24th NATIONAL CONGRESS OF SURGERY ABSTRACTS

CASE PRESENTATIONS

[P-010]

A rare cause of ileus: Jejunal schwannoma

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Objective: Small bowel tumors constitute a small proportion of all gastrointestinal system tumors. Among benign mesenchymal tumors, schwannomas are quite rare. Although they are most commonly located in the stomach (approximately 60%) and the colon (approximately 3%), the development of schwannoma in the small intestine-particularly in the jejunal region-is uncommon. In this study, a case diagnosed with jejunal schwannoma presenting with mechanical ileus is presented in the context of the literature.

Material and Methods: A 61-year-old male patient presented to the emergency department with worsening abdominal pain that had persisted for several days. Contrast-enhanced abdominal computed tomography (CT) was reported as suggestive of ileus. With a preliminary diagnosis of mechanical ileus, emergency laparotomy was performed, during which a constricting mass was identified in the distal jejunum and resection with side-to-side anastomosis was carried out. Histopathological examination revealed a benign mesenchymal tumor consistent with a peripheral nerve sheath tumor (schwannoma). The postoperative course was uneventful, and the patient was discharged on postoperative day 8.

Results: Schwannomas are benign mesenchymal tumors originating from the peripheral nerve sheath. They are most commonly located in the stomach, whereas small bowel involvement is rare and jejunal localization is particularly uncommon; therefore, they are often overlooked in the differential diagnosis. Jejunal schwannomas usually grow slowly and may remain asymptomatic for long periods. When symptomatic, they present with nonspecific findings such as abdominal pain, chronic constipation, occult gastrointestinal bleeding, or anemia. Acute mechanical small bowel obstruction is rare and usually requires emergency surgery. In our case, a history of chronic constipation one year prior supports the insidious nature of these tumors. Radiological findings are non-specific. Contrast-enhanced CT may show focal bowel wall thickening, an intramural mass, or proximal bowel dilatation; however, these findings overlap with gastrointestinal stromal tumors (GIST), adenocarcinomas, and lymphomas. Therefore, careful small bowel evaluation is essential in patients with persistent or unexplained gastrointestinal symptoms. Definitive diagnosis relies on histopathological and immunohistochemical examination. S-100 positivity supports schwannoma, while CD117 negativity is critical for excluding GIST. Complete surgical resection is curative with a low recurrence risk. Our patient recovered without recurrence during one-year follow-up.

Conclusion: Jejunal schwannomas are very rare tumors. Because they may clinically lead to ileus, it is important to consider them in the differential diagnosis, particularly in cases of unexplained small bowel obstruction.

Keywords: Benign mesenchymal tumor, GIS schwannoma, mechanical bowel obstruction

Figure 1. Upright abdominal radiograph demonstrating prominent air-fluid levels in the ileal loops; absence of gas in the distal colon is consistent with mechanical bowel obstruction.

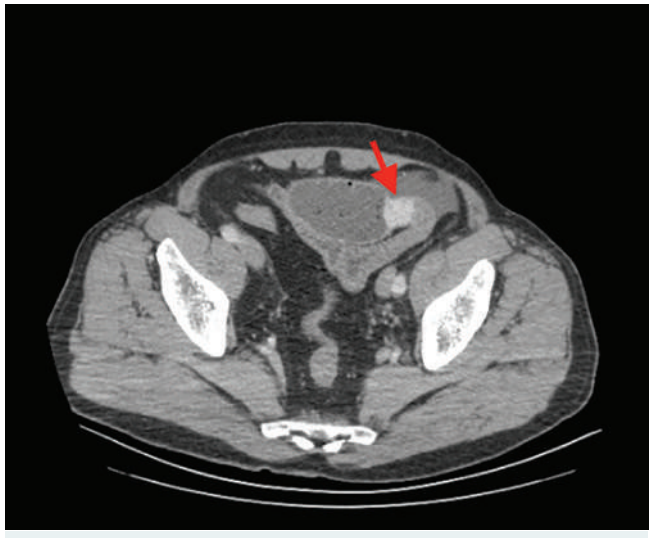

Figure 2. Contrast-enhanced abdominal CT (axial view) showing a transition zone at the level of the distal jejunum with marked dilatation of the proximal small bowel loops.

Figure 3. Contrast-enhanced abdominal CT obtained one year prior to presentation (axial view): retrospective evaluation reveals focal jejunal wall thickening causing partial luminal narrowing.

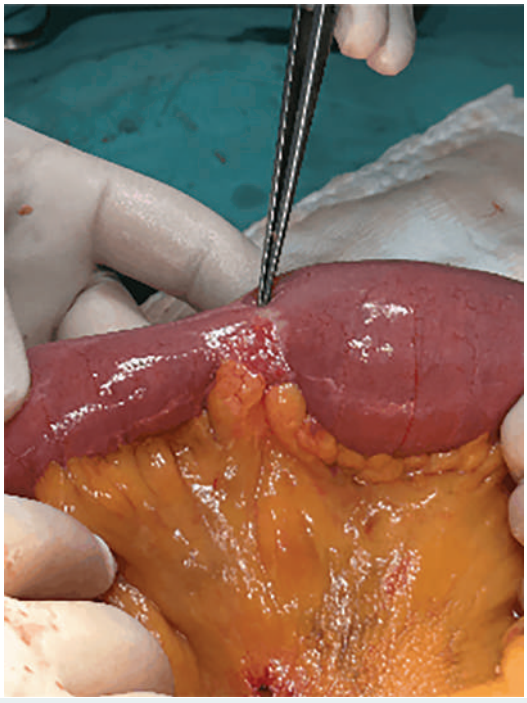

Figure 4. Intraoperative image showing an intramural mass lesion causing luminal narrowing of the distal jejunum.

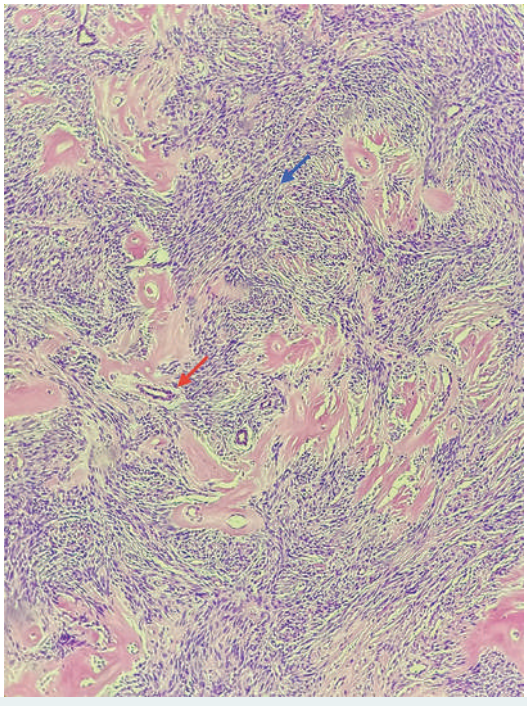

Figure 5. Spindle-shaped Schwannian cells with wavy nuclei arranged in short fascicles within a fibrohyalinized stroma (H&E, ×200).

[P-012]

A rare cause of recurrent small intestine obstruction: Well-differentiated ileal neuroendocrine tumor

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Objective: Small intestine neuroendocrine tumors (NETs) are one of the common subtypes of gastrointestinal neuroendocrine neoplasms. Those located in the ileum, in particular, may remain asymptomatic for a long time due to their slow growth and submucosal localization. Clinical findings are generally nonspecific. Diagnosis is often made when complications such as mechanical ileus or mesenteric fibrosis develop. Therefore, in patients presenting with recurrent ileus attacks, small bowel NETs should always be considered in the differential diagnosis, despite their rarity.

Material and Methods: The clinical course, imaging findings, surgical approach, and histopathological results of a 52-year-old female patient presenting with recurrent mechanical ileus attacks were retrospectively evaluated.

Results: Contrast-enhanced abdominal computed tomography (CT) at the patient's initial presentation revealed findings consistent with ileus. The patient was managed conservatively and discharged after clinical improvement. Two months later, the patient presented again with complaints of severe abdominal pain, nausea, vomiting, and inability to pass gas or stool. An upright abdominal X-ray showed air-fluid levels. A current contrast-enhanced CT scan showed asymmetric wall thickening in a 2 cm segment of the ileal loop. A nodular lesion was detected in the adjacent mesenteric fatty tissue, and there was marked bowel dilatation proximally. The patient underwent surgery with a preliminary diagnosis of mechanical ileus. A mass lesion narrowing the intestinal lumen was observed approximately 100 cm proximal to the ileocecal valve. Segmental small bowel resection and primary anastomosis were performed. There were no complications in the postoperative period. The patient was discharged on the fifth day. Histopathological examination of the resection specimen was consistent with a well-differentiated NET.

Conclusion: In patients presenting with recurrent mechanical ileus attacks, especially when symptoms recur despite conservative treatment, small bowel NETs should be considered in the differential diagnosis. Segmental wall thickening on computed tomography and the presence of accompanying mesenteric nodular lesions are diagnostic indicators. Timely surgical resection ensures both a definitive diagnosis and successful clinical outcomes.

Keywords: Small intestine, mechanical ileus, neuroendocrine tumor, ileal tumor, bowel obstruction

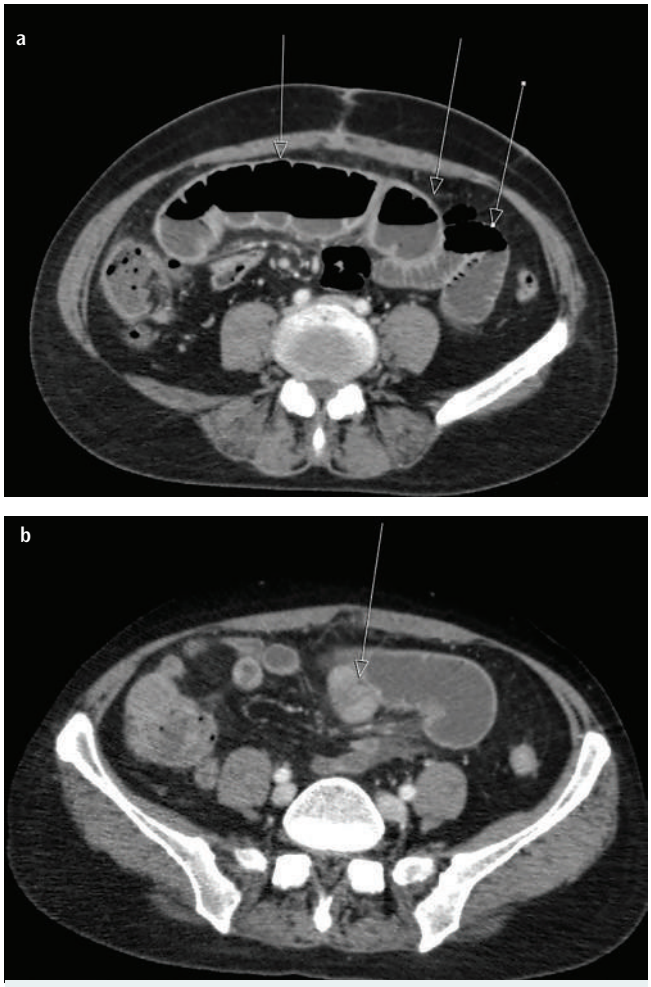

Figure 1. Ileus finding on contrast-enhanced abdominal CT scan. a) Findings of proximal ileus. b) Asymmetric wall thickness increase in ileal loops.

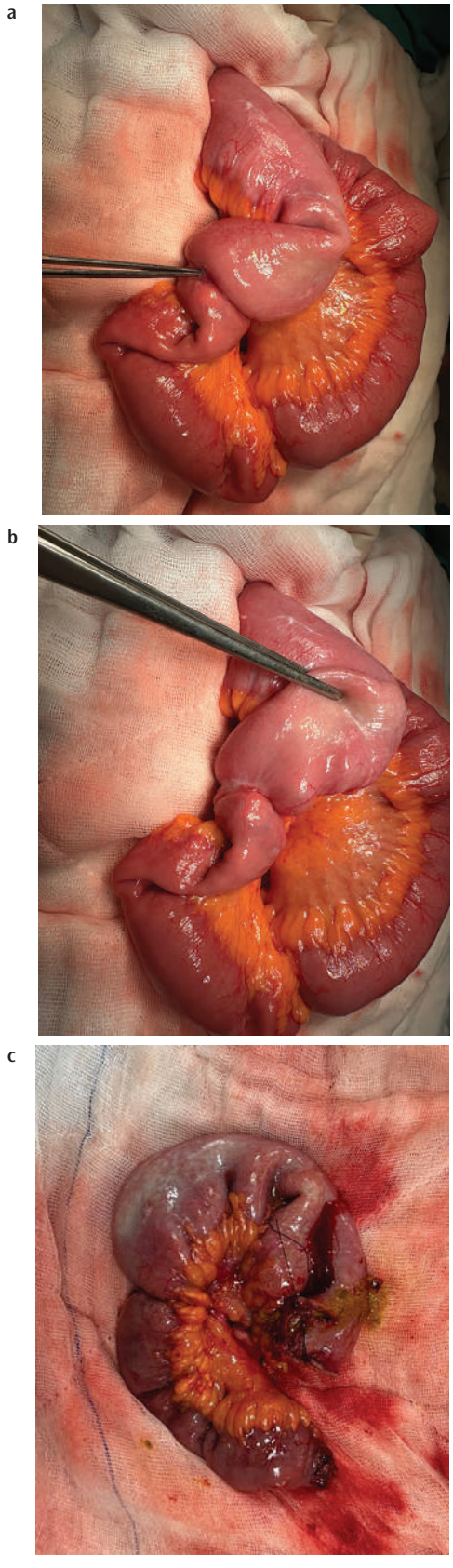

Figure 2. Intraoperative findings. **a)** Mass lesion that significantly narrows the intestinal lumen. **b)** Mass lesion significantly narrowing the intestinal lumen, proximal dilated. **c)** Segmental small bowel resection material.

[P-013]

A rare case report of a trichilemmal cyst extending from the anus to the scrotum

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Objective: A trichilemmal cyst is a generally benign cutaneous lesion originating from skin appendages, particularly hair follicles, and is filled with keratin. It occurs in approximately 5-10% of the population, with nearly 90% of cases located on the scalp due to the high concentration of hair follicles. Although trichilemmal cysts are almost always benign, rare cases may show proliferative activity, and malignant transformation with distant metastasis has been reported in approximately 2% of cases in the literature. Therefore, complete surgical excision with clear margins is the recommended treatment.

Results: A 47-year-old male patient presented to our clinic with swelling starting laterally to the anus and ending laterally to the scrotum. Magnetic resonance imaging revealed a subcutaneous cystic lesion approximately 20 cm in length, with no connection to the spermatic cord or scrotum. Microbiological culture of aspirated cyst fluid showed no pathogenic growth. Rectosigmoidoscopy demonstrated no communication between the lesion and the rectum. The lesion was completely excised with clear surgical margins and preservation of cyst integrity for diagnostic and therapeutic purposes. Histopathological examination confirmed a non-proliferative trichilemmal cyst. The postoperative course was uneventful, and no additional pathology was detected during follow-up.

Conclusion: Although trichilemmal cysts are most commonly located on the scalp, this case highlights the importance of considering trichilemmal cysts in the differential diagnosis of anal and perianal masses. Definitive diagnosis relies on histopathological examination following complete surgical excision with clear margins.

Keywords: Trichilemmal cyst, puborectal cyst, anal region cyst

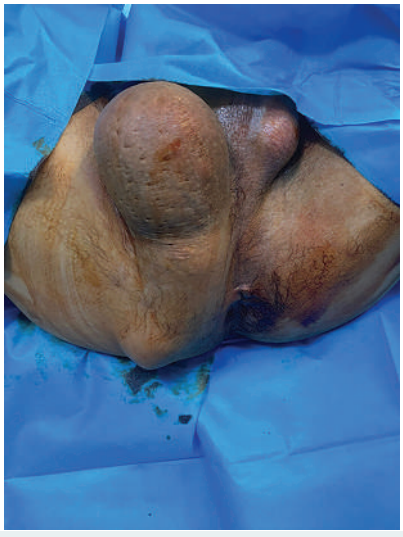

Figure 1. Image of the mass before excision.

Figure 2. Macroscopic image of the mass.

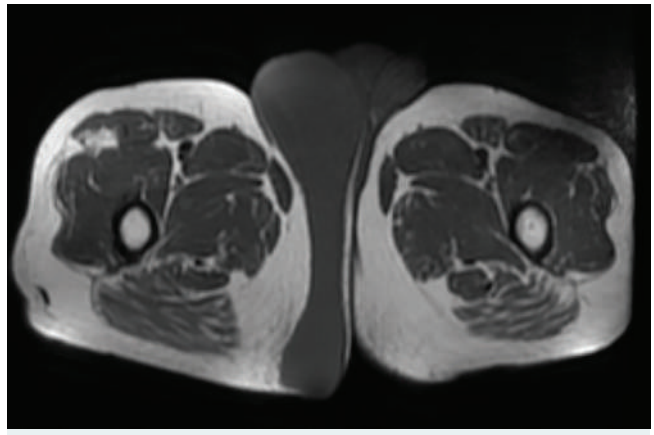

Figure 3. MRI image of the mass.

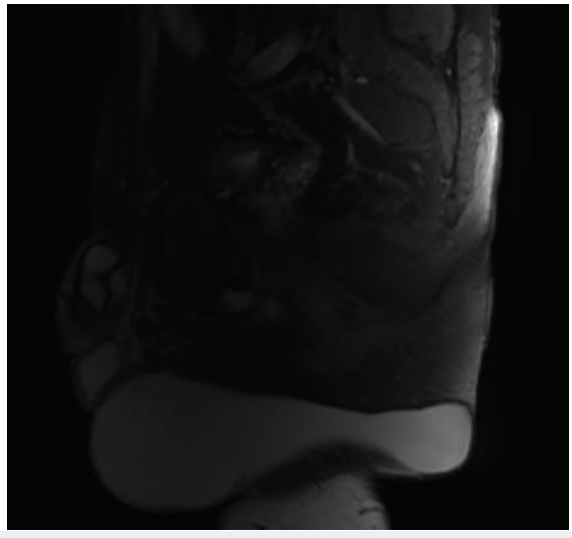

Figure 4. MRI image of the mass.

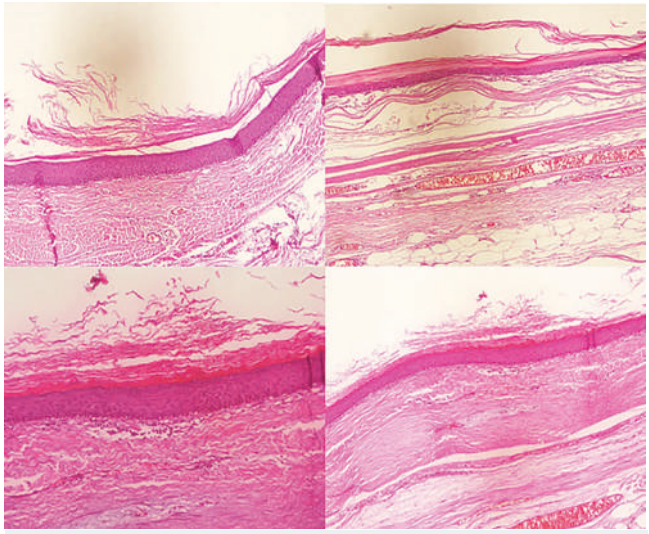

Figure 5. Microscopic image of the mass.

[P-014]

Oncoplastic approach in giant phyllodes tumor: Goldilocks mastectomy and nipple-sparing technique

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Objective: Phyllodes tumors are rare fibroepithelial neoplasms of the breast. Particularly, "malignant" and "giant" (over 5 cm) forms may require mastectomy to ensure negative surgical margins. Reconstruction after mastectomy is critical for the patient's quality of life. Here, we aim to present a case of a giant phyllodes tumor recurrence treated with a left nipple-sparing mastectomy and dermal flap reconstruction (goldilocks mastectomy).

Material and Methods: A 46-year-old female patient, who was operated on three years ago for a "Borderline Phyllodes Tumor" in the left breast and subsequently lost to follow-up, presented with breast asymmetry and a giant mass.

• **Physical examination:** A tense, palpable mass filling the entire left breast was noted, accompanied by a significant increase in venous vascularity on the skin.

• **Imaging:** Contrast-enhanced mammography and MRI revealed a lobulated, heterogeneous solid lesion (BI-RADS 4c) measuring approximately 26x22 cm, filling all quadrants and extending into the axillary tail.

• **Pre-op diagnosis:** Following a tru-cut biopsy result of "Borderline Phyllodes Tumor", surgery was planned.

Results: • **Surgical procedure:** The patient underwent a left "Nipple-Sparing Mastectomy" combined with "Dermal Flap Reconstruction" (Goldilocks Mastectomy).

• **Intraoperative observations:** No pectoral fascia invasion was found.

• **Specimen:** The excised specimen measured 30 cm.

• **Pathology:** Postoperative histopathological examination confirmed a "Malignant Phyllodes Tumor" with a tumor size of 25 cm, atypia in stromal cells, 7/10 HPF mitosis, and a 40% Ki-67 index.

• **Surgical margins:** Margins were negative (5 mm distance).

• **Follow-up:** The case was evaluated by the oncology board, and 4 cycles of cisplatin + adriamycin chemotherapy were planned. Satisfactory cosmetic results were observed at the 1-month postoperative follow-up.

Conclusion: Wide resection and oncologically safe margins are indispensable in the surgical treatment of giant phyllodes tumors. The Goldilocks mastectomy technique is an effective oncoplastic method, especially for large-volume breasts, as it eliminates the need for implants or free flaps by providing an acceptable breast volume using the patient's own dermal tissue. This case demonstrates that aesthetic results can be optimized in giant masses without compromising oncological principles

Keywords: Dermal flap reconstruction, goldilocs mastectomy, malignant phyllodes tumor

Figure 1. Preoperative token the pictures.

Figure 2. Postoperative token the pictures.

[P-015]

Migration to a distant contralateral region following breast wire localization: A rare complication in the literature

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Objective: Wire-guided localization is a widely used and reliable method for the surgical treatment of non-palpable breast lesions. However, rare but potentially serious complications such as wire displacement, breakage, or migration to extra-mammary anatomical sites have been reported. While literature indicates that wire migration typically occurs within the same breast or to the ipsilateral thoracic wall, migration to contralateral and distant anatomical regions is extremely rare. This case report presents an extraordinary instance where a localization wire migrated from the right breast to the left shoulder joint following stereotactic marking and was subsequently removed surgically.

Material and Methods: A 52-year-old female patient, scheduled for right breast-conserving surgery and sentinel lymph node biopsy (SLNB) due to right breast malignancy, was referred to the radiology department for preoperative stereotactic localization on the day of surgery. Following the localization procedure, the patient was taken to the operating room; however, the operation was cancelled due to an active herpes simplex infection on her lip identified during the anesthesia evaluation. The patient was discharged with medical treatment as per dermatological recommendations. Three days after discharge, she presented to the emergency department complaining that the wire tip had retracted under the skin and was subsequently admitted.

Results: Imaging revealed that the wire placed in the right breast had unexpectedly migrated to the contralateral side, advancing into and embedding within the left shoulder joint region. Following the trajectory of the wire under ultrasound (USG) guidance, the wire was successfully removed through a surgical incision in the left shoulder. No complications occurred during the procedure.

Conclusion: Although wire migration following localization is rare, surgical delays can increase this risk. This case highlights that a localization wire can migrate beyond the breast tissue to contralateral and distant anatomical sites. In cases of surgical delay following wire localization, reevaluating the position of the wire and adopting a multidisciplinary approach are of paramount importance for the effective and safe management of potential complications

Keywords: Breast localization, localization wire migration breast-conserving surgery (BCS)

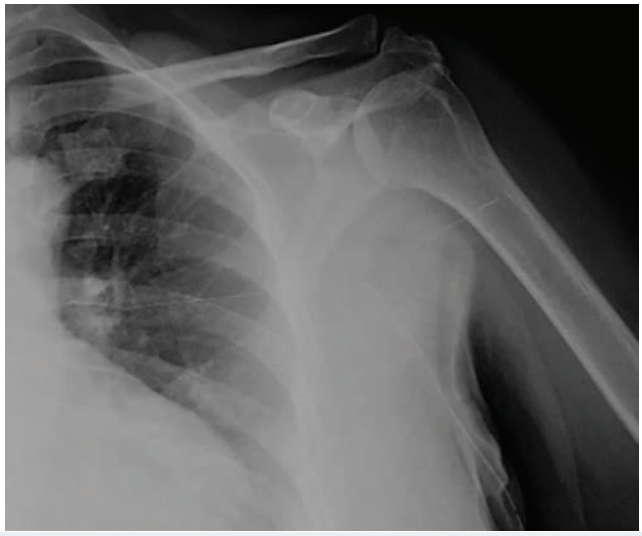

Figure 1.

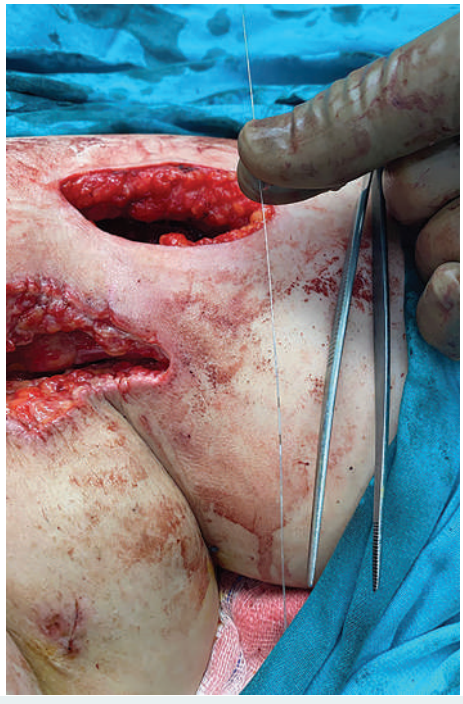

Figure 2.

[P-016]

Breast cancer developing six years after prophylactic bilateral simple mastectomy: A case report

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Objective: Breast cancer is the most common malignancy among women. Advances in genetic testing, screening programs, and multidisciplinary management enable prevention and early diagnosis, leading to improved disease-free survival. Genetic predisposition is a major risk factor, with *BRCA2* mutations among the most common. In mutation carriers, prophylactic mastectomy and routine mammographic screening after age 40 within national programs facilitate early detection and improve survival. Although prophylactic mastectomy significantly reduces cancer risk, malignancy may still develop, as demonstrated in this case.

Material and Methods: A 35-year-old woman underwent genetic testing in 2019 due to breast cancer in her two older sisters and was found to carry a *BRCA2* mutation. Breast ultrasonography showed a BI-RADS 2 lesion. She underwent prophylactic bilateral simple mastectomy with implant reconstruction; pathology was benign. She was followed with semiannual ultrasonography. In June 2025, lesions measuring 26×14 mm and 16×12 mm were detected in the right breast. Core needle biopsy was unsuitable because of the implant; incisional biopsy revealed invasive lobular carcinoma, estrogen- and progesterone-receptor positive, HER2 negative, with a Ki-67 index of 12%. PET-CT demonstrated right breast lesions and suspicious right axillary lymph nodes. After four cycles of neoadjuvant chemotherapy, follow-up imaging showed resolution of uptake.

Results: The patient was evaluated multidisciplinary. In October 2025, right subcutaneous mastectomy and sentinel lymph node biopsy were performed, followed by expander placement in collaboration with plastic surgery. Isosulfan blue was injected for mapping. Sentinel lymph node biopsy and subcutaneous mastectomy, including the nipple-areola complex to the pectoral fascia, were completed without implant damage. The specimen weighed 148 g. The implant was replaced with a tissue expander. She was discharged on postoperative day one without complications.

Conclusion: Patients with *BRCA2* mutations who undergo prophylactic mastectomy should continue close imaging surveillance. As shown in this case, breast cancer may arise in residual tissue despite risk-reducing surgery.

Keywords: Breast cancer, BRCA-2 mutation, prophylactic mastectomy

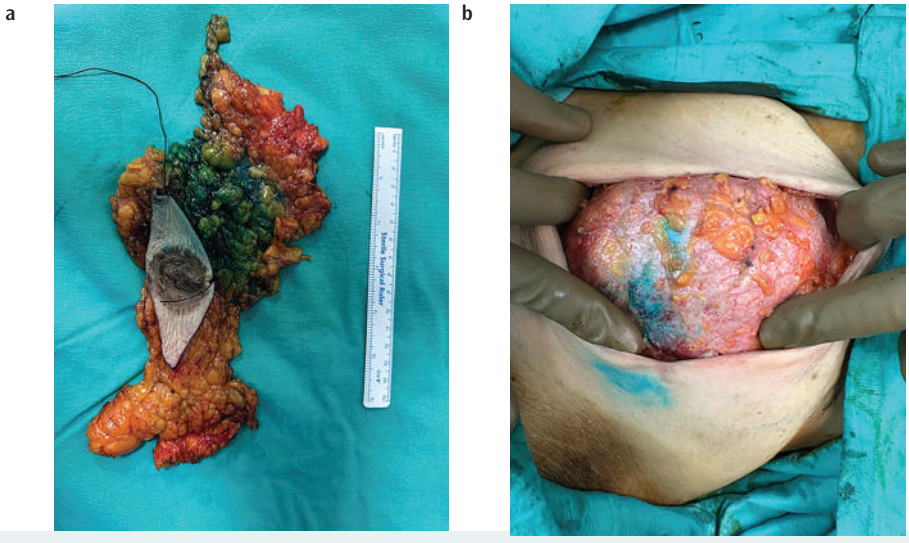

Figure 1. Intraoperative imagine. **a)** Spesimen. **b)** Intraoperative breast tissue.

[P-017]

Giant thyroid metastasis of renal cell carcinoma emerging fifteen years later: A rare case mimicking primary tumor

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Objective: Renal cell carcinoma (RCC) is known as the "great mimicker" due to the unpredictable biological behavior of tumor cells and its potential for hematogenous spread. Although thyroid metastases are clinically rare (1.1-3%), RCC is the most frequently detected primary focus in such cases. The most characteristic feature of RCC metastases is their ability to emerge years after the resection of the primary tumor; latent periods of up to 20 years have been reported in the literature. This poses a significant diagnostic challenge, particularly because it can be confused with primary clear cell neoplasms of the thyroid. This case presents a rare metastasis presenting as a 10.2 cm giant mass 15 years after nephrectomy.

Material and Methods: A 54-year-old male patient presented with a sense of pressure in the neck and a rapidly growing swelling. His medical history revealed a nephrectomy 15 years ago due to left RCC. Radiological examination showed a giant nodule, 10.2 cm in size with heterogeneous signal intensity, nearly completely filling the parenchyma of the right thyroid lobe (Figure 1). Total thyroidectomy was performed due to clinical suspicion and significant compressive symptoms in the patient, whose cytological findings were reported as "atypia of undetermined significance".

Results: Histopathological examination revealed a tumoral structure infiltrating the thyroid tissue, consisting of cells with extensive clear-eosinophilic cytoplasm and prominent nucleoli. Immunohistochemical staining showed that the tumor cells were strongly positive for PAX-8, CD10, and vimentin, while testing negative for TTF-1 and thyroglobulin (Figure 2). This immunoprofile and morphological findings confirmed the diagnosis of "Clear Cell RCC Metastasis".

Conclusion: Although the rich vascularization of the thyroid seems favorable for metastasis, high iodine content and rapid blood flow are factors that make metastatic settlement difficult. This case highlights the metastatic capacity of RCC, which can reach giant sizes exceeding 10 cm even after a long latent period of fifteen years. The greatest diagnostic challenge is that RCC morphologically mimics the clear cell variants of primary thyroid tumors. Consequently, in patients with a history of RCC, the possibility of metastasis must always be excluded in thyroid masses, even if decades have passed since the nephrectomy. In differential diagnosis, the use of specific markers such as PAX-8 and CD10 is vital to prevent incorrect radioactive iodine treatment and to determine the correct oncological surgical strategy. Appropriate surgical resection is the most effective method for providing local control and long-term survival in these cases.

Keywords: Renal cell carcinoma, thyroid metastasis, giant nodule, pathology

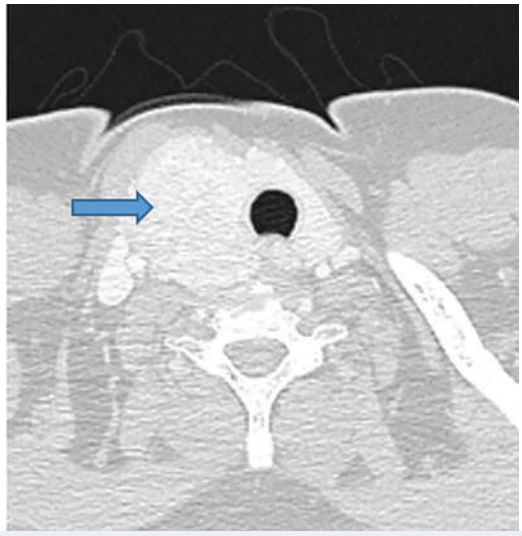

Figure 1. A 10 cm metastatic mass causing tracheal compression and deviation (axial CT scan).

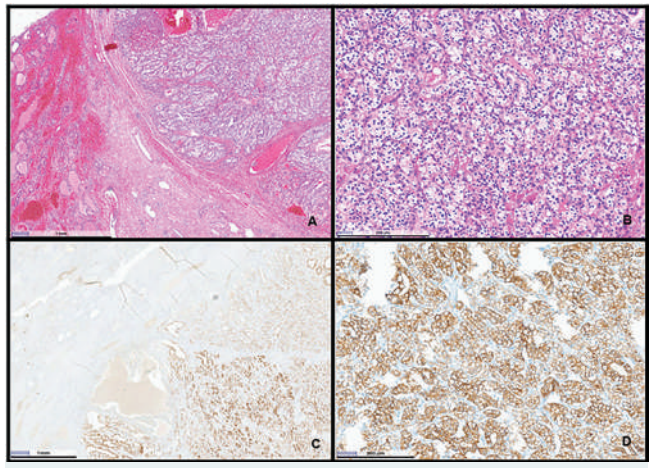

Figure 2. Metastasis of clear cell renal cell carcinoma showing a solid nodular pattern within the thyroid parenchyma (**A**). Tumor area consisting of clusters and sheets of cells with abundant clear cytoplasm belonging to clear cell renal cell carcinoma (**B**). Immunohistochemically, a positive immune reaction is observed in tumor cells with the RCC antibody. This antibody is negative in the thyroid parenchyma (**C**). The CA-IX antibody applied immunohistochemically shows a 'box-like' pattern of positive immune reaction in tumor cells (**D**).

[P-018]

Persistent hyperparathyroidism requiring three stage surgery

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Objective: Primary hyperparathyroidism is most commonly caused by a parathyroid adenoma and is typically cured with surgical treatment. However, in a subset of patients, biochemical remission cannot be achieved after surgery, resulting in persistent disease. The most frequent causes of persistent hyperparathyroidism include multiglandular disease, supernumerary glands, and ectopic parathyroid tissue. In such cases, reoperative neck surgery may be required, and accurate localization becomes crucial. We present a case requiring three-stage surgical intervention due to persistent hyperparathyroidism.

Material and Methods: A 42-year-old male patient presented to the emergency department with hypercalcemic crisis. Laboratory evaluation revealed a parathyroid hormone (PTH) level of 400 pg/mL. Serum calcium levels were approximately 20 mg/dL both preoperatively and between surgical interventions. Preoperative Imaging Before the First Surgery Tc-99m sestamibi parathyroid scintigraphy demonstrated MIBI retention in the posterior inferior aspects of both the right and left thyroid lobes, suggestive primarily of parathyroid pathology (adenoma/hyperplasia). Based on these findings, the patient underwent the first surgery, and the suspected parathyroid tissue was excised. The pathological specimen measured approximately 4×2×1.2 cm, consistent with parathyroid adenoma. Due to the absence of postoperative biochemical improvement, a second surgery was planned. Right total thyroidectomy and left superior parathyroidectomy were performed. Despite this intervention, serum calcium and PTH levels remained markedly elevated. Preoperative Imaging Before the Third Surgery Repeat parathyroid scintigraphy demonstrated focal increased uptake in the right upper paratracheal region, compatible with a parathyroid adenoma. Based on these findings, a third surgical exploration was undertaken.

Results: During the third operation, meticulous exploration revealed ectopic parathyroid tissue located between the esophagus and trachea. The ectopic gland was excised. Following the final surgery, serum PTH and calcium levels normalized, and the patient had an uneventful postoperative course.

Conclusion: In cases of persistent primary hyperparathyroidism where biochemical remission is not achieved after initial surgery, repeat localization studies are critically important. Cervical imaging modalities should be reassessed, and reoperative neck exploration should be carefully and systematically planned according to the obtained findings. With accurate localization and an experienced surgical approach, biochemical cure can be achieved.

