment in premature babies, born in North Macedonia in period from 2008-2023.

Materials and methods: In this retrospective study was analyzed the data of premature babies which were followed in the period from 2008-2023. In Republic of North Macedonia for screening of ROP are used recommendations from the American Association for Pediatric Ophthalmology and Strabismus, with clearly defined inclusions for the screening program for ROP of all prematurus with a birth weight (BW) of 1500 g or less and / or born at 30 gestational weeks (GW) or earlier and selected infants with a birth weight between 1500 to 2000 g with unstable clinical course.

Results: According to the adopted criteria, screening was conducted in 5914 premature babies with 19795 examinations. Screening in these prematures resulted in the detection of active premature retinopathy with an absolute indication of active treatment in 664 prematures. In addition, 383 newborns were treated with laser photocoagulation, while 281 children with Anti-VEGF therapy.

Conclusion: The results concluded that premature infants born at 30 gestational weeks (GW) or earlier and/or birth weight (BW) 1500g or less and selected prematures with a birth weight between 1500 g and 2000 g but with unstable clinical course and neonatology high risk assessment, should mandatorily be screened for ROP.

Keywords: screening for ROP, retinopathy of prematurity (ROP), prematures, birth weight (BW), gestational age (GA), laserphotocoagulation (LPC).

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**Fundus Autofluorescence Imaging*****Ilir Arapi******Associate Professor of Ophthalmology******Medical Retina & Uveitis Consultant******University Hospital Center “Mother Teresa”******University of Medicine, Tirana, Albania******Sector - Editor / Editorial Board Member: International Ophthalmology******Associated - Editor: BMC Ophthalmology******arapi_ilir@hotmail.com***

Fundus autofluorescence imaging (FAF) is a new imaging method that allows topographical localization of the distribution of lipofuscin in the monolayer of retinal pigmented epithelial cells as well as other fluorophores that may appear with diseases of the outer layers of the retina as well as in the subneurosensory space. The excessive accumulation of lipofuscin granules in the lysosomes of retinal pigmented epithelial cells represents a frequent pathogenetic mechanism in the development of various pathologies of hereditary and complex retinal origin, including age-related macular degeneration. FAF imaging has been shown to be useful in understanding pathophysiological mechanisms, diagnosis, identification of predisposing factors for disease progression, and monitoring of new therapies. FAF imaging provides information beyond that obtained by conventional imaging methods, such as fundus retinography, fluorescein angiography (FFA), and optical coherence tomography (OCT). Recent study reports suggest FAF as a promising tool for monitoring eyes with posterior uveitis that helps predict final visual outcome, particularly in patients with infectious and noninfectious uveitis. This presentation summarizes the basic principles and findings of FAF in various retinal diseases.

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Anti-Vascular Endothelial Growth Factor Therapy in Non Age Related Degenerative Macular Neovascularisation

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Introduction. Macular neovascularisation (MNV) is a pathological feature of many human blinding diseases. MNV is a severe, prevalent and progressive complication of macular disease that is characterized by neovascularization of the choroid in macular area causing gradual vision impairment. It often impacts a relatively young working population and has a poor visual prognosis if left untreated.

Purpose. In this article, we review the effectiveness of the antiVEGF treatment along with a discussion of the current research for anti-VEGF eyes in non age related degenerative macular neovascularisation.

Methods. A systematic literature review was completed using Medline and EMBASE for publications. The search strategy combined terms for non age related degenerative MNV, special emphasis on MNV secondary to Degenerative Myopia and Angioid Streak.

Results. Various treatment modalities have been utilised in the past with limited success. Individuals with MNV can achieve strong, long-term visual acuity outcomes after undergoing treatment with anti-VEGF injections and is useful to avoid late-stage complications. The research shows that a higher number of injections for these patients better preserves VA, suggesting the need for more proactive treatment. However most of the evidence is from small case series or prospective studies with short-term follow-up and there is limited long-term data on visual outcomes.

Conclusion. Anti-VEGF therapy is effective at stabilising visual acuity in patients with choroidal neovascularisation secondary to non age related degenerative MNV, however there is a gradual decline in visual acuity observed with 5–10 years of follow-up and a high rate of recurrence over time. Furthermore, subfoveal MNV have worse visual outcome compared with extrafoveal and juxtafoveal MNV. A higher number of injections yielded better chances of maintaining good VA, suggesting the need for intensive treatment.

Keywords: antiVEGF, macular neovascularisation, degenerative myopia, Angioid streak

SATURDAY - OCTOBER 13

**Congenital Cataracts: What has changed?***Huban Atilla**Ankara University, School of Medicine**Department of Ophthalmology**hatilla@medicine.ankara.edu.tr***Named Lecture: Prof. Dr. Qamil Haxhija
for Leadership in Ophthalmology**

Cataract surgery in adults is the most commonly applied surgical procedures in many countries but childhood cataracts are among the rare diseases. Congenital and pediatric cataracts are one of the leading causes of treatable diseases in childhood blindness and low vision cases and vision problems. There have been many changes in etiology, treatment and follow-up of cataracts in childhood. Developments in genetic evaluation enable diagnosis of many idiopathic or syndromic cataracts. The treatment has changed from no surgery to early, even emergency surgery in the last few decades. The decision of treatment options and the follow-up of congenital and pediatric cataracts changed also. Results of multicenter studies and technological innovations have increased our understanding to improve outcomes. Ocular imaging with optical coherence tomography has enhanced our understanding of the microstructural effects on pediatric eyes during and after cataract surgery.