Keywords: Hyperparathyroidism, parathyroid neoplasms

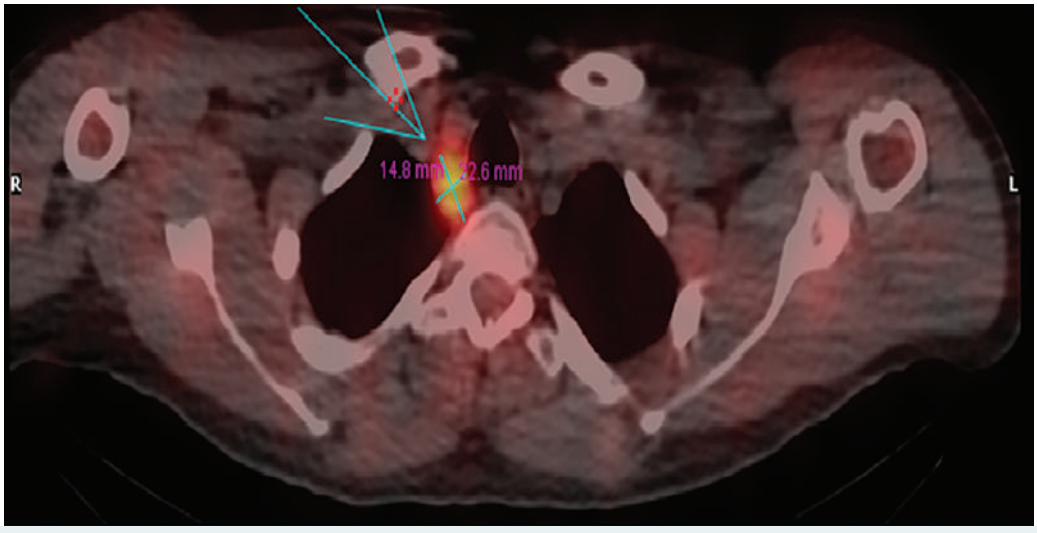

Figure 1. Scintigraphic image after the second surgery. Scintigraphy shows a focus consistent with parathyroid adenoma in the right paratracheal region.

[P-019]

Gallbladder duplication: A rare case report

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Objective: Congenital anomalies of the gallbladder are rare, and a wide range of anatomical malformations affecting its shape, size, number, and position have been described. Septate gallbladder is among the malformations that has not been well documented, because it is usually asymptomatic or discovered accidentally during the evaluation of jaundice or at postmortem examination. Variations in the cystic duct and vasculature in the portal triad have also not been well described. These anomalies are important to know for surgeons because of associated anatomical variations of main bile duct and hepatic artery and increased risk of common bile duct injury.

Results: We report the case of a double gallbladder in a forty-two year old man. He presented with recurrent episodes of biliary colic. Laboratory analysis of liver function was normal. Her blood values were within normal range. Preoperative ultrasound imaging confirmed the gallbladder filled with stones. There was no information about the number gallbladder, presence of septa, cystic arteries, and cystic ducts. A laparoscopic cholecystectomy was planned for the patient. During intraoperative exploration, anatomical variations were identified, including a double cystic artery and a double cystic duct. Due to these findings and concerns regarding operative safety, the procedure was converted to open surgery. Following a right subcostal incision, further exploration was performed. The common bile duct was identified and found to be normal. Two separate cystic ducts originating from the common bile duct and two cystic arteries arising from the hepatic artery were clearly visualized and carefully dissected. After precise identification of all biliary and vascular structures, a safe cholecystectomy was successfully completed without complications. Gross examination of the surgical specimen revealed a duplicated gallbladder separated by a septum. Histopathological evaluation confirmed the presence of a double gallbladder associated with double cystic duct and double cystic artery origins.

Conclusion: Duplication of the gallbladder is a rare congenital abnormality, which requires special attention to the biliary ductal and arterial anatomy. Accurate diagnosis and careful surgical planning are critical in managing double gallbladder cases to avoid iatrogenic injuries.

Keywords: Cholecystectomy, congenital malformation, double gallbladder

[P-020]

Distal pancreatectomy with en bloc celiac axis, partial superior mesenteric vein-portal vein resection and supraceliac aorta and common hepatic artery anastomosis with interposed saphenous vein graft case report

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Objective: Pancreatic ductal adenocarcinoma is an aggressive solid tumor where the 5-year survival rate rarely exceeds 10%, despite advances in surgical techniques and systemic therapies. Tumors located in the pancreas body and neck are often considered "locally advanced" at diagnosis due to their proximity to critical vascular structures like the celiac trunk (CTr). The modified Appleby procedure (distal pancreatectomy with en bloc celiac axis resection, DP-CAR) is an aggressive approach developed to improve survival in patients responding to neoadjuvant chemotherapy. This technique relies on retrograde hepatic perfusion provided by the superior mesenteric artery (SMA) via pancreaticoduodenal arcs and the gastroduodenal artery (GDA) to allow R0 resection. When this arc is insufficient, hepatic arterial revascularization is required.

Material and Methods: A 59-year-old female with hypertension presented with epigastric and back pain. Contrast-enhanced Computed Tomography revealed a 45x39 mm hypodense lesion in the pancreas body, invading the CTr branching level and causing splenic vein thrombosis. CA19-9 was 402 U/mL. Endoscopic ultrasonography confirmed that the mass invaded the CTr, as well as the splenic artery and vein. Biopsy confirmed pancreatic adenocarcinoma. Following 6 cycles of FOLFIRINOX, regression was observed. And modified Appleby procedure was planned. Preoperative celiac angiography demonstrated hepatic arterial flow via the GDA through the pancreatoduodenal arcade.

Results: During surgery, no metastases were observed. The tumor invaded the retroperitoneum and posterior stomach. Upon clamping the common hepatic artery (CHA), Doppler ultrasound showed arterial flow from the SMA to the liver via the GDA, but acceleration time was prolonged. Consequently, DP-CAR was performed alongside splenectomy, partial gastric resection, retroperitoneal lymph node dissection, and partial resection of the superior mesenteric vein (SMV) and portal vein (PV). An end-to-end anastomosis was performed between the distal SMV and proximal PV. Subsequently, an end-to-end anastomosis was created between the supraceliac aorta and the CHA using an interposed saphenous vein graft. Hepatic flow was confirmed via Doppler.

Conclusion: DP-CAR is a procedure that provides a survival advantage in selected patients with unresectable pancreatic cancer; however, it is associated with high morbidity and mortality rates. The most common causes of mortality are gastric/hepatic ischemia, and post-pancreatectomy hemorrhage. As DP-CAR is an invasive procedure, patients must be selected with extereme care. The feasibility of DP-CAR depends on the presence of adequate collateral flow to both the liver and the stomach to avoid ischemia. Therefore, it is essential to evaluate the patency of the GDA and the pancreatoduodenal arcade to determine the necessity of preoperative celiac axis embolization or arterial reconstruction.

Keywords: Arterial reconstruction, modified appleby procedure, pancreatic adenocarcinoma

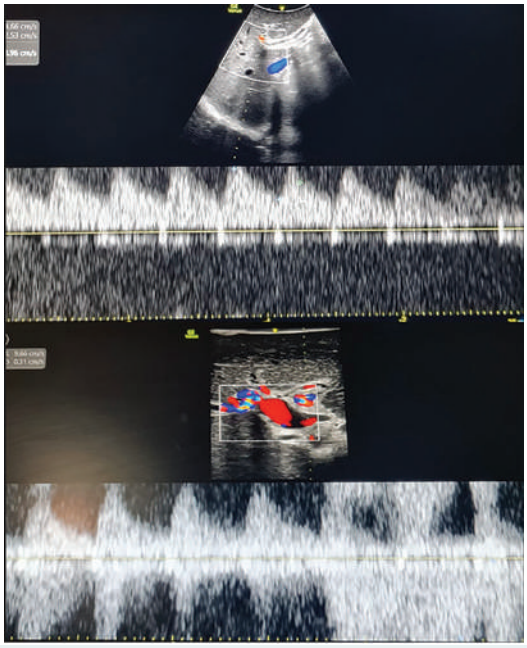

Figure 1. Intraoperative Doppler USG.

Intraoperative Doppler ultrasonography images: The upper image shows a prolonged acceleration time in the hepatic artery prior to anastomosis. The lower image demonstrates the restoration of normal arterial waveform and flow parameters following arterial reconstruction.

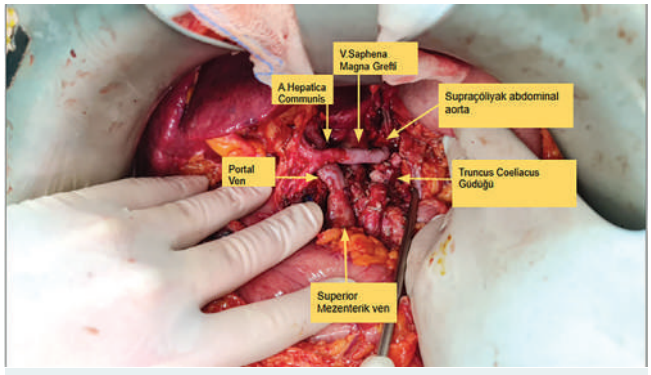

Figure 2. Intraoperative picture.

[P-024]

Ileal ureter reconstruction after long-segment ureteral resection due to recurrent sigmoid colon adenocarcinoma: A case report

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Objective: Long-segment ureteral defects may arise due to iatrogenic injury, radiation fibrosis, or malignancy. When the defect exceeds the limits suitable for primary anastomosis, Boari flap, or psoas hitch reconstruction, ileal ureter substitution becomes a viable alternative. Ileal ureter replacement was first introduced by Shoemaker in 1906 and later popularised by Goodwin in 1959. We present a case of recurrent sigmoid colon adenocarcinoma requiring long-segment ureteral resection and successful ileal ureter reconstruction.

Material and Methods: A 60-year-old male patient, who underwent anterior resection surgery for sigmoid colon adenocarcinoma four years prior, was diagnosed with moderately differentiated adenocarcinoma (pT3N2BM0) and received postoperative chemotherapy. Three years postoperatively, a local recurrence mass invading the left ureter was detected in the same area. Following a multidisciplinary evaluation, surgical resection was planned. During the operation, the tumor was found to infiltrate a long segment of the left ureter, and, in accordance with oncological principles, the affected ureteral segment along with the tumor was resected en bloc. Since primary ureteral anastomosis was not possible due to the length of the defect, continuity was achieved through ileal reconstruction (Figure 1).

Results: The postoperative course was uneventful. Renal function remained stable, and the patient was discharged uneventfully on postoperative day 16. In the 1st postoperative month, radiological examinations revealed that the anastomosis was intact (Figure 2).

Conclusion: Management of long-segment ureteral defects remains complex. Reconstruction options depend on defect length and location. Complete tumor excision must be balanced with preservation of renal function. Ileal ureter substitution provides a tension-free reconstruction in cases where alternative techniques are not feasible. In our case, the long-segment defect following oncologic resection precluded primary repair. Ileal substitution allowed restoration of urinary continuity without compromising oncologic principles. No early complications were observed. Ileal ureter reconstruction is a reliable option for extensive ureteral defects following oncologic resection of locally recurrent colorectal cancer. Multidisciplinary planning and meticulous technique are key to favourable outcomes.

Keywords: Ileal ureter, ureteral reconstruction, colorectal cancer recurrence

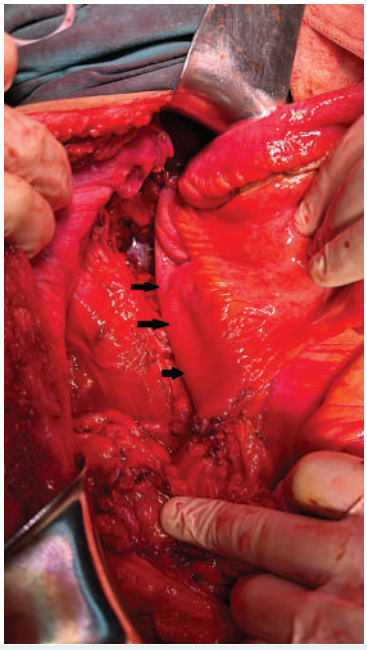

Figure 1. Transposed small intestine segment.

Figure 2. Postoperative magnetic resonance image (MRI) (the double J catheter placed in the ureter is clearly seen within the loop).

[P-033]

Emergency laparoscopic low anterior resection due to sigmoidal colon trauma secondary to high pressureized compressed air; case report

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Objective: Transanal insufflation with high-pressure compressed air is a rare but potentially life-threatening cause of colorectal barotrauma. Patients may rapidly develop severe abdominal pain, distension, pneumoperitoneum, and—if perforation occurs—fecal peritonitis. Injury most commonly involves the rectosigmoid region and sigmoid colon, and timely recognition with appropriate surgical management is critical to prevent morbidity and mortality.

Material and Methods: A 30-year-old man presented to the emergency department with abrupt-onset severe abdominal pain and marked distension that began approximately 2 hours after co-workers directed an industrial high-pressure air device toward his anal area over clothing as a practical joke. He reported no immediate anal pain or bleeding. He had no prior abdominal surgery, comorbidities, allergies, or regular medications. Vital signs were stable except for minimal tachypnea. Physical examination revealed diffuse abdominal tenderness with peritoneal signs. Digital rectal examination showed no bleeding or palpable rectal wall abnormality. Chest radiography showed no thoracic injury, while an abdominal radiograph demonstrated pneumoperitoneum. Abdominal CT revealed generalized free intraperitoneal air, prompting emergency diagnostic laparoscopy. Prior to abdominal surgery, anoscopy was performed and showed no laceration, hemorrhage, or rectal wall defect.

Results: Emergency laparoscopy revealed minimal hemorrhagic fluid in the pelvis without active bleeding and no fecal contamination. Multiple serosal defects (approximately 1-3 cm) were observed in about 15 areas involving the upper rectum and sigmoid colon; minimal hematomas were noted on the sigmoid appendices epiploicae without active hemorrhage. No pathology was identified in other colonic segments or solid organs. No clearly visible full-thickness perforation was identified intraoperatively; however, given the extent of serosal injury and the risk of occult perforation, laparoscopic low anterior resection was performed, selecting a secure distal margin beyond the rectal serosal defects. After specimen extraction with the proximal segment intact, intraluminal air insufflation of the resected segment confirmed a ~1 cm full-thickness perforation on the posterior aspect of the sigmoid colon. Resection was completed and a coloanal anastomosis was performed laparoscopically. The postoperative course was uneventful.

Conclusion: Colorectal barotrauma from high-pressure compressed air can produce extensive serosal injury and an occult perforation that may not be apparent on initial laparoscopic inspection. In hemodynamically stable patients without shock, significant fecal contamination, or major rectal destruction, laparoscopic resection with primary anastomosis can be an effective treatment option. Early diagnosis and prompt operative management are essential, and workplace safety measures are key to prevention.

Keywords: Colorectal barotrauma, compressed air, laparoscopic low anterior resection, pneumoperitoneum, sigmoid colon perforation

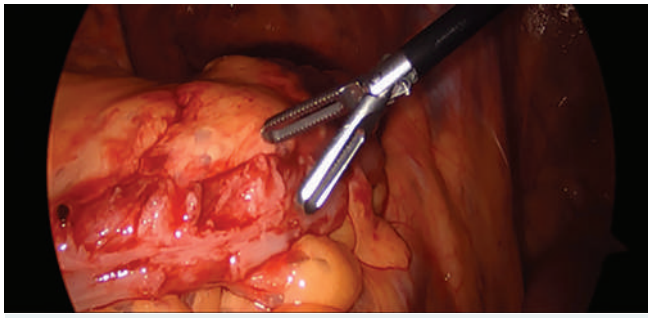

Figure 1. Along with the sigmoid colon, upper rectum and distal desending colon multiple serosal defects were observed. Intraoperative laparoscopic view demonstrating multiple serosal defects involving the sigmoid colon, upper rectum, and distal descending colon.

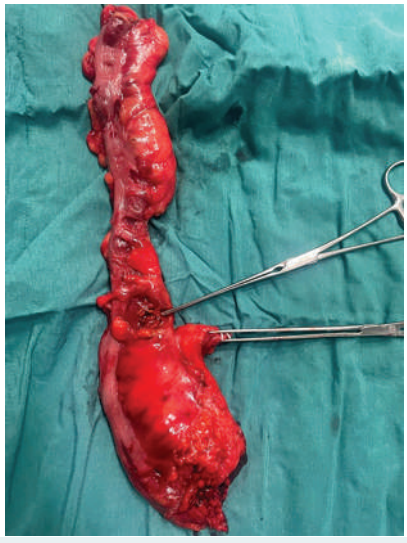

Figure 2. Gross appearance of the resected specimen demonstrating multiple serosal defects and the perforation site.

[P-034]

Small bowel intussusception secondary to colonic diverticular perforation: A rare cause of acute abdomen

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Objective: Adult intussusception is rare and usually associated with an underlying organic pathology. Invagination of a small bowel loop into the rectum is exceptionally uncommon. We present a case of acute abdomen caused by a strangulated small bowel loop protruding from the rectosigmoid junction into the rectum.

Material and Methods: A 75-year-old male presented with rectal bleeding, nausea, vomiting, and abdominal pain for three days. Physical examination revealed generalized guarding and rebound tenderness. Digital rectal examination detected hematochezia and a palpable mass. Laboratory tests showed leukocytosis (17,000/mm³) and elevated CRP (154 mg/L). CT demonstrated dilated small bowel loops and pelvic free fluid. Emergency rectosigmoidoscopy revealed a strangulated small bowel loop 5 cm from the anal verge.

Results: During emergency laparotomy, a 10-cm strangulated small bowel segment was found protruding through a diverticulitis-related perforation on the anterior rectosigmoid wall. After reduction, necrosis was identified and resected with anastomosis. Hartmann's procedure was performed. The patient was discharged on postoperative day five.

Conclusion: Although rare, small bowel intussusception into the rectum should be considered in patients presenting with rectal bleeding or prolapse-like symptoms. Early surgical intervention is essential to reduce morbidity and mortality.

Keywords: Intussusception, small bowel strangulation, colonic diverticular perforation

Figure 1. A small bowel loop observed on rectosigmoidoscopy.

Figure 2. A small bowel loop protruding from the rectosigmoid junction on computed tomography (CT).

[P-035]

Synchronous squamous cell carcinoma and adenoid cystic carcinoma of the breast: A rare case

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Objective: Squamous cell carcinoma (SCC), adenoid cystic carcinoma (ACC) of the breast are exceedingly rare histopathological subtypes among breast malignancies. Both tumors frequently demonstrate hormone receptor-negative profiles, their biological behavior and clinical course may differ significantly. The aim ofthis study is to present the clinical, pathological, and therapeutic features of a rarecase in which synchronous SCC and ACC of the breast were identified.

Material and Methods: A 41-year-old female patient presented to our clinic with a palpable breast mass. On physical examination, irregularly bordered mass measuring approximately 2 cm was detected in the right breast at the 1 o'clock position, located 3-4 cm from the areola. No additional pathology was identified inthe left breast or bilateral axillary regions. Mammography and ultrasonography revealed a solid lesion categorized as BI-RADS5. Tru-cut biopsy was performed, and the histopathological diagnosis was SCC. Staging work-up for distant metastasis was negative. Following multidisciplinary breast tumor board evaluation, the patient was scheduled for surgery. The patient underwent segmental mastectomy with SLNB in accordance with oncoplastic principles. Resection was performed with clear surgical margins, and the SLNB were reported as benign. However, histopathological examination of the surgical specimen revealed twodistinct tumor. In addition to SCC, ACC, a subtype of triple-negative breast cancer known for its favorable prognosis, was identified. Surgical margins were negative, and no metastasis was detected in the sentinel lymph nodes. Immunohistochemical analysis demonstrated that both tumor components were negative for ER-PR-HER2. Considering that breast-conserving surgery had been performed and taking into account the histopathological findings, the patient was referred for adjuvant radiotherapy. Chemotherapy was not administered due to negative surgical margins and absence of lymph node involvement. The decision regarding systemic therapy was made through a multidisciplinary evaluation based on patient characteristics and tumorbiology.

Results: SCC accounts for less than 0.1% of all breast cancers and is generally associated with an aggressive clinical course. In contrast, ACC, although rare in the breast, typically demonstrates an indolent clinical behavior and favorable prognosis. The synchronous presence of these two rare tumor types within the same breast has been reported only in a very limited number of cases inthe literature. Although both tumors may pose challenges in treatment planning, it is well recognized that ACC may exhibit a biological behavior distinct from that of conventional triple-negative breast cancers. Therefore, treatment strategies should not rely solely on immunohistochemical profiles but must also be individualized according to histopathological subtype and clinical characteristics. Given the potential for rapid progression in SCC, close postoperative surveillance is warranted in suchpatients. The coexistence of these two distinct tumor types further underscores the importance of a multidisciplinary approach in treatment planning.

Conclusion: Synchronous coexistence of SCC and ACC in the breast is an extremely rare condition. In this case, negative surgical margins were achieved with breast-conserving surgery, and the decision regarding adjuvant therapy was made based on the histopathological characteristics of the tumors. This case highlights the importance of managing the diagnostic, therapeutic process of rare breast tumors through a multidisciplinary approach.

Keywords: Squamous cell carcinoma, adenoid cystic carcinoma, breast cancer

[P-036]

Gestational gigantomastia: A rare pregnancy-related breast disorder

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Objective: Gestational gigantomastia (GG) is a rare condition characterized by excessive, often bilateral, breast tissue enlargement that usually appears toward the end of the first trimester of pregnancy. Patients typically present with rapid and extreme breast enlargement, back pain, dyspnea, mobility limitation, and breast skin complications such as pain, ulceration, bleeding, scaling, and sensory loss. Most affected patients are young, multiparous women without significant medical, surgical, or family history. Due to the severe impact on quality of life, surgical treatment is widely considered the gold standard. Medical therapies targeting hormonal effects include anti-estrogens and dopamine agonists, while diuretics and corticosteroids may reduce tissue and skin edema.

Material and Methods: A 24-year-old woman, approximately 24 weeks pregnant, presented to our breast surgery clinic with a 5-month history of rapid breast enlargement, back pain, and neck pain. She reported menarche at the age of 14, a 12 pack-year smoking history, and a diagnosis of multiple sclerosis with cervical spinal involvement. There was no significant family history of malignancy. On physical examination, the breasts were markedly enlarged, symmetrical, and tender, with edematous skin. Breast ultrasonography revealed dilated superficial veins, bilateral ductal ectasia, numerous bilateral anechoic cysts, and a few benign-appearing solid lesions. Considering her pregnancy and personal preference, an initial conservative approach with close follow-up was adopted.

Results: Three months later, the patient delivered a healthy infant. Postpartum evaluation considered cabergoline (a D2 receptor agonist) and tamoxifen 20 mg/day for three months; however, due to the persistence of severe symptoms, surgical treatment was chosen. Bilateral reduction mammoplasty was performed using a superomedial pedicle technique, and the nipple-areolar complexes were prepared as grafts. The excised tissue measured 29.5×18.5×5 cm from the right breast and 30×19.5×4.5 cm from the left breast. Histopathological examination revealed dilated cutaneous lymphatics, stromal edema, fibrosis, and fibroadenomas. The postoperative course was uneventful, and the patient was discharged on the second postoperative day.

Conclusion: While medical therapy may be considered in the management of gestational gigantomastia, surgical intervention remains the definitive treatment in the majority of patients with advanced breast enlargement, providing effective and lasting symptom relief.

Keywords: Gestational gigantomastia, macromastia, reduction mammoplasty

Figure 1. Macromastia. Macromastia at the time of presentation.

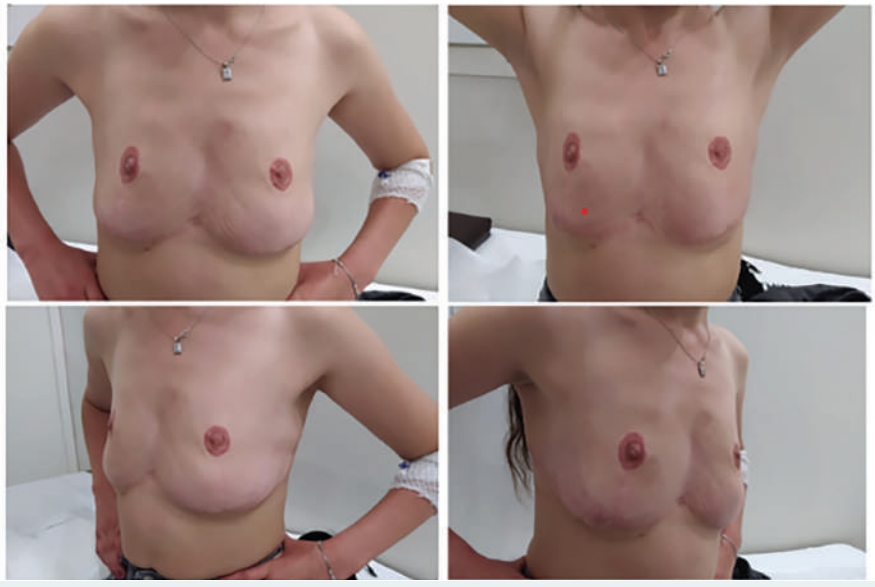

Figure 2. Post-op. Reduction of breast volume following surgery.

[P-037]

A rare lesion mimicking malignancy: Two cases of syringomatous tumor of the nipple

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Objective: Syringomatous tumor of the nipple is a rare benign neoplasm with locally infiltrative behavior. It is most commonly observed in young and middle-aged women. Because it can clinically and radiologically mimic malignancy, definitive diagnosis relies on histopathological examination. Wide local excision is recommended for treatment. We aimed to present two cases diagnosed in our clinic.

Material and Methods: Case 1A 40-year-old female patient presented with discharge from the left nipple. Ultrasonography revealed dense microcalcifications in the left nipple. Parenchymal distortion was observed in the periareolar region at the 12 o'clock position of the left breast. In the left axilla, 2-3 lymph nodes measuring 12.5×6 mm with preserved central hilum and mildly thickened cortex were detected. Breast magnetic resonance imaging (MRI) demonstrated intense contrast enhancement in the left nipple and retroareolar region, along with diffusion restriction in a 15×9 mm area. Radiologically, the findings were suspicious for malignancy. Tru-cut biopsy findings, when evaluated together with the retroareolar localization of the lesion, were primarily consistent with "Syringomatous Tumor of the Nipple". Case 2A 70-year-old female patient presented with retraction of the left nipple. Mammography demonstrated a 7.5 mm low-density nodular opacity located 14 mm from the nipple (BI-RADS 0). Breast MRI revealed a relatively irregularly marginated heterogeneous solid mass measuring 32×27 mm in the retroareolar region of the left breast, causing nipple retraction (BI-RADS 4C). Histopathological examination of biopsy sections showed an infiltrative pattern composed of squamous differentiation and syringomatous structures within a collagenized spindle-cell stroma. The histopathological findings were considered in the differential diagnosis of "Low-Grade Adenosquamous Carcinoma (Metaplastic Carcinoma)" and "Syringomatous Tumor of the Nipple".

Results: Both patients underwent lumpectomy. The excised surgical specimens were submitted for histopathological evaluation. Final pathology in both cases confirmed syringomatous tumor of the nipple. Surgical margins were negative in both patients.

Conclusion: Syringomatous tumor of the nipple is a rare benign neoplasm with locally infiltrative characteristics that frequently mimics invasive carcinoma clinically and radiologically. Although perineural invasion may be observed, no metastatic potential has been reported. Complete excision with negative surgical margins is curative. Accurate histopathological evaluation is crucial to prevent unnecessary radical surgery.

Keywords: Syringomatous tumor of the nipple, nipple discharge, retraction of the nipple

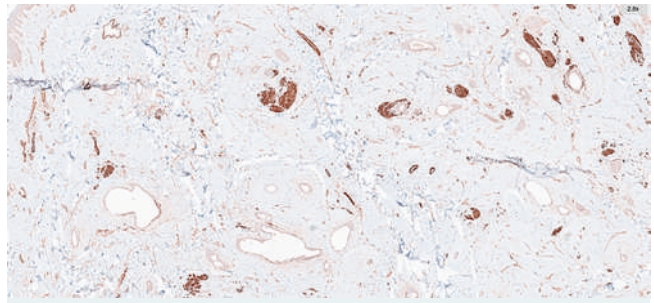

Figure 1. Lumpectomy material.

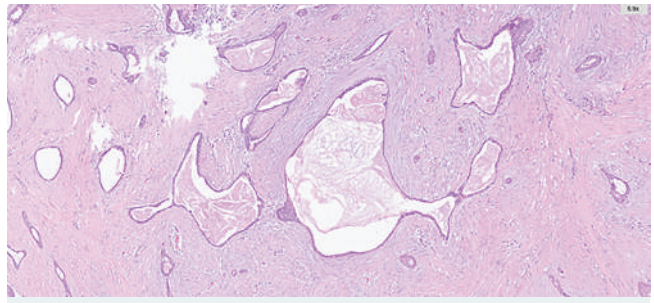

Figure 2. Lumpectomy material.

[P-038]

A rare form of goiter: Amyloid goiter - case presentation

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Objective: Amyloid goiter is characterized by the accumulation of an insoluble protein formed as a result of abnormal folding called amyloid, leading to a marked enlargement of the thyroid gland. The definitive diagnosis is made by pathological evaluation. Thyroid malignancies should be excluded in the differential diagnosis. Immunohistochemical evaluation should be performed to determine the subtype of the accumulated amyloid. Amyloid goiter rarely occurs as an isolated condition; there is usually an underlying systemic disease. Primary amyloidoses are associated with plasma cell dyscrasias, while secondary amyloidoses are associated with FMF, RA, chronic osteomyelitis, tuberculosis and IBD. The incidence of amyloid goiter is remarkably high in patients who develop amyloidosis associated with FMF and undergo hemodialysis due to renal failure.

Material and Methods: In this case, the diagnosis, treatment and follow-up process of a patient who underwent bilateral total thyroidectomy and tracheostomy due to amyloid goiter at our clinic was evaluated.

Results: A 44-year-old patient with known HT, FMF and secondary amyloidosis-related renal failure who underwent renal transplantation two years ago experienced sudden cardiac arrest at home. After 30 minutes of CPR, the patient was intubated and placed on inotropic support in the intensive care unit for follow-up during the post-CPR period. A tracheostomy was planned, but due to a massive goiter in the neck, the tracheostomy could not be performed and a thyroidectomy was planned instead. A neck ultrasound performed prior to thyroidectomy revealed solid nodules filling both lobes almost completely and intermingling with each other. A neck CT scan showed a deviated trachea to the left and a multinodular goiter appearance. The patient underwent bilateral total thyroidectomy and a tracheostomy was performed. The patient died on the 4th postoperative day due to general deterioration. Widespread amyloid deposition was observed in the examined thyroidectomy material.

Conclusion: Patients typically present with a progressive and rapidly advancing, hard, painless mass in the neck. Secondary to compression, dyspnea, dysphagia and dysphonia may occur. The vast majority of patients are euthyroid. Ultrasound, CT and MRI can be used as imaging methods. The primary and most effective treatment for amyloid goiter is thyroidectomy. There are three main strategies in treatment: relieving compression symptoms, establishing a definitive histopathological diagnosis and most importantly, managing the underlying disease. Amyloid goiter is rare but has an important place in clinical practice because it is a harbinger of an underlying systemic disease. Amyloid goiter may not only be a disease of the thyroid but also a potential indicator of a systemic process requiring a multidisciplinary approach.

Keywords: Amyloid, goiter, thyroidectomy

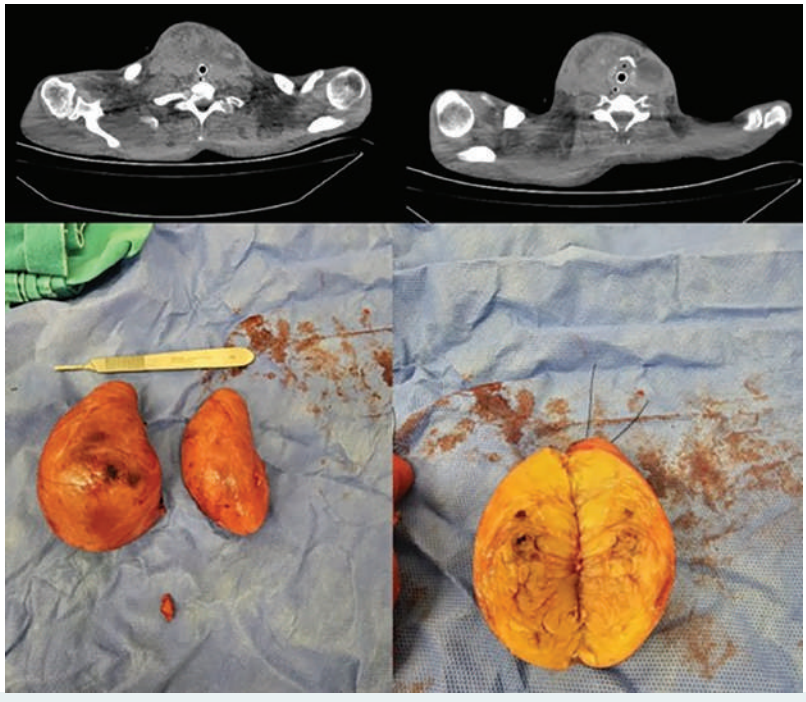

Figure 1. Preoperative CT scan and surgical specimen.

[P-039]

Delayed tracheal perforation after retrosternal thyroid surgery: A rare complication

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Objective: Thyroidectomy is a widely performed and generally safe surgical procedure for treating both benign and malignant thyroid diseases. While common complications include vocal-cord paralysis, hypoparathyroidism, hypocalcemia, and cervical hematoma, tracheal injuries are exceedingly rare, occurring in only approximately 0.06% of cases. Tracheal damage is typically identified and repaired intraoperatively. However, "delayed" tracheal necrosis and perforation arising from prolonged mechanical compression, tissue ischemia, or secondary infection carry significant morbidity risks. This report discusses a rare case of delayed perforation developing on the 11th postoperative day in a patient operated on for a giant- retrosternal goiter and its subsequent conservative management.

Material and Methods: A 49-year-old male presented with a heterogeneous thyroid mass showing significant retrosternal extension. Preoperative CT imaging revealed that the lesion displaced the trachea to the right, extended to the first-degree branches of the aorta in the mediastinum, and narrowed the tracheal lumen to approximately 10 mm. The patient underwent bilateral total thyroidectomy, and no complications were observed during the early postoperative period. However, on the 11th postoperative day, following an uncontrolled coughing fit, the patient returned with complaints of discharge and air-leakage from the cervical incision line. Physical examination revealed significant mobility of the neck skin flaps during expiration and air leakage synchronized with respiration. A fistula tract of approximately 2 cm was observed on the Kocher incision scar (Figure 1).

Results: Flexible laryngoscopic evaluation showed the left vocal-cord fixed in a paramedian position, while the right vocal-cord remained mobile. Radiological assessment identified a tracheal defect accompanied by pneumonia foci in the right lung (Figure 2). A conservative treatment plan was implemented instead of surgical revision: rifampicin and boric acid powder were applied to the incision line. Air-leakage was controlled using a pressure bandage with a sterile gauze-ball placed over the defect. Broad-spectrum intravenous antibiotic therapy was administered for 10 days. The patient was discharged following clinical improvement monitored through daily dressing changes. Long-term follow-up revealed no development of tracheal strictures or permanent hoarseness. The pathology report was "multifocal papillary microcarcinoma limited to the thyroid".

Conclusion: Delayed tracheal necrosis and perforation is an extremely rare but potentially life-threatening complication following thyroidectomy. In cases with preoperative tracheal compression, preventing intraoperative vascular and thermal damage is vital. Vigilance is required for signs such as sudden-onset dyspnea, subcutaneous emphysema, or air-leakage from the incision line postoperatively. Early diagnosis, aggressive infection control, and a multidisciplinary approach can yield successful outcomes with conservative treatment in selected cases.

Keywords: Thyroidectomy, tracheal perforation, retrosternal goiter

Figure 1. Clinical appearance. A 2-cm fistula tract on the Kocher incision line and skin changes consistent with active air leakage, developing after an uncontrolled coughing fit on the 11th postoperative day.

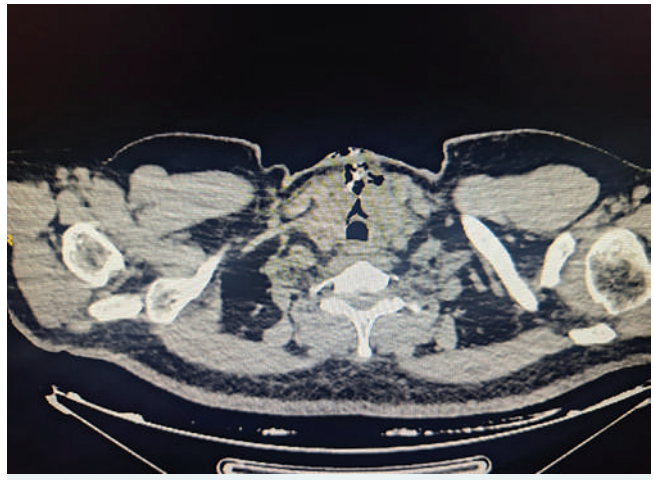

Figure 2. Radiological appearance. Axial neck CT scan showing disruption of tracheal lumen integrity (perforation) and emphysema consistent with air leakage into adjacent soft tissue planes.

Figure 3. Excised fistula tract.

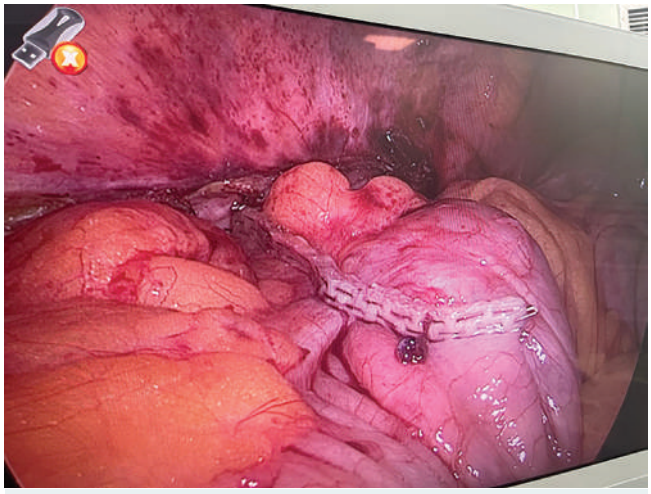

Figure 4. Intraoperative image. Appearance of colon loops and surgical site after excision of fistula tract.

[P-040]

Late-onset enterocutaneous fistula and recurrent retroperitoneal abscesses following spilled gallstones during laparoscopic cholecystectomy: A rare case report

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Objective: Iatrogenic gallbladder perforation and the subsequent spilling of gallstones into the peritoneal cavity is an intraoperative complication reported in up to 40% of laparoscopic cholecystectomy (LC) cases. Although these stones usually remain asymptomatic, they can cause serious morbidity, such as abscesses, foreign body granulomas, or complex fistulizations years later, particularly in patients with immune-modifying comorbidities like diabetes mellitus. This report discusses the surgical management of a rare case presenting with a retroperitoneal abscess and enterocutaneous fistula seven years after an LC procedure.

Material and Methods: A 44-year-old male with insulin-dependent diabetes mellitus presented with purulent drainage in the right lumbar region and a history of recurrent intra-abdominal abscesses. His medical history revealed gallbladder perforation and spilled stones during an LC in 2017. MRI findings showed 1.5 cm loculated abscess foci extending to the psoas muscle posterior to the right kidney, fistula tracts opening to the skin at the L3-L4 levels, and a mesenteric abscess focus adjacent to the anterior left lobe of the liver. A multidisciplinary operation was performed by general surgery and orthopedics teams. Laparoscopic exploration identified an enterocutaneous fistula line between the colon and the peritoneum, which was resected using a 45 mm endo-GIA. Subsequently, the patient's position was changed to excise the lumbar fistula tract and debride necrotic tissues near the psoas. Following a progressive oral intake protocol, the patient was discharged recovered on the 16th postoperative day. At the one-month follow-up, the patient remained asymptomatic with complete healing.

Results: Literature indicates that symptoms arising from "lost gallstones" can manifest up to 20 years postoperatively; the 7-year latent period in our case supports this data. The migration of stones into the retroperitoneal space can lead to challenging conditions like psoas abscesses and enterocutaneous fistulas. In diabetic patients, impaired leukocyte function enhances the tendency for foreign body reactions to combine with infection, facilitating fistulization. While MRI is the gold standard for mapping tracts, definitive treatment requires the complete surgical excision of all stones and the fistula tract rather than simple drainage.

Conclusion: Spilled gallstones represent a rare but significant source of morbidity that can present as complex fistulas years after surgery. For clinical success, it is critical to meticulously document intraoperative stone spillage, thoroughly investigate surgical history in chronic fistula cases, and implement early postoperative enteral nutrition to optimize healing.

Keywords: Enterocutaneous fistula, laparoscopic cholecystectomy, lost gallstones

Figure 1. Enterocutaneous fistula. Excised fistula tract, intraoperative image.

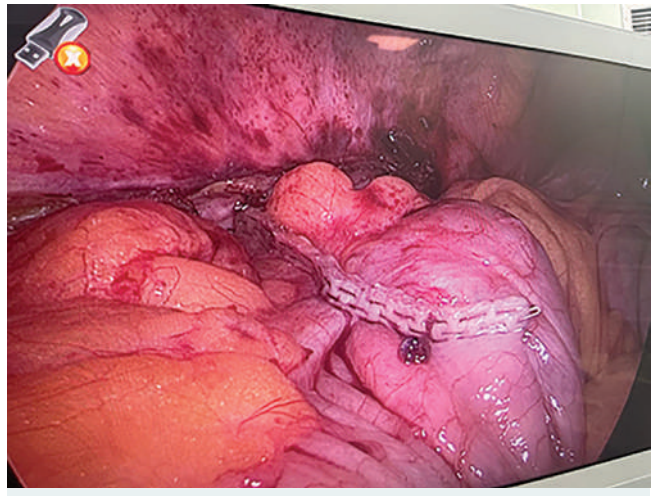

Figure 2. Appearance of the colonic loops and the operative bed following excision of the fistula tract.

[P-057]

Splenic abscess due to *Brucella melitensis* mimicking a malignant cystic lesion: A challenging diagnostic case

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Objective: Splenic abscess is a rare but potentially life-threatening clinical condition. In endemic regions, *Brucella* species should always be considered among infectious etiologies. However, radiological findings and elevated tumor marker levels may mimic malignant splenic lesions and complicate the diagnostic process.

Material and Methods: This is a case report of a splenic abscess caused by *Brucella melitensis* mimicking a malignant cystic lesion.

Results: A 26-year-old male patient presented with complaints of fever and abdominal pain. Laboratory investigations revealed elevated inflammatory markers and markedly increased CA 19-9 levels. Imaging studies demonstrated a large, thick-walled cystic lesion originating from the spleen; the lesion was initially considered compatible with a hydatid cyst or mucinous neoplasm. Endoscopic ultrasound-guided fine-needle aspiration yielded necrotic and infected material. Microbiological culture grew *Brucella melitensis*. Due to the large size of the lesion, its close relationship with adjacent organs, and persistent suspicion of malignancy, the patient underwent laparoscopic splenectomy and cyst excision. The postoperative course was uneventful.

Conclusion: This case demonstrates that splenic abscesses secondary to brucellosis may closely mimic malignant cystic splenic lesions both radiologically and biochemically, particularly in the presence of markedly elevated tumor markers. CA 19-9 levels can be significantly elevated in infectious and inflammatory processes and should not be interpreted as definitive evidence of malignancy. In endemic areas, brucellosis must be included in the differential diagnosis of cystic splenic lesions. In selected patients, surgical management provides both definitive diagnosis and effective treatment and remains a safe therapeutic option. Splenic abscesses due to brucellosis may mimic malignant cystic lesions in terms of both radiological and laboratory findings. Elevated tumor marker levels do not always indicate malignancy. In selected cases, surgical treatment remains a safe and definitive approach.

Keywords: Splenic abscess, brucellosis, CA 19-9, cystic splenic lesions

[P-058]

Chronic self-inflicted rectal trauma leading to superior rectal artery pseudoaneurysm: Successful endovascular management in an elderly patient on antiplatelet therapy

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Objective: Superior rectal artery pseudoaneurysm (SRAP) is an extremely rare but potentially life-threatening cause of lower gastrointestinal bleeding. Reported etiologies include pelvic trauma, colorectal interventions, inflammatory processes, and radiation injury. Because of its rarity, diagnosis may be delayed. Contrast-enhanced computed tomography angiography (CTA) and digital subtraction angiography are essential for early detection. Endovascular embolization has increasingly replaced surgical intervention in hemodynamically stable patients. We present a case of SRAP secondary to chronic repetitive rectal trauma and provide a focused review of previously reported cases.

Material and Methods: A single-patient case was retrospectively analyzed, including clinical presentation, imaging findings, interventional procedure details, and follow-up outcomes. Additionally, a focused literature review of reported SRAP cases between 2000 and 2024 was performed using PubMed-indexed publications to evaluate etiology, management strategies, and outcomes.

Results: An 82-year-old male presented with acute massive rectal bleeding. His medical history included hypertension, coronary artery disease, previous coronary artery bypass grafting, pacemaker implantation, and ongoing clopidogrel therapy. He reported a 3-4-year history of chronic constipation and repetitive manual rectal evacuation using a metallic spoon. CTA demonstrated a 5-mm pseudoaneurysm arising from a distal branch of the left superior rectal artery. Selective angiography confirmed the lesion, and coil embolization was successfully performed. Hemostasis was achieved without ischemic complications. The literature review identified fewer than 20 reported SRAP cases. Most were associated with trauma or iatrogenic injury. Endovascular embolization demonstrated high technical success with low complication rates, whereas surgical management was reserved for unstable patients.

Conclusion: SRAP should be considered in patients with acute rectal bleeding, particularly in the presence of chronic rectal trauma or antiplatelet therapy. CTA enables rapid diagnosis. Selective coil embolization is a safe and effective first-line treatment. Awareness of this rare entity may reduce diagnostic delay and improve outcomes.

Keywords: Superior rectal artery pseudoaneurysm, lower gastrointestinal bleeding, endovascular coil embolization, computed tomography angiography

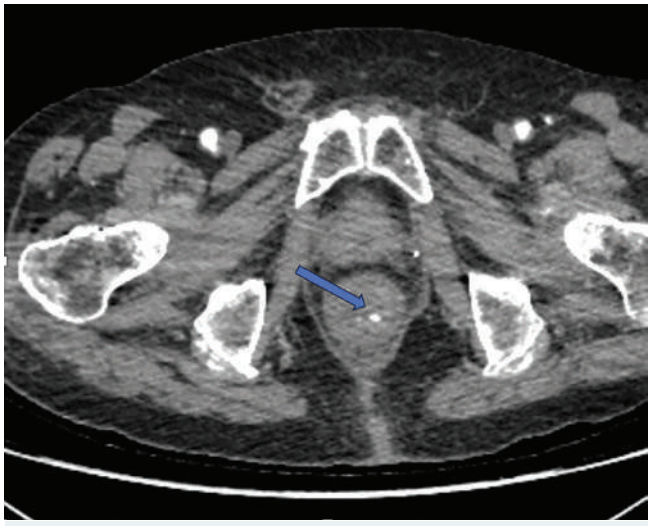

Figure 1. Contrast-enhanced CTA at admission. Demonstrating a 5-mm pseudoaneurysm arising from a distal branch of the left superior rectal artery (arrow), identified as the source of active lower gastrointestinal bleeding.

Figure 2. Pre-embolization digital subtraction angiography. Inferior mesenteric artery confirming the pseudoaneurysm in the distal branch of the superior rectal artery (arrow) prior to endovascular treatment.

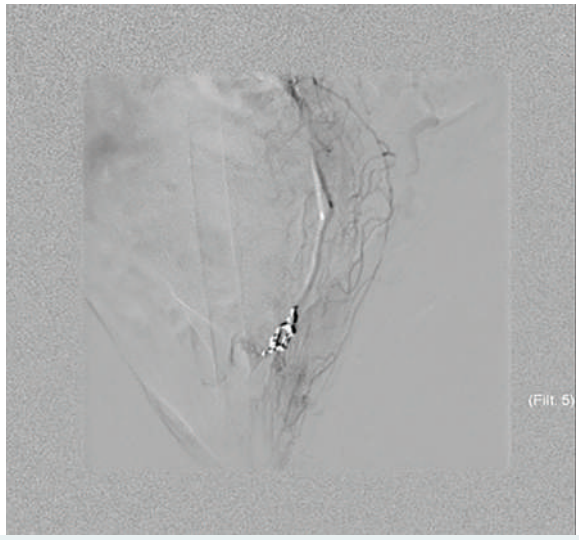

Figure 3. Post-embolization digital subtraction angiography. Complete occlusion of the pseudoaneurysm following selective coil embolization, with preservation of distal collateral perfusion and no evidence of contrast extravasation.

[P-059]

Rectal mass presenting at young age: Diffuse high-grade B-cell non-Hodgkin lymphoma

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Objective: Non-Hodgkin lymphoma (NHL) is a malignancy primarily affecting lymph nodes but capable of extranodal involvement. The gastrointestinal system is the most common extranodal site, although rectal involvement is rare and often clinically mistaken for adenocarcinoma. This case report presents diffuse high-grade B-cell NHL initially manifesting with constipation and bleeding.

Material and Methods: A 23-year-old male patient presented with lower gastrointestinal bleeding and constipation. Physical examination and colonoscopy were performed. Biopsies were obtained from the rectal lesion and sent for histopathological examination. Staging was completed with cross-sectional imaging and PET-CT. Clinical, endoscopic, pathological, and radiological findings led to diagnosis, followed by multidisciplinary tumor board evaluation of treatment options.

Results: History revealed fever, fatigue, night sweats, and 10 kg weight loss over two months. Physical examination identified multiple lymph nodes (>1 cm) in bilateral cervical, axillary, and inguinal regions. Digital rectal examination detected a posteriorly localized, mucosa-elevating, relatively smooth-surfaced, bleeding mass occupying half the lumen in the lower and middle third of rectum. Tumor marker CA 125 was elevated (62 U/mL, n <30). Computed tomography revealed multiple enlarged lymph nodes in thoracic, abdominal, and pelvic regions, with an approximately 11 cm mediastinal mass lesion consistent with widespread lymphomatous involvement. Rectal protocol MRI staged the tumor as cT4bN2bM1. Histopathological examination of biopsy material showed diffuse infiltration by atypical lymphoid cells. Immunohistochemical analysis confirmed high-grade B-cell NHL diagnosis, and the patient was referred to medical oncology.

Conclusion: Presentation of diffuse high-grade B-cell NHL as a rectal mass in young patients is extremely rare. This case emphasizes that lymphoma should be considered in the differential diagnosis of rectal tumors.

Keywords: Non-Hodgkin lymphoma, rectal neoplasm, lower gastrointestinal bleeding

[P-060]

A rare diagnostic dilemma after breast-conserving surgery: Differential diagnosis of titanium clip-induced hypersensitivity reaction and radiation dermatitis

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Objective: Marking the tumor bed with titanium clips following breast-conserving surgery (BCS) is a standardized procedure to facilitate accurate target volume definition and precision of the boost dose in adjuvant radiotherapy (RT). Titanium is widely preferred in medical implants due to its biocompatibility and favorable biomechanical properties. However, emerging literature suggests that these clips may trigger localized type IV delayed-type hypersensitivity reactions, particularly in patients with nickel cross-reactivity or specific metal sensitivities. The clinical presentation often overlaps with post-RT radiation dermatitis or cellulitis, posing a significant diagnostic challenge for clinicians.

Material and Methods: A 62-year-old female patient presented with a 17 mm mass in the lower-inner quadrant of the right breast. Following BCS and sentinel lymph node biopsy, histopathological analysis revealed a stage I (pT1N0M0) mixed invasive ductal carcinoma with a 90% mucinous component (ER+, PR+, CerbB2: +1). Four titanium clips were placed in the excision cavity during surgery. The patient, who reported a history of contact dermatitis to non-gold metals, received hypofractionated RT (40 Gy in 15 fractions to the whole breast plus a 10 Gy boost) starting four weeks post-surgery. Following RT, persistent erythema, induration, and increased local temperature were observed at the operative site.

Results: Initial treatments targeting radiation dermatitis and infection, including topical/systemic steroids and antibiotics, yielded no clinical improvement. Subsequent dermatological evaluation via patch testing revealed a strong positive reaction to nickel sulfate. The clinical condition was interpreted as a secondary allergic reaction to the titanium clips (possibly due to trace nickel content or titanium itself). Consequently, surgical intervention was planned. The clips were localized using stereotactic wire guidance and surgically excised. Postoperatively, the patient's symptoms rapidly regressed, and complete clinical resolution was achieved. The patient remains on hormonal therapy (letrozole).

Conclusion: This case underscores the necessity of a multidisciplinary approach in managing chronic skin reactions following BCS. In cases of "radiation dermatitis" that remain refractory to standard therapies and are localized to the surgical site, hypersensitivity to implanted metallic materials must be considered in the differential diagnosis. For patients with a known history of metal allergy, utilizing biopolymer clips or alternative marking techniques during surgical planning may minimize the risk of such complications.

Keywords: Breast cancer, titanium clip hypersensitivity, nickel allergy, radiation dermatitis, surgical excision

Figure 1. Clinical appearance of marked erythema and local inflammation in the surgical field following radiotherapy, refractory to standard treatments.

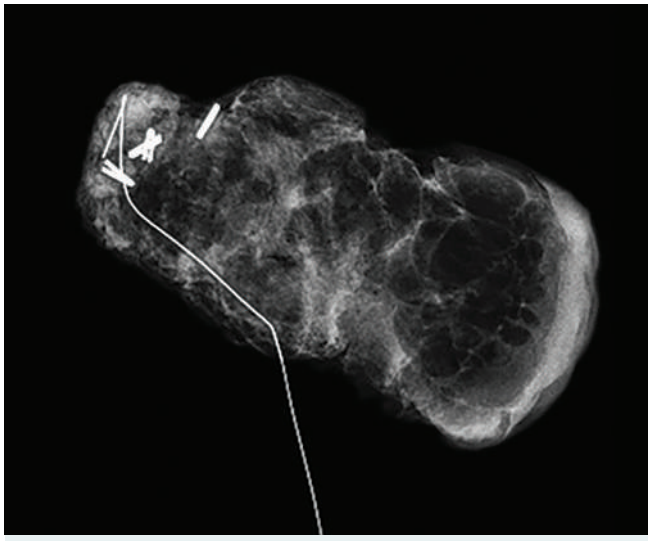

Figure 2. Mammographic image showing stereotactic wire localization of the titanium clips for surgical excision as the source of the allergic reaction.

[P-062]

Gastric fistulization into a mastectomy site: A rare and challenging clinical entity

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Objective: Gastrocutaneous fistulas are rare but serious complications typically associated with surgery, malignancy, or interventional procedures. A gastro-mammary fistula draining into a mastectomy site represents an exceptionally rare clinical entity. We present an unusual case with a complex clinical course.

Material and Methods: An 81-year-old female patient underwent modified radical mastectomy for invasive breast cancer approximately 4.5 years earlier, followed by adjuvant chemotherapy and radiotherapy. About 1.5 years prior, percutaneous radiofrequency ablation was performed for liver metastasis. Following the procedure, the patient experienced recurrent hospitalizations due to abdominal pain and abscess formation at the mastectomy site. During the most recent admission, discharge resembling gastric contents was observed from the mastectomy site. Contrast-enhanced computed tomography demonstrated a fistulous tract between the stomach and the mastectomy scar region. The patient was transferred to the general surgery department and evaluated in a multidisciplinary setting.

Results: Due to advanced age and comorbidities, endoscopic management was initially preferred. Endoscopic clipping of the internal fistula opening was attempted but was unsuccessful. Subsequently, placement of a percutaneous endoscopic gastrostomy tube through the fistula tract was performed to achieve controlled fistula drainage; however, leakage persisted. Surgical intervention was therefore undertaken, consisting of gastric wedge resection and wound debridement. On postoperative day three, the patient developed sudden cardiac arrest and was declared deceased despite resuscitative efforts.

Conclusion: Gastro-mammary fistula is an extremely rare and challenging clinical condition. Prior surgical history and interventional procedures may contribute to fistula development. Advanced age and comorbidities significantly influence treatment decisions. A multidisciplinary approach is essential in the management of such atypical fistulas.

Keywords: Gastrocutaneous fistula, breast cancer, radiofrequency ablation

[P-063]

Occult papillary thyroid carcinoma lymph node metastasis detected during surgery for tertiary hyperparathyroidism: A case report

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Objective: Papillary thyroid carcinoma (PTC) is generally a malignancy with a favorable prognosis; however, in some cases, it may present with lymph node metastasis without a clinically detectable primary tumor. Particularly in immunosuppressed patients, the tumor biology has been reported to exhibit a more aggressive course. The detection of occult PTC during neck surgeries performed for tertiary hyperparathyroidism is extremely rare. In this case report, we present a PTC lymph node metastasis incidentally identified within parathyroidectomy specimens in a renal transplant recipient.

Material and Methods: A 43-year-old female patient had a history of cadaveric renal transplantation in January 2025. She was diagnosed with tertiary hyperparathyroidism due to persistent hypercalcemia refractory to medical therapy and markedly elevated parathyroid hormone levels. High-resolution thyroid ultrasonography demonstrated a 5×4 mm hypoechoic nodule with punctate microcalcifications in the right thyroid lobe, categorized as TIRADS 7. Parathyroid scintigraphy revealed a hyperfunctioning parathyroid lesion located in the inferior region of the left thyroid lobe, consistent with parathyroid adenoma or hyperplasia. The patient subsequently underwent subtotal (3/4) parathyroidectomy with concomitant excision of the thyrothymic ligament.

Results: Histopathological examination revealed parathyroid hyperplasia in the right superior and left parathyroid glands. In the tissue specimens labeled as the right inferior parathyroid gland, four metastatic lymph nodes were identified, the largest measuring 5 mm in diameter. The lymph nodes exhibited morphological features consistent with PTC, including the presence of psammoma bodies, and extranodal extension was observed in one lymph node. An additional lymph node containing psammomatous calcifications within the thyrothymic ligament was also considered metastatic. Immunohistochemical analysis demonstrated positivity for TTF-1 and HBME-1. Postoperative histopathological evaluation revealed that the specimen submitted as the right inferior parathyroid gland contained metastatic lymph nodes. Additionally, a lymph node identified within the thyrothymic ligament specimen exhibited psammomatous-type calcifications and was therefore considered metastatic. Hyperfunctioning parathyroid tissue is observed in the area corresponding to the left inferior parathyroid lodge.

Conclusion: Although central lymph node metastasis is not uncommon in cases of occult PTC, the presence of multiple metastatic lymph nodes with extranodal extension in the absence of an identifiable primary tumor is noteworthy. In renal transplant recipients, chronic immunosuppression has been implicated in the development of more aggressive tumor biology in differentiated thyroid carcinomas, potentially contributing to advanced nodal disease at presentation. This case underscores the critical importance of meticulous histopathological examination of all surgical specimens obtained during surgery for tertiary hyperparathyroidism and highlights that occult thyroid malignancies in immunosuppressed patients may present with clinically significant metastatic disease.

Keywords: Occult thyroid cancer, papillary thyroid carcinoma, tertiary hyperparathyroidism

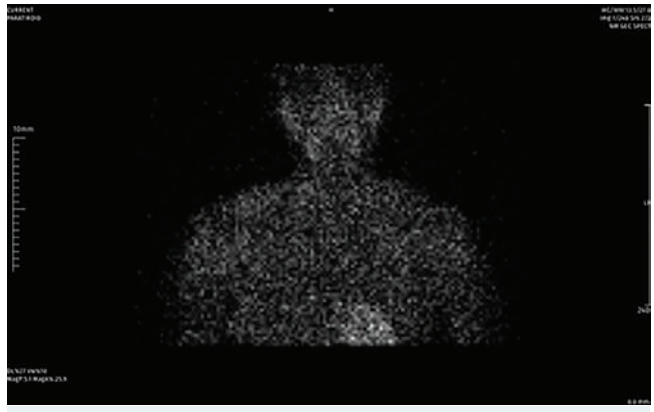
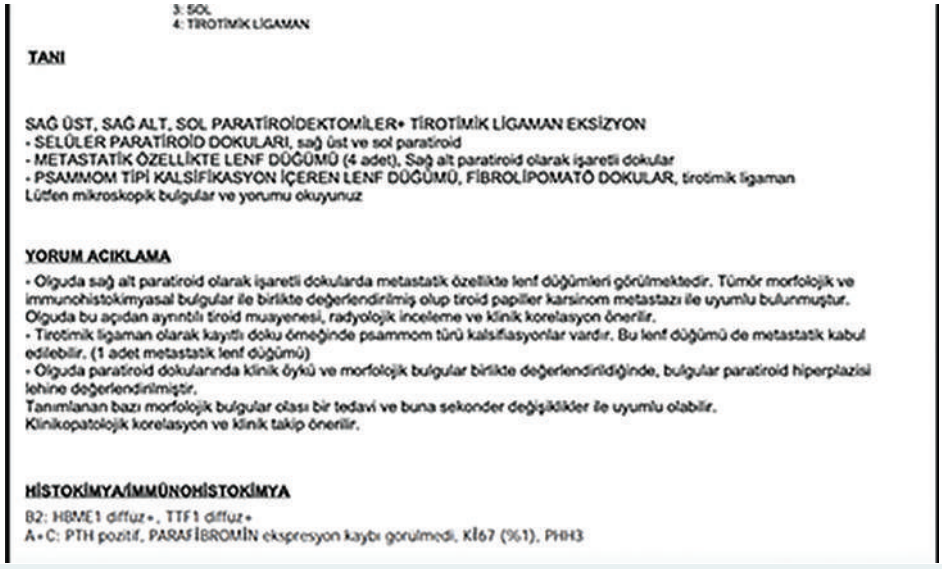


Figure 1. Preoperative Tc-99m MIBI parathyroid scintigraphy.



3: SOL
4: TİROTİMİK LİGAMAN

TANI

SAĞ ÜST, SAĞ ALT, SOL PARATİROİDEKTOMİLER+ TİROTİMİK LİGAMAN EKSİZYON
- SELÜLER PARATİROİD DOKULARI, sağ üst ve sol paratiroid
- METASTATİK ÖZELLİKTE LENF DÜĞÜMÜ (4 adet), Sağ alt paratiroid olarak işaretli dokular
- PSAMMOM TİPİ KALSİFİKASYON İÇEREN LENF DÜĞÜMÜ, FİBROLİPOMATÖ DOKULAR, tirotimik ligaman

Lütfen mikroskopik bulgular ve yorumu okuyunuz

YORUM AÇIKLAMA

- Olguda sağ alt paratiroid olarak işaretli dokularda metastatik özellikte lenf düğümleri görülmektedir. Tümör morfolojik ve immunohistokimyasal bulgular ile birlikte değerlendirilmiş olup tiroid papiller karsinom metastazı ile uyumlu bulunmuştur. Olguda bu açıdan ayrıntılı tiroid muayenesi, radyolojik inceleme ve klinik korelasyon önerilir.
- Tirotimik ligaman olarak kayıtlı doku örneğinde psammom türü kalsifasyonlar vardır. Bu lenf düğümü de metastatik kabul edilebilir. (1 adet metastatik lenf düğümü)
- Olguda paratiroid dokularında klinik öykü ve morfolojik bulgular birlikte değerlendirildiğinde, bulgular paratiroid hiperplazisi lehine değerlendirilmiştir.

Tanımlanan bazı morfolojik bulgular olası bir tedavi ve buna sekonder değişiklikler ile uyumlu olabilir.
Klinikopatolojik korelasyon ve klinik takip önerilir.

HİSTOKİMYA/İMMÜNOHİSTOKİMYA

B2: HBME1 diffuz+, TTF1 diffuz+
A+C: PTH pozitif, PARAFİBROMİN ekspresyon kaybı görülmedi, Ki67 (%1), PHH3

Figure 2. Postoperative pathology result.

[P-064]

Parathyroid adenoma arising from autotransplanted tissue: A rare cause of primary hyperparathyroidism

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Objective: Primary hyperparathyroidism (PHPT) is most commonly caused by a solitary parathyroid adenoma and is characterized by hypercalcemia and elevated parathyroid hormone levels. Parathyroid autotransplantation is frequently performed during thyroidectomy when gland perfusion is compromised in order to prevent permanent hypoparathyroidism. Although autotransplanted parathyroid tissue may remain viable and functional for many years, adenoma formation in grafted tissue is extremely rare. Most reported cases in the literature are associated with secondary hyperparathyroidism or multiple endocrine neoplasia syndromes. The aim of this study is to present a case of PHPT caused by an adenoma arising from autotransplanted parathyroid tissue approximately three decades after thyroid surgery.

Material and Methods: Clinical, laboratory, radiological, and surgical findings of a 60-year-old female patient presenting with hypercalcemia and elevated parathyroid hormone levels were retrospectively evaluated. The patient had previously undergone total thyroidectomy and parathyroid autotransplantation for multinodular goiter. Neck ultrasonography, Tc-99m sestamibi scintigraphy, and four-dimensional computed tomography (4D-CT) were used for lesion localization. Intraoperative PTH monitoring and histopathological findings were analyzed following surgical treatment.

Results: Initial ultrasonography and sestamibi scintigraphy were inconclusive. 4D-CT demonstrated a small arterially enhancing lesion adjacent to the right strap muscles. Targeted ultrasonography confirmed the lesion. Minimally invasive parathyroidectomy was performed under intraoperative ultrasonographic guidance. Intraoperative PTH levels decreased from 318 pg/mL to 70 pg/mL, indicating adequate resection. Histopathological examination confirmed a parathyroid adenoma arising from autotransplanted tissue. Postoperatively, serum calcium and PTH levels normalized, and the patient's symptoms improved.

Conclusion: Adenoma formation in autotransplanted parathyroid tissue is a rare but important cause of PHPT and may occur decades after thyroidectomy. Careful evaluation of prior surgical history and autotransplantation sites is essential in patients with unexplained hyperparathyroidism. Advanced imaging modalities such as 4D-CT can facilitate localization of atypically located parathyroid lesions and contribute to accurate surgical planning.

Keywords: Primary hyperparathyroidism, parathyroid autotransplantation, parathyroid adenoma

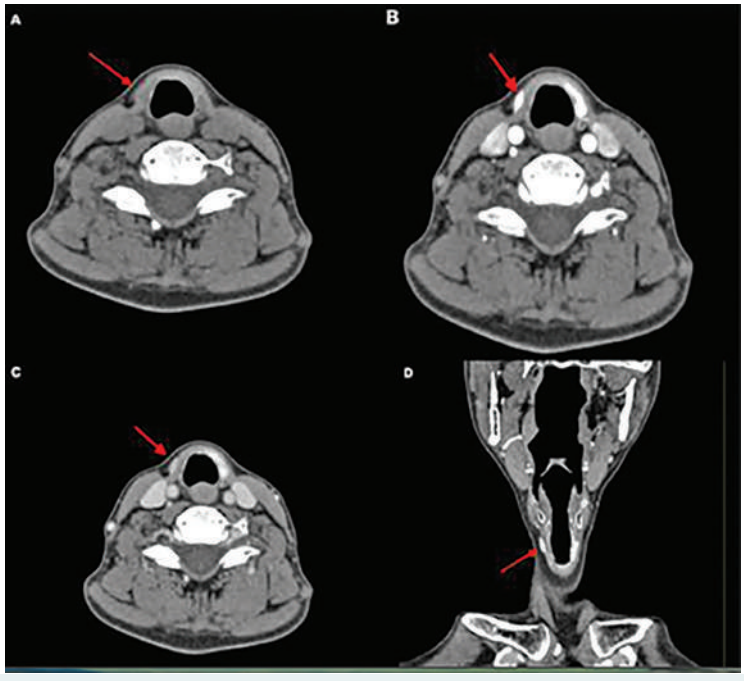

Figure 1. Four-dimensional contrast-enhanced CT imaging of the neck. (A) Non-contrast axial image shows an isodense fusiform lesion. (B) Axial arterial-phase images demonstrate a well-defined, avidly enhancing 7×5 mm lesion located anterior to the strap muscles. (C) The lesion exhibits a washout pattern on venous-phase images. (D) The arterial-phase coronal reconstructed image demonstrates an arterially hyperenhancing, tear-drop-shaped lesion located adjacent to the strap muscles, consistent with an autotransplanted parathyroid adenoma.

[P-065]

Laparoscopic cholecystectomy in a patient with situs inversus: Case report

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Objective: Situs inversus totalis (SIT) is a rare congenital anomaly characterized by the mirror-like arrangement of thoracic and abdominal organs. Its incidence is reported to be approximately 1/5,000-20,000. This variation presents significant challenges, particularly in terms of orientation and ergonomics during surgery. In this study, we aimed to share our experience with laparoscopic cholecystectomy in a patient diagnosed with SIT on the background of the rare Kartagener syndrome, along with a review of the literature.

Material and Methods: A 66-year-old female patient with Kartagener syndrome (situs inversus, chronic sinusitis, bronchiectasis) presented to our clinic with complaints of abdominal pain in the left upper quadrant radiating to the back after meals. Ultrasonography confirmed cholelithiasis and the location of the gallbladder in the left upper quadrant. The patient's laboratory findings were normal. Elective cholecystectomy was planned for the patient. The operation was performed with the surgical tower and ports positioned to create a mirror image of standard laparoscopic cholecystectomy. Critical visibility was achieved by following safe cholecystectomy steps. The cystic artery and cystic duct were safely dissected and clipped, and the gallbladder was removed without any complications. No biliary tract variation anomalies were observed during the operation. No complications developed in the postoperative period. Port entry points video presentation of laparoscopic cholecystectomy performed on a patient with SIT.

Results: Laparoscopic cholecystectomy in the presence of SIT is technically challenging, especially for right-handed dominant surgeons. Various port placement and surgeon positioning strategies have been described in the literature, including mirror-image American and French techniques. Khanzada et al. reported that mirror-image positioning of the surgical team and ports improved operation time and ergonomics. In a series of 12 cases by Jani et al., the modified French technique was shown to be safe and effective; with technical adaptations, complication rates were similar to those in patients with normal anatomy. In our case, cholecystectomy was planned according to the American technique; despite the confusion and difficulty caused by the mirror image during the operation, the surgery was completed without complications, meeting all the requirements for safe cholecystectomy.

Conclusion: In conclusion, laparoscopic cholecystectomy, while technically challenging, is a safe treatment option for patients with SIT. However, detailed preoperative evaluation, appropriate surgical modifications and strategic port placement, adherence to surgical principles, and adaptability are critical for successful surgery. When performed by experienced teams, clinical outcomes similar to those seen in patients with normal anatomy can be achieved in SIT patients.

Keywords: Laparoscopic cholecystectomy, situs inversus totalis

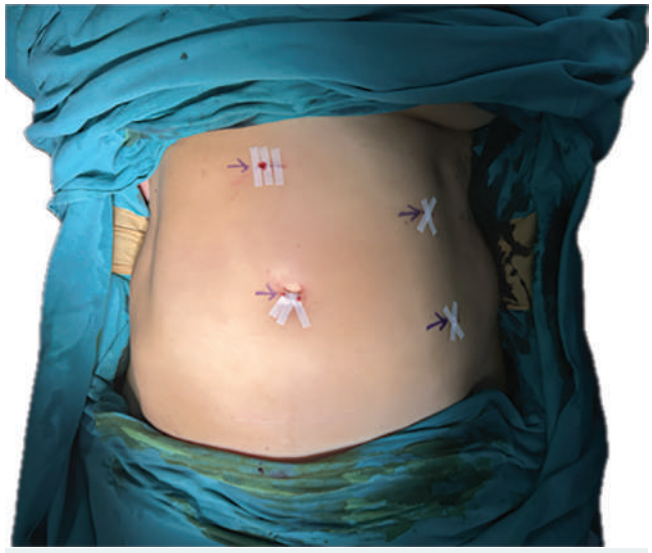

Figure 1. Port entry points.

Figure 2. The video can be accessed via QR code.

[P-066]

Hepatic hydatid cyst fistulized to the lung: Surgical management and a multidisciplinary approach

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Kütahya City Hospital, Kütahya

Objective: Hydatid disease is an endemic zoonotic infection caused by *Echinococcus granulosus*, predominantly affecting the liver and lungs. Although hepatic hydatid cysts are often asymptomatic, rupture may result in severe and potentially life-threatening complications. Transdiaphragmatic fistulization of a hepatic hydatid cyst into the thoracic cavity and lung is a rare but highly morbid condition. In particular, type 4 hydatid cysts with atypical radiological features may lead to delayed diagnosis. The rupture mechanism is associated with prolonged pressure exerted by the cyst, diaphragmatic erosion, alterations in intrathoracic pressure, and a history of previous surgical interventions. According to the World Health Organization classification, type 4 hydatid cysts are considered degenerative and inactive; however, their solid appearance may mimic malignancy, abscesses, or other solid lesions.

Material and Methods: A 76-year-old female patient was diagnosed with indirect hemagglutination assay (IHA) positivity in 2022. Imaging findings were consistent with a type 4 hydatid cyst. The patient was evaluated by interventional radiology and deemed unsuitable for puncture-aspiration-injection-reaspiration (PAIR) therapy. Albendazole treatment was initiated, and IHA seronegativity was observed at the 6-month follow-up. No increase in cyst size was detected during routine follow-up. Three years later, the patient was hospitalized by the pulmonology department with a preliminary diagnosis of pneumonia. Due to clinical deterioration, thoracic computed tomography was performed, revealing fistulization of the hepatic hydatid cyst into the thoracic cavity. The patient was referred to our department and underwent emergency surgery. Multiloculated cystic lesions are observed within the lung parenchyma in the right hemithorax, adjacent to the diaphragm. Cystic structures are present in the basal segments of the right lower lobe, accompanied by surrounding parenchymal changes. Disruption of diaphragmatic integrity and the presence of an inserted thoracic tube are noted.

Results: The operation was performed in collaboration with the thoracic surgery department. Intraoperatively, bilious and purulent fluid was observed in the thoracic cavity. After drainage and debridement, a fistulous tract was identified on the diaphragm. The diaphragm was incised, and the hydatid cyst cavity located at the hepatic dome was debrided. A bile duct detected at the inferior aspect of the cyst cavity was sutured and closed. Postoperatively, bile leakage from the thoracic drain was observed, and endoscopic retrograde cholangiopancreatography was performed. Following the procedure, the patient's clinical condition improved, and she was discharged uneventfully after a 30-day follow-up period.

Conclusion: This case demonstrates that hydatid cysts may cause serious complications despite serological negativization over time. Therefore, clinical and radiological findings should be evaluated in conjunction with serological tests. Although PAIR is an effective treatment option in selected cases, it is generally not recommended for type 4 or complicated hydatid cysts.

Keywords: Hepatic hydatid cyst, hydatid cyst complication, ERCP

Figure 1. Coronal thoracic computed tomography image.

Figure 2. Axial thoracic computed tomography.

[P-067]

Pseudopapillary neoplasia of the pancreas in childhood: Our experience with pancreatectomy

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Objective: Solid pseudopapillary tumors of the pancreas are rare, low-grade malignant exocrine neoplasms of the pancreas. They are known in the literature as "Frantz tumors". Although they account for only 1-3% of all pancreatic tumors, they represent 70% of pancreatic tumors in children. Typically seen in patients aged 20-30 years, 20-25% of cases occur in the pediatric population. The mass grows slowly and symptoms generally appear secondary to compression. The most common symptoms are abdominal pain and a palpable mass. Tumor markers are mostly normal in blood tests. Approximately 10% of cases are incidentally detected. In this report, we present surgical approaches for two pediatric patients with incidentally detected pancreatic masses.

Material and Methods: Two patients with pancreatic masses were evaluated in these cases, where the general surgery and pediatric surgery clinics jointly managed the diagnosis, treatment and follow-up process.