SATURDAY - OCTOBER 13

**Pseudoexfoliation in Cataract Surgery*****Arjeta Grezda, Erindi Murati******UCCK, Eye Clinic******Presenting Author: Arjeta Grezda******arjeta_demi@yahoo.com***

Pseudoexfoliation syndrome (PXF or PEX) is an age-related systemic syndrome that primarily targets the ocular tissues through the gradual deposition of a white fibrillar material, mainly in the crystalline capsule, Zinn's zonules, and pupillary margins. PEX usually causes increased intraocular pressure, with changes of the optic nerve and changes in the visual field that lead to the diagnosis of pseudoexfoliation glaucoma (PEX Glaucoma).

Pseudoexfoliation syndrome presents a challenge to surgeons because of the increased weakening of zonular apparatus and insufficient dilation of the pupil. Because of these difficulties during surgery, complications in these patients are several times higher than in patients without pseudoexfoliation. Using the right surgical instruments such as (viscoelastic, iris hooks and capsular tension ring, three-piece IOL, etc.), the risk of intraoperative complications can be reduced, allowing the surgeon to treat difficult cases with greater confidence and security.

SATURDAY - OCTOBER 13

**Open Globe Injuries: Review of Evaluation, Management, and Surgical Pearls***Ilir Osmani, Kristina Sisarica, Sumeja Kasami**PHI Sistina-Specialized ophthalmology hospital,**Skopje, RN Macedonia**Presenting Author: Ilir Osmani**iosmani@gmail.com*

Open globe injuries are full-thickness defects of the eyewall and can be caused by sharp or blunt trauma. They are ocular emergencies and if not timely treated can lead to irreversible and permanent visual loss. We present case series of 5 patients treated in our hospital.

The goal of evaluation is to identify the mechanism and extent of the injury. Surgical exploration is needed and primary closure is indicated whenever possible. Suture technique is vital to produce the best outcome and special attention should be paid to corneal sutures.

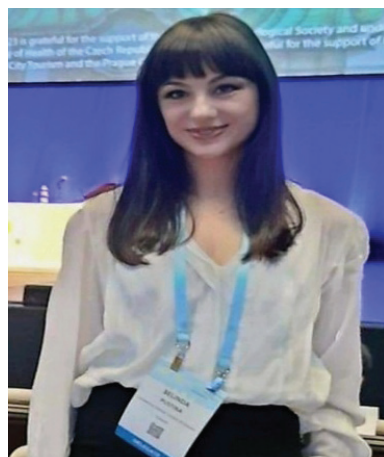
Intraocular infection risk is relatively high, requiring immediate empiric broad spectrum antibiotics.

This study demonstrates successful anatomic outcomes of 5 patients with penetrating ocular injuries. Visual outcomes were variable, and although these patients have generally have guarded visual prognoses, favorable results may be achieved in select scenarios.

In this review, best practices for evaluation and management are reviewed and our surgical approach and techniques are described.

Key words: vitreoretinal surgery, ocular trauma, repair of open globe, intraocular foreign bodies

SATURDAY - OCTOBER 13



Our experience in patients with Keratoconus treated with “Cross-Linking”

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Purpose: To evaluate the safety and efficacy of “Cross Linking” (CXL) in patients with keratoconus at the Eye Clinic, University Clinical Center of Kosovo (UCCCK), 2019-2023.

Methods: This is a retrospective study that included all patients diagnosed with keratoconus and operated with CXL at the Eye Clinic, UCCCK, November 2019- September 2023.

The CXL procedure was based on the Dresden protocol where 0.1% riboflavin in 20% dextran and 3mW/cm² of UVA for 30 min were used in patients with removal of the corneal epithelium “epi off” with a thickness of more than 400 microns and hypotonic riboflavin dissolution. 0.1% without dextran for CXL without removing the epithelium “epi on” in patients with corneal thickness below 400 microns.

Results: In all cases after conventional CXL visual acuity and tomographic parameters were stabilized. We only had postoperative complications in two cases with bacterial keratitis.

Conclusion: Treatment with standard CXL has been safe and has shown efficacy in stopping the progression of keratoconus and stabilizing visual acuity. Epi on CXL was associated with less discomfort, pain and complication compared to epi off CXL.

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Comparison of the Effects of Different Multifocal Lenses on Visual Acuity and Patient Satisfaction after Cataract Surgery

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Objective: To compare and evaluate visual acuity, patient satisfaction, and spectacle independence after trifocal IOL implantation compared with quadrifocal and monofocal lenses.

Design: Prospective, by availability, case series.

Material and methods: The study included 18 patients who underwent cataract surgery with phacoemulsification. The patients were divided into 3 groups: Group 1 (7 eyes) had the trifocal IOL implanted; Group 2 (7 eyes) had the quadrifocal IOL implanted; Group 3 (4 eyes) which is the control group a monofocal lens was implanted.

Results: The average value of uncorrected visual acuity for far (NCDVO) after 6 months after surgery ranges from 0.98 in the first group to 0.9 in the second and third groups. 17 patients (94.4%) in all groups did not need glasses for far, while monofocal group needed glasses for near and medium distance. There were no significant differences in patient satisfaction rates between the three groups.

Conclusion: Data suggest that distance visual acuity is similar between all groups, while near is better in the multifocal group. Patient satisfaction is quite high for all groups.

Key words: multifocal and monofocal IOL, phacoemulsification, visual function, glare.

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**Is there a Need for Prophylactic Intraocular Pressure****Lowering Measures in Anti-VEGF Therapy:****Unravelling the Pathophysiology*****Qëndresë Daka******Department of Pathophysiology, Medical Faculty,******University of Prishtina, Prishtinë, Kosova******Eye Clinic, University Clinical Centre of Kosova, Prishtinë, Kosova******Qendrese.daka@uni-pr.edu***

Inhibition of VEGF has been proven effective in preventing vision loss and, in some cases, improving vision in various ischemic retinal disorders. The safety profile of anti-VEGF agents is generally favourable, but despite the significant benefits, their use is not without potential adverse effects. A commonly reported side effect after intravitreal application is a transient increase in intraocular pressure (IOP), the major risk factor for development and progression of glaucoma. The purpose of the present study is to elaborate the need for prophylactic intraocular pressure lowering measures in anti-VEGF therapy by unravelling the pathophysiology.

A causal relationship between glaucoma and anti-VEGF is difficult to demonstrate due to the interaction with retinal diseases. Elevated IOP remains the major risk factor and its mechanical effect appears important for glaucoma pathogenesis. Close monitoring and adjustable IOP-lowering treatment are recommended for high risk patients, including patients with glaucoma, angle anomalies, OHT or family history of glaucoma, patients receiving a high number of injections or at shorter intervals, and patients with capsulotomy. Strategies for timely identification of patients at risk and prevention of sustained elevated IOP are needed.

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General Overview on Post-Covid 19 Diabetes Mellitus and Diabetic Retinopathy, statistics, treatment options. Retrospective study Jan 2022 - Jan 2023

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Introduction: Diabetic retinopathy is a serious sight-threatening complication of diabetes. Diabetes interferes with the body's ability to use and store sugar (glucose). The disease is characterized by too much sugar in the blood, which can cause damage throughout the body, including the eyes. Over time, diabetes affects and damages small blood vessels throughout the body, including the retina. Diabetic retinopathy occurs when these tiny blood vessels leak blood and other fluids. This causes the retinal tissue to swell, resulting in cloudy or blurred vision.

In 2020, the number of adults worldwide with DR, VTDR, and CSME was estimated to be 103.12 million, 28.54 million, and 18.83 million, respectively; by 2045, the numbers are projected to increase to 160.50 million, 44.82 million, and 28.61 million, respectively.

Purpose: Diabetic retinopathy results from the damage diabetes causes to the small blood vessels located in the retina. These damaged blood vessels can cause vision loss. Fluid can leak into the macula, the area of the retina responsible for clear central vision. In an attempt to improve blood circulation in the retina, new blood vessels may form on its surface. These fragile, abnormal blood vessels can leak blood into the back of the eye and block vision, blurred, double, or distorted vision or trouble reading, floaters or spots in vision. In addition to that, partial or total loss of vision, a shadow or veil across your field of vision also pain, pressure, or constant redness of the eye.

Methods: In Albania total adult population 2,103,000, prevalence of diabetes in adults: 11.5%, total cases of diabetes in adults: 249,200. There was a total of 12,689 patients check-up yearly in Endocrinology. New patients 2,950 per year at 2022. We examined about 1,379 patients already diagnosed with DM 2, DM 1 and 901 new subjects with DM2 , 478 with DM1. The patients underwent VA, BVCA, Biomicroscopy, Fundus Oculi Exam, OCT-Angiography and B-scan. Non-proliferative diabetic retinopathy (NPDR) is the early stage of the disease in which symptoms will be mild or nonexistent. In NPDR, the blood vessels in the retina are weakened. Tiny bulges in the blood vessels, called microaneurysms, may leak fluid into the retina. This leakage may lead to swelling of the macula. (PDR) is the more advanced form of the disease. At this stage, circulation problems deprive the retina of oxygen new, fragile blood vessels can begin to grow in the retina and into the vitreous, the gel-like fluid that fills the back of the eye. The new blood vessels may leak blood into the vitreous, clouding vision. The risk of developing the eye condition can increase as a result of: Having diabetes for a long time. Poor control of blood sugar level. High blood pressure. High cholesterol. Pregnancy. Tobacco use. Poor food diet, lack of physical activity. All of these are considered high risk factors.

Diagnosis: All patients underwent for DR at baseline and possibly at follow-ups every 3-6-12 months, as appropriate, in accordance with the modified criteria of Early Treatment of Diabetic Retinopathy Study. All the patients were divided into non-DR (NDR) and DR groups. If present, each eligible eye was graded as mild, moderate, severe nonproliferative DR (NPDR), and proliferative DR (PDR).

Results: Diabetic retinopathy treatment works very well to prevent, delay, or reduce vision loss. Treatment options include: Laser treatment (photocoagulation), Anti-VEGF (vascular endothelial growth factor) or an anti-inflammatory intravitreal injection, vitrectomy or PPV.

Conclusion: DM control and management is heavily dependent on the level of patient assent and cannot succeed without full patient acquiescence. Evidence shows that DM patients spend 99% of their time managing their disease and only 1% is dedicated to consultations with health professionals. Full DM management requires a multidisciplinary approach, single interventions such as the control of serum glucose level within the recommended ranges might be helpful as well. The treatment of DR is important to improve the overall care of diabetic patients and to delay the progress of DR.

We have noticed an increase during the post-covid period in the number of new diabetic patients, this is observed as a result of the side effects of Covid-19 as well as the prolonged use of corticosteroids that have been used to treat the complications of Covid-19. We must pay attention specially in new cases with DM to clearly find anamnesis in order to identify as early as possible DM, to improve the QOL and to preserve vision.