Results: Case 1: A 17-year-old female patient with no known medical history presented to the outpatient clinic due to failure to gain weight. The requested abdominal ultrasound revealed a hyperechoic lesion measuring 55x52 mm in the head of the pancreas, containing solid and cystic components. The abdominal CT scan showed a 55-mm mass in the head of the pancreas with peripheral contrast enhancement. A tru-cut biopsy was planned from the mass. No complications were observed in the postoperative period. The patient was discharged on the 8th postoperative day. No recurrence was observed during follow-up at 3 years postoperatively. Case 2: A 15-year-old female patient with no known medical history presented to the outpatient clinic with abdominal pain and a palpable mass. A solid lesion measuring 90x65x107 mm in size, with heterogeneous characteristics and internal vascularization, was observed in the body-tail section of the pancreas. The patient underwent a spleen-preserving distal pancreatectomy. The patient was discharged on the 6th postoperative day. No complications were observed during the postoperative period. No recurrence was observed during the 3-month postoperative follow-up.

Conclusion: The definitive diagnosis of pancreatic pseudopapillary neoplasm is established through pathological and immunohistochemical evaluations. In immunohistochemical staining, beta-catenin, CD10, CD56, CD99, vimentin and NSE are typically positive, while chromogranin-A is negative. Surgical resection is the only effective treatment. The extent of surgical resection varies depending on the location of the mass. Five-year survival after complete resection is over 95%. Recurrence is usually seen in 6-7% of cases within the first 4 years. It most commonly metastasizes to the liver and peritoneum. Complete resection is essential for successful treatment. In the pediatric population, success rates are increasing and complication rates are decreasing thanks to a multidisciplinary team approach to the patient.

Keywords: Child, pancreas, pseudopapillary neoplasia

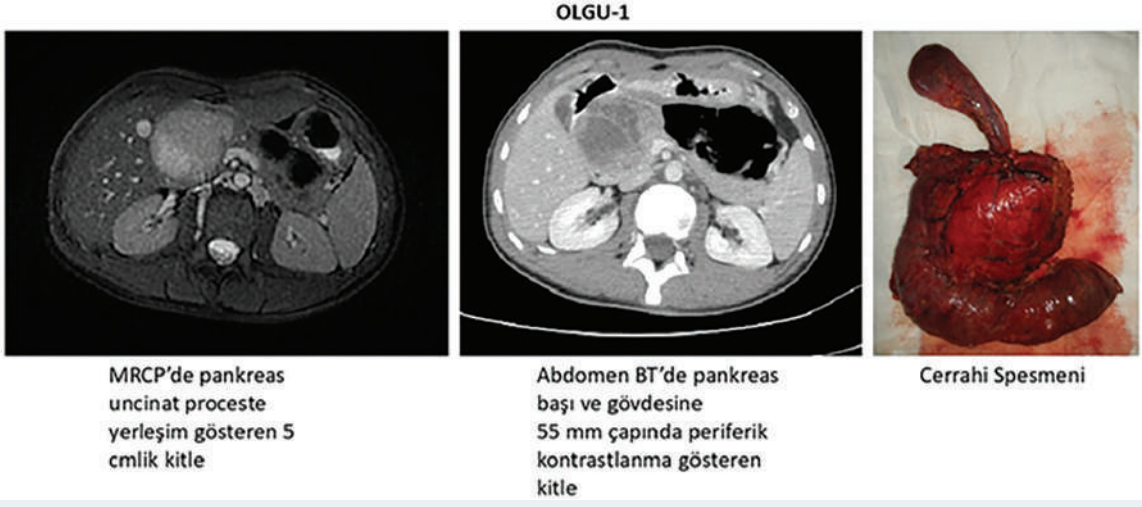

Figure 1. Case 1.

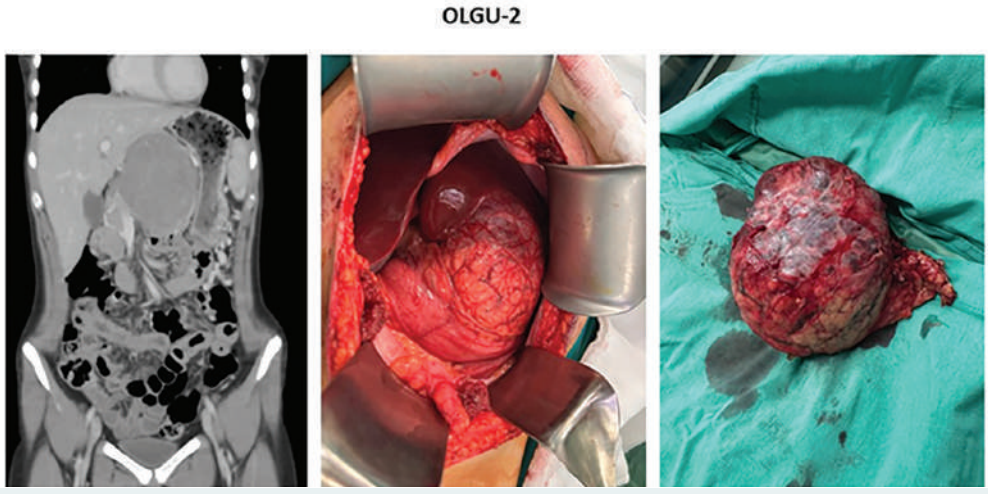

Figure 2. Case 2.

[P-068]

Pancreatic head adenocarcinoma in a 19-year-old patient evaluated for suspected bile duct injury

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Objective: In patients presenting with jaundice, malignancies should be kept in mind as much as benign causes. Particularly in young patients, the diagnosis of pancreatic cancer can be delayed due to its rarity in this age group. This case is presented to highlight the diagnostic challenges, as the patient was initially evaluated following a cholecystectomy with a preliminary diagnosis of bile duct injury, but was subsequently diagnosed with pancreatic head adenocarcinoma.

Material and Methods: This is a retrospective review of our patient whose treatment process was completed in our clinic.

Results: A 19-year-old female patient presented with jaundice on the 4th postoperative day following a laparoscopic cholecystectomy performed at an external center. Laboratory investigations revealed elevated cholestatic enzymes and bilirubin levels of 4.73/8.59 mg/dL. MRCP and percutaneous transhepatic cholangiography showed blunt termination of the distal common bile duct. Based on these findings, the patient was operated on with a preliminary diagnosis of bile duct injury (bismuth type E). During exploration, no injury was identified; biopsies were taken from the common bile duct and the head of the pancreas. Assuming a benign stricture in the distal common bile duct, a choledochoduodenostomy was performed. Following the report of adenocarcinoma from the diagnostic tru-cut biopsies of the pancreatic head, the patient underwent a Whipple procedure (pancreaticoduodenectomy). Pathological examination revealed a moderately differentiated adenocarcinoma, 1.7 cm in diameter. Surgical margins and oncological processes are currently being followed up with evaluations from different centers.

Conclusion: The symptoms of pancreatic cancer, such as jaundice and pain, are non-specific, and diagnostic specificity is limited by clinical findings alone. This case highlights that suspicion of malignancy must always be maintained in young patients presenting with postoperative jaundice, regardless of history or age. During intraoperative processes involving a diagnostic dilemma, biopsy and frozen section examination should not be avoided, and standard surgical principles must not be compromised.

Keywords: Bile duct injury, pancreatic cancer, Whipple procedure

[P-069]

Primary pancreatic lymphoma: A rare case

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Objective: In this case report, we aim to present a patient whose treatment was completed after a mass located in the head of the pancreas, causing obstructive jaundice, and which could not be diagnosed due to a crushing artifact in the preoperative biopsy, was diagnosed as primary pancreatic lymphoma (PPL) upon histopathological examination following pancreaticoduodenectomy.

Material and Methods: PPL is a rare disease, constituting less than 1% of extranodal lymphomas and approximately 0.2-0.5% of pancreatic tumors. According to the definition by the World Health Organization, PPL is a type of extranodal lymphoma that primarily occurs in the pancreas and should be localized in the pancreas for the majority of the disease, but lymph node and distant metastases can be seen. Due to the similarity of the clinical presentation, PPL is often confused with pancreatic adenocarcinoma during the diagnostic process. Imaging methods are insufficient for definitive diagnosis; pathological examination of tissue samples obtained by methods such as percutaneous, endoscopic, and EUS-FNA is necessary. Unlike adenocarcinoma, PPL is a disease that responds well to chemotherapy and has a better prognosis. Accurate differential diagnosis is crucial to avoid unnecessary surgical interventions.

Results: A 48-year-old female patient presented with jaundice and itching. Laboratory investigations revealed cholestasis and liver function tests above normal levels, while tumor markers were within normal limits. Radiological examinations showed dilation of the intrahepatic and extrahepatic bile ducts, an 8-mm hypointense nodular appearance narrowing the lumen posterior to the distal common bile duct, and asymmetric wall thickening in the medial part of the second duodenum. ERCP was planned. Endoscopic examination revealed coarse ulcerated and irregular mucosa at the papilla level. A biopsy yielded ulcerated, inflamed papilla samples, prompting a repeat endoscopy and biopsy. This biopsy yielded ulcerated, inflamed ampulla samples showing widespread crushing artifacts. The patient, who underwent pancreaticoduodenectomy after the cholangitis subsided and cholestasis levels reached acceptable limits, was discharged with a plan for oncological treatment after the main specimen revealed diffuse large B-cell lymphoma.

Conclusion: Accurate preoperative diagnosis is critical in the management of PPL to protect the patient from unnecessary and highly morbid surgical interventions. Data presented in the literature emphasize that chemotherapy is the primary treatment for PPL and that surgical resection does not provide a significant advantage in survival; on the contrary, it increases morbidity. Therefore, in masses that may be radiologically confused with pancreatic adenocarcinoma, histopathological confirmation must be performed before a surgical decision is made.

Keywords: PPL, EUS-FNA, pancreaticoduodenectomy

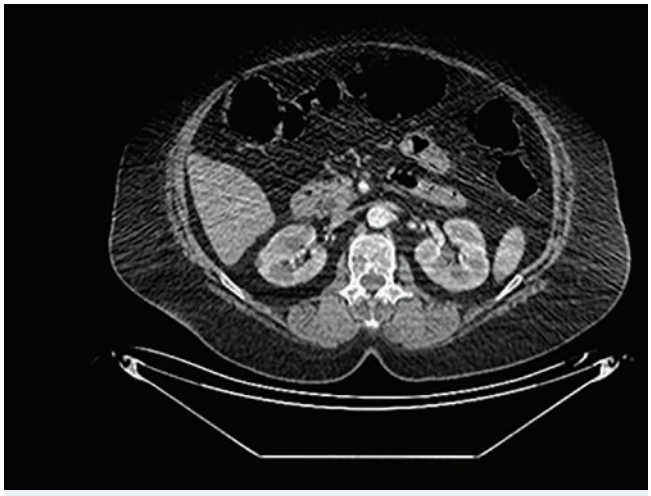

Figure 1. Tomography image.

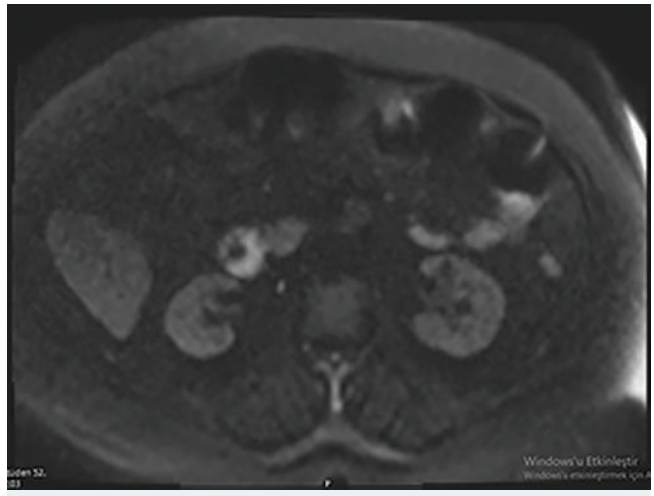

Figure 2. MR image.

[P-070]

Laparoscopic reversal of Roux-en-Y gastric bypass with conversion to sleeve gastrectomy for dumping syndrome

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Objective: Roux-en-Y gastric bypass (RYGB) may be performed following sleeve gastrectomy (SG) due to mechanical complications or severe food intolerance. However, RYGB itself may lead to significant postoperative complications such as dumping syndrome, hypoglycemia, and impaired quality of life. Reversal (takedown) of RYGB with restoration of restrictive anatomy represents a rarely reported and technically demanding revisional bariatric procedure. We present a case of laparoscopic RYGB reversal with conversion to SG performed for severe dumping syndrome.

Material and Methods: A 20-year-old male underwent laparoscopic SG in 2020 at an external center. Postoperatively, he developed reflux and solid food intolerance. In 2022, a laparoscopic revision (twist correction and partial bridectomy) was performed; however, symptoms persisted. In 2023, endoscopic and radiological evaluations revealed a stricture at the level of the incisura angularis, and an open RYGB was performed. Severe postoperative dumping syndrome subsequently developed, and the patient was referred to our center. Due to persistent and quality-of-life–limiting dumping symptoms, revisional surgery was planned and performed in 2025. During laparoscopic exploration, the gastrojejunostomy was carefully dissected and divided, the Roux limb was excluded, and intestinal continuity was preserved. The gastric pouch and remnant stomach were mobilized, and a stapled gastro-gastrostomy was created using a linear stapler to restore restrictive sleeve anatomy. During laparoscopic RYGB reversal, a gastro-gastrostomy anastomosis is created between the gastric pouch and the remnant stomach using a circular stapler. This technique restores the restrictive sleeve anatomy. Following the detection of a gastro-gastrostomy leak on postoperative day 9, an internal drainage catheter was placed endoscopically. After radiological confirmation of leak resolution, the catheter was removed endoscopically at 6 weeks.

Results: On postoperative day 9, drainage of oral intake through the surgical drain was observed. Endoscopic evaluation revealed a 0.5-1 cm defect at the gastro-gastrostomy site. A bariatric stent was initially placed but removed on postoperative day 2 due to intolerance. Internal drainage was subsequently established using a double-J catheter. Clinical and radiological follow-up demonstrated progressive resolution of the leak. After radiological confirmation of fistula closure, the catheter was removed endoscopically at 6 weeks. The patient achieved full oral intake with marked improvement of dumping symptoms and remained clinically stable during follow-up.

Conclusion: Reversal of RYGB with conversion to SG may be considered in selected patients with severe dumping syndrome. Anastomotic leakage remains a significant complication in such complex revisional procedures; however, it can be managed with appropriate advanced endoscopic interventions. Careful surgical planning and experience are essential in complex revisional bariatric surgery.

Keywords: Roux-en-Y gastric bypass reversal, conversion to sleeve gastrectomy, anastomotic leakage

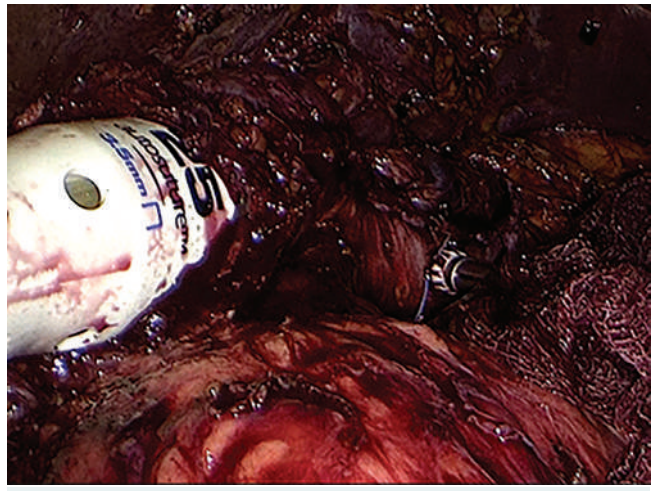

Figure 1. Gastro-gastrostomy anastomosis created using a circular stapler.

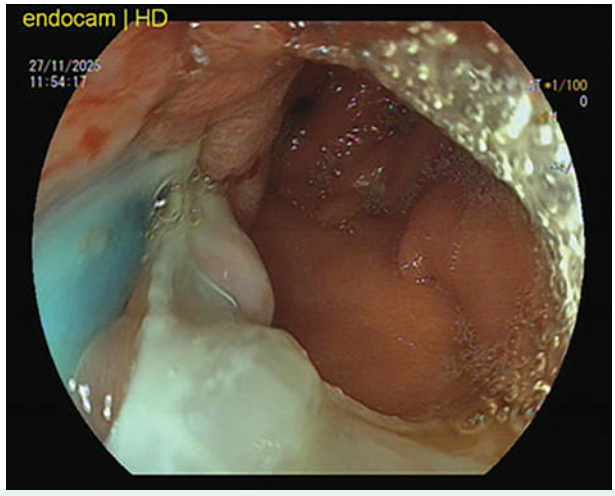

Figure 2. Endoscopic removal of the drainage catheter from the leak site at 6 weeks.

[P-071]

Acute splenic torsion following sleeve gastrectomy: Laparoscopic splenopexy-a case report

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Objective: Splenic complications following sleeve gastrectomy are rare and may result from disruption of splenic suspensory ligaments, leading to abnormal splenic mobility, venous congestion, and torsion.

Material and Methods: A 31-year-old woman with a history of sleeve gastrectomy presented with acute onset left upper quadrant abdominal pain of one-day duration. Laboratory evaluation revealed normal liver and renal function tests, normal coagulation parameters, and normal complete blood count values except for mild elevation of acute-phase reactants. Previous imaging demonstrated chronic splenomegaly without torsion. Extensive etiological investigations for splenomegaly were unremarkable. Contrast-enhanced computed tomography revealed newly developed acute anterior splenic torsion associated with focal ischemic changes, splenic vein tortuosity, free fluid, and collateral vessels consistent with left-sided portal hypertension.

Results: Laparoscopic meshless splenopexy using a preperitoneal pouch technique was successfully performed for symptomatic relief. The postoperative course was uneventful, with resolution of pain and radiologic improvement.

Conclusion: Acute splenic torsion with ischemic changes may occur on a background of chronic splenomegaly after sleeve gastrectomy. In patients with preserved splenic viability, laparoscopic splenopexy represents a safe and effective spleen-preserving alternative to splenectomy.

Keywords: Splenic torsion, sleeve gastrectomy, laparoscopic splenopexy

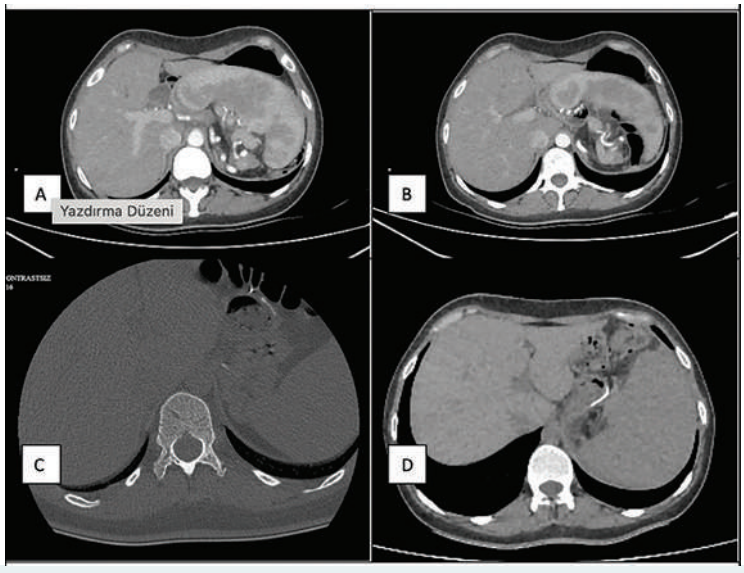

Figure 1. Radiologic findings before and after laparoscopic splenopexy. (A) Preoperative contrast-enhanced CT demonstrating anterior displacement of the spleen with heterogeneous parenchymal enhancement and patchy ischemic areas consistent with acute splenic torsion. (B) Preoperative CT showing a tortuous splenic pedicle and distorted splenic vessels, suggestive of vascular twisting and venous outflow obstruction. (C) Contrast-enhanced CT performed two years earlier demonstrating splenomegaly with the spleen located in its normal anatomical position, without evidence of torsion or vascular distortion. (D) Postoperative CT demonstrating restoration of the spleen to its normal anatomical position with reduction of the previously observed patchy parenchymal changes. The spleen remains enlarged but shows improved homogeneous enhancement.

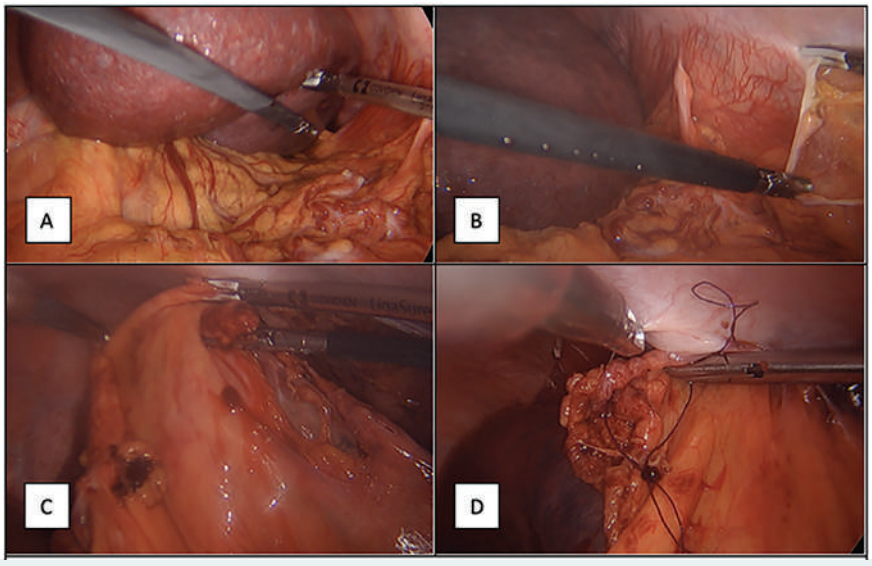

Figure 2. Intraoperative steps of laparoscopic splenopexy. (A) Intraoperative view demonstrating splenomegaly with ischemic discoloration of the splenic parenchyma. Prominent collateral vessels secondary to impaired splenic venous perfusion are visible around the spleen. (B) Creation of the preperitoneal flap for splenic fixation. (C) Placement of the spleen into the preperitoneal pouch after adequate flap mobilization. (D) Closure of the preperitoneal flap using absorbable sutures to secure the spleen in its anatomical position.

[P-072]

A case of gastric perforation presenting with silent abdomen and massive pneumoperitoneum

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Objective: Gastric perforation, classically known as "board abdomen," is an acute surgical emergency presenting with severe peritonitis. However, perforations occurring in atypical locations due to chronic non-steroidal anti-inflammatory drug (NSAID) use can present with unusual clinical outcomes. This case report describes a clinically asymptomatic case of gastric perforation due to NSAID use.

Material and Methods: Patients presenting to our hospital's tertiary emergency department undergo diagnostic, imaging, and specialist evaluation processes. After their treatment is determined, they are admitted to the relevant department if deemed necessary, and their final treatment, including surgery, is carried out.

Results: Case Report: A 32-year-old female patient presented to the main ward with complaints of significant abdominal distension and weakness. Physical examination revealed a very pale appearance, but no signs of acute illness such as tachycardia, dyspnea, or the need for positioning; vital signs were within physiological limits. Detailed history revealed chronic use of naproxen. Abdominal examination showed distension and tympanic sounds; however, no tenderness or pain was felt on palpation. Laboratory tests revealed a very low hemoglobin level (3.5 g/dL), indicating chronic anemia. Blood transfusions were initiated, and further imaging studies were planned to elucidate the etiology of the abdominal distension. Radiographic examination revealed widespread free air. Oral contrast imaging was repeated; however, no contrast leakage was observed in the peritoneal cavity, so surgery was not initially planned; the patient was kept under observation. During the follow-up period, it was observed that the pneumoperitoneum gradually increased within 6-8 hours and spread to the subcutaneous tissue of the chest and trunk. Due to this progressive condition, a decision was made to perform a diagnostic abdominal surgery (laparotomy). During the laparotomy, a hole (perforation) of approximately 5 mm in size was found on the anterior surface of the gastric fundus, and it was understood that this was the source of the massive air. There was no sign of chronic ulceration in this area of the stomach. The perforation was partially closed by the spleen. This perforation was closed with an omental patch, the abdomen was cleaned, and the surgery was concluded. The patient recovered within 3 days, started oral food intake, and was discharged from the hospital.

Conclusion: Inappropriate NSAID use can lead to atypical gastric perforations, causing unusual clinical presentations. Excessive pneumoperitoneum and subcutaneous emphysema may be indicators of this condition. This case highlights how important progressive radiological findings are for intervention decisions, even in the absence of classic symptoms.

Keywords: Gastric perforation, NSAIDs, pneumoperitoneum, asymptomatic perforation

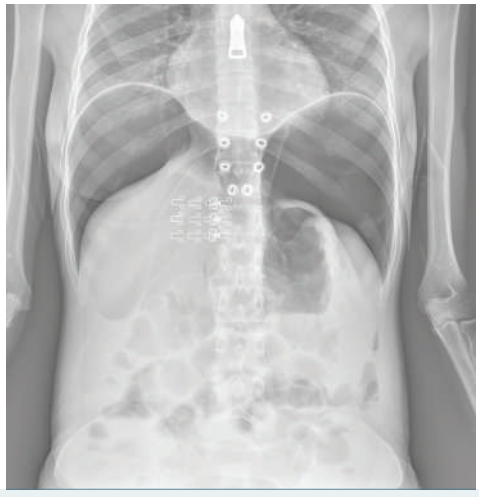

Figure 1. Standing abdominal X-ray.

Table 1. Imaging findings		
Test	**Result**	**Unit**
HGB	14.2	g/dL
RBC	4.46	10^{12}/µL
WBC	9.87	10^{9}/µL
CRP	0.7	mg/L
Chloride (Cl)	101	mEq/L
Potassium (K)	2.73	mEq/L
Sodium (Na)	141	mEq/L
e-GFR	156	-
Creatinine	0.33	mg/dL

[P-073]

Repair of an incarcerated scrotal hernia in an adult dwarf patient with type IV mucopolysaccharidosis (Morquio syndrome) using open preperitoneal Nyhus procedure: A case report

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Objective: Type IV mucopolysaccharidosis (Morquio syndrome) is a rare metabolic disorder characterized by skeletal dysplasia, short stature, and thoracic deformities. The incidence of Morquio syndrome ranges from 1 in 250,000 to 1 in 1,000,000 live births. In these patients, the choice of anesthesia and surgical approach presents significant challenges due to skeletal, thoracic, abdominal, and cardiac abnormalities. When surgical intervention is required, laparoscopic abdominal surgery may not always be feasible. In the present case, the patient was admitted for emergency surgery with a preliminary diagnosis of incarcerated scrotal hernia, and mesh repair was performed using a preperitoneal approach through a lower midline abdominal incision.

Material and Methods: A 44-year-old immobilized male patient with a diagnosis of type IV mucopolysaccharidosis presented to the emergency department with constipation for one week and abdominal distension and pain for three days. The patient reported nausea without vomiting. His medical history included hip arthroplasty, tympanoplasty, and spinal surgery. On physical examination, the patient, who was 80 cm in height and weighed 22 kg, had a distended abdomen and an incarcerated left scrotal hernia, which was irreducible. Computed tomography revealed markedly dilated ileal loops, and ileus was diagnosed. A nasogastric tube was inserted and emergency surgery was planned. Due to anatomical and respiratory characteristics, a laparoscopic approach was considered inappropriate. The abdomen was entered through a lower midline incision and the cecum and ileal loops herniated into the scrotum were reduced into the abdominal cavity. Colon and small bowel loops were viable with preserved perfusion. The preperitoneal space was accessed through the same lower midline incision, the hernia sac was reduced, and mesh repair was performed using an open preperitoneal technique. The operation was completed without complications.The postoperative course was uneventful, and the patient was followed for six days and discharged in stable condition.

Results: In patients with type IV mucopolysaccharidosis, laparoscopic surgery and general anesthesia may carry a high risk due to short stature, thoracic deformities, and airway difficulties. The literature contains a limited number of reports regarding complicated hernia repair in this patient population. The open preperitoneal approach provides a safe and effective alternative in cases where laparoscopy is not feasible.

Conclusion: Surgical management of complicated hernias in patients with type IV mucopolysaccharidosis requires special consideration. The midline preperitoneal approach is a useful and effective technique for incarcerated scrotal hernias and allows bowel resection to be performed through the same incision when necessary. In cases where laparoscopy is not feasible, open preperitoneal mesh repair can be safely performed.

Keywords: Midline preperitoneal repair, incarcerated inguinal hernia, mucopolysaccharidosis type IV

Table 1. Laboratory results		
Test	**Result**	**Unit**
HGB	14.2	g/dL
RBC	4.46	10^{12}/µL
WBC	9.87	10^{9}/µL
CRP	0.7	mg/L
Chloride (Cl)	101	mEq/L
Potassium (K)	2.73	mEq/L
Sodium (Na)	141	mEq/L
e-GFR	156	-
Creatinine	0.33	mg/dL

Figure 1. Mucopolysaccharidosis type IV.

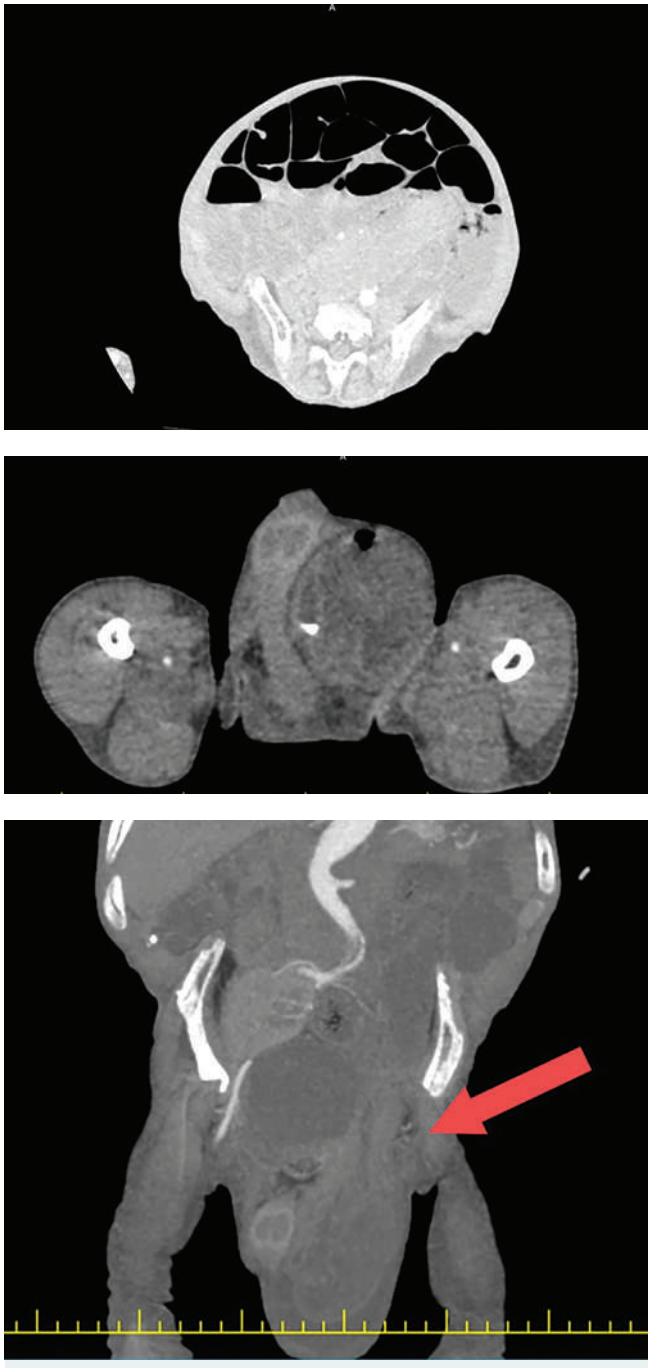

Figure 2. Imaging findings.

[P-074]

Living-donor liver transplantation for liver-confined colorectal cancer metastases: A case with long-term follow-up

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Objective: Surgical resection is the cornerstone of curative treatment for colorectal liver metastases. Nevertheless, despite advances in modern systemic chemotherapy, targeted agents, immunotherapy strategies, and liver-directed therapies, a considerable proportion of patients eventually develop unresectable disease. This challenge is particularly evident in patients with metastases confined to the liver who no longer have effective surgical options. In recent years, liver transplantation has gained increasing attention as a potentially curative strategy in highly selected patients. This report presents the detailed clinical, surgical, and oncologic outcomes of a patient with long-standing liver-confined colorectal cancer metastases treated with living-donor liver transplantation (LDLT).

Material and Methods: A 33-year-old woman was diagnosed with colon adenocarcinoma following emergency subtotal colectomy for acute intestinal obstruction and gastrointestinal bleeding in 2019. Pathological staging revealed pT3N2 disease. Initial staging demonstrated multiple liver-confined metastases without extrahepatic spread. The patient underwent systemic chemotherapy and targeted therapy followed by multisegmental liver metastasectomies and local ablative treatments, achieving disease control for approximately three years. In 2023, isolated intrahepatic recurrence occurred. Due to insufficient future liver remnant and intolerance to further chemotherapy, LDLT was planned after multidisciplinary evaluation.

Results: LDLT using a right-lobe graft was performed in May 2023. The surgical procedure included partial inferior vena cava resection and diaphragmatic resection. Postoperative recovery was uneventful, with satisfactory early graft function. No episodes of acute or chronic rejection, vascular complications, or severe infections were observed during follow-up. The patient was maintained on standard immunosuppressive therapy and enrolled in a strict oncologic surveillance program. Serial assessments included liver function tests, tumor markers, and cross-sectional imaging. At the most recent follow-up on January 2, 2026, all laboratory parameters were within normal ranges, and imaging studies demonstrated no evidence of intrahepatic recurrence or extrahepatic metastasis, indicating sustained complete remission.

Conclusion: LDLT may provide durable disease-free survival incarefully selected patients with liver-confined colorectal cancer metastases. Key advantages of the living-donor approach include optimal timing without waiting-list progression, the ability to select recipients with favorable tumor biology, and predictable graft availability. High donor safety standards, rapid postoperative recovery, and close oncologic surveillance further support the feasibility of this strategy. Meticulous patient selection, comprehensive staging, multidisciplinary decision-making, and structured long-term follow-up are essential to achieve favorable outcomes.

Keywords: Colorectal cancer, liver metastasis, long term survival

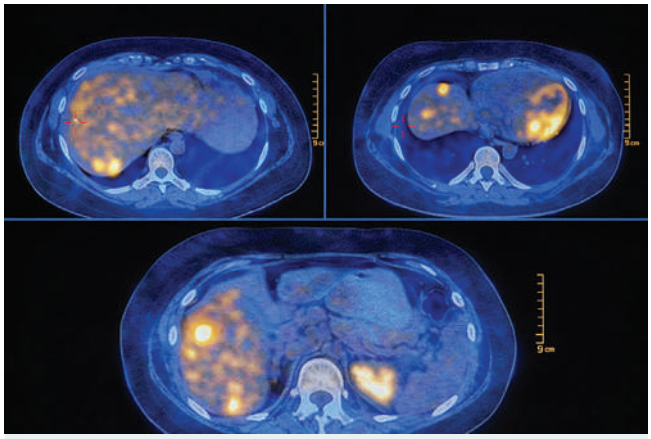

Figure 1. Initial PET view.

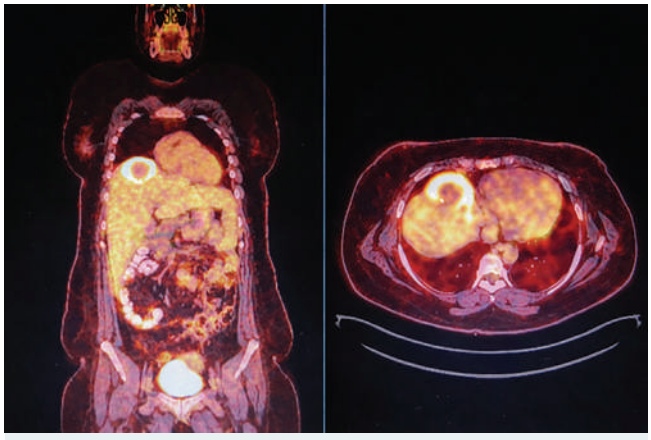

Figure 2. PET before LDLT.

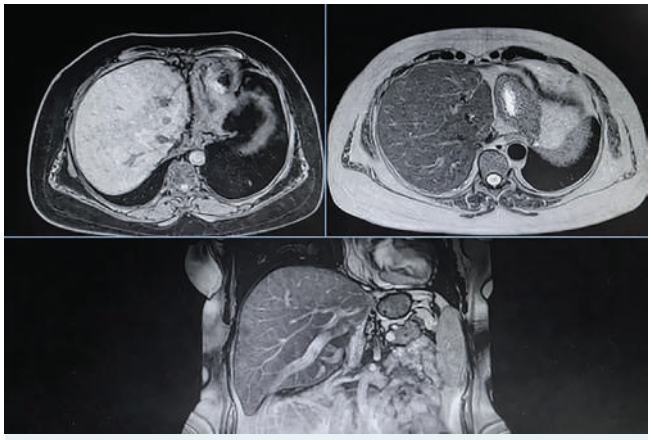

Figure 3. Last follow-up MRI.

[P-076]

Management of incidental Meckel's diverticulum detected during colon adenocarcinoma surgery: A case report and literature review

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Objective: Meckel's diverticulum (MD) is the most prevalent congenital anomaly of the gastrointestinal tract, arising from the incomplete obliteration of the omphalomesenteric duct. While it is a true diverticulum involving all layers of the intestinal wall, the necessity of surgical resection for asymptomatic MD discovered incidentally during unrelated procedures remains a subject of ongoing debate in the literature.

Material and Methods: A 75-year-old male patient presented with a six-month history of abdominal pain and rectal bleeding. Following a diagnosis of sigmoid colon adenocarcinoma, a laparotomy was performed. Intraoperative exploration revealed an ulcerovegetative mass in the sigmoid colon and an incidental, asymptomatic, broad-based MD, approximately 6 cm in length, located 60 cm proximal to the ileocecal valve. Localized adhesions suggested prior subclinical inflammatory episodes. Following an oncological anterior resection, a segmental small bowel resection with primary anastomosis was performed for the MD. This decision was based on the patient's advanced age and the anticipated initiation of adjuvant chemotherapy; it was determined that potential MD-related complications during immunosuppression could significantly increase morbidity and disrupt the oncological treatment course. Histopathological examination confirmed colonic adenocarcinoma (11/18 positive lymph nodes) and a benign MD with no ectopic tissue or malignancy. The patient was discharged uneventfully on the fifth postoperative day.

Results: Management strategies for asymptomatic MD vary widely in the literature. While some authors advocate for resection regardless of age due to potential complications, others recommend specific criteria such as age under 50, male gender, and diverticular length exceeding 2 cm to justify surgery. Conversely, some studies suggest that prophylactic resection may unnecessarily increase postoperative complication rates.

Conclusion: This case emphasizes that surgeons must perform a meticulous whole-abdomen exploration rather than focusing solely on the primary pathology. The approach to incidental MD should be individualized. In patients facing immunosuppression due to malignancy, prophylactic resection is a reasonable and proactive strategy to prevent future complications that could jeopardize the patient's systemic treatment.

Keywords: Meckel's diverticulum, sigmoid colon adenocarsinoma, incidental resection, prophylactic resection, surgical management

Figure 1. Incidentally detected Meckel's diverticulum. Meckel's diverticulum detected incidentally during intra-abdominal exploration.

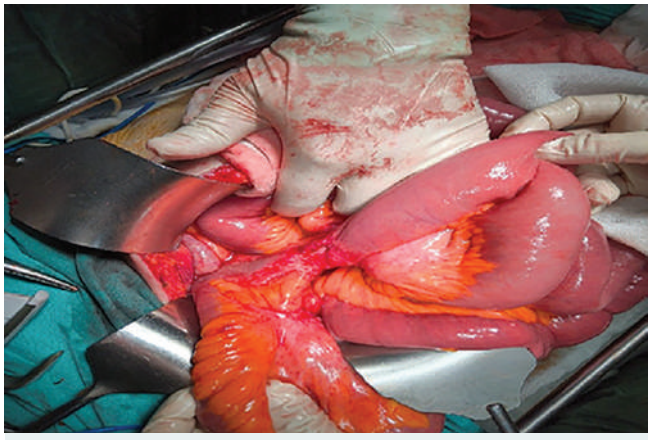

Figure 2. Meckel's diverticulum and adhesions in surrounding tissues. Meckel's diverticulum and adhesions in surrounding tissues.

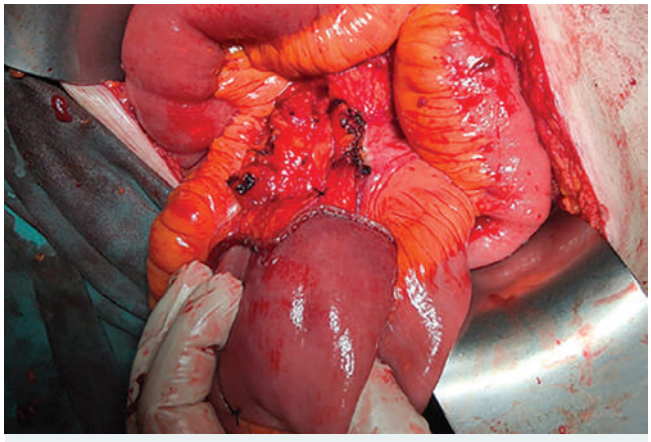

Figure 3. Resection anastomosis performed on the Meckel's diverticulum area. Side-by-side stapler resection and anastomosis was performed in the Meckel's diverticulum area.

[P-077]

Severe anal stenosis developing after pelvic radiotherapy: A rare case report

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Objective: Anal stenosis is a rare but clinically significant condition caused by pathological narrowing of the anal canal, leading to difficulty or inability to defecate. It most commonly results from anorectal surgery, particularly hemorrhoidectomy, while inflammatory bowel disease, infections, trauma, and rarely pelvic radiotherapy may also be responsible. Radiation-induced anal stenosis is exceptionally rare and is attributed to chronic microvascular injury, ischemia, and progressive fibrosis. Due to its rarity, diagnosis may be delayed, especially in patients without prior anorectal surgery. This report presents a case of severe anal stenosis following pelvic radiotherapy for cervical cancer and its management.

Material and Methods: A 75-year-old female patient presented with progressive constipation, pencil-thin stools, and difficulty in defecation. She had no prior history of anal or anorectal surgery. Her medical history revealed moderately differentiated squamous cell carcinoma of the cervix diagnosed by incisional tru-cut biopsy and staged as FIGO stage IB. The patient received five cycles of chemotherapy combined with pelvic radiotherapy consisting of 28 fractions, including the anal canal within the radiation field. Approximately six months after completion of radiotherapy, a marked deterioration in bowel habits was reported. Physical examination revealed a fibrotic and markedly narrowed anal verge, and digital rectal examination could not be performed due to severe stenosis. Under spinal anesthesia, evaluation demonstrated near-complete obliteration of the anal canal by dense circumferential fibrotic tissue. Controlled radial incisions were performed using unipolar electrocautery to partially widen the anal canal, without intraoperative complications.

Results: Colonoscopy performed 48 hours after the procedure revealed diffuse fecal contamination, millimetric hematomas on the colonic walls, and mucosal elevations suggestive of ulceration at 10 cm and 40 cm from the anal verge. Retroflexion demonstrated internal hemorrhoids and a fissure line at the 7 o'clock position of the anal canal. Biopsies obtained from suspicious areas showed melanosis coli without dysplasia or malignancy, excluding radiation proctitis and secondary malignancy. No early postoperative complications occurred. The patient's constipation symptoms improved significantly, and at 1-, 3-, and 6-month follow-up visits, no evidence of recurrent stenosis or need for further dilation was observed.

Conclusion: Severe anal stenosis after pelvic radiotherapy is a rare but important complication. In patients with prior radiotherapy presenting with unexplained constipation or defecation difficulty, anal stenosis should be considered. Controlled radial electrocautery incisions may provide an effective diagnostic and therapeutic option in advanced cases, and long-term management should be individualized.

Keywords: Anal stenosis, pelvic radiotherapy, cervical cancer, radiation induced fibrosis, electrocautery incision

Figure 1. Postoperative.

[P-078]

Complicated breast abscess developing on the background of diabetic mastopathy

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Objective: Diabetic mastopathy (sclerosing lymphocytic lobulitis) is a rare, benign fibroinflammatory breast disease in patients with a long history of diabetes mellitus, which can clinically and radiologically mimic malignancy. Patients typically present with a firm mass in the breast. Although infection and abscess formation are rare, the clinical course can become complicated with poor glycemic control.

Material and Methods: This study is a case report evaluating the clinical, surgical, and metabolic processes of a patient with a complicated breast infection developing on the basis of diabetic mastopathy. Clinical, laboratory, and microbiological data, along with the surgical and medical treatments, were reviewed through the patient's medical record. The diagnosis and treatment were managed with a multidisciplinary approach involving surgery, infectious diseases, and endocrinology departments. All data were anonymized and presented in accordance with ethical guidelines.

Results: A 47-year-old female patient with a long-standing history of type 2 diabetes mellitus presented with a lesion that began as an acne-like lesion in the lower quadrant of the right breast about a week ago and rapidly progressed into an abscess. In addition to type 2 diabetes, the patient had a history of hypertension, arrhythmia, allergic asthma, obstructive sleep apnea, hypothyroidism, and HPV. Despite initial topical treatment, clinical progression was observed, leading to abscess drainage in the emergency department. Due to recurrence, the patient was admitted for inpatient care. On physical examination, a necrotic, infected wound was found in the lower right breast quadrant. The patient underwent serial surgical debridements and negative pressure wound therapy was initiated. On the 21st day of linezolid therapy, initial aspirates and tissue cultures showed no growth, but later *Acinetobacter baumannii* was isolated. Given the ongoing clinical improvement, negative acute-phase reactants, and healthy wound appearance, this finding was interpreted as colonization. An endocrinology consultation revealed the patient's HbA1c was 11.7%, indicating poor glycemic control. Insulin dosages were increased to improve metabolic regulation, and the patient was noted to be at high metabolic risk for surgical interventions. A comprehensive evaluation of clinical, surgical, and metabolic data led to the conclusion that the case was consistent with a complicated breast infection developing on the basis of diabetic mastopathy.

Conclusion: Diabetic mastopathy is a rare breast disease, but it can become complicated by severe infections in the presence of poor glycemic control. This case demonstrates that a multidisciplinary approach and metabolic regulation are as important as surgical treatment in managing breast infections in diabetic patients.

Keywords: Diabetic mastopathy, negative pressure wound therapy, sclerosing lymphocytic lobulitis

Figure 1. Before surgery.

Figure 2. After surgery.

[P-079]

Retroperitoneal paraganglioma as a cause of secondary hypertension: A case detected in an etiological investigation

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Objective: Paragangliomas are uncommon neoplasms arising outside the adrenal gland, often presenting with catecholamine-secreting activity that can lead to episodic attacks or resistant hypertension. In this report, we describe a case involving a retroperitoneal mass identified during the diagnostic workup for hypertension.

Material and Methods: A 52-year-old male patient was evaluated for secondary hypertension due to persistent elevation of blood pressure despite adherence to a comprehensive medical regimen with multiple antihypertensive agents. Diagnostic investigations revealed a 62 by 59 mm retroperitoneal mass adjacent to the inferior vena cava and abdominal aorta, at the level where the left renal vein exits. A paraganglioma was suspected based on imaging findings, and the case was subsequently referred to the multidisciplinary oncology council for further assessment. Preoperative preparation was completed, and a decision was made to proceed with surgical exploration.

Results: During surgery, an 8x6 cm solid mass with cystic components, surrounded by a capsule, was observed on the left renal vein, located between the vena cava and the abdominal aorta. The mass was resected along with its capsule. Histopathological examination was consistent with paraganglioma.

Conclusion: Secondary causes should be carefully evaluated in cases of resistant or unexplained hypertension. Although retroperitoneal paraganglioma is uncommon, maintaining awareness of it is essential to avoid diagnostic delays and to guide appropriate management.

Keywords: Paraganglioma, retroperitoneal mass, secondary hypertension

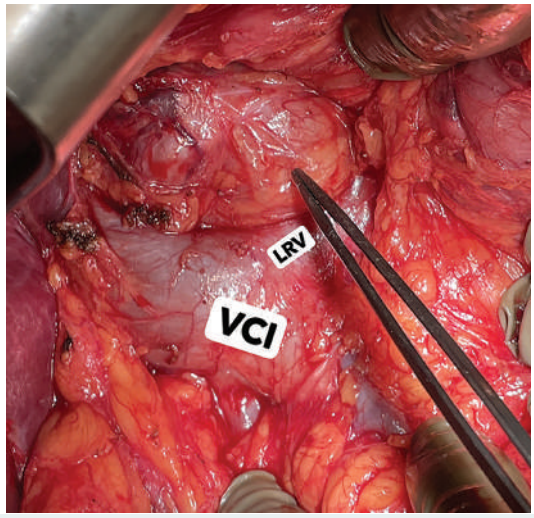

Figure 1. Intraoperative view of the mass detected in the retroperitoneal space.

VCI: Inferior vena cava, LRV: Left renal vein.

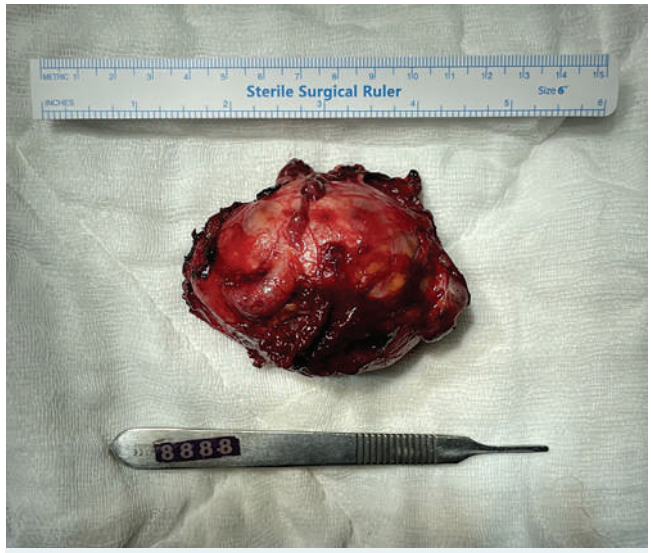

Figure 2. Image of the mass after resection.

[P-080]

Gastric metastasis of breast cancer presenting with gastric outlet obstruction

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Objective: Breast cancer rarely metastasizes to the gastrointestinal tract; however, such involvement is more commonly observed in the invasive lobular carcinoma (ILC) subtype. Gastric metastas is often present with nonspecific symptoms and may closely mimic primary gastric malignancies, resulting in delayed or incorrect diagnosis. Gastric outlet obstruction as the initial manifestation of breast cancer metastasis is particularly uncommon. This report aims to present a rare case of gastric outlet obstruction caused by gastric metastasis of invasive lobular breast carcinoma and to emphasize the importance of clinicopathological correlation.

Material and Methods: Clinical data, endoscopic findings, radiological imaging, histopathological examination, and immunohistochemical analyses of a patient presenting with gastric outlet obstruction were retrospectively reviewed. Upper gastrointestinal endoscopy with targeted biopsies was performed. Contrast-enhanced abdominal computed tomography was used for radiological assessment. Histopathological diagnosis was established using routine hematoxylin-eosin staining and a comprehensive immunohistochemical panel to determine the origin of the tumor.

Results: A 70-year-old female patient with a history of left-sided invasive lobular breast carcinoma presented with constipation, reduced oral intake, and symptoms suggestive of gastric emptying disturbance. Upper gastrointestinal endoscopy revealed a circumferential vegetative mass extending from the antrum to the pylorus and duodenal bulb, causing marked luminal narrowing consistent with gastric outlet obstruction. Histopathological evaluation of gastric biopsies demonstrated infiltration by atypical epithelial cells with hyperchromatic nuclei and scant eosinophilic cytoplasm. Immunohistochemical analysis showed tumor cells positive for pan-cytokeratin, CK7, and GATA-3, while CK5/6, CDX2, PAX-8, and LCA were negative, supporting the diagnosis of gastric metastasis from breast carcinoma. Contrast-enhanced abdominal computed tomography revealed diffuse gastric wall thickening, a mass lesion obliterating the antropyloric lumen, and findings consistent with peritoneal carcinomatosis, including omental cake appearance and diffuse ascites. Due to progressive obstructive symptoms, the patient underwent palliative gastroenterostomy.

Conclusion: Gastric metastasis of invasive lobular breast carcinoma should be considered in patients presenting with gastric outlet obstruction, especially in those with a history of breast cancer. Differentiation from primary gastric malignancies requires careful integration of clinical history, radiological findings, and immunohistochemical profiling. Although curative surgery is not feasible in metastatic disease, palliative surgical interventions can provide effective symptom relief and improve quality of life.

Keywords: Breast cancer, gastric metastasis, gastric outlet obstruction

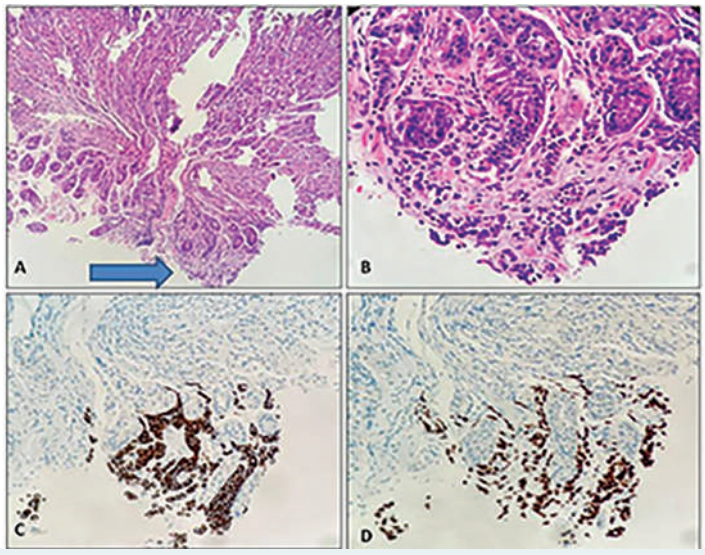

Figure 1. Morphological and immunohistochemical findings. (A) Low-power view showing neoplastic infiltration in the deep portion of the gastric mucosal biopsy specimen (arrow) (hematoxylin-eosin, ×200). (B) High-power view demonstrating diffuse infiltration of atypical epithelial cells with hyperchromatic nuclei and signet-ring-like morphology (H&E, ×400). (C) Tumor cells showing cytoplasmic positivity for CK7 (Immunohistochemistry, ×400). (D) Tumor cells demonstrating nuclear positivity for GATA3 (Immunohistochemistry, ×400).

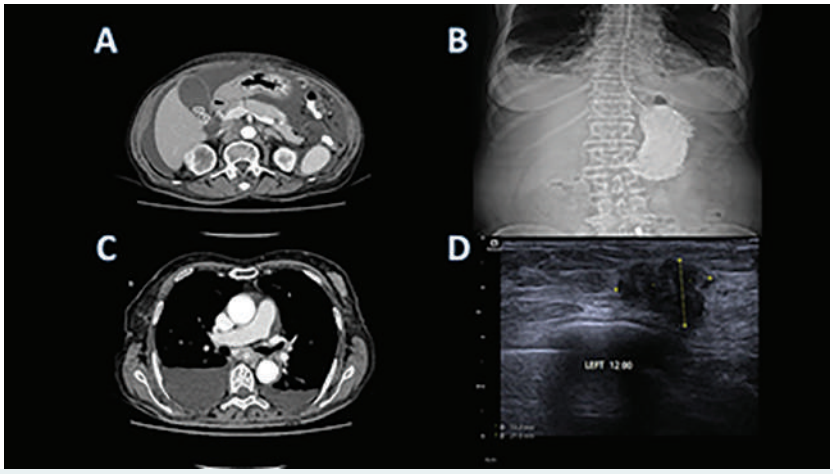

Figure 2. Radiological findings. (A) Contrast-enhanced abdominal CT demonstrating diffuse gastric wall thickening and a mass lesion in the antropyloric region causing luminal narrowing. (B) Upper gastrointestinal contrast study showing marked narrowing in the antropyloric region consistent with gastric outlet obstruction. (C) Thoracic CT demonstrating an irregular, solid mass lesion in the left breast. (D) Breast ultrasonography showing a hypoechoic, irregularly bordered mass lesion measuring approximately 21×13 mm at the 12 o'clock position of the left breast.

[P-083]

Cutaneous fistula developing at the intervention site following PAIR procedure in liver hydatid cyst: A case report

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Objective: Cystic echinococcosis (CE) is a zoonotic infection caused by *Echinococcus granulosus*, typically characterized by liver involvement. The puncture, aspiration, injection, re-aspiration (PAIR) technique, developed as an alternative to surgery in the treatment of hepatic CE, is a minimally invasive method recommended by the WHO for CE1 and CE3a stages due to its short hospital stay and low cost. However, complications such as allergic reactions and biliary fistulas may develop following PAIR. Cutaneous fistulization is a very rare complication that develops along the PAIR tract and significantly affects the patient's quality of life. In this presentation, we aimed to discuss the surgical management of a resistant cutaneous fistula developing after PAIR, in the light of the literature.

Material and Methods: An eighteen-year-old female patient presented with a persistent biliary discharge from the intervention site following a PAIR procedure performed on September 8, 2025, for a hydatid cyst in the left lobe of the liver. *Echinococcus* IgG antibody testing and radiological imaging were utilized during the diagnostic process. Liver MRI revealed a cystic lesion measuring 3.5×4 cm in segments 2-3, consistent with WHO-CE2/3. MRCP showed a communication between the intrahepatic bile ducts and the cyst wall. Due to the high-output fistula that did not close with conservative methods, a decision for surgical intervention was made.

Results: During exploration, a fistula tract extending between the PAIR entry site and the cyst cavity in the left lobe of the liver was identified. During the surgical procedure, the fistula tract was completely excised, the cyst content was cleared, and the identified micro-biliary communication points were sutured. Cystectomy and omentopexy were performed to obliterate the cyst cavity and prevent recurrence. The patient, whose skin discharge ceased and biliary drainage stopped during the postoperative period, was discharged without complications.

Conclusion: PAIR complications range from 5-25%, yet cutaneous fistulas remain rare. Etiopathogenesis involves high intracystic pressure, back-flow induced necrosis, and short needle tracks. Primarily, missed micro-biliary communications redirect bile toward the tract. MRCP is diagnostic. While percutaneous drainage suits low-output cases, radical surgery like cystectomy with omentopexy definitively treats high-output biliary fistulas. Despite PAIR's minimal invasiveness, high-morbidity complications require prompt surgical consideration.

Keywords: Cutaneous fistula, cystic echinococcosis, PAIR complications

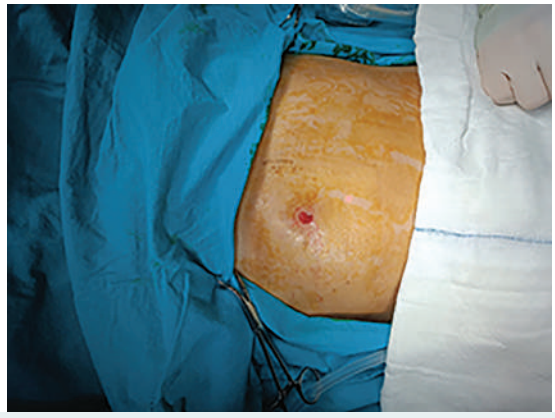

Figure 1. Cutaneous fistulization (formation of a tract between the cyst and the skin).

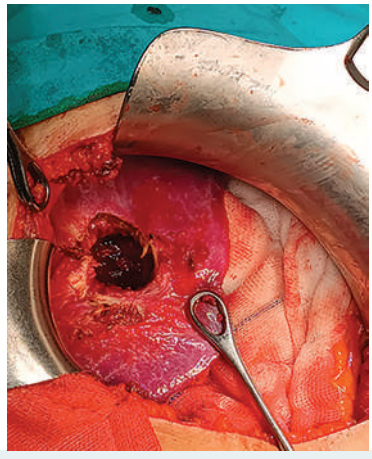

Figure 2. Cutaneous fistulization (formation of a tract between the cyst and the skin).

[P-084]

Post-robotic Ivor Lewis esophagectomy nursing care: A case report

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Objective: Surgical resection is one of the fundamental steps in curative treatment for malignancies of the esophagus and gastric cardia region. Robotic surgical techniques offer advantages such as less tissue trauma, early mobilization, and shorter hospital stay. However, close nursing care, particularly during ward monitoring after robotic esophagectomy, is crucial for respiratory function, pain management, drainage management, nutrition, bleeding risk, and infection risk. The aim of this case presentation is to demonstrate the contribution of nursing care provided during ward monitoring to patient recovery in a patient who underwent robotic Ivor Lewis esophagectomy.

Material and Methods: A 63-year-old female patient presented with complaints of epigastric pain and dysphagia; endoscopic and pathological examinations resulted in a diagnosis of adenocarcinoma located in the gastric cardia. Following neoadjuvant chemotherapy, the patient underwent robotic Ivor Lewis esophagectomy, esophagogastrostomy, and retroperitoneal lymph node dissection. The patient was monitored in the intensive care unit for two days after the operation, and after achieving hemodynamic stability, was transferred to the surgical ward.

Results: Nursing care in the ward was planned with a focus on maintaining respiratory function, drain monitoring, pain management, reducing infection risk, and early mobilization. The patient had one chest tube, one Jackson-Pratt drain, and a peripheral venous catheter. The number, color, and characteristics of the drains were monitored and recorded at regular intervals. Due to the presence of a chest tube, breath sounds, oxygen saturation, and signs of dyspnea were closely evaluated, and the patient was taught deep breathing and coughing exercises. Pain level was monitored using a numerical pain scale, and analgesic treatment was administered as ordered by the physician. Drain and catheter care was performed using aseptic techniques, and the patient was regularly evaluated for signs of infection. The patient was observed during feeding, considering the risk of aspiration, and fluid and electrolyte balance was monitored. Early and gradual mobilization was supported, and the patient was encouraged to safely resume daily activities. The patient was discharged on the 6th postoperative day. In this case, the systematic and planned implementation of ward nursing care played a significant role in preventing complications in the postoperative period.

Conclusion: Planned, holistic, structured, and individualized nursing care applied in the ward period after robotic esophagectomy offers an effective approach in preventing surgical complications and supporting the patient's safe recovery process. Effective nursing care directly supports the success of surgical treatment.

Keywords: Robotic surgery, esophagectomy, nursing care

[P-090]

When axillary radiotherapy reaches the eye: The cause of acute central scotoma, macular hemorrhage, and radiation-induced macular degeneration in a 70-year-old female patient with stage IIIB breast cancer

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Objective: Radiotherapy is widely used in the treatment of breast cancer, and its cardiac and pulmonary toxicities are well recognized. However, although the retina is an extremely radiosensitive organ, ocular injury is rarely considered during regional radiotherapy planning.

Material and Methods: A 70-year-old female patient with stage IIIB breast cancer received adjuvant radiotherapy to the axillary region. During treatment, the ipsilateral arm was positioned in full abduction and elevation. No ocular shielding was applied during radiotherapy. Written informed consent was obtained from the patient for publication of this case report.

Results: Two years after completion of radiotherapy, the patient developed sudden onset of central visual loss in the form of an acute central scotoma. Funduscopic examination revealed a fresh macular hemorrhage. Optical coherence tomography demonstrated subretinal fluid and disruption of the retinal pigment epithelium. Fluorescein fundus angiography showed active leakage from newly formed abnormal vessels, findings consistent with choroidal neovascularization and radiation-induced macular degeneration.

Conclusion: Excessive arm elevation may have altered beam geometry and increased scatter radiation toward the orbit. In the absence of ocular protection, secondary radiation may reach the macula, leading to endothelial injury, ischemia, pathological neovascularization, and hemorrhage. This mechanism explains the delayed yet sudden visual loss observed in this patient. The retina is at risk during axillary radiotherapy. Ocular protection should be considered during treatment planning, and the potential for radiation-induced visual loss should be clearly explained to patients before the initiation of therapy.

Keywords: Axillary radiotherapy, breast cancer, macular degeneration, radiation retinopathy

[P-091]

Adrenal metastasis of pleomorphic sarcoma: A rare case report

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Objective: Pleomorphic sarcoma is one of the most common soft-tissue sarcoma subtypes, accounting for 10-15% of malignant soft-tissue tumors. The lungs, liver, and bones are the most frequent metastatic sites, while adrenal gland metastasis is extremely rare and reported only in a few case reports. Surgical resection of isolated adrenal metastasis may offer a survival benefit in selected patients.

Material and Methods: A 49-year-old male underwent surgery in 2018 for a posteriorly located left thigh mass, which was diagnosed as high-grade pleomorphic sarcoma. After adjuvant radiotherapy, a metastatic nodule in the left lower lung lobe was resected in 2020. During follow-up, metastasis developed in the right paraspinal region and left deltoid muscle; the patient received 20 cycles of chemotherapy and achieved a complete response. Local recurrence occurred in 2022 and was surgically resected.

Results: In the second quarter of 2025, a progressive solid lesion measuring 8×6.5 cm was detected in the right adrenal gland with high FDG uptake (SUV_{max}: 9.7) on PET-CT. The patient underwent right adrenalectomy. Intraoperatively, the mass was adherent to the retrohepatic vena cava; an iatrogenic injury occurred and was repaired primarily. Pathology confirmed metastatic pleomorphic sarcoma. Postoperative follow-up for 6 months after adrenalectomy is uneventful.

Conclusion: Adrenal metastasis of pleomorphic sarcoma is extremely rare. Surgical resection of isolated adrenal lesions can provide effective local control and disease-free survival. Even in cases with invasion of major vascular structures, adrenalectomy can be safely performed in experienced centers.

Keywords: Pleomorphic sarcoma, adrenal metastasis, adrenalectomy, soft tissue sarcoma, case report

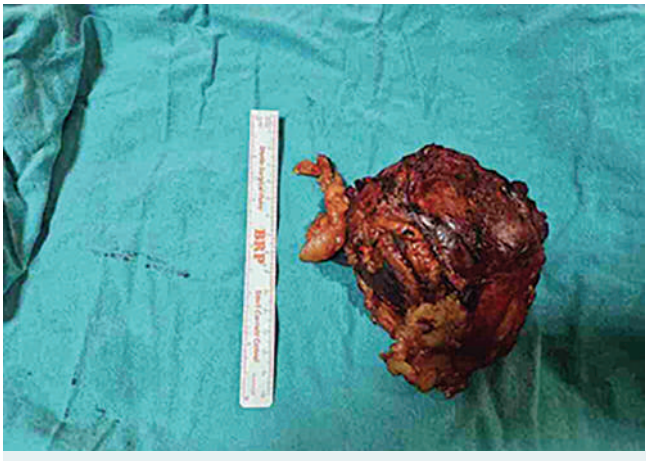

Figure 1. Macroscopic appearance of the resected adrenal gland containing metastatic pleomorphic sarcoma.

[P-103]

Bleeding well-differentiated gastric neuroendocrine tumor managed with a NOTES-based minimally invasive endoscopic approach: A case report

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Objective: Gastric neuroendocrine tumors (gNETs) are rare gastric neoplasms with heterogeneous biological behavior and are usually detected incidentally. Presentation with upper gastrointestinal bleeding is uncommon. Advances in therapeutic endoscopy have expanded organ-preserving options for selected patients, and NOTES-based minimally invasive concepts support effective treatment without skin incisions. We report a bleeding well-differentiated gNET successfully managed using an advanced minimally invasive endoscopic approach and highlight the importance of close surveillance.

Material and Methods: A 38-year-old woman without comorbidities was referred for upper gastrointestinal bleeding. An external center had identified a bleeding pedunculated gastric mass and recommended surgery. After multidisciplinary evaluation, minimally invasive endoscopic management was planned. Endoscopy demonstrated a ~5 cm pedunculated polypoid lesion on the greater curvature of the gastric corpus and adjacent diminutive polyps. An endoloop was placed at the stalk for preemptive hemostasis, followed by snare polypectomy with transoral retrieval. Due to suspected tumor involvement at the resection margin, a second session was performed with endoscopic mucosal resection after submucosal injection; intraprocedural arterial bleeding was controlled using hemoclips. The patient was enrolled in close endoscopic follow-up.

Results: Initial histopathology was consistent with a well-differentiated neuroendocrine tumor (Grade 1; Ki-67 2%; low mitotic activity). Specimens from the second session showed focal higher proliferation (Ki-67 5-10%), suggesting a Grade 2 component. Follow-up endoscopy at two months revealed diminutive polyps near the scar that were removed; pathology again demonstrated Grade 1 NET. No perforation or major post-procedural complications occurred, and no recurrence was observed during follow-up.

Conclusion: In bleeding well-differentiated gNETs, advanced minimally invasive endoscopic management may be a safe and effective alternative to surgery in appropriately selected patients at experienced centers. Variable Ki-67 findings across specimens suggest intratumoral heterogeneity, supporting comprehensive histopathological assessment and structured endoscopic surveillance.

Keywords: Gastric neuroendocrine tumor, minimally invasive endoscopy, upper gastrointestinal bleeding

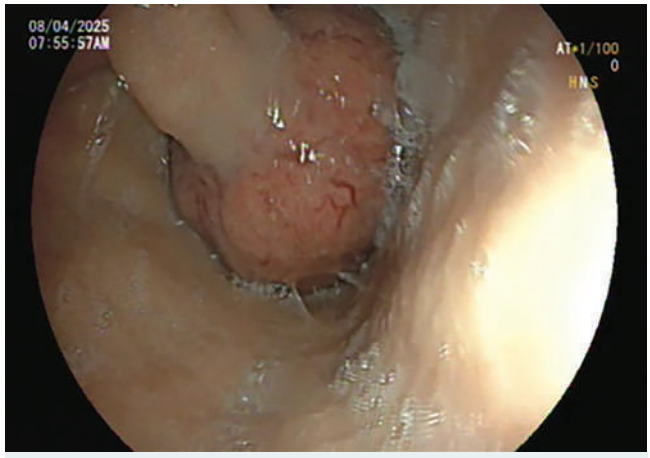

Figure 1. Endoscopic view of a giant polypoid lesion with an irregular stalk, about 5 cm in diameter, observed in the large curvature of the gastric corpus at the first gastroscopy.

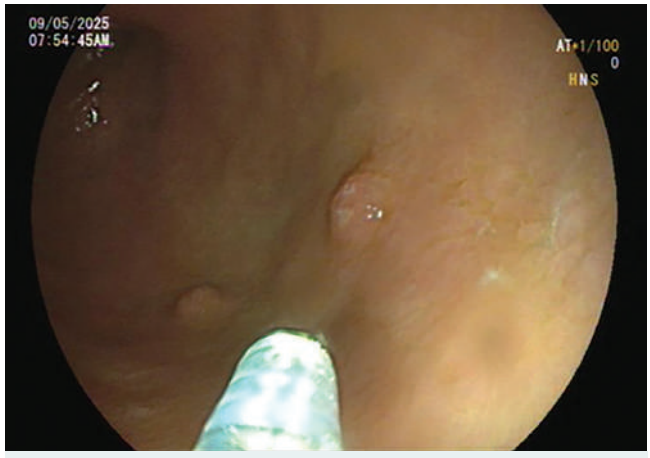

Figure 2. In the second session of gastroscopy, multiple diminutive polyps observed in and around the scar tissue showing battery convergence in the previous polypectomy area.

[P-104]

Unusual breast metastasis of gastrointestinal stromal tumor

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Objective: Gastrointestinal stromal tumor (GIST) is the most common mesenchymal neoplasm of the gastrointestinal tract and is believed to originate from the interstitial cells of Cajal. Metastasis most frequently involves the liver and peritoneum. Breast metastasis is extremely rare, with only a few cases reported in the literature. We present a rare case of isolated breast metastasis from a primary gastric GIST without liver or peritoneal involvement.

Material and Methods: A 70-year-old female patient previously underwent wedge resection for a gastric GIST and received adjuvant imatinib therapy for three years. After five years of disease-free follow-up, a mass was detected in the left breast. The patient underwent breast magnetic resonance imaging (MRI), PET-CT, abdominal CT, endoscopy, and colonoscopy. A biopsy of the breast mass was performed, followed by segmental resection. Histopathological and immunohistochemical analyses were conducted.

Results: Histopathological examination of the breast mass revealed a mesenchymal neoplasm. Immunohistochemical staining demonstrated similar characteristics between the primary gastric tumor and the breast lesion, including positivity for CD117 and CD34. Systemic evaluation showed no evidence of liver or peritoneal metastasis. The findings were consistent with isolated distant breast metastasis from the primary gastric GIST.

Conclusion: Breast metastasis from GIST is an exceptionally rare clinical entity and should be considered in the differential diagnosis of spindle cell lesions of the breast, particularly in patients with a history of GIST. Immunohistochemical evaluation plays a crucial role in establishing the diagnosis. This case contributes to the literature by demonstrating isolated breast metastasis without hepatic involvement.

We made a literature review, breast metastasis from GIST have been previously described three cases (Table 1).

Keywords: Breast, GIST, metastasis

Figure 1. Left breast mass, breast MRI.

Table 1. Literature review

	Author	Year	Age	Gender	Side	Primary location	Clinical status
1	Hasbay et al.	2017	46	Female	Left	Unknown	Systemic disease in diagnosis
2	Filonenko et al.	2022	55	Female	Right	Rectum	Systemic disease in diagnosis
3	Back et al.	2023	62	Female	Right	Jejunum	Systemic disease in diagnosis
4	Sarohan et al. (present case)	2025	70	Female	Left	Stomach	Isolated, monofocal, distant breast metastasis

[P-105]

Thoracic wall extraskeletal Ewing sarcoma: A rare case report

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Objective: Ewing sarcoma is predominantly a primary bone tumor; however, extraosseous involvement is rare and may clinically mimic benign soft-tissue lesions. In this report, we present the clinical, histopathological, and molecular characteristics of an extraskeletal Ewing sarcoma originating from the thoracic wall.

Material and Methods: A 21-year-old female patient presented with a rapidly enlarging subcutaneous mass in the right hypochondriac region that had progressed over a three-month period. Ultrasonographic evaluation revealed a 46×19 mm heterogeneous, hypervascular solid lesion, and surgical excision was subsequently performed. Intraoperatively, the mass was observed to extend between the intercostal muscle planes. Histopathological examination demonstrated a monomorphic population of small round cells, rosette-like structures, and areas of necrosis. Immunohistochemical analysis showed positivity for NKX2.2, while fluorescence *in situ* hybridization identified EWSR1 rearrangement with a t(22q12) translocation, supporting the diagnosis of Ewing sarcoma. The patient was referred for oncological follow-up and further treatment planning.

Results: Extraskeletal Ewing sarcomas may present as rapidly growing soft-tissue masses and encompass a broad differential diagnosis. Confirmation of the diagnosis relies on the integration of morphological findings with immunohistochemical markers and molecular analyses. Thoracic wall involvement poses additional challenges with regard to surgical planning and local disease control.

Conclusion: Ewing sarcoma should be considered in the differential diagnosis of rapidly enlarging thoracic wall masses in young patients. Early recognition and appropriate referral play a crucial role in establishing an effective and timely treatment strategy.