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The Effect of Hyperglycemia on Intraocular Pressure in Patients with Type 1 Diabetes

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Introduction: Epidemiological studies indicate that patients with type 1 diabetes are at higher risk of having high intraocular pressure. In in vitro models studies have shown that high level of sugar in the blood can cause deposition of extracellular matrix in the trabeculum. This deposition contributes to the obstruction of drainage of the aqueous humor through the trabecular meshwork.

Aim: The purpose of this study is to determine if high glucose level in the blood as measured by HbA1c (glucolized hemoglobin) increases intraocular pressure in patients suffering from type 1 diabetes.

Methods: The study design is an observational prospective study. 100 patients will be tested for blood glucose level through the HbA1c test (no older than 3 months) and subsequently have their eye pressure checked. 50 patients matched for age and sex will form the control group. They will be compared to 50 patients that have been diagnosed with type 1 diabete. Values of the HbA1c result will be compared to the intraocular pressure. The data will be calculated using Chi-square tests. The relationship between hyperglycemia and intraocular pressure will be evaluated through linear regression. P value <0.5 will be considered as significant.

Discussion: Patients that have a high HbA1c (over 9.5) usually have hyperglycemia and not well controlled diabetes. High levels of glucose accumulates in the eye's humor aquosus thereby increasing the volume of the eye. Persistent hyperglycemia changes the histologic configuration of the trabecular meshwork by causing deposition of extracellular matrix on the trabeculum and therefore decreasing its filtrating capacity.

Conclusion: Hyperglycemia as determined through HbA1c levels causes increased intraocular pressure in patients with type 1 diabetes compared to the normal population.

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Pterygium Surgery with Limbo-Conjunctival Autograph, without Sutures (with Adhesive Fibrin), Impact on Recurrences and Pain

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The purpose of the work (objectives): The purpose of this paper is to compare the impact on relapses and pain, of pterygium surgery with limbo-conjunctival autograft, with other surgical methods.

Methodology: This is a retrospective cohort study. The medical documentation of 56 patients, who underwent pterygium surgery at “Q.L.S Kubati”, was analyzed. The results are presented through graphs, tables and photographs.

Results: The last 56 cases were analyzed. Subjective complaints have been redness of the eye, burning and a foreign body feeling. The oldest patient was 62 years old, while the youngest was 28 years old. The average age was 52 years. The right eye was affected in 25 cases, while the left in 31. Females 14, males 42. Pain during the operation was mild, tolerable. After the operation, the pains were more severe and lasted 2-3 days (analgesics were used for their relief).

Conclusion: With the method applied with autotransplant, recurrences have been reduced to 5-6%. Meanwhile, in the previously applied methods, relapses reached 30-40% of cases.

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**Retraction of the Lower Lid**
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Retraction of lower eyelid is a rare condition, where lower eyelid is in the lower position than corneal limbus exposing sclera. Usually is caused by Thyroid Eye Disease. Often is judged as ptosis in contra lateral side.

Treatment is surgical: In mild cases release of lower eyelid retractors from its attachments is sufficient, although with limited success.

In more severe cases treatment consists in recession of lower eyelid retractors, with tissue graft between lower eyelid retractors and the lower edge of tarsal plate.

In our experience the best material for grafting is autogenous fascia lata.

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Unilateral Infiltration of the Optic Nerve and Orbit Revealing Relapse of an Acute Lymphoblastic Leukemia

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Purpose. To describe the clinical presentation and imaging features of a leukemic optic nerve and orbit infiltration.

Case report. A 10-year-old child with past history of treated acute lymphoblastic leukemia 5 years ago, presented to our clinic with decreased vision, eye pain during ocular motility and severe protrusion and exotropia of the left eye. At the moment of our examination, pediatrician confirmed that the child was healthy.

Results. At presentation, very pronounced protrusion and exotropia of the left eye. Normal visual acuity in his right eye and 20/200 in his left eye. Painful ocular motility, limited elevation, abduction and adduction as well as convergence insufficiency. Ishihara test showed impaired red-green colour vision. Diminished light brightness and contrast sensitivity in his left eye and a relative afferent pupillary defect was present. Fundus examination showed severe hyperaemia and oedema of the optic disc with blurring margins and whitish-yellowish peripapillary leukemic infiltrates, flame-shaped haemorrhages. MRI result showed the presence of a perineural lobulated expansive lesion that infiltrates the intraconal fat. The described mass displaces the eyeball ventral and causes axial proptosis while posteriorly extends to the prechiasmatic segment of the left ocular nerve with its infiltration; penetrates into the posterior third of the ethmoidal sinus as well as towards the left cavernous sinus, with dural involvement beside the left middle cranial fossa. The orbital apex is dilated and completely occupied by the described substrate. Bone marrow biopsy (myelogram), flow-cytometry and lumbar puncture demonstrated blast infiltration and therefore was confirmed ocular relapse of the lymphoblastic leukemia.

Conclusion. Optic nerve leukemic infiltration has a severe prognosis. Isolated optic nerve relapse of leukemic infiltration is of paramount importance to early diagnosis, as vision can be saved if treatment is initiated promptly.

Keywords: optic disc infiltration, optic disc edema, leukemia

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**Orbital Cavernous Hemangiomas***Naser Salihu¹, Yllke Salihu², Mentor Gorani¹**¹University Hospital Center of Kosova, Eye Clinic**Prishtina**²University Eye Clinic, Würzburg, Germany**Presenting Author: Naser Salihu**nasersalihu@yahoo.com*

Introduction: The cavernous hemangiomas are the most common orbital tumors in adults and women are affected more than men. Their location is most often within the muscle cone but can be found everywhere in the orbit.