Keywords: EWSR1, extraskeletal Ewing sarcoma, soft tissue tumor

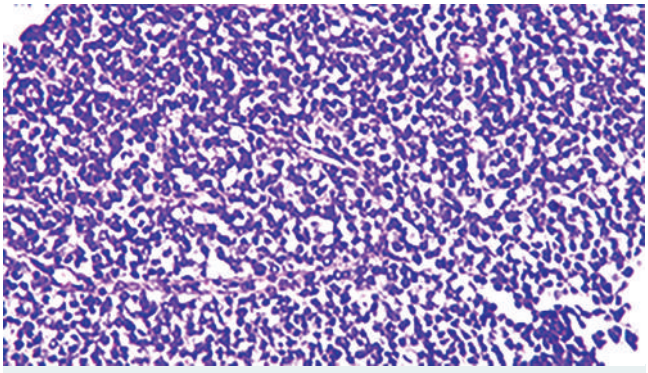

Figure 1. Histopathological features of extraskeletal Ewing sarcoma (H&E staining).

Hematoxylin and eosin–stained sections reveal a tumor composed of uniform small round cells with scant cytoplasm and round to oval nuclei. Occasional rosette-like structures and focal areas of necrosis are observed, consistent with the morphology of a small round blue cell tumor.

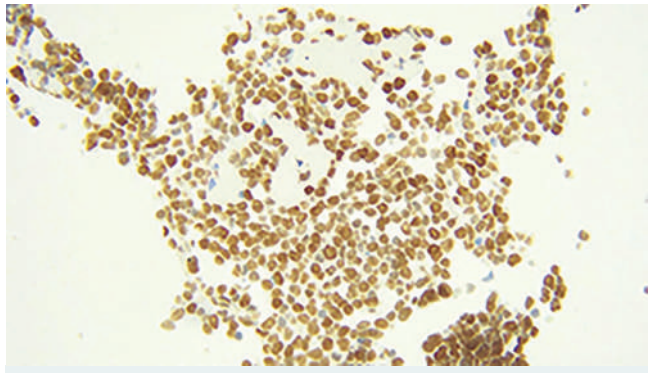

Figure 2. Immunohistochemical findings in extraskeletal Ewing sarcoma (NKX2.2 positivity).

Immunohistochemical analysis demonstrates diffuse nuclear positivity for NKX2.2 in tumor cells. The monomorphic population of small round cells is consistent with the diagnosis of Ewing sarcoma.

[P-106]

The effect of age on clinical and laboratory findings in patients with acute colonic diverticulitis: Comparison of patients over and under 70 years of age

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Objective: This study aims to evaluate the differences in clinical characteristics, complication rates, and laboratory parameters between patients over 70 years of age diagnosed with acute colonic diverticulitis and other age groups.

Material and Methods: Twenty-one patients over 18 years of age, of both sexes, diagnosed with acute colonic diverticulitis by clinical evaluation and computed tomography were included in the study. Patients were divided into two groups: those over 70 years of age and those under 70 years of age.

Results: The proportion of patients over 70 years of age was 19.9% (n=40), and the proportion of patients under 70 years of age was 80.1% (n=161). While female patients were in the majority in the over-70 age group, the proportion of male patients was higher in the under-70 age group (p=0.005). Right colon diverticulitis involving the cecum and ascending colon was not observed in patients over 70 years of age (p=0.022). Although the complication rate was higher in the under-70 age group, it was not statistically significant (p=0.060). In the multivariate regression analysis performed with variables that were significant with p<0.01 in univariate analyses of laboratory findings, only low GFR and high INR showed a significant difference between the two patient groups.

Conclusion: Right colon diverticulitis was not observed in patients over 70 years of age. It is known that symptomatic right colon diverticula are more common in younger patients, and the results of our study are consistent with the literature. Multivariate analysis showed a significant difference in GFR and INR in patients over 70 years of age. Low GFR and high INR are important indicators of organ failure, especially in the context of multiple organ dysfunction syndrome. Both parameters are of great importance in evaluating the severity and course of organ dysfunction in critically ill patients. The faster development of clinical deterioration in elderly patients may necessitate close monitoring and inpatient treatment. In our study, no significant difference was observed in complication rates between patient groups over and under 70 years of age. Although age is often considered a risk factor for complications, it is not a parameter that alone predicts negative outcomes. In addition, the presence of comorbidities, the type of surgical procedure performed, and the patient's overall health status are more critical in determining outcomes. This supports a more personalized patient care approach focusing on comprehensive preoperative assessments and individualized postoperative management strategies to ensure optimal outcomes in all patients.

Keyword: Acute colonic diverticulitis

[P-107]

The challenging stoma care process from debulking surgery to short bowel syndrome: A case report

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Objective: Complications following gynecological oncology surgeries can seriously affect both the physical health and quality of life of the patient. Conditions such as anastomotic leakage, stoma ischemia, and short bowel syndrome are significant problems that negatively impact the patient's quality of life and treatment process. Peristomal complications require a multidisciplinary approach and meticulous wound/stoma care. This presentation addresses the complex stoma management and care process following repeated surgeries.

Material and Methods: A 63-year-old female patient was diagnosed with Stage 4 Serous Ovarian Carcinoma and underwent total colectomy with debulking (TAH + BSO + omentectomy) at a university hospital, where an end-of-stomach ileostomy was created in the right quadrant and she was discharged. Three months after the surgery, she presented to our hospital with hyperemia and discharge in the peristomal area. She underwent surgery due to anastomotic leakage. Early ischemia in the newly created stoma was regularly monitored. Because the ischemia progressed towards the incision line and an abscess developed, a second surgery was performed 20 days later to debride the infective slag-filled areas and establish a vacuum system. The newly created stoma had to be moved back to the right quadrant. Following the second surgery, the patient, diagnosed with short bowel syndrome, was monitored with parenteral nutrition, gradually opened orally, and mobilization was supported. From the early postoperative period, efforts were made to improve and protect peristomal skin integrity using barrier spray, stoma powder, hydrocolloid dressing, hyaluronic acid-based silver spray, and a stoma belt. Due to the proximity of the peristomal area to the incision line and contact with bowel contents, cleaning was performed with a hypochlorous acid-based wound antiseptic.

Results: Initially, the patient experienced leakage and skin irritation requiring adapter changes four times a day. However, after the implementation of barrier methods and the transition to a convex system, the adapter change interval was extended to five days. Peristomal skin integrity was preserved, and drainage to the incision line was prevented. The patient's gradual transition from parenteral to oral feeding and mobilization improved proportionally with increased stoma security.

Conclusion: In high-output stoma situations such as short bowel syndrome, proper product selection and professional stoma care are vital. Maintaining stoma viability and ensuring peristomal skin integrity significantly improves the patient's quality of life and contributes positively to stoma adaptation. In challenging and multi-stage surgeries, individualized stoma care, conducted in collaboration with the patient, plays a crucial role in the successful completion of the treatment process.

Keywords: Stoma care, wound care, stoma and wound care nursing

Figure 1. Stoma monitoring process.

Figure 2. Healing process.

[P-108]

Breast-localized Mondor disease: The importance of clinicopathological correlation in a rare case mimicking malignancy

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Objective: Mondor disease is a rare clinical entity characterized by thrombophlebitis of the superficial veins of the breast and anterior chest wall. Because it may clinically and radiologically mimic malignancy with findings such as a palpable cordlike induration and skin retractionlike appearance, it is important in the differential diagnosis. Conditions to be considered in the differential diagnosis of Mondor disease include cellulitis, erythema nodosum, lymphangiectasia, lymphangioma and metastatic skin cancers. In Mondor disease, the lateral thoracic vein, thoracoepigastric vein and superior epigastric vein may be involved with the thoracoepigastric vein being the most commonly affected. In this case report we present the diagnostic process of a patient with concern for breast cancer in whom malignancy was excluded and a diagnosis of Mondor disease was established through correlation of clinical and radiological findings with histopathology.

Material and Methods: A 36 year old female patient presented with sudden onset localized tenderness in the retroareolar region of the right breast, exacerbated by movement, along with a sensation of a cordlike, firm band under the skin. Her history revealed recent use of a tight bra and engagement in activities/exercises straining the upper extremity; she denied fever, nipple discharge or marked erythema. There was no family history of breast cancer. On physical examination, a localized firm area with associated tenderness was noted on palpation in the right retroareolar region. On inspection, a linearly oriented, cord-like band appearance conse immunohistochemical stent with the patient's description, along with mild skin retraction, was observed. Following clinical evaluation, breast ultrasonography was planned. Imaging demonstrated a solid lesion measuring approximately 17×10 mm in the retroareolar region of the right breast, with oval contours, well-defined margins, and focal areas of cystic degeneration. To exclude malignancy, a biopsy was obtained from the lesion, and histopathological examination with immunohistochemical evaluation, where appropriate, was performed.

Results: Histopathological examination revealed prominent inflammatory cell infiltration within the breast parenchyma, with lymphocyte-predominant inflammatory involvement of some venous walls, findings indicative of thrombophlebitis of superficial venous structures (Figures 1 and 2). On immunohistochemical analysis, no findings suggestive of malignancy or invasion were observed with pan-cytokeratin (Pan-CK) staining (Figure 3). When evaluated together with the clinical and imaging findings, the overall picture was considered consistent with Mondor disease.

Conclusion: Breast-localized Mondor disease may mimic mass lesions on physical examination and imaging, leading to suspicion of malignancy. Therefore, histopathological confirmation and clinicopathological correlation are of critical importance to avoid unnecessary surgical interventions. This case demonstrates that careful evaluation of venous wall inflammation and exclusion of malignancy through immunohistochemical methods are decisive in the diagnostic process. In most patients, a conservative approach is sufficient, and excessive interventions should be avoided in patient management.

Keywords: Biopsy, breast, clinicopathological correlation, Mondor disease, superficial thrombophlebitis

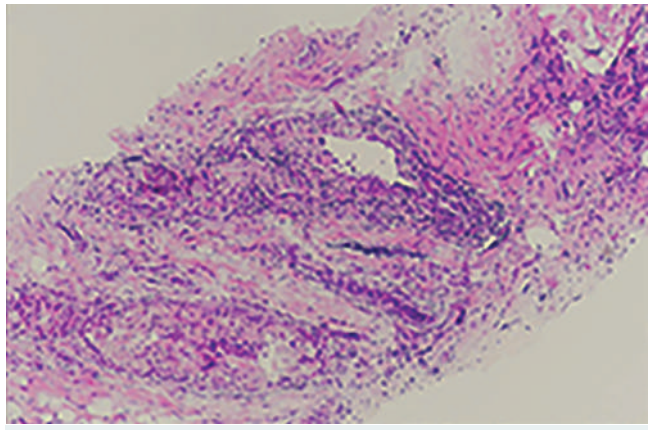

Figure 1.

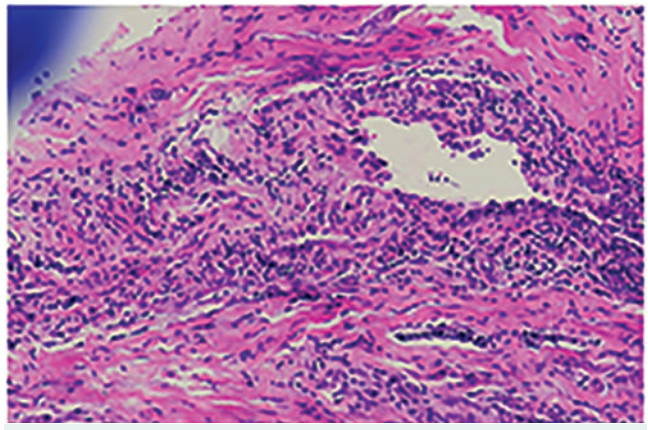

Figure 2.

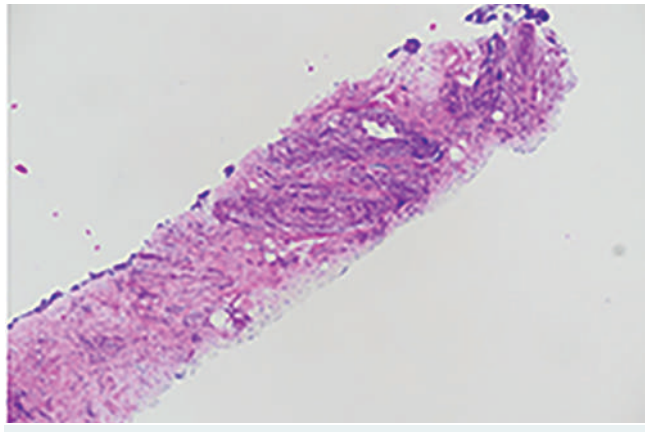

Figure 3.

[P-109]

A rare complication of calculous chronic cholecystitis: A case of cholecystocutaneous fistula

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Objective: Cholecystocutaneous fistula is a rare complication in contemporary practice, characterized by the spontaneous fistulization of the gallbladder to the skin. The most common cause is untreated calculous cholecystitis, and its incidence has markedly decreased due to early surgical interventions.

Material and Methods: The patient's clinical, radiological, intraoperative, and histopathological data were evaluated retrospectively. Preoperative assessment was performed using physical examination, laboratory tests, and contrast-enhanced abdominal computed tomography (CT). Surgical treatment was carried out via an open approach through a right subcostal incision. The resection specimen was submitted for standard histopathological examination.

Results: A 74-year-old female patient presented with a long-standing draining wound in the right upper quadrant. Her medical history revealed intermittent right upper quadrant pain. On physical examination, a cutaneous fistula opening with purulent drainage was observed in the right hypochondrium. Laboratory tests showed leukocytosis and elevated inflammatory markers. Contrast-enhanced abdominal CT demonstrated gallstones, marked thickening of the gallbladder wall, and a fistulous tract extending from the gallbladder to the skin surface. The findings were consistent with a cholecystocutaneous fistula. The patient was operated on under elective conditions. During exploration through a right subcostal incision, the gallbladder was found to be adherent to the anterior abdominal wall and opening to the skin surface via a fistulous tract. The gallbladder containing stones was dissected, and a cholecystectomy was performed. The fistulous tract was totally excised. After achieving hemostasis, a drain was placed and the operation was concluded. The postoperative course was uneventful. The patient was discharged without complications. Histopathological examination was consistent with chronic calculous cholecystitis.

Conclusion: Cholecystocutaneous fistula, although rare today, is a serious complication of chronic calculous cholecystitis. It should be considered in the differential diagnosis in the presence of a chronic draining lesion in the right upper quadrant. Contrast-enhanced CT plays an important role in diagnosis and surgical planning. The definitive treatment is cholecystectomy and total excision of the fistulous tract. Successful outcomes can be achieved with appropriate surgical intervention.

Keyword: Cholecystocutaneous fistula

Figure 1. Preoperative CT image. Preoperative CT scan shows a cholecystocutaneous fistula.

Figure 2. Intraoperative cholecystocutaneous fistula tract. The intraoperative cholecystocutaneous fistula tract was identified and excised.

[P-110]

A rare case of SGLT-2–associated refractory metabolic acidosis following robotic left hemicolectomy

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Objective: Sodium-glucose cotransporter-2 (SGLT-2) inhibitors are oral antihyperglycemic agents widely used in the management of type 2 diabetes mellitus and are generally considered safe. However, euglycemic diabetic ketoacidosis (EDKA) is a rare but serious complication associated with this drug class. Unlike classical diabetic ketoacidosis, SGLT-2 inhibitor-associated DKA may present with severe metabolic acidosis despite normal or only mildly to moderately elevated serum glucose levels. In addition, cases of non-ketotic, normal anion gap metabolic acidosis have also been reported. During the perioperative period, surgical stress, acute illness, and reduced carbohydrate intake may increase the risk of EDKA. Near-normal glucose levels may delay diagnosis and treatment. Herein, we present a case of non-ketotic, euglycemic/mildly hyperglycemic metabolic acidosis that developed after reinitiation of empagliflozin following robotic left hemicolectomy.

Material and Methods: A 59-year-old male was diagnosed with adenocarcinoma on biopsy obtained from the sigmoid colon during screening colonoscopy performed due to family history. Robotic left hemicolectomy was planned. Sitagliptin, insulin glargine, and empagliflozin were discontinued two days prior to surgery. On postoperative day 6, oral intake was resumed and antidiabetic therapy was restarted.

Results: On postoperative day 7, the patient developed nausea, vomiting, tachycardia, and polyuria. Cardiac, pulmonary, and intra-abdominal complications were excluded. Arterial blood gas analysis revealed severe metabolic acidosis with pH 7.041, bicarbonate 9 mmol/L, sodium 147 mmol/L, chloride 121 mmol/L, and lactate 2.1 mmol/L. Plasma glucose was 249 mg/dL, creatinine 0.73 mg/dL, and albumin 4.3 g/dL. Urinalysis showed negative ketones and positive glucose. Normal lactate levels excluded lactic acidosis and sepsis. The patient was diagnosed with euglycemic/mildly hyperglycemic hyperchloremic metabolic acidosis. Oral antidiabetic agents were discontinued, and intensive intravenous fluid resuscitation along with insulin infusion therapy was initiated. The primary goals of treatment were correction of volume depletion, restoration of glucose–insulin balance, and suppression of keto/preketotic metabolism. Clinical and metabolic improvement was observed during follow-up. Repeat urinalysis demonstrated persistent glycosuria with negative ketones. The patient was discharged after adjustment of antidiabetic therapy.

Conclusion: SGLT-2 inhibitors increase urinary glucose excretion by inhibiting proximal tubular glucose reabsorption. Persistence of glycosuric effects beyond 48 hours after drug discontinuation, combined with postoperative stress hormone elevation and inadequate caloric intake, may reduce the insulin-to-glucagon ratio and precipitate resistant metabolic acidosis. Therefore, discontinuation of SGLT-2 inhibitors at least 48-72 hours prior to surgery is recommended. High clinical awareness is essential in atypical presentations to enable early diagnosis and prompt, effective management.

Keywords: Robotic left hemicolectomy, SGLT-2 inhibitors, postoperative metabolic acidosis

Table 1. Arterial blood gas values

pH	Lactate	Glucose	Chloride	HCO_3-	Sodium
7.061	2.9	247	-	7.2	141
7.041	2.1	247	116	6.0	146
7.302	0.8	151	-	11.6	143
7.203	1.5	158	121	9.9	147
7.334	1.3	149	116	13.0	146

[P-111]

Colonic perforation due to ventriculoperitoneal shunt migration: A rare complication

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Objective: Ventriculoperitoneal (VP) shunting remains the most commonly performed surgical procedure for the management of hydrocephalus. Although VP shunts are generally considered safe, various complications may occur, including infection, obstruction, mechanical failure, and catheter migration. Gastrointestinal perforation caused by distal catheter erosion is an extremely rare but serious complication, potentially leading to peritonitis, sepsis, and mortality. In this report, we present an unusual case of asymptomatic sigmoid colon perforation with transanal protrusion of the VP shunt catheter.

Material and Methods: This report describes the clinical presentation, radiological findings, surgical management and postoperative course of a patient diagnosed with colonic perforation secondary to VP shunt migration. Clinical examination, laboratory evaluation, abdominal computed tomography and intraoperative findings were reviewed retrospectively.

Results: A 27-year-old male patient with a history of decompressive craniectomy developed post-hemorrhagic hydrocephalus and underwent VP shunt placement in 2021. He was admitted to the emergency department after noticing extrusion of the distal catheter through the anus. Remarkably, the patient did not report abdominal pain, fever, nausea, vomiting, or changes in bowel habits. On physical examination, the distal end of the shunt catheter was visibly protruding from the anal canal. Abdominal examination revealed no tenderness, guarding, or rebound, and laboratory findings were unremarkable, suggesting the absence of acute intra-abdominal infection. Abdominal computed tomography demonstrated that the peritoneal catheter had migrated into the pelvic cavity, perforated the sigmoid colon, and advanced intraluminally through the rectum, resulting in transanal extrusion. A diagnosis of asymptomatic colonic perforation secondary to VP shunt migration was established. The patient underwent urgent exploratory laparotomy. Intraoperative findings confirmed perforation of the sigmoid colon caused by the catheter. The shunt was identified in the subcutaneous tract, ligated at the abdominal entry site, and the distal segment was carefully removed transanally. The colonic defect was repaired primarily. Postoperatively, the patient was closely monitored in collaboration with the neurosurgery team. No complications such as peritonitis or sepsis developed, and the patient was discharged uneventfully on postoperative day five.

Conclusion: Colonic perforation due to VP shunt migration is a rare but potentially life-threatening complication. Clinical presentation may be subtle, and patients can remain asymptomatic until transanal protrusion occurs. Most reported cases in the literature present with abdominal symptoms or infectious complications, whereas our patient remained clinically asymptomatic. Early recognition, appropriate imaging, and timely surgical management are crucial for preventing severe infectious outcomes. Multidisciplinary follow-up is essential in the treatment of such complex cases.

Keywords: Hydrocephalus, ventriculoperitoneal shunt, catheter migration, colonic perforation, transanal protrusion

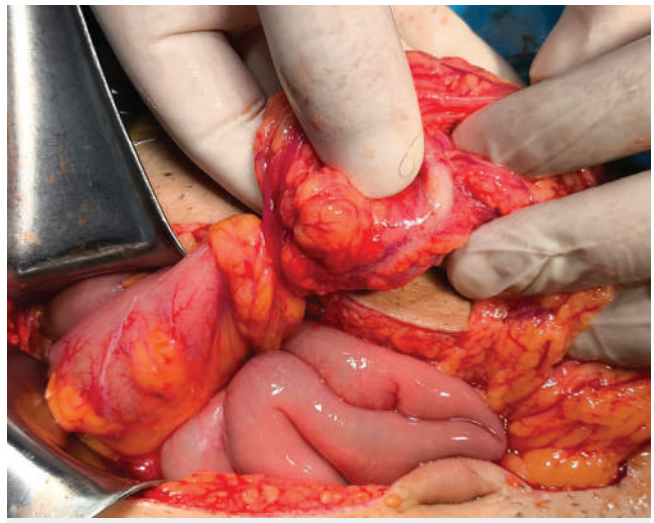

Figure 1. Intraoperative view of sigmoid colon perforation caused by distal migration of the VP shunt catheter.

Figure 2. Removal of the migrated distal VP shunt catheter during surgery.

[P-112]

Emergency laparoscopic appendectomy in a patient with a history of semaglutide use who developed appendiceal mesenteric infarction: A case report

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Objective: The appendix mesentery contains the arteries, veins, and lymphatic vessels of the appendix. The appendix is usually supplied by a single terminal artery. Due to the single terminal artery nature of the Arteria appendicularis passing through the appendix mesentery, infarction inevitably leads to rapid ischemia of the appendix, and surgical appendectomy is the only treatment option. On the other hand, Semaglutide, an active ingredient whose use is rapidly increasing today for obesity/weight management indications, is a GLP-1 receptor agonist and was discovered in 2012. It was approved by the FDA in 2017. In 2018, its use for obesity/weight management indications began in the US. There are studies in the literature indicating that it does not increase the risk of infarction. This case presentation describes a patient with a history of Semaglutide use who developed appendiceal mesenteric infarction.

Material and Methods: The clinical and laboratory data of the patient included in the study were reviewed retrospectively.

Results: A 33-year-old male patient with no known comorbidities or history of surgery presented to the emergency department with complaints of nausea and vomiting accompanied by abdominal pain localized to the right lower quadrant, which had been progressively worsening for 5 days. It was learned that the patient had started semaglutide treatment at another center 29 days prior to presentation due to obesity. There is no history of coagulation disorders in the family. Physical examination revealed generalized abdominal tenderness, defense, and rebound tenderness in the right lower quadrant. Rectal examination was normal. Laboratory tests showed WBC: 12.2×10^9/L, total bilirubin: 1.7 mg/dL, direct bilirubin: 0.4 mg/dL, CRP: 14.9 mg/L; INR: 0.9 within normal limits. Contrast-enhanced abdominal CT showed a 16×12 mm hypodense area in the distal vermiform appendix with retrocecal placement and marked contamination in the surrounding mesenteric fat tissue. Based on the current clinical and radiological findings, emergency surgery was planned. During exploration, an approximately 2 cm area of infarction was detected in the appendix mesentery, and laparoscopic appendectomy was performed. The patient had an uneventful postoperative course and was discharged on postoperative day 2 with an ASA prescription.

Conclusion: The development of isolated mesenteric infarction of the appendix following semaglutide use in this patient without comorbidities or coagulation disorders suggests that further clinical and experimental studies are needed to elucidate the potential vascular or microcirculatory effects of semaglutide.

Keywords: Appendix, semaglutide, mesenteric infarction of the appendix

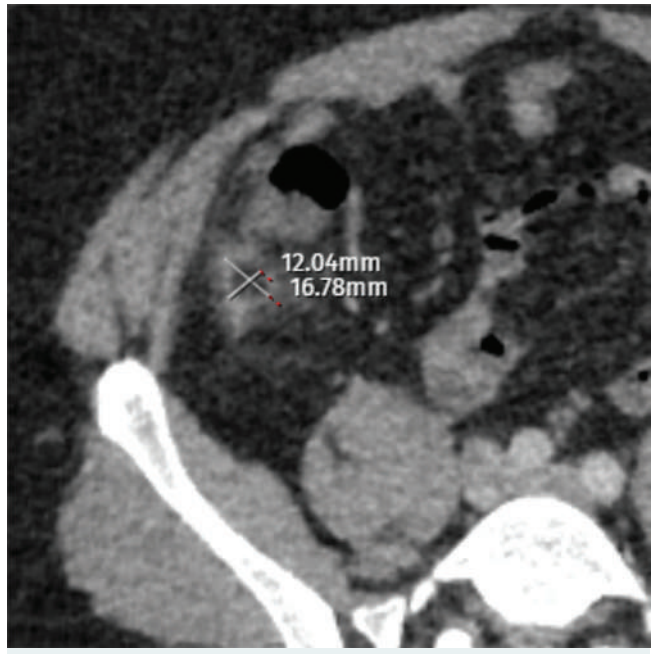

Figure 1. CT imaging. Fat necrosis? Mental infarction? Area at the distal vermiform appendix.

Figure 2. Main specimen.

[P-113]

Ruptured cholangitic liver abscess presenting as acute abdomen in locally advanced pancreatic cancer: A case report

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Objective: Pancreatic cancer is an aggressive malignancy associated with high mortality and morbidity. Gastrointestinal perforations are rare in locally advanced pancreatic cancer and are typically linked to direct tumor invasion or post-chemoradiotherapy necrosis. However, acute abdomen secondary to the rupture of a cholangitic abscess is highly atypical and infrequently documented in literature.

Material and Methods: We retrospectively evaluated the clinical course of a 65-year-old male patient with locally advanced pancreatic cancer and a metallic biliary stent. The diagnostic process, findings of emergency surgical exploration for acute abdomen, and postoperative biliary restoration via ERCP are analyzed and reported.

Results: We report the case of a 65-year-old man diagnosed two months prior with locally advanced pancreatic head adenocarcinoma, who had undergone metallic biliary stent placement. He initially presented to the emergency department with epigastric pain, nausea, and vomiting. His symptoms transiently improved with symptomatic treatment, and he was discharged against medical advice. He re-presented the following day with persistent complaints. Imaging revealed intraperitoneal free air, and a physical examination demonstrated signs of an acute abdomen, necessitating emergent surgical exploration. Intraoperative findings ruled out definite perforation in the duodenum, stomach, or small bowel. Instead, widespread peritonitis and a biliary leak were identified adjacent to the mass invading the hepatoduodenal ligament, originating from the rupture of a cholangitic abscess located in hepatic segment 2. The deformed Glisson's capsule overlying the abscess was incised, the cavity was debrided, and the intrahepatic bile ducts were repaired. Postoperatively, an endoscopic retrograde cholangiopancreatography (ERCP) was performed to replace the obstructed stent, and the patient achieved clinical improvement with targeted antibiotic therapy. Perforation in patients with pancreatic cancer is a marker of poor prognosis, most commonly resulting from tumor invasion into adjacent organs. In contrast, our case highlights a rare acute abdomen etiology caused by the rupture of a cholangitic liver abscess that developed secondary to a blocked biliary stent. This emphasizes the critical importance of biliary stent surveillance and aggressive cholangitis management in the multidisciplinary care of locally advanced pancreatic cancer patients.

Conclusion: In patients with locally advanced pancreatic cancer who develop an acute abdomen, atypical causes such as the rupture of a cholangitic abscess due to stent occlusion must be considered in the differential diagnosis, in addition to perforation related to tumor invasion. Early surgical intervention and prompt control of the infectious source are paramount for improving survival in these patients.

Keywords: Pancreatic cancer, cholangitis, liver abscess, rupture, biliary stent

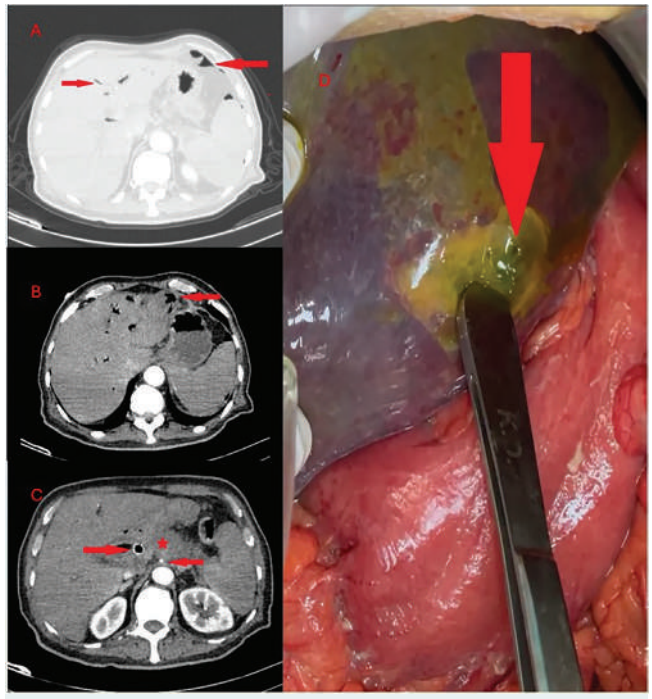

Figure 1. Preoperative radiological evaluation and Intraoperative findings. (A) Abdominal CT scan shows subdiaphragmatic free air (left arrow) and intrahepatic pneumobilia (right arrow). (B) Suspected rupture area at the level of Segment 2 of the liver (left arrow). (C) Mass at the head of the pancreas (star) and metallic biliary stent (right arrow). (D) Intraoperative image: Glisson's capsule opened, cavity debridement performed, and U-suture repair.

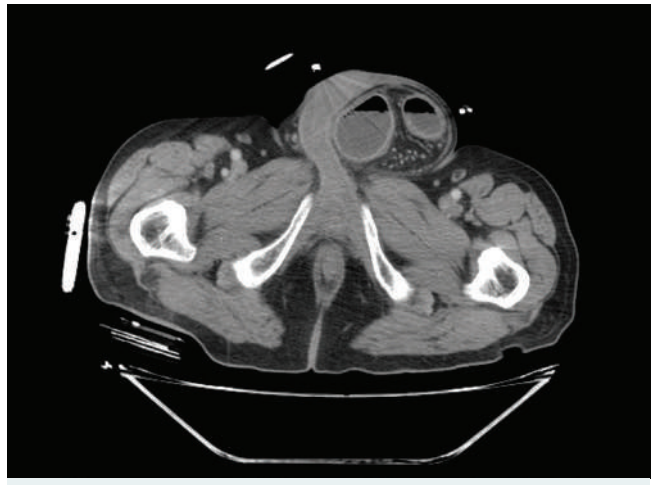

Figure 2. Sigmoid colon within the strangulated hernia on CT.

[P-114]

Persistent postoperative distension revealing an occult colorectal cancer after emergency inguinal hernia repair

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Objective: Strangulated inguinal hernias are a frequent cause of emergency surgery. The presence of a colon segment within the hernia sac is rare, and the presence of a secondary mechanical obstruction due to distal colorectal malignancy is even more unusual. This poster aims to present a rare case of a patient operated on for a strangulated inguinal hernia, in whom persistent postoperative distension revealed underlying occult colorectal cancer.

Material and Methods: This study retrospectively evaluated the clinical course, imaging and endoscopic findings, and surgical treatment of a patient who underwent surgery for ileus. Informed consent was obtained from the patient.

Results: A 71-year-old male patient presented to the emergency department with complaints of inability to pass gas and stool, nausea, and vomiting for two days, along with an unreducible swelling in his left groin. Physical examination revealed a strangulated left inguinal hernia and abdominal distension. Plain abdominal X-ray showed colonic air-fluid levels. Abdominal CT showed incarceration of a segment of the sigmoid colon in the left inguinal canal and dilation throughout the entire colon proximally. Following nasogastric decompression, the patient underwent emergency surgery. Exploration under spinal anesthesia revealed a strangulated but viable sigmoid colon with good blood supply within the hernia sac. The bowel was reduced to the abdomen, and due to the absence of contamination, the hernia was repaired with prolene mesh. On the first postoperative day, persistent abdominal distension led to further nasogastric decompression and enema administration. On the second day, due to increased distension and the passage of approximately 2000 mL of fecal matter via nasogastric drainage, a contrast-enhanced whole-abdomen CT scan was performed. The CT scan revealed significant dilation throughout the colon and small intestine, starting from the rectosigmoid junction. Rectosigmoidoscopy revealed a mass lesion 16 cm from the anal verge, completely obstructing the lumen. The patient underwent reoperation 48 hours postoperatively, with low anterior resection of the rectosigmoid junction. Due to proximal colonic dilation and the patient's clinical condition, anastomosis was omitted, and the Hartmann procedure was chosen instead. Pathology reported the tumor as a T2N0 stage adenocarcinoma. The patient had an uneventful postoperative course and was discharged; no recurrence was detected during follow-up, and the colostomy was closed.

Conclusion: Persistent postoperative distension following strangulated inguinal hernia should not be dismissed with the assumption of paralytic ileus. Especially in elderly patients, the possibility of distal mechanical obstruction and occult colorectal malignancy should be kept in mind, and a secondary area of obstruction should be ruled out with early further investigation.

Keywords: Colonic obstruction, inguinal hernia, postoperative distension, strangulation

Figure 1. The initial pre-operative CT scan showed the sigmoid colon within a strangulated hernia. CT scan of sigmoid colon within strangulated hernia.

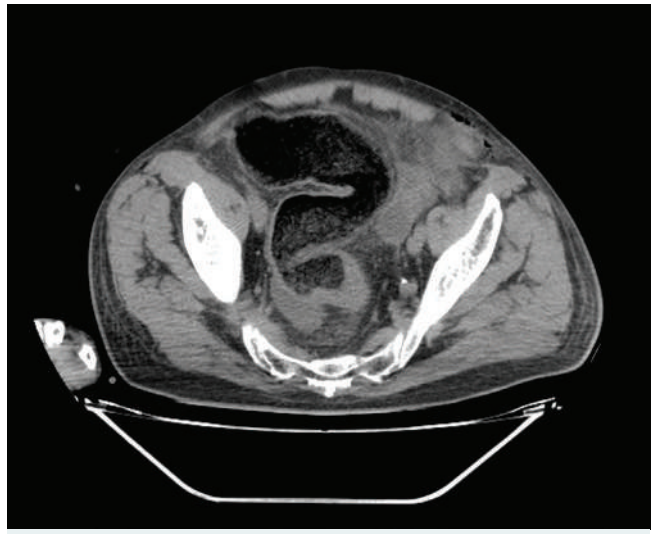

Figure 2. Contrast-enhanced CT scan on the second postoperative day revealed a scirrhous mass at the rectosigmoid junction and dilation proximal to it.

[P-115]

Pancreatic injury in major blunt trauma

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Objective: Blunt pancreatic injuries are relatively rare, accounting for only 0.25% of all trauma cases and 2.4% of abdominal traumas, and are associated with 4.3% of trauma-related mortality. Isolated pancreatic injuries are uncommon. In this study, we present two cases of AAST Grade 4 pancreatic injuries that were managed using non-operative approaches.

Material and Methods: The clinical courses of two patients with high-grade pancreatic injuries were retrospectively reviewed and compared with current literature.

Results: Two patients with AAST Grade IV pancreatic injuries were initially managed with non-operative follow-up. In one patient, distal pancreatectomy with splenectomy was performed due to deterioration of hemodynamic parameters and the development of generalized peritonitis at the 30th hour of follow-up. The second patient was successfully managed non-operatively and discharged. The operated patient was a 27-year-old male with pancreatic injury accompanied by multiple extremity traumas. Following the initial operation, he underwent three additional re-explorations for peritoneal lavage. At approximately one month of follow-up, he continues to be monitored with a pancreatic fistula producing a daily output of approximately 100 mL. The second patient was a 43-year-old male with an isolated pancreatic injury. CT-guided drainage catheters were placed for pseudocysts by the interventional radiology team. MRCP and ERCP demonstrated misalignment of the proximal and distal ends of the transected pancreatic duct, and stent placement was not feasible. During follow-up, the patient was discharged at the end of the first month with a daily drainage output of less than 50 mL.

Conclusion: In patients with grade IV pancreatic injuries, the treatment approach should be individualized according to the patient's hemodynamic status and clinical course. While surgical intervention may be unavoidable in certain cases, non-operative management can be considered a viable option in carefully selected patients when managed in appropriately equipped centers with multidisciplinary expertise. These cases highlight the importance of close monitoring and flexible treatment strategies in the management of high-grade pancreatic injuries.

Keywords: Blunt pancreatic injury, non-operative management

Figure 1. Control tomography of the operated patient taken before the operation.

Figure 2. Admission CT scan of a patient who underwent non-operative treatment.

[P-116]

Management of postoperative nursing care in a patient who underwent pancreaticoduodenectomy (Whipple) due to periampullary tumor: A case presentation

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Objective: The aim of this study is to evaluate the nursing care provided during the diagnostic, treatment, and surgical processes of a patient diagnosed with a periampullary tumor who underwent pancreaticoduodenectomy (Whipple procedure).