Treatment is usually reserved for symptomatic patients and includes surgical excision using lateral or anterior orbitotomy depending on the tumor location.

Objective: To present our experience in management of orbital cavernous hemangiomas.

Material and methods: A retrospective study which includes 23 cases operated from cavernous hemangiomas in the Eye Clinic of Prishtina during 2017-2022. Patients were 35 to 63 years old. In all of cases proptosis has been a dominant symptom. It was followed by globe displacement, visual loss, diplopia and local pain. Patients underwent complete ophthalmic examinations included visual acuity, visual fields, pupillary responses, ocular motility and inspection of the external surface of the globes, eyelids and surrounding structures, dilated fundus examination, intraocular pressure, ultrasound, CT scan and MRI examination. All patients underwent surgical treatment under general anesthesia using anterior and lateral orbitotomy depending on the tumor location in orbit. Lateral orbitotomy was applied in 16 cases whereas other cases have been treated with anterior orbitotomy. The most common intraoperative complication was hemorrhage, which we avoided with careful cauterization.

Results: Postoperative results were satisfactory in most of cases regards to functional and cosmetics aspects, except in two cases which had transitory extraocular motility problems. Other postoperative complications such are: loss of visual acuity, visual field defects, relative afferent pupillary defects, neutrophic keratitis, intraorbital hemorrhage, dry eye, wound infection, orbital cellulitis and cosmetic problems did not occur.

Conclusion: Precise location of cavernous hemangiomas in orbit and the right surgical approach are key to a successful treatment with good functional and cosmetic results.

Key words: Cavernous orbital hemangiomas, surgical treatment

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**Cyclic Esotropia***Era Tateshi**Bekim Tateshi**Eye Clinic, University Clinical Center of Kosova**eratateshi@gmail.com*

Cyclic esotropia is an extremely rare condition, which in most of cases is characterized by regularly periods of orthophoria and esotropia, classically it follows 48-hour cycle: 24 hours of orthophoria and 24- hours of esotropia. A 9-year-old hyperopic boy, was seen with esotropia of 5 months duration. Our checkup was the second one. At his first checkup, hyperopic glasses were prescribed in other institution. His parents claimed that esotropia was more evident early in the morning and afternoon, “so at 17:00 o’clock his eyes are ‘straight’ “– said his mother. From the first checkup they were told to do some analyzes like neurological evaluation which was normal, including imaging and blood work to rule out thyroid pathology and myasthenia. We asked them to see the patient many more times at different periods of the day, so we could be sure for the diagnose. We decided for monocular surgery, recession of medial rectus for 6.0 mm and resection of lateral rectus for 7 mm. Results of the surgery were excellent. He has straight eyes at distance and near still.

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Laparoscopic Pyloromyotomy for Hypertrophic Pyloric Stenosis in Children: Does it Improve the Quality of Surgical Services?

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Named Lecture: Prof. Dr. Hajredin Ukelli & Asst. Prof. Faik Kafexholli for Pediatric Surgery

Background: Pyloromyotomy is the standard procedure for surgical treatment of infantile hypertrophic pyloric stenosis (IHPS). Laparoscopic pyloromyotomy (LP) was introduced in 1990 and is used as a standard technique for IHPS at our institution since 2009. The purpose of this presentation is to demonstrate the technique of LP and to present the current results with this technique at our institution.

Methods: We retrospectively identified all patients who were treated for IHPS at our institution from 2011–2022 and analyzed the demographic data of the patients, the surgical approaches, days of stay in the hospital, and complications. Postoperative feeding protocol was the same for all patients aiming to reach full enteral feeds on postoperative day 3.

Results: Out 119 infants treated for IHPS, 94 (79%) were male. Their median age at surgery was 34 days (range 12–127), and median stay in the hospital 5 days (range 3–19). Eight patients were treated by laparotomy using the open surgery by the supraumbilical approach (Bianchi) and 111 patients received a LP. In 5 cases (4%) a second surgery was needed due to insufficient myotomy. In 2 of these cases the revisions were done by laparotomy (Bianchi) and in 3 cases a redo LP was performed. Two mucosal perforations were noted during LP which were both repaired during the same intervention after conversion to laparotomy (Bianchi). In one case postoperative incisional hernia needed a surgical repair. LP was performed using the 5 mm umbilical camera and trocarless insertions of working 3mm instruments. The procedure is terminated when pyloric mucosa protrudes through the whole length of the incision (Figure).

Conclusion: LP is the favored technique for treatment of IHPS at our Institution. Although easy and fast in the hands of experienced surgeons, LP requires meticulous training as it may be associated with more complications than laparotomy (Bianchi).

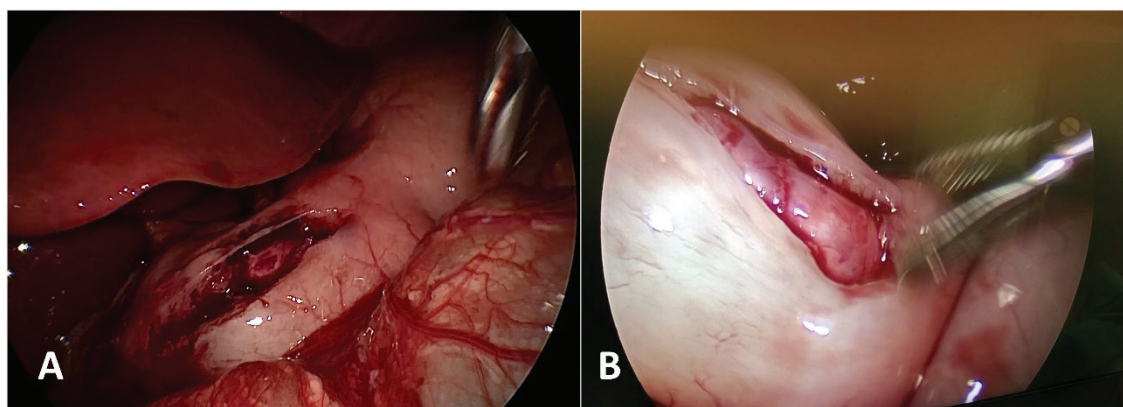


Figure: This composite figure shows the length of the laparoscopic pyloromyotomy which should be around 2 cm (A) and the required protrusion of the pyloric mucosa through the whole length of the pyloromyotomy (B).

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**Laparoscopic pyeloplasty: Tips, tricks, and pitfalls*****Baran Tokar******Professor of Pediatric Surgery and Pediatric Urology******Head of Pediatric Urology******Department of Pediatric Surgery******Director of "Center for Computer Aided Diagnosis and Treatment in Health"******Eskisehir Osmangazi University, School of Medicine, Eskisehir, Türkiye******barantokar@gmail.com***

Laparoscopic pyeloplasty is a challenging procedure in children, especially in infant age. Difficulties encountered in surgical exposure, determining the exact borders of the pathologic region, ureteral spatulation and suturing might affect the success of the surgery. The aim of this presentation is to delineate tips, tricks and pitfalls of the procedure in children.

Training phases of the laparoscopic pyeloplasty, principles of ergonomics, how to position the patient depending on the age and surgical team, what are the appropriate instruments and devices, steps of the surgery including the starting phase with trocar insertion to trocar incision closure, difficulties, challenges, tips and trick of the operation are the points that should be discussed for laparoscopic pyeloplasty.

Training on simulators and in animal labs before hands on practice, having experience of laparoscopic diagnostic and ablation surgery before attempting a reconstructive procedure are the main points for beginners. The surgeon should also need to have open surgery experience to adapt his/her past experience to laparoscopic procedure. Principles of ergonomics, having right instruments, devices, and surgical staff with experience in laparoscopy should be considered. It is much more difficult to get good ergonomics and success in children comparing to adult. There should be justified indications for surgery and well-organized postoperative follow-up.

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**How to Implement Artificial Intelligence Studies in Pediatric Surgery*****Baran Tokar******Professor of Pediatric Surgery and Pediatric Urology******Head of Pediatric Urology******Department of Pediatric Surgery******Director of “Center for Computer Aided Diagnosis and Treatment in Health”******Eskisehir Osmangazi University, School of Medicine, Eskisehir, Turkiye******barantokar@gmail.com***

The aim of this presentation is to explain the major subtypes, machine learning and deep learning/computer vision, in artificial intelligence (AI), including their implementation in medicine and specifically in pediatric surgery. The examples from surgical branches and pediatric surgery for big data analysis and clinical decision support systems will be discussed with their current and future applications to surgical practice.

Traditional database methods have difficulties for accumulating very large and raw data sets with no limit. Machine learning as AI subtypes, aims to find the best solution for feature problems by gaining experience from a very large and constantly growing data set. Deep learning networks, as another subtypes of AI, may help us in image recognition. Deep learning is a multilayer computational system having a set of interconnected processing elements with autodidactic quality. While machine learning architecture might evaluate medical numeric data with no limit; deep learning networks may evaluate medical scans, lesions on inspection and surgical incisions, images of endoscopic and open surgery, histopathological images and also they may perform real time image processing. Workflow in AI studies should be structured as steps including data preparation, AI modeling, training and test step and deployment.

How do we deploy AI into surgical practice? Artificial Intelligence extracts data from medical record, integrate preoperative, intraoperative events and postoperative outcomes. It may analyze and link each individual surgeon's data with population data from several other surgeons, also can provide prediction based solutions and warnings on the preoperative risk factors. A deep learning algorithm with well-structured training may complete decision making process with comparable performance with radiologists and surgeons.

While constructing a study on surgical image recognition; resolution, quality of images, standardization and data size are the important limitations. Low tissue contrast, irregular shape, unclear boundaries and large location variance cause difficulties in segmenting the objects in medical images. For small data sets synthetic data generation could be considered.

Decision Support Models could also be designed by AI in Surgery. It may use past experience/current situation, detection and classification in pathologic lesions, guiding and suggestion of the next step and prediction of complication.

Real time image processing in surgical cases, especially in endoscopic procedure would be also possible in the future. Cascading the operational processes, image recognition, surgical camera stability in intra-abdominal surgeries such as laparoscopic cholecystectomy, sleeve gastrectomy and sigmoidectomy, estimation of the time left, determining the need for any equipment at each step, evaluation of environmental facts might also be implemented by AI. Objective assessment of surgical skill in training is another topic that could be well-structured by AI.

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Gastroduodenal Duplication in a 3-month child

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Introduction: Duplications of the alimentary tract are a diverse and complex spectrum of congenital malformations and can be found anywhere along the digestive tract from the oral cavity to the anorectal region. Alimentary tract duplications are uncommon and may present as solid or cystic tumors, intussusception, perforation, or GI bleeding. A high index of suspicion is required in such cases. Appropriate investigations, including imaging techniques, should be directed toward adequate and planned surgery.