Material and Methods: Patient: 61-year-old female.

Chief complaint: Fatigue, abdominal pain.

History: Three months ago, the patient presented to a different medical center with fatigue and abdominal pain. Investigations revealed choledocholithiasis. Further imaging with CT and endoscopic retrograde cholangiopancreatography detected a periampullary tumor. She was referred to our department after evaluation by the Gastrointestinal-Oncology Council. The patient was admitted to General Surgery (Ward 53) for surgical management.

Present condition: No active complaints. No jaundice. Normal stool and urine color. No abdominal pain.

Past surgery: None.

Allergies: None.

Medical history: Diabetes mellitus.

Medications: Novomix FlexPen, Forziga.

Surgical procedure: Pancreaticoduodenectomy on 15.01.2026. Postoperatively, the patient was monitored in the general surgery ICU for 2 days. After achieving hemodynamic stability, she was transferred to Ward 53 with an NG tube, feeding tube, one sump drain, Foley catheter, arterial line, and two peripheral IV lines.

Results: In the postoperative period, comprehensive nursing care was provided. To prevent atelectasis, breathing exercises were taught and early mobilization was encouraged. Drain output was monitored for amount and color, and the sump drain was changed as scheduled. Hourly urine output was measured via Foley catheter, and the patient was observed for signs of infection. Pain was assessed using a standardized scale, and prescribed analgesics were administered. As the patient was receiving anticoagulants, bleeding risk was closely monitored and laboratory values were recorded. Blood glucose levels, previously uncontrolled preoperatively, were carefully followed and regulated postoperatively. Due to leakage around the sump drain, it was removed and replaced with a wound pouch; the drainage characteristics were monitored and documented each shift. On postoperative day 6, oral feeding was commenced with a prescribed dumping diet. A multidisciplinary approach supported the patient's daily activities and self-care. Systematic nursing care played a key role in preventing potential postoperative complications.

Conclusion: Pancreaticoduodenectomy is an effective treatment option for periampullary tumors when performed with appropriate patient selection and a multidisciplinary approach. In this case, it was observed that teamwork and structured nursing care played a significant role in patient management from the diagnostic process through surgery and the postoperative care period. In surgical patients, early diagnosis, appropriate surgical intervention, and systematic care practices are critical in reducing complications and accelerating recovery.

Keywords: Nursing care, postoperative period, pancreaticoduodenectomy

Figure 1. Relationship of the pancreatic pseudocyst with the stomach and omentum during laparoscopic exploration. Contrast-enhanced abdominal computed tomography shows a recurrent pancreatic pseudocyst at the level of the pancreatic body–tail, accompanied by marked ductal dilatation and surrounding peripancreatic inflammatory changes.

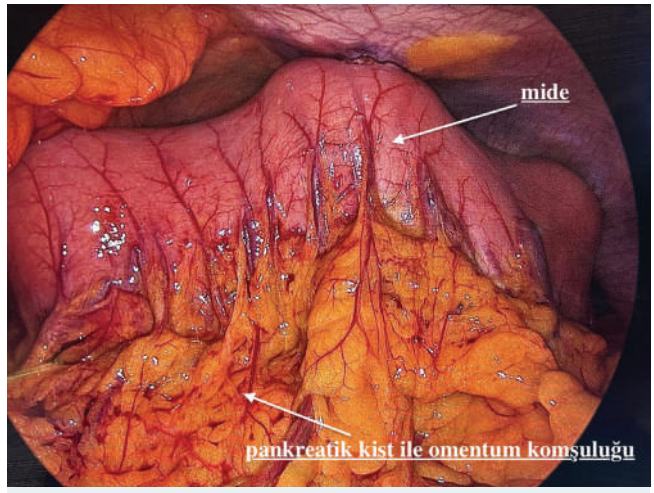

Figure 2. View of laparoscopic intragastric cystogastrostomy and the anastomosis line. During laparoscopic exploration, the pancreatic pseudocyst is seen in close proximity to the posterior gastric wall and the omentum. The cyst is located posteriorly and displaces the stomach anteriorly.

[P-119]

Laparoscopic management of a recurrent pancreatic pseudocyst despite minimally invasive interventions: A case report

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Objective: Percutaneous and endoscopic interventions are considered first-line treatment options for pancreatic fluid collections following acute necrotizing pancreatitis. However, despite these minimally invasive approaches, recurrent pancreatic pseudocysts remain a clinical challenge, particularly in complex cases 3. This case report presents the laparoscopic surgical management of a recurrent pancreatic pseudocyst in a patient who previously underwent percutaneous and endoscopic interventions.

Material and Methods: A 41-year-old male patient with no known comorbidities or familial/genetic pancreatic disease presented with abdominal pain exacerbated by fatty meals and was diagnosed with acute biliary pancreatitis. Despite medical treatment, persistent pancreatitis findings and the development of a giant pancreatic pseudocyst were observed. The patient underwent percutaneous cholecystostomy and endoscopic cystogastrostomy at different centers. Following laparoscopic cholecystectomy, the patient remained clinically stable; however, approximately one year later, follow-up imaging revealed a recurrent pancreatic pseudocyst with marked ductal dilatation at the pancreatic body-tail junction (Figure 1). Due to persistent symptoms and recurrence despite conservative and endoscopic management, laparoscopic exploration was performed. Intraoperatively, the pseudocyst was found to be located posteriorly, closely associated with the stomach and omentum, causing anterior displacement of the stomach (Figure 2). A laparoscopic intragastric cystogastrostomy was performed. As shown in Figure 3, the cyst was drained transgastrically through the posterior gastric wall, and a wide cystogastrostomy anastomosis was created. The postoperative course was uneventful, oral intake was resumed early, and the patient was discharged. At one- and three-month follow-up visits, the patient remained asymptomatic, and no recurrence was detected on imaging.

Results: Current management of pancreatic fluid collections following acute necrotizing pancreatitis favors a step-up approach with minimally invasive techniques. While percutaneous and endoscopic interventions are effective in many cases, recurrence remains a concern, particularly in patients with necrotizing pancreatitis. Previous studies have reported that, in selected cases, surgical drainage may provide more durable long-term outcomes compared to endoscopic approaches. In patients with large, complex, or recurrent pancreatic pseudocysts—especially those who have undergone multiple prior interventions—laparoscopic surgical management represents an important treatment option. This case highlights that, despite advances in minimally invasive endoscopic techniques, surgery continues to play a critical role in the management of complex pancreatic fluid collections.

Conclusion: Pancreatic pseudocysts may recur despite percutaneous and endoscopic interventions. In recurrent and complex cases, laparoscopic surgery is a safe and effective treatment option. A step-up and multidisciplinary approach is essential to achieve optimal outcomes in the management of pancreatic pseudocysts.

Keywords: Pancreatic pseudocyst, recurrence, laparoscopic surgery, step-up approach, cystogastrostomy

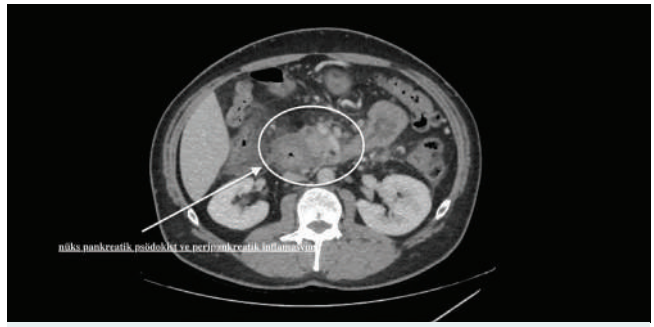

Figure 1. Contrast-enhanced computed tomography showing a recurrent pancreatic pseudocyst. Contrast-enhanced abdominal computed tomography demonstrates a recurrent pancreatic pseudocyst located at the body–tail region of the pancreas, accompanied by marked ductal dilatation and surrounding peripancreatic inflammatory changes.

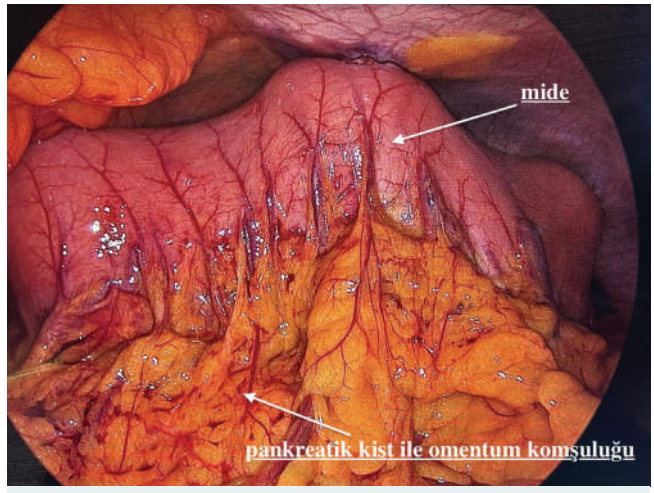

Figure 2. Laparoscopic view of the pancreatic pseudocyst and its relationship with the stomach and omentum. During laparoscopic exploration, the pancreatic pseudocyst is seen in close proximity to the posterior wall of the stomach and the omentum. The cyst is located posteriorly and causes anterior displacement of the stomach.

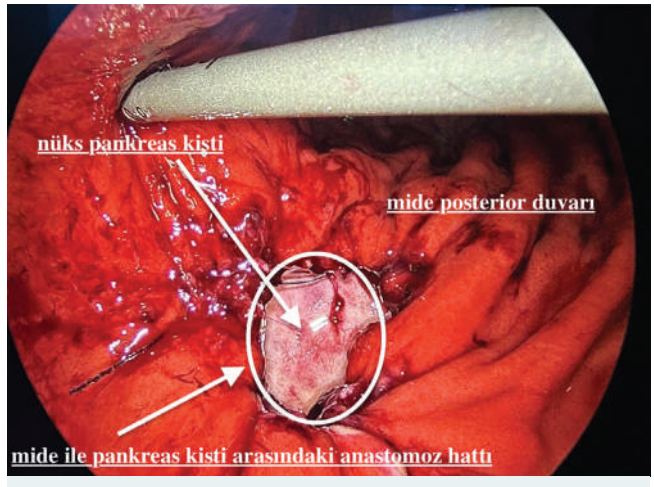

Figure 3. Laparoscopic intragastric cystogastrostomy and anastomosis site. The pancreatic pseudocyst was drained laparoscopically using a transgastric approach through the posterior gastric wall, and a wide cystogastrostomy anastomosis was created. The anastomosis site and cyst cavity are clearly visualized intraoperatively.

[P-121]

Temporary closure of anterior abdominal wall defect developing after recurrent liposarcoma excision with BTM on prolene mesh

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Objective: Biodegradable temporary matrices (BTM) create granulation tissue suitable for skin grafting in deep lesions where the skin and subcutaneous tissue are completely absent. We wanted to present our application of skin grafting after BTM in a case of recurrent liposarcoma that underwent extensive abdominal wall excision.

Material and Methods: We retrospectively evaluated the surgical excision, BTM application, and grafting performed on a recurrent patient who had previously undergone liposarcoma excision twice in the abdominal wall, after no metastasis was detected following PET-CT.

Results: A 47-year-old male patient had previously undergone two surgical treatments for liposarcoma in the abdominal wall. He was evaluated for a recurrent mass larger than 40 cm in diameter extending into the peritoneum on the anterior abdominal wall. PET-CT showed no distant metastasis. The mass had extended into the peritoneum, incorporating the rectus fascia and the muscle itself on one side. During excision, surgical margins could not be evaluated with frozen-section biopsies. While awaiting pathological examination, prolene mesh was placed to induce granulation formation. Upon negative surgical margins, the wound was covered with BTM. The prolene mesh was fully integrated and largely preserved due to granulation. When the BTM delaminated and was removed, the skin was covered with split-thickness grafts taken from the thigh. In the follow-up, the patient developed localized prolene mesh exposure. The exposed meshes were removed, and wound care treatments were applied. After three months, the patient, who had no remaining wound problems, was transferred to the oncology clinic.

Conclusion: BTMs are commonly used in burn treatment. However, in recent years they have also found a place in chronic wound treatment. In this case, we prepared a wound of a size that could not be closed with flaps or wound care methods for grafting. We do not consider it correct to place BTMs without evaluating the surgical margin. Therefore, we triggered granulation by placing prolene mesh for a short period, but we saw high-quality granulation tissue on the prolene mesh before BTM, and therefore we did not remove it completely. Thanks to BTM, we applied grafts to the high-quality granulation tissue that developed on the exposed mesh without infection. We removed the exposed prolene mesh areas with wound care methods. Our unconventional approach developed specifically for this case. However, the application of BTM on prolene mesh has served as an example for us in the treatment of complex wounds such as hernia repairs that develop wound complications.

Keywords: BTM, wound, graft

Figure 1. Mass, excised and BTM application.

Figure 2. Grafted wound.

[P-125]

Late-diagnosed coexistance of intraabdominal serouse carcinoma and B-cell lymphoma: Case report

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Objective: Trauma, benign and malignant pathologies are important in the etiology of intraabdominal masses. Multidisciplinary approach is important in cases where a preliminary diagnosis of hematological disease is present. Patients often present late for surgical intervention, and this case report aims to highlight the importance of diagnosis in a patient with a preliminary diagnosis of B-cell non-Hodgkin lymphoma who had both intramesenteric serous carcinoma and B-cell lymphoma.

Results: A 77-year-old woman presented with palpable abdominal swelling and pain, was referred to the hematology department for further investigation due to lymphocytosis detected in her hemogram at an external center. Computed tomography scan revealed a septated mass lesion extending into the pelvis, approximately 30x23x22 cm, containing cystic components of varying density, and a similar lesion measuring 10x3 cm with a tendency to coalesce, located adjacent to the pelvis (Figure 1). Bone marrow biopsy showed involvement of B-cell non-Hodgkin lymphoma. Exploratory laparotomy revealed two masses in the abdomen; the larger mass projected into the abdominal cavity between the mesenteric layers, was of retroperitoneal origin, and showed loose adhesions to the uterus. A second mass, also retroperitoneally located, was found adjacent to it (Figure 2). Total extirpation of the masses revealed a total weight of 6.200 grams. The masses were found not to be of ovarian origin. The patient's postoperative period was without any complications and was referred to the hematology clinic. Histopathological examination of the mass revealed a diagnosis of "non-invasive low-grade serous carcinoma," and immunohistochemical examination showed neoplastic B lymphocytes with CD20(+), PAX5(+), Bcl-2(+), Bcl6(-), Cd10(-), CyclinD1(-), SOX11(-), TDT(-), Annexin-A1 (-), CD5 (-), CD23 (-), and IgD (-) immunophenotype, and a proliferation index of approximately 20% with Ki-67, thus confirming the diagnosis of marginal zone lymphoma. The patient was initiated on rituximab treatment in accordance with R-Bendamustine chemotherapy in the hematology clinic.

Conclusion: In surgical practice for the diagnosis of intraabdominal masses, the patient's medical and family history are important, early diagnosis should be achieved using laboratory and imaging methods. Since delayed diagnosis can lead to mass growth, it is essential to treat the mass before emergency situations such as compression symptoms, bleeding, perforation, obstruction occur. However, there is no immunohistochemical method to differentiate between primary and genital organ-derived serous carcinomas. Therefore, the mass in our patient contains a combination of primary serous carcinoma and B-cell lymphoma, and this possibility should be considered in the differential diagnosis in similar cases during the early stages of the disease.

Keywords: Intraabdominal mass, lymphoma, serous carcinom

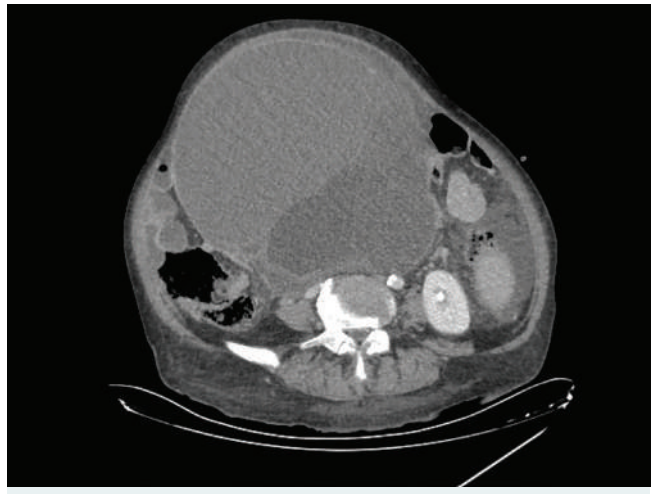

Figure 1. Preoperative CT image. Imaging of intraabdominal giant mass.
CT: Computed tomography.

Figure 2. Intraoperative image of the mass. Image of intraabdominal giant mass in laparotomy.

[P-126]

Brachial artery-axillary vein arteriovenous fistula created using autologous saphenous vein in a hemodialysis patient with exhausted vascular access: An alternative solution

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Objective: Establishing and maintaining reliable vascular access is essential for long-term survival and quality of life in patients undergoing hemodialysis. Repeated arteriovenous fistula (AVF) procedures, prolonged central venous catheterization, and progressive vascular deterioration may eventually lead to exhaustion of available access sites. This situation represents a major clinical challenge, particularly in patients receiving long-term hemodialysis. The use of autologous vessels is preferred over synthetic grafts due to lower rates of infection and thrombosis. However, alternative surgical approaches are required when superficial veins are inadequate. In this report, we present a case of brachial artery-axillary vein AVF created using an autologous saphenous vein graft in a patient with exhausted vascular access.

Material and Methods: A 64-year-old male patient undergoing hemodialysis for four years was evaluated. The patient had a medical history of hypertension. Previous vascular access procedures included right radiocephalic and brachiocephalic AVFs, central venous catheterization, and left radiocephalic and brachiocephalic AVFs. Due to failure of all previous access sites, an alternative vascular access strategy was planned. Preoperative Doppler ultrasonography demonstrated a brachial artery diameter of 4 mm and an axillary vein diameter of 7 mm. Based on these findings, the use of an autologous saphenous vein graft was considered appropriate. The saphenous vein was harvested from the left leg and reversed before implantation. An end-to-side anastomosis was created between the brachial artery and the axillary vein using the parachute technique with 5/0 polypropylene sutures. The total operative time was 124 minutes. All procedures were performed in accordance with standard surgical protocols. Written informed consent was obtained from the patient.

Results: No intraoperative or early postoperative complications, including bleeding, thrombosis, infection, or hematoma, were observed. Postoperative clinical examination revealed adequate thrill and bruit, indicating satisfactory blood flow through the fistula. At the sixth postoperative week, follow-up Doppler ultrasonography showed a fistula diameter of 6 mm and a flow volume of 650 mL/min, confirming successful maturation. The fistula was successfully cannulated for hemodialysis at the eighth postoperative week. During follow-up, the access remained patent and fully functional, allowing uninterrupted dialysis sessions.

Conclusion: Brachial artery-axillary vein AVF created using an autologous saphenous vein graft appears to be a safe and effective alternative for hemodialysis patients with exhausted vascular access. Favorable maturation parameters and sustained patency observed in this case support the potential role of this technique in selected patients. Careful patient selection and meticulous surgical technique are essential for achieving optimal outcomes.

Keywords: Autologous saphenous vein, exhausted vascular access, brachial-axillary fistula

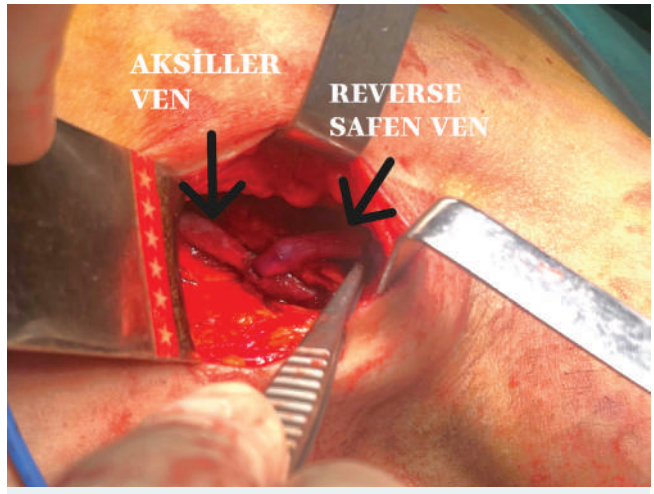

Figure 1. Proximal anastomosis. Intraoperative view of the proximal anastomosis between the axillary vein and the reversed autologous saphenous vein graft.

Figure 2. Distal anastomosis and ultrasonography (USG) image. Intraoperative view of the distal anastomosis created between the brachial artery and the reverse autologous saphenous vein graft. Control USG performed at the 6th week after surgery.

[P-155]

A rare case report: An intra-abdominal mass caused by actinomyces infection

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Objective: Actinomycosis is a rare, subacute to chronic infection caused by Actinomyces species, which are Gram-positive, filamentous, non–acid-fast, anaerobic or microaerophilic bacteria. The infection is typically characterized by granulomatous and suppurative inflammation and, in its chronic form, progresses with multiple abscess formations and granulation tissue containing sulfur granules. Approximately 70% of cases are caused by *Actinomyces israelii* or *Actinomyces gerencseriae*.

Material and Methods: A 55-year-old male with no comorbidities or prior abdominal surgery presented with abdominal distension and a 15-kg weight loss over two months. Physical examination revealed a palpable abdominal mass, and he was referred for further evaluation. Laboratory findings showed elevated inflammatory markers (CRP 213 mg/L, WBC 12.86×10^9/L) with normal tumor markers. Colonoscopy demonstrated a suspicious lesion in the left colon; biopsies revealed chronic active inflammation with eosinophilic infiltration. Abdominal computed tomography (CT) identified a 57×74 mm mass in the right lower quadrant involving the terminal ileum and rectosigmoid junction, with associated bowel wall thickening and right ureteral invasion causing hydronephrosis. PET-CT showed intense FDG uptake (SUV_{max} 17.77) confined to the mass, with no distant involvement. The patient underwent elective surgery. Intraoperatively, a granulomatous mass invading the colon, distal small intestine, duodenum, ureters, and retroperitoneum was identified. Debulking surgery with colectomy was performed, leaving a rectal stump and creating a jejunostomy. Duodenal injury due to tumor invasion was repaired, and a feeding jejunostomy was placed. Histopathological examination revealed actinomycosis with xanthogranulomatous inflammation and abscess formation. The patient was treated with intravenous meropenem followed by oral amoxicillin and was discharged in good condition.

Conclusion: Actinomycosis is a disease that can occur in the presence of risk factors such as surgical or invasive procedures, trauma, or diabetes mellitus, and may present with a wide range of clinical manifestations depending on the affected region of the body. However, as demonstrated in our case, it is important to recognize that actinomycosis can also develop in the absence of any identifiable risk factors.

Keywords: Actinomycosis, intra-abdominal mass, debulking

Figure 1. Appearance of the mass on CT scan, horizontal section.

CT: Computed tomography.

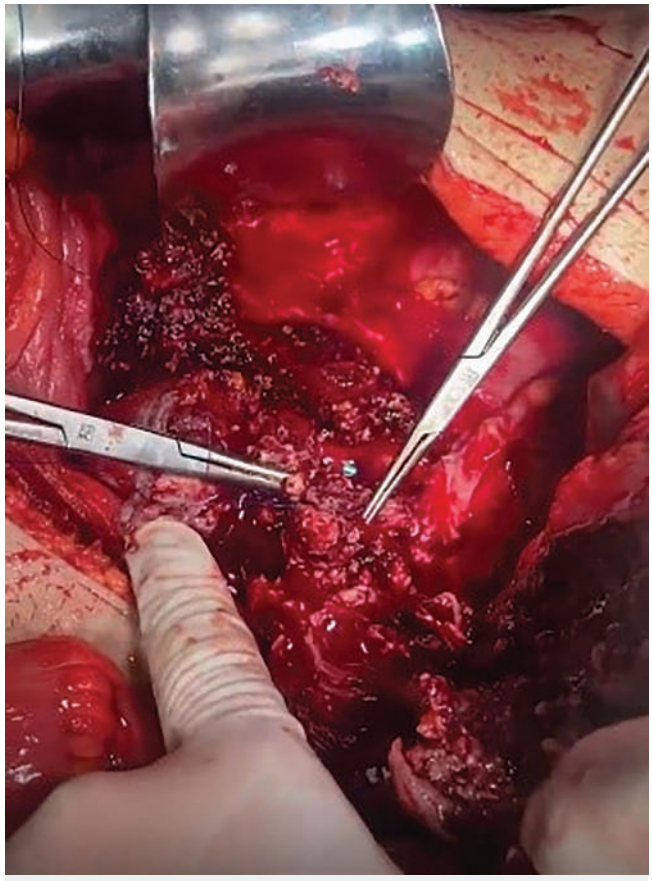

Figure 2. Intraoperative view following debulking surgery.

[P-156]

Metaplastic breast carcinoma: A rare case report of coexistence of invasive ductal carcinoma and mesenchymal sarcoma

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Objective: Metaplastic breast cancer is a histologically and molecularly diverse cancer type. It is a rare and poorly prognostic malignancy, accounting for 0.2-5% of all breast cancers. Therefore, metaplastic cancer has the worst prognosis compared to other types of breast cancer and plays a significant role in global breast cancer mortality.

Results: This report presents a 70-year-old woman with metaplastic breast carcinoma. The patient was followed up at an external center with a cystic lesion in her right breast. During the follow-up period, it was observed that the cystic area grew rapidly and caused necrosis in the skin. Follow-up imaging revealed a solid component within the cyst, prompting frozen section examination followed by segmental mastectomy and sentinel lymph node sampling. Histopathological examination revealed an 11x8x4 cm lesion containing T2N0, nuclear grade III, ER (-), PR (-), cerbB2 (-), invasive ductal carcinoma, high-grade papillary carcinoma *in situ*, and high-grade mesenchymal sarcoma components. The patient received adjuvant radiotherapy and is being followed up 11 months postoperatively without recurrence.

Conclusion: In conclusion, metaplastic breast cancer has very different clinical and pathological characteristics from invasive ductal carcinoma. Its large size, high grade, and associated local recurrence and poor prognosis are negative features. Despite these negative characteristics, breast-conserving surgery can be performed in patients for whom it is possible, with adjuvant radiotherapy planned. The infrequent occurrence of nodal involvement should not rule out axillary surgery in these tumors, which can contain many components.

Keywords: Metaplastic carcinoma, invasive ductal carcinoma, mesenchymal sarcoma of the breast

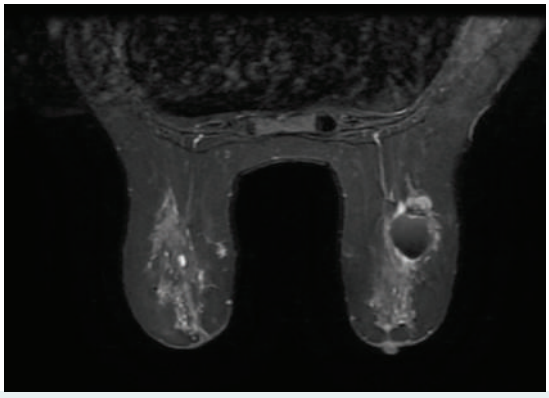

Figure 1. Patient's 2022 MRI image.
MRI: Magnetic resonance imaging.

Figure 2. The patient's final condition before the operation.

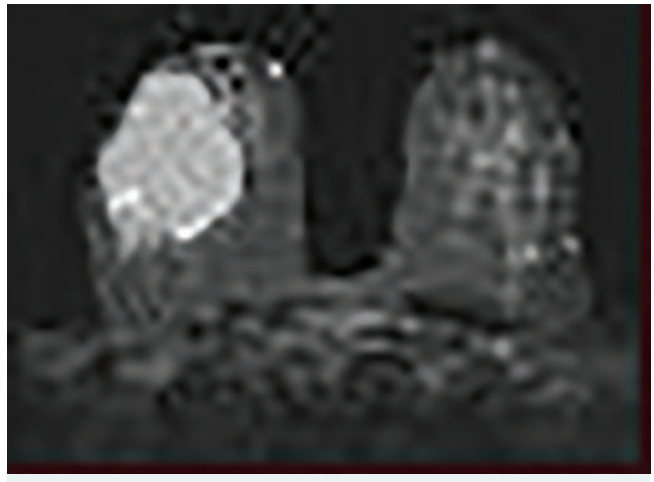

Figure 3. Patient's 2024 MRI image.
MRI: Magnetic resonance imaging.

[P-157]

Approach to metaplastic squamous cell carcinoma of the breast: A rare case

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Objective: Metaplastic breast carcinomas account for less than 1% of all breast malignancies. Metaplastic squamous cell carcinoma is a distinct subtype characterized by prominent squamous differentiation, keratinization, and absence of glandular structures. Most tumors demonstrate a triple-negative immunophenotype, lacking estrogen receptor, progesterone receptor, and HER2 expression. Due to the absence of specific clinical and radiological findings, definitive diagnosis is usually established by histopathological and immunohistochemical examination. Fine-needle aspiration and core needle biopsy may have limited diagnostic accuracy, and excisional biopsy is often required for definitive diagnosis.

Material and Methods: A 67-year-old female patient presented with a complaint of a palpable mass in the left breast. Mammography and ultrasonography revealed a 26x2 mm lesion in the upper outer quadrant of the left breast, described as a complex cyst containing internal echoes with layering, without pathological vascularization on Doppler sonography, and partially mobile internal echoes (BI-RADS 4A). Preoperative fine-needle aspiration biopsy performed prior to surgery reported atypical cells with large nuclei. To obtain a definitive diagnosis, a wire-localized excisional biopsy was planned. Histopathological examination of the excisional biopsy specimen revealed metaplastic squamous cell carcinoma. Immunohistochemical evaluation demonstrated that the tumor cells were ER 0%, PR 0%, HER2 0%, and the Ki-67 proliferation index was 40%; these findings were consistent with the triple-negative phenotype reported in the literature. Following the definitive diagnosis, the patient underwent PET-CT for oncological staging. No distant organ metastases were detected. A small, mildly hypermetabolic lymph node (SUV_{max}: 2.7) was observed in the right axilla, and a second operation for sentinel lymph node biopsy was planned. During this procedure, four sentinel lymph nodes were identified and removed using subcutaneous periareolar injection of methylene blue, and no metastases were detected. Axillary lymph node involvement in metaplastic breast carcinoma has been reported to be lower than in invasive ductal carcinoma.

Results: Metaplastic squamous cell carcinoma of the breast is a rare malignancy with aggressive biological behavior. Poor response to conventional systemic chemotherapy has been reported, contributing to an unfavorable prognosis compared with invasive ductal carcinoma. The frequent occurrence of inconclusive or suspicious cytological findings highlights the importance of excisional biopsy for accurate diagnosis. Although surgical resection remains the cornerstone of treatment, the role of adjuvant chemotherapy and radiotherapy remains controversial.

Conclusion: Metaplastic squamous cell carcinoma of the breast is rare; excisional biopsy confirms diagnosis, negative sentinel nodes may avoid axillary dissection, and it should be considered in differential diagnosis.

Keywords: Breast tumor, metaplastic breast carcinoma, squamous cell carcinoma

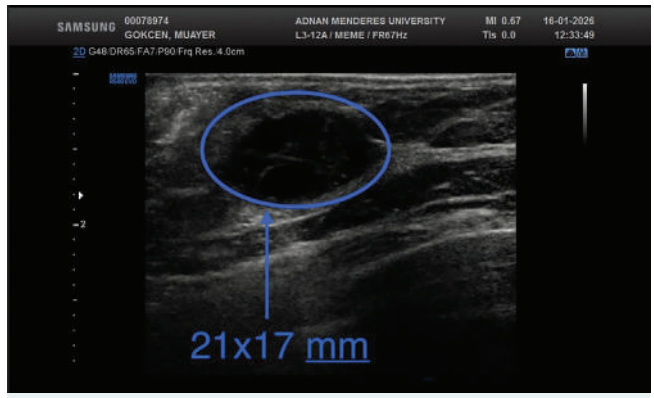

Figure 1. Ultrasonography (USG). Preoperative USG image of the lesion.

Figure 2. Mammography. Preoperative mammography image of the lesion.

[P-158]

Migration of an intra-abdominal drainage catheter into the ileal lumen after surgery for perforated appendicitis: A case report

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Objective: Surgical drainage catheters are commonly used after intra-abdominal procedures to prevent fluid accumulation, control infection, and facilitate postoperative monitoring. Despite their prophylactic and therapeutic benefits, drainage catheters may rarely cause serious complications. Intraluminal migration of a surgical drain into the bowel is an extremely rare but potentially life-threatening event, with only a limited number of cases reported in the literature. Migration of a drainage catheter following appendectomy is particularly uncommon. In this report, we present a rare case of ileal intraluminal migration of a drainage catheter resulting in enterocutaneous fistula formation after surgery for perforated appendicitis.

Material and Methods: This study is a retrospective case report of a 26-year-old male patient who underwent emergency surgery for perforated appendicitis and subsequently developed intraluminal migration of an intra-abdominal drainage catheter. Clinical findings, laboratory parameters, radiological imaging, operative findings, and postoperative follow-up data were reviewed. Diagnosis and treatment decisions were guided by contrast-enhanced computed tomography and surgical exploration findings.

Results: The patient underwent emergency laparotomy for perforated appendicitis with fecal peritonitis. Appendectomy, intra-abdominal abscess drainage, and irrigation were performed, followed by placement of four Jackson-Pratt drainage catheters into the right and left paracolic gutters, pelvis, and appendectomy bed. On postoperative day 11, gastrointestinal content was observed draining from the catheter placed in the appendectomy bed. Oral contrast-enhanced computed tomography revealed that the drainage catheter had migrated intraluminally into the ileum. As the patient remained clinically stable, conservative management was initially preferred. After resolution of intra-abdominal inflammation, elective surgery was performed. Intraoperatively, the drainage catheter was found to have fistulized into an ileal loop approximately 50 cm proximal to the ileocecal valve and progressed intraluminally. Segmental ileal resection with primary anastomosis was performed. The postoperative course was uneventful, and the patient was discharged without complications.

Conclusion: Although intra-abdominal drainage catheters are valuable tools in postoperative management, they may rarely lead to serious complications such as intraluminal bowel migration and enterocutaneous fistula formation. Early recognition based on clinical findings and prompt radiological evaluation are essential to reduce morbidity. Careful patient selection, appropriate drain type, and early removal of drainage catheters may help prevent such complications. This rare case highlights the importance of vigilance regarding drain-related complications and contributes to the limited literature on this subject.

Keywords: Drainage catheter migration, perforated appendicitis, enterocutaneous fistula

Figure 1. Drain.

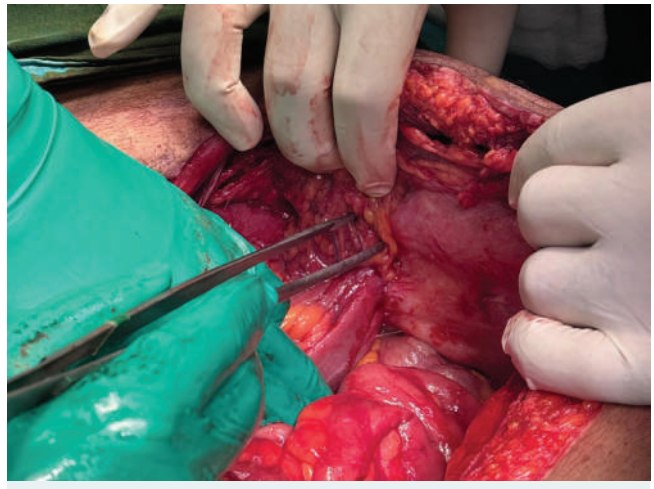

Figure 2. Drain migration.

[P-159]

Fecal-related stercoral rectosigmoid perforation: A serious complication of fecal impaction

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Objective: Chronic constipation is a common clinical problem in the elderly population and significantly reduces quality of life. Prolonged constipation can lead to hardening and accumulation of feces, a condition defined as fecaloma, which is frequently observed in elderly patients. Although fecaloma is usually benign, it can rarely lead to serious and life-threatening complications. Most important of these is stercoral colon perforation, which is associated with a high mortality rate. Stercoral perforation typically occurs in elderly individuals with multiple systemic comorbidities, limited mobility, and dependency in daily living activities.

Material and Methods: A 67-year-old male patient with a long-standing history of chronic constipation presented to the emergency department with progressively worsening abdominal pain for two days, accompanied by inability to pass gas and stool. Physical examination revealed significant abdominal distension and diffuse tenderness in all quadrants. Laboratory tests showed leukocytosis (WBC: 14,500/mm^3). Abdominal computed tomography demonstrated widespread fecalomas at the level of the left colon and rectum, accompanied by free air within the abdominal cavity. Based on these findings, the patient was taken for emergency surgical intervention. A large perforation area was identified at the rectosigmoid junction, with fecal contents spread into the abdominal cavity. A Hartmann procedure was performed. The distal rectum was closed with a stapler, the fecalomas in the left colon were evacuated, and an end colostomy was created. The postoperative course was uneventful, and the patient was discharged on postoperative day seven with appropriate recommendations.

Results: Constipation and fecal impaction are common clinical conditions, especially in elderly and bedridden patients. Prolonged fecal stasis leads to the formation of hardened fecal masses within the colonic lumen, known as fecalomas. Although the presence of fecaloma usually does not cause serious problems, in rare cases, increased intraluminal pressure may lead to ischemia of the colonic wall, which can subsequently result in stercoral perforation. Stercoral perforation is a severe and potentially fatal condition that occurs when hardened fecal masses exert continuous pressure on the intestinal wall, leading to loss of bowel integrity. Following perforation, intestinal contents can spread into the peritoneal cavity, resulting in severe peritonitis, rapid bacteremia, and multi-organ failure. The Sudeck point, located at the rectosigmoid junction where the marginal artery circulation is limited, is a watershed area prone to ischemia in the presence of increased intraluminal pressure and fecaloma.