Case Report: A 3-month-old female arrived at the Emergency Department (ED) of Pediatric Surgery, at University Clinical Center Prishtina, with vomiting after feeding, abdominal distention and an abdominal mass found by his mother. The patient had a history of suspected duodenal atresia by antenatal ultrasounds (double bubble sign found) However, this congenital malformation was ruled out postnatally after a normal upper gastrointestinal series. Physical examination at the ED revealed a giant abdominal mass located in the hypogastrium. A Computed tomography (CT) scan of the abdomen was done. A huge hypodense cystic mass attached at major curvature of the stomach and duodenum with the dimensions of $10 \times 12.8 \times 3$ cm and an approximate volume of 280 cc was documented. The patient underwent surgical exploration and complete excision of the cyst. Postoperative recovery was uncomplicated, and he was discharged on postoperative day 7. At 6 months follow-up he remains well, and his weight has increased normally.

Discussion: Gastric Duplication accounts for fewer than 4 % of all gastrointestinal tract Duplications. The majority are located along the greater curvature, are cystic in nature, and are not in continuity with the lumen of the stomach and duodenum. Ultrasound will show a cystic mass in epigastrium. Communication with the pancreatic duct and recurrent pancreatitis have been reported. Extralobar bronchopulmonary sequestrations may attach to the gastroesophageal junction and associated with a gastric duplication. (66,67 Ravitch) The treatment of gastroduodenal duplication is complete excision. Most will not communicate directly with the stomach lumen. When a communication exists, a two-layer closure of the defect is all that is necessary.

Conclusions: GID can lead to life-threatening complications. Prenatal diagnosis should lead to expeditious post-natal investigation and treatment before the onset of symptoms or complications. Laparoscopy/laparotomy should be considered in patients when the diagnosis of an intraabdominal mass is clear.

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Strangulation of the Abdominal Organs in Previously Not Diagnosed Diaphragmatic Hernias – 2 Case Presentations

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Introduction: Diaphragmatic hernias are usually congenital and they usually occur in the neonatal period. They do occur in adults as well, albeit very rarely. Clinical awareness of this uncommon condition should be raised especially when evaluating a patient with respiratory symptoms and atypical abdominal pain, as a delay in appropriate diagnosis and management can result in significant morbidity and mortality. History of the patient and physical examination, accompanied by imagery should raise the suspicion of the condition.

Diaphragmatic hernias are commonly congenital and they predominantly involve the very young neonatal group. Clinical suspicion of this uncommon condition should be raised especially in patients that present with respiratory symptoms accompanied by atypical abdominal pain. A delay in diagnosis and treatment can be fatal to the patient, thus beside the clinical exam imagery is mandatory to exclude the diagnosis.

Case Presentation: We report two cases of strangulation of the stomach and other organs in thoracic cavity in patients with previously non-diagnosed diaphragmatic hernia. The first patient is a 13year old boy who suffered a blunt trauma to the upper abdomen, the second patient is a 12year old girl with spontaneous incarceration of the abdominal organs through diaphragmatic defect.

Discussion: Diaphragmatic hernias are usually congenital and they usually occur in the neonatal period. Left-sided diaphragmatic hernias are more common, because the right pleuroperitoneal canal closes earlier and the liver protects the right diaphragm.

Conclusion: Despite being rare, this disorder should be recognized, examined, and treated appropriately to avoid fatal complications. Early diagnosis is very important for the urgent surgical intervention, which remains the only curative treatment for diaphragmatic hernia associated with strangulated abdominal organs.

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Congenital Colonic Stenosis: A rare cases of intestinal obstruction

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Congenital megaprepuce is a rare abnormality of type of inconspicuous penis also known as “volcano penis”, characterized by sever phimosis with major ballooning of excessive inner prepuce that may result in this appearance. Due to gross dilatation of the preputial sac in consequence of urinary pooling creating a “preputial bladder” that need almost always a manual expression to resolve, the surgery is inevitable not only to manage the esthetic implication but also to deal with the consequences of this condition like: hidden penis, severe ballooning, dribbling, difficult micturition, urinary infections, and later in life painful erection and psychological difficulties. In this article we have presented three uncircumcised children with congenital megaprepuce diagnosed, operated and followed-up by the same surgeon, by using single stage approach surgery that is shown to provide completed resolution with no complication and satisfactory results in function and cosmesis.

Keywords: Congenital megaprepuce; Phimosis; Inner preputial ballooning; Single stage surgery; Anatomical approach.

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Lymphatic Malformation in Children

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Lymphatic malformations are congenital vascular malformations with lymphatic differentiation.

A lymphatic malformation is a lymphatic vessel that isn't formed correctly. Lymphatic malformations are low-flow vascular malformations that arise occur due to errors in vascular development. Lymphatic malformations are benign and usually noted at birth or in the first few years of life. A multimodal and interdisciplinary approach is essential to care for patients with lymphatic malformations. The most common locations for lymphatic malformation are the axilla and neck, also they can occur at several locations in the body including the abdomen. In symptomatic cases, acute complications may necessitate immediate surgery. The abdominal location is rather rare and accounts for approximately 5% of all lymphatic malformations. Abdominal lymphatic malformation can arise from omentum, mesentery, gastrointestinal tract, and retroperitoneum. Clinical presentation is extremely variable. Clinical presentations include abdominal pain, abdominal lump, vague abdominal discomfort, and secondary complications including intestinal obstruction, volvulus, ischemia, and bleeding. There is a broad spectrum of radiological manifestations.

We present the results of lymphatic malformation diagnosed in a series of children treated at the Clinic of Pediatric Surgery, in HUČSK. The diagnosis of lymphatic malformation in our cases were based on the histopathological examination. Treatment options vary based upon size of cysts and location. Management options include observation, pharmacotherapy, sclerotherapy, and surgical procedures.

Keywords: Lymphatic malformation, neck, axilla, abdomen.

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Clarifying the Dilemmas of Hypospadias Classification

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Introduction: There are many dilemmas of classifications of hypospadias, before surgical intervention, in order to be able to conceive the most appropriate operative method, for specific cases. There are many authors that described certainly preoperative classifications, but we all know that there are many specific elements that are not visible before surgery. Therefore, there is a need to evaluate patients, during the intervention, to achieve more objective evaluations of hypospadias.

Objective: The purpose of this paper is the analysis of the published literature, to explain the classification, and analysis of our surgical cases, specifically the intraoperative classification of cases, based on a specific form of classification.

Material and method: We performed a retrospective review of articles published in PubMed, to analyze and select a more appropriate form of classification. After the detailed analysis, we decide to base it on the intraoperative classification of hypospadias, provided by Hadidi. The research includes pediatric surgery patients (>1 year) who will undergo surgical repair of hypospadias. Inclusion criteria are patients over 1 year of age, who didn't undergo previous penile surgery and patients with glanular, subcoronal, distal penile, and midshaft penile hypospadias.

Results: A total of 26 patients aged from 2 years to 12 years old were unrolled. The mean age was 5.5 years. Before the chordee correction, 9 of our patients had glanular hypospadias, 14 distal hypospadias, and 3 proximal hypospadias. After the chordee correction, 12 of our patients had glanular hypospadias, 13 distal hypospadias, and 1 proximal hypospadias. Five of our patients had complete prepuce, and 22 had incomplete prepuce. Five of our patients had no cleft glans, 17 had incomplete cleft glans, and 4 had flat glans. Nine of our patients had no chordee, 13 superficial chordees, and 4 deep chordees. 21 patients had urethral plate widths under 1 cm, and 5 had more than 1 cm. None of our patients had penile torsion. Two of our patients had penoscrotal transposition.

Conclusions: Adequate classification of hypospadias, by analyzing all the anatomical elements of the anomaly, allows us to have a clear vision of the appropriate decision-making of their surgical treatment. This type of classification would allow us to standardize the detailed description of the anomaly, facilitating more precise communication between penile surgeons around the globe.

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Congenital Colonic Stenosis: A rare cases of intestinal obstruction

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As an extremely rare type of colonic atresia, it is difficult to think firstly on congenital stenosis of the colon in cases with intestinal obstruction. We present five cases diagnosed and treated successfully in Pediatric Surgery Clinic from 2010 to 2021 in attempt to share our experience in managing Congenital Colonic Stenosis. All five cases attended the ward with signs of abdominal distension, chronic constipation and intermittent vomiting, these signs of intestinal obstruction as a result of intraoperatively confirmed congenital stenosis at the level of the ascending colon in two cases, one at the distal ileus and ascending colon, in the transverse and in the descending colon with one case each. Intraoperatively those cases were managed by resection of stenotic part and primarily end-to-end anastomosis in two cases, end-to-end anastomosis under covering lateral colo-colostomy in one patient, by Hartman colostomy in one and loop ileostomy in the fifth one. Including one complicated case with stoma prolapse in all five cases, the post-operative period was uneventful and with satisfactory outcomes. Although Congenital Colonic Stenosis is a very rare cause of intestinal obstruction in neonates and pediatric age groups, it should be listed in the differential diagnoses.

Keywords: Congenital colonic stenosis; Pediatric intestinal obstruction; Ileostomy; Colonostomy; End-to-end anastomosis.

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Congenital Kidney Diseases in Children are most common reason of Chronic Kidney Disease

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During intrauterine growth, kidneys develop on 9th gw. And further development is depend on factors motherhood, genetic, enviroiment. And the possible anomalies are a lot. As many as 150 different genetic disorders are found to cause kidney abnormalities isolated, combinet with other organs or syndromic. Disorders functional or structural anatomic. Might be familiar genetic. Almos 30% of this anomalies are found during intrauterine life, by Obstretian. Kidney disorders are corrected sugicaly in adequat time and right correction in order to prevent kidney function maximally.and some might need surgical correction further in bigere age like cystic diseases. As earlied detected and corrected the better disease prognose. And treatment is not alwayes full recovery, some of them should be further followed with treatment. 10% of adult people and almos all children with inborn anomalies end up with CKD, RRT, transplant. And transition to adult fellow up and treatment is a big chalenge for patient.

Although with multidisciplinary aproach of team Obstretician, Pediatric Nephrologis, Peidatric Surgeon, Urologist, Neurosurgeon and Parent with carefull monitoring from birth to adulthood we can preserve and maintenin the maximal potential of the patients kidney.

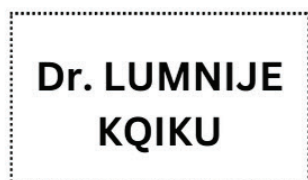
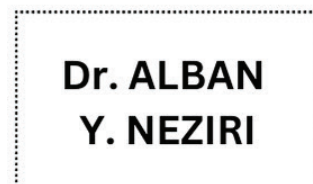
Key words: kidney abnormalities, children, chronic kidney disease, multidisciplinary

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