Conclusion: Stercoral perforation is a rare but serious emergency surgical condition with a high mortality risk, particularly in elderly patients with chronic constipation and comorbidities.

Keywords: Chronic constipation, fecaloma, stercoral perforation

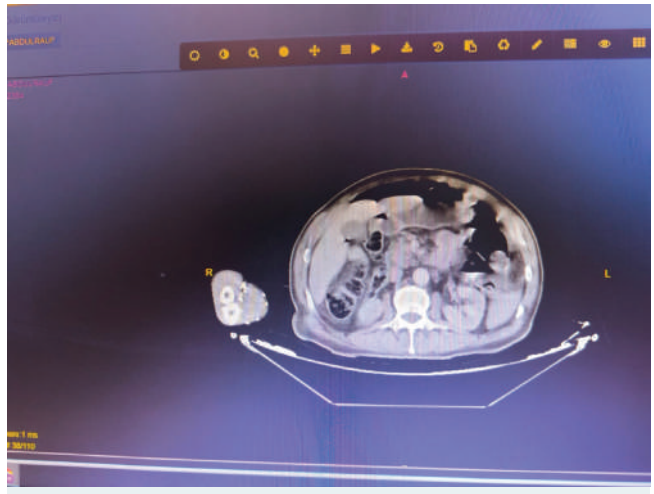

Figure 1. Computed tomography (CT) image. Intra-abdominal free air image in CT scan.

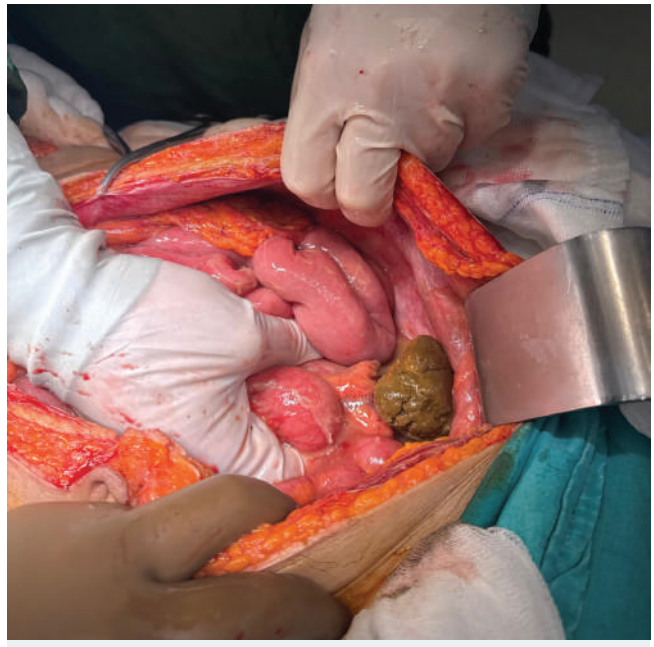

Figure 2. Rectosigmoid perforation and intra-abdominal fecaloma. Intraoperative image of rectosigmoid perforation.

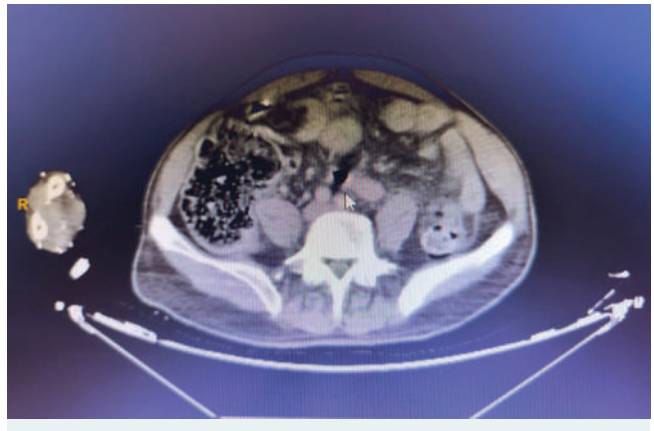

Figure 3. Fecaloma image on tomography.

[P-160]

Combined preoperative botulinum toxin A injection and progressive pneumoperitoneum for the repair of a type II giant inguinoscrotal hernia: A case report

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Objective: Giant inguinoscrotal hernias are rare and challenging conditions. They are classified using two anatomical landmarks: The midpoint of the inner thigh and the superior border of the patella. Hernias extending above the midpoint are classified as type I, those below as type II, and those extending below the patella as type III. Hernioplasty alone is often insufficient in type II and III hernias due to loss of domain caused by long-standing herniation. Tensioned closure may result in respiratory compromise or abdominal compartment syndrome. This study presents a successful combined botulinum toxin A and progressive pneumoperitoneum approach in a type II case.

Material and Methods: In the preoperative evaluation, computed tomography (CT) was used as the primary imaging modality for abdominal assessment. The abdominal cavity and hernia sac were assumed to be ellipsoid in shape. Volumetric calculations were performed by selecting the maximum craniocaudal, transverse, and anteroposterior diameters from all CT slices. The day of the patient's initial presentation was designated as day 0. Abdominal cavity volume and hernia sac volume were calculated using CT images obtained on day 0 (Figure 1). On day 1 of follow-up, botulinum toxin was administered under ultrasound guidance by interventional radiology. A total dose of 200 IU (100 IU on the right and 100 IU on the left) was injected into the external oblique, internal oblique, and transversus abdominis muscles at three points on each side. Follow-up imaging was performed on day 10, and volumetric measurements and lateral abdominal wall muscle elongation were calculated. On day 20, an intraperitoneal catheter was placed. Insufflation was performed through this catheter with 500 mL of room air administered twice daily. This procedure was continued for five days. The patient was closely monitored with serial abdominal examinations, vital sign assessments, and urine output measurements. On day 26, the patient underwent elective surgical repair. Abdominal cavity volume and hernia sac volume calculations were performed using the ellipsoid volume formula, where a is the radius in the craniocaudal plane, b is the radius in the transverse plane, and c is the radius in the anteroposterior plane. Ellipsoid volume: $V=4/3\cdot\pi\cdot a\cdot b\cdot c$.

Results: Following botulinum toxin administration, the abdominal cavity volume increased to 4387 mL. Additionally, elongation of the lateral abdominal wall muscles by 4-5 cm was observed. CT performed on day 25 after progressive pneumoperitoneum demonstrated a further increase in abdominal cavity volume to 7084 mL. All procedures performed, along with changes in abdominal cavity volume, variations in lateral abdominal wall muscle length, and the ratio of hernia sac volume to abdominal cavity volume, are summarized in conclusion.

Conclusion: This case shows that botulinum toxin A and progressive pneumoperitoneum correct loss of domain and allow tension-free repair in type II inguinoscrotal hernia.

Keywords: Giant inguinoscrotal hernia, loss of domain, botulinum toxin A, progressive pneumoperitoneum

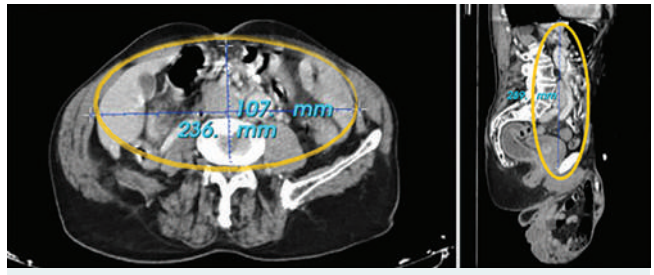

Figure 1. Abdominal cavity volume and hernia sac volume calculations.

Table 1. Volume changes

Parameter	Day 0	Day 10	Day 25
Abdominal cavity volume	3794	4387	7084
Hernia sac volume/abdominal cavity volume (%)	44%	38%	23%
Right lateral muscle length (mm)	237	244	291
Left lateral muscle length (mm)	229	234	287

[P-161]

Local recurrence and leukemia twelve years after breast cancer treatment: A rare case report in a TP53-positive patient

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Objective: Li-Fraumeni syndrome (LFS) is a hereditary cancer predisposition syndrome first described in 1969 by Frederick P. Li and Joseph F. Fraumeni Jr. It is caused by germline mutations in the *TP53* tumor suppressor gene, which regulates the cell cycle and induces apoptosis in response to DNA damage. *TP53* mutations are associated with a broad spectrum of malignancies, including breast cancer, sarcomas, brain tumors, and hematologic cancers. The tumor spectrum in LFS is age-dependent, with adrenocortical carcinoma, choroid plexus tumors, and rhabdomyosarcoma in childhood; osteosarcoma, leukemia, and gliomas in young adulthood; and breast and gastrointestinal cancers in early adulthood. This case highlights the development of a secondary hematologic malignancy in a *TP53*-positive breast cancer patient with long-term survival.

Material and Methods: A 54-year-old woman had been diagnosed with left breast invasive ductal carcinoma (ER+, PR+, HER2-) 12 years earlier and was treated with breast-conserving surgery, adjuvant AC-T chemotherapy, radiotherapy, and five years of hormonotherapy. Imaging performed for suspected ipsilateral recurrence revealed a 1.5×1 cm spindle cell malignant tumor with marked pleomorphism and 6-7 mitoses per 10 high-power fields on excisional biopsy.p53 positivity on immunohistochemistry prompted molecular analysis, which identified a heterozygous *TP53* c.844C>T (p.Arg282Trp) variant. Following genetic counseling, bilateral prophylactic mastectomy was performed. During follow-up, the patient developed bone pain, and PET/CT showed increased FDG uptake in the femur. Bone marrow biopsy confirmed acute myeloid leukemia. She underwent allogeneic bone marrow transplantation but died due to early post-transplant complications.

Results: This case is notable because it demonstrates both a solid tumor (breast cancer) and a hematologic malignancy (AML) developing years later in a *TP53*-positive patient. *TP53* mutations, particularly those associated with LFS, confer a lifetime cancer risk of up to 70-90%. Although hematologic malignancies typically occur in early childhood in this syndrome, they developed after age 50 in our patient. In addition, chemotherapeutic agents used in breast cancer treatment—especially alkylating agents and anthracyclines—may contribute to therapy-related AML; however, the presence of a germline mutation indicates an underlying genetic predisposition. The decision for prophylactic mastectomy may therefore be important not only for pathological risk but also for patients with genetic susceptibility. This case highlights the need for careful long-term surveillance for secondary hematologic malignancies in *TP53*-positive individuals.

Conclusion: Breast cancer patients harboring *TP53* mutations have an increased risk of developing secondary hematologic malignancies. Therefore, long-term genetic counseling, a personalized oncologic approach, and multidisciplinary follow-up are of great importance in this patient population.

Keywords: *TP53* mutations, breast cancer, Li-Fraumeni syndrome

[P-162]

Extended surgical approach for substernal goiter: Bilateral total thyroidectomy with sternotomy

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Objective: Substernal goiter is defined as the presence of more than half of the enlarged thyroid mass below the sternal notch. Its incidence varies, but it is seen in approximately one in 5,000 people.While 20-40% of cases are detected incidentally during radiological examinations, the majority of cases present with symptoms such as dyspnea, dysphagia, and hoarseness secondary to mass compression.Approximately 81-99% of substernal goiter cases can be treated surgically with a cervical incision, while 2-19% require more invasive approaches such as sternotomy or thoracotomy. In this case, we present a bilateral total thyroidectomy with sternotomy in a patient with symptomatic substernal goiter.

Material and Methods: In this case, the diagnosis, treatment, and follow-up process of a patient who underwent bilateral total thyroidectomy with sternotomy due to substernal goiter at our clinic was evaluated.

Results: A 57-year-old male patient with a history of known diabetes, hypertension, and coronary artery disease, who is an ex-smoker, presented to the outpatient clinic with neck swelling and progressive dyspnea. On examination, a multinodular goiter was palpated in the substernal region. Blood tests showed euthyroid thyroid function. Due to its retrosternal location, a contrast-enhanced neck CT scan was planned. The CT scan showed hypodense nodules extending retrosternally, containing coarse calcifications in places. The patient was evaluated by a surgical endocrinology team consisting of general surgery, endocrinology, anesthesiology and resuscitation, ear nose and throat, and cardiovascular surgery teams. A decision was made to perform bilateral total thyroidectomy with sternotomy. The substernally located thyroid tissue was removed from the posterior mediastinum via sternotomy. The patient was intubated and monitored in the intensive care unit for two days postoperatively. Subsequently, the patient was transferred to the ward, and no pathology was observed in the postoperative vocal cord examination. The patient was discharged on the 6th postoperative day. No complications were observed during postoperative follow-up. The pathology results showed no malignancy.

Conclusion: Patients diagnosed with substernal goiter should undergo multidisciplinary evaluation during the preoperative period. Computed tomography is the primary imaging method used in the preoperative evaluation process to plan the surgical procedure and determine the necessity of sternotomy. During surgical treatment, the degree of extension into the mediastinum and the anatomical relationship with the surrounding tissue should be evaluated. Substernal goiter surgery has a higher morbidity rate compared to standard thyroid surgery. In these cases, not avoiding sternotomy increases surgical safety and reduces the risk of complications. The effective use of CT and a multidisciplinary approach play an effective role in determining the appropriate surgical approach.

Keywords: Goiter, sternotomy, thyroidectomy

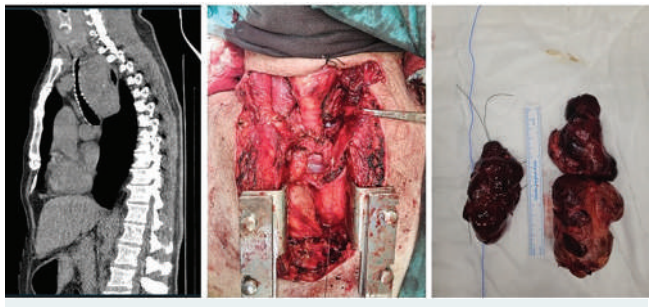

Figure 1. Intraoperative case image and surgical specimen.

[P-163]

Completecholedoc obstruction and choledocoduodenal fistula at 9 months after cholecystectomy

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Objective: A 52-year-old female patient underwent cholecystectomy at an external center and presented to our hospital with jaundice and abdominal pain 9 months postoperatively. Imaging revealed complete obstruction of the common bile duct, and further investigation/endoscopic/interventional/surgical treatment options were planned for the patient.

Material and Methods: Initially, a percutaneous biliary tract (PTC) procedure was planned for the patient. A cholangiogram revealed a tract identified as a choledochoduodenal fistula, but without bile flow. External biliary drainage catheters were placed in the right and left hepatic ducts via PTC. Subsequently, an ERCP procedure was performed, locating and cannulating the fistula tract opening in the bulb, but bile drainage was not achieved. Therefore, a decision was made to proceed with surgical exploration. Surgical exploration revealed a severely dense and adherent hepatoduodenal ligament. The common bile duct was dissected, showing complete obstruction just distal to the level of the confluence, and severely dilated proximal to the stenosis, with an approximate diameter of 3 cm. The choledochoduodenal fistula tract was also located and excised. A Roux-N-Y hepaticojejunostomy was performed. The external biliary drainage catheters were preserved to ensure anastomotic safety. External biliary drainage catheters were discontinued one month after discharge.

Results: Nine months after cholecystectomy, a benign biliary stricture, potentially causing complete obstruction of the common bile duct, was considered the primary cause. Intraoperative exploration revealed no clips, staples, or sutures in the common bile duct. However, a choledochuodenal fistula allowed for continued bile drainage, enabling the patient to live with asymptomatic benign biliary stricture for nine months. Spontaneous obliteration of the fistula tract resulted in symptoms due to bile stasis.

Conclusion: Jaundice, abdominal pain, and intrahepatic bile duct dilation after cholecystectomy generally suggest the possibility of surgical complications/injury; however, it should be kept in mind that benign biliary strictures can also present with bile duct obstruction, proximal segment bile duct dilation, and jaundice. Nevertheless, in our patient, the presence of a choledochuodenal fistula prevented bile stasis even in the presence of complete obstruction, allowing for an asymptomatic course.

Keywords: Clodedoch cholecystectomy bile

[P-164]

Organ-preserving surgical experience in a young woman with solid pseudopapillary neoplasm of the pancreatic head

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Objective: Solid pseudopapillary neoplasm (SPN) is one of the rare epithelial tumors of the pancreas with low malignant potential. It accounts for approximately 1-3% of all pancreatic tumors and is observed predominantly in young women. Clinical findings are often non-specific; it most commonly presents with abdominal pain or as an incidentally detected mass. Although imaging modalities are helpful in guiding the diagnosis, definitive diagnosis is established through histopathological examination. In SPN, surgical resection is curative, and long-term survival rates are high. Particularly in young patients, parenchyma-sparing surgical approaches aimed at preserving pancreatic function have gained increasing importance.

Material and Methods: A 22-year-old female patient presented with recurrent epigastric abdominal pain. Laboratory investigations revealed mildly elevated serum amylase and CA 19-9 levels. Contrast-enhanced abdominal CT and magnetic resonance imaging demonstrated a well-circumscribed, solid mass measuring approximately 5×4 cm in the head of the pancreas. The lesion showed no invasion of the surrounding vascular structures, and no distant metastasis was detected. Although radiologically consistent with SPN, the possibility of malignancy could not be completely excluded. Considering the presence of a resectable mass and the patient's young age, surgical resection was planned by multidisciplinary board decision without performing a preoperative biopsy. The patient underwent central pancreatectomy with Roux-en-Y pancreaticojejunostomy. Preoperative CT imaging shows a 5 cm tumor located in the body and head of the pancreas.

Results: During the operation, a well-circumscribed solid mass was identified in the head of the pancreas, without invasion into the surrounding tissues. The resection was macroscopically complete. Histopathological examination reported the tumor size as 5 cm and established the diagnosis of solid pseudopapillary carcinoma. The surgical margins were negative for tumor involvement (R0 resection). No metastasis was detected in the resected lymph nodes. No major complications developed in the postoperative period. Serum amylase and CA 19-9 levels returned to normal ranges during follow-up. The patient was discharged without any problems, and no evidence of recurrence was observed during early follow-up visits.

Conclusion: Although SPN is rare in young female patients, its prognosis is generally favorable. This case demonstrates that R0 resection can be achieved without lymph node involvement despite the diagnosis of solid pseudopapillary carcinoma. In appropriately selected patients, central pancreatectomy may be a safe and effective organ-preserving surgical option that contributes to the preservation of pancreatic function.

Keywords: Solid pseudopapillary neoplasm, tumor of the head of the pancreas, organ preserving surgery

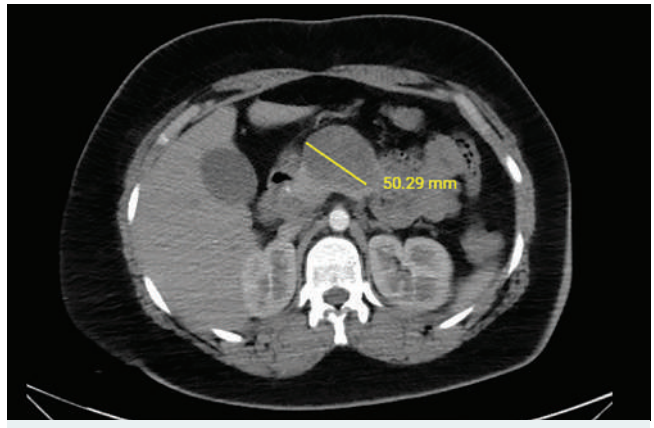

Figure 1. Preoperative CT images. Following resection, 8 cm of pancreatic tissue was preserved in the tail and 2 cm in the head of the pancreas.

CT: Computed tomography.

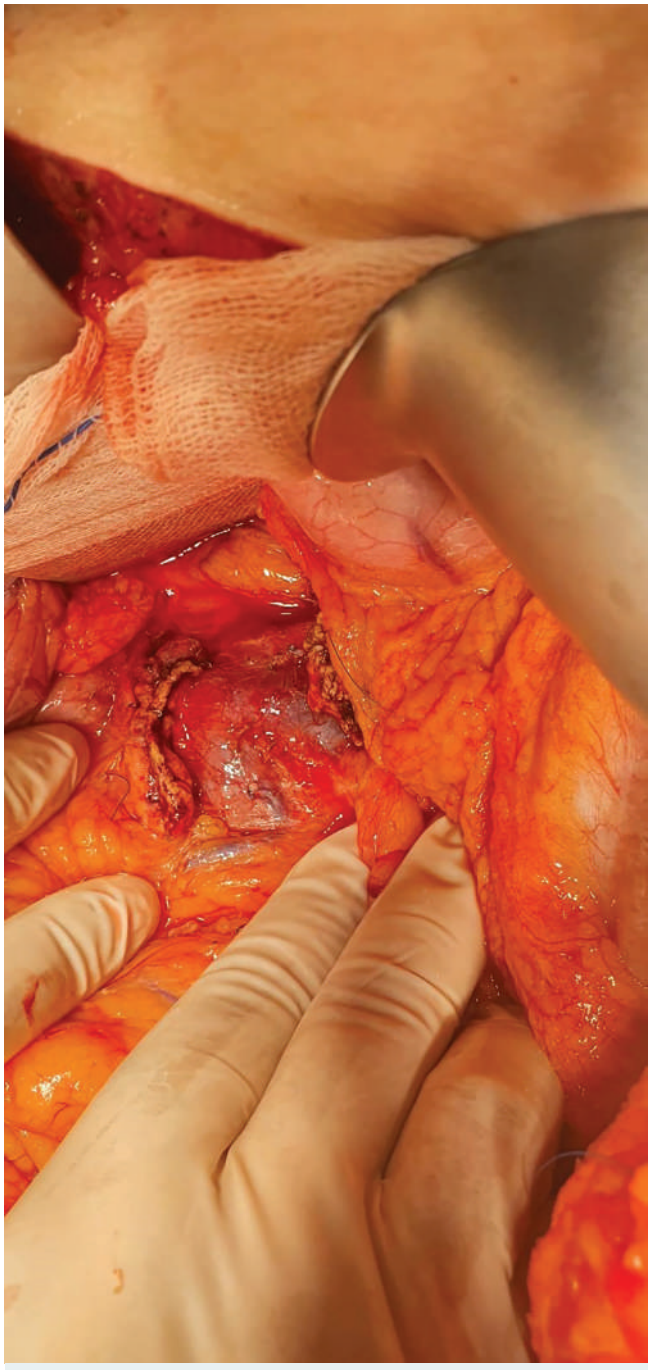

Figure 2. Post-resection image. Following resection, 8 cm of pancreatic tissue was preserved in the tail and 2 cm in the head of the pancreas.

[P-165]

Use of stent and endo-SPONGE therapy in esophageal perforation

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Objective: Esophageal perforation and postoperative anastomotic dehiscence are challenging clinical conditions associated with high morbidity. Although surgical intervention has traditionally been the mainstay of treatment, minimally invasive endoscopic techniques such as esophageal stenting and endoscopic vacuum therapy (endo-SPONGE) have recently emerged as effective alternatives in selected patients.

Material and Methods: Forty-five-year-old female patient underwent upper gastrointestinal endoscopy for dyspepsia, nausea, and vomiting, which revealed a well-defined 2-cm submucosal lesion located 20 cm from the incisors. The patient was operated on via thoracotomy, and a posteromediastinal mass was excised. Intraoperatively, esophageal invasion was identified, resulting in a minimal esophageal defect that was primarily repaired with double-layer suturing. One month postoperatively, the patient presented with nausea and fever. Endoscopic evaluation demonstrated anastomotic dehiscence and fistula formation at the site of primary repair. A fully covered esophageal stent was placed. During follow-up, progressive esophageal wall thinning and tissue loss involving approximately one-third of the esophageal lumen were observed due to prolonged stent therapy. Consequently, treatment was converted to endoscopic vacuum therapy. Endo-SPONGE was applied twice monthly for a total of five sessions.

Results: Serial endoscopic evaluations during vacuum therapy showed a significant reduction in defect size. The diameter of the paraesophageal cavity decreased from 4 cm to 2 cm, and the depth regressed from 3.5 cm to 2 cm. Granulation tissue formation was observed, and complete closure of the fistula tract was achieved. Following successful healing, endo-SPONGE therapy was discontinued and a fully covered esophageal stent was reinserted. After three uneventful stent controls, the stent was removed one month later. The patient tolerated oral intake well and returned to normal daily activities.

Conclusion: This case demonstrates that esophageal perforations can be successfully managed without additional surgery using minimally invasive endoscopic techniques in appropriately selected patients.

Keywords: Esophageal stent, endo-SPONGE therapy

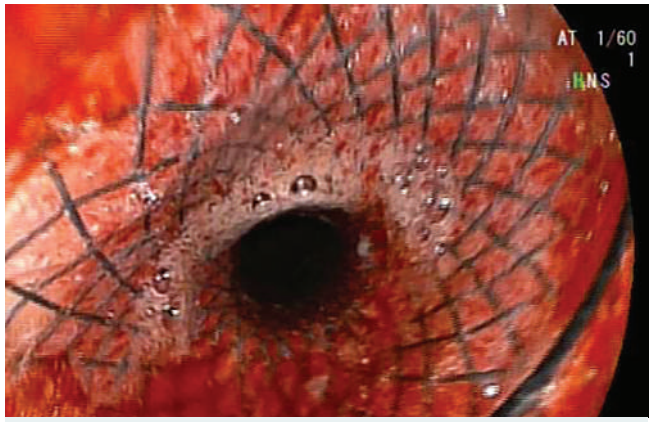

Figure 1. Esophageal stent placement.

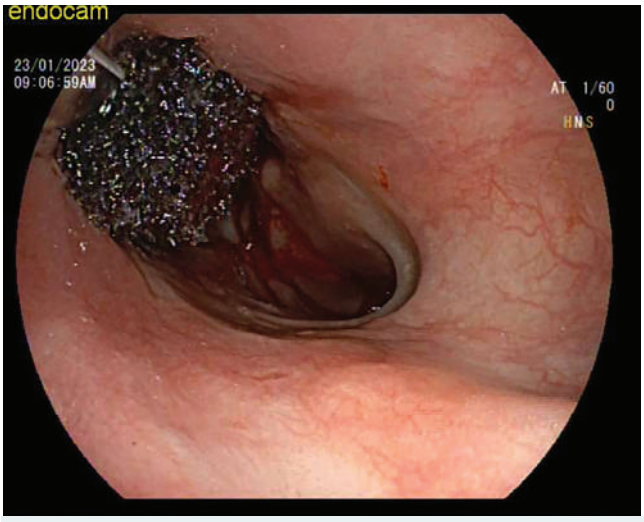

Figure 2. Endo-SPONGE vacuum therapy.

[P-166]

A rare case of Meckel's diverticulum perforation: A case report

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Objective: Meckel's diverticulum is the most common congenital anomaly of the gastrointestinal tract and is usually asymptomatic. Complications of Meckel's diverticulum secondary to foreign bodies are extremely rare. Perforations caused particularly by sharp foreign bodies have been reported in only a limited number of cases in the literature. In this case report, we aimed to present a localized perforation of Meckel's diverticulum caused by ingestion of a sewing pin.

Material and Methods: A 20-year-old female patient presented to an external emergency department after accidentally swallowing a sewing pin that she had been holding in her mouth while fixing her headscarf. As there were no signs of acute abdomen, she was followed up with daily standing abdominal radiographs. Due to the lack of progression of the foreign body during a 10-day follow-up period, she was referred to our center for endoscopic evaluation. Endoscopic intervention was not considered because the pin was localized in the ileum. The patient reported right lower quadrant pain; however, abdominal examination findings were unremarkable. Since no progression was observed on radiographs despite oral contrast administration and enemas, surgical intervention was planned.

Results: During laparotomy, a Meckel's diverticulum was identified, and the sharp end of the sewing pin was found to have perforated the tip of the diverticulum and penetrated into the omentum. As there was no intra-abdominal contamination, diverticulectomy was performed using a linear stapler.

Conclusion: Meckel's diverticulum may serve as an anatomical trap for foreign bodies. In cases of sharp foreign body ingestion, Meckel's diverticulum should be kept in mind as a rare site of perforation.

Keywords: Meckel's diverticulum, perforation, sharp foreign body

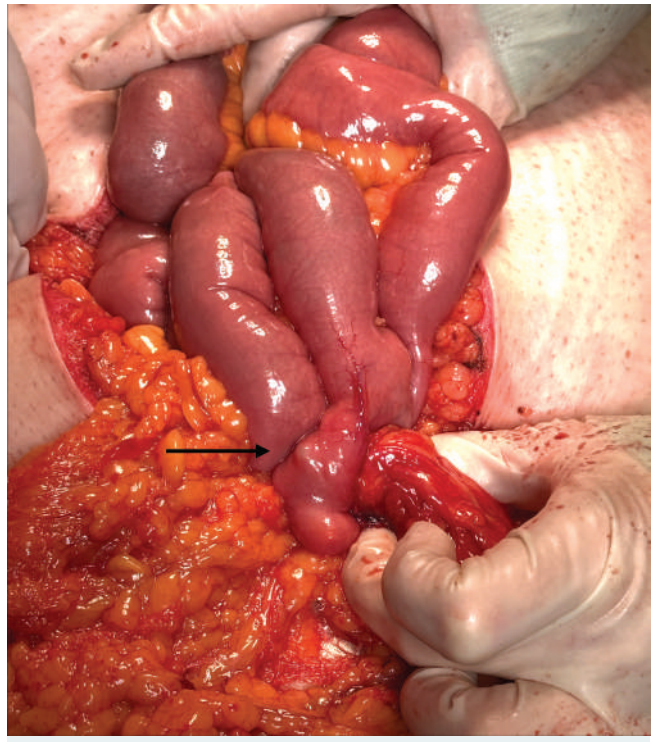

Figure 1. Foreign body within Meckel's diverticulum.

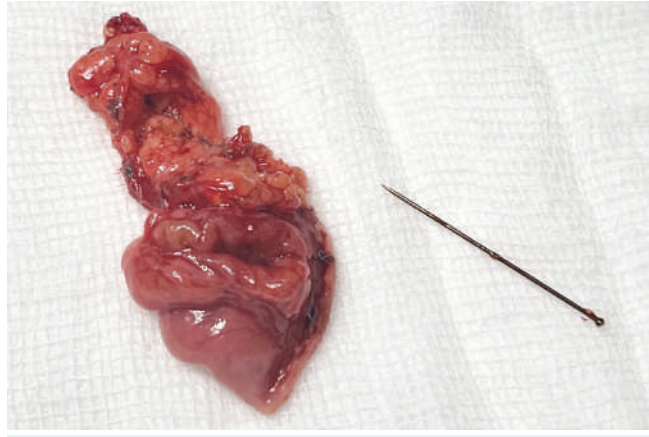

Figure 2. Resected Meckel's diverticulum specimen and a safety pin.

[P-167]

Spontaneous spleen rupture secondary to infectious mononucleosis

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[2]*Pamukkale University Hospital, Denizli*

Objective: The etiology of spontaneous splenic rupture can be classified into six subgroups: infectious, neoplastic, inflammatory, congenital or structural, iatrogenic, idiopathic. In this classification, reviewed 632 relevant publications and examined a total of 845 patients. In this review, pathological rupture due to one or more etiological causes was observed in 93% of cases. In the remaining 7%, the spleen was normal (idiopathic rupture). Neoplastic diseases were the most frequent etiology (30.3%), followed by infectious causes (27.3%). The remaining 7% classified as idiopathic. Among neoplastic causes, hematological malignancies were reported as the most common. Among infectious causes, viral infections are the most common, followed by bacterial, protozoal infections. Among inflammatory etiologies, the most frequent causes include acute, chronic pancreatitis, pancreatic cancer, amyloidosis, Wegener's granulomatosis. Treatment options for SSR include total splenectomy (84.1%), organ-preserving surgery (1.2%), conservative treatment (14.7%).

Material and Methods: This is a poster presentation of a patient diagnosed with SSR due to EBV infection and who underwent surgery for this reason.

Results: A 21-year-old male patient presented with complaints of sore throat, fever, malaise, and left upper quadrant pain that started 3 days prior. He had no known underlying medical conditions. He had started treatment for an upper respiratory tract infection two days prior to admission; however, his symptoms had progressively worsened despite treatment. SPO_2: 100, BP: 125/72 mmHg, pulse: 105/min, temperature: 37.5 °C. Physical examination revealed marked tonsillar hypertrophy, cervical, submandibular lymphadenopathy, hepatosplenomegaly, and tenderness, guarding in the left upper quadrant. Laboratory tests showed leukocytosis (17.3 K/uL), significant elevation of liver transaminases (AST: 216 IU/L, ALT: 347 IU/L), increased LDH (489 U/L), thrombocytopenia (123 K/uL). Abdominal CT scan revealed hepatosplenomegaly, perisplenic, perihepatic free fluid, subcapsular hematoma. These findings were considered to be spontaneous splenic rupture. Due to the absence of a history of trauma and the sudden onset of splenic rupture, infectious causes were investigated. Serological tests showed positive results for EBV, VCA IgM, and IgG, leading to a diagnosis of spontaneous splenic rupture secondary to infectious mononucleosis. Emergency splenectomy was performed. During the operation, 1000 cc of free hemorrhagic fluid aspirated, and a ruptured hematoma observed in the lower pole of the spleen. The patient monitored in the intensive care unit for 48 hours after surgery and discharged after 7 days. An infection prevention protocol and necessary vaccination programs planned, and regular check-ups recommended. Pathology results showed no malignancy.

Conclusion: SSR although rare, is a life-threatening complication of IM. It should be considered in cases of left upper quadrant pain with hemodynamic instability. Early intervention with surgery when conservative treatment options fail is life-saving.

Keywords: Emergency surgery, Epstein-Barr virus, infectious mononucleosis, splenectomy, spontaneus splenic rupture

Figure 1. CT scan image. Spleen laceration, perisplenic fluid, and subcapsular hematoma.

CT: Computed tomography.

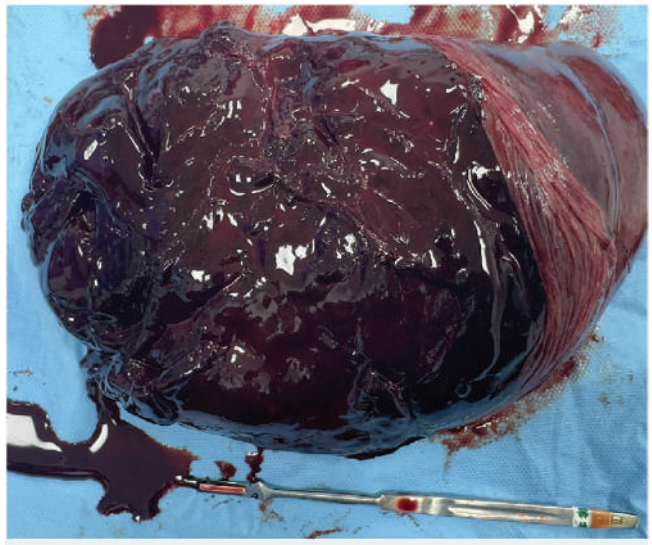

Figure 2. Postoperative image of splenectomy material.

[P-168]

Diagnosis of Behçet's disease in a young male patient presenting with superior mesenteric vein thrombosis: Surgical approach and multidisciplinary management

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Objective: Superior mesenteric vein (SMV) thrombosis is a rare but potentially life-threatening condition due to the risk of intestinal ischemia and high mortality. Its clinical presentation ranges from non-specific abdominal symptoms to bowel infarction and perforation. In young patients presenting with isolated venous thrombosis, underlying systemic inflammatory or vasculitic diseases should be carefully investigated. Behçet's disease is a multisystemic vasculitis that may involve the venous system and, in rare cases, present with mesenteric venous thrombosis. This report describes the diagnostic process and multidisciplinary management of a young male patient presenting with SMV thrombosis who was subsequently diagnosed with Behçet's disease.

Material and Methods: The clinical course, laboratory findings, and radiological imaging of a 20-year-old male patient presenting with abdominal pain and diarrhea were retrospectively reviewed. Surgical decision-making criteria and the multidisciplinary diagnostic approach were analyzed.

Results: The patient presented with a two-week history of epigastric abdominal pain and recent onset of watery diarrhea. Physical examination revealed abdominal distension with mild diffuse tenderness, without peritoneal signs. Laboratory evaluation showed marked leukocytosis (20,000/mm³) and elevated C-reactive protein levels (200-223 mg/L), while serial lactate measurements demonstrated a decreasing trend. Contrast-enhanced abdominal computed tomography revealed a filling defect in the proximal SMV. On the fourth day of hospitalization, CT angiography demonstrated a thrombus in the proximal SMV with loss of distal luminal flow. Despite these findings, no radiological evidence of intestinal ischemia, necrosis, or perforation was observed. Given the patient's clinical stability, normalization of lactate levels, and absence of peritoneal signs, surgical intervention was deferred, and conservative management with therapeutic-dose low-molecular-weight heparin was initiated. The patient's clinical condition gradually improved without surgical complications. Further evaluation for thrombotic etiology revealed negative results for JAK2 mutation and paroxysmal nocturnal hemoglobinuria. Dermatological findings, including recurrent oral aphthae, papulopustular lesions, a history of uveitis, and recurrent thromboembolic events, led to the diagnosis of Behçet's disease according to the International Criteria for Behçet's disease. Immunosuppressive therapy was initiated, and anticoagulation was continued with warfarin.

A thrombus consistent with a filling defect is observed in the proximal SMV; no accompanying findings of overt intestinal ischemia or free air are identified.

Conclusion: In young patients presenting with SMV thrombosis, underlying systemic vasculitides should be investigated after excluding acute surgical pathology. This case highlights that Behçet's disease may present with isolated venous occlusion and that conservative management can be safely applied under appropriate clinical conditions. Early diagnosis and multidisciplinary evaluation are essential to avoid unnecessary surgical intervention.

Keywords: Superior mesenteric vein thrombosis, Behçet's disease, acute abdomen, multidisciplinary approach, conservative management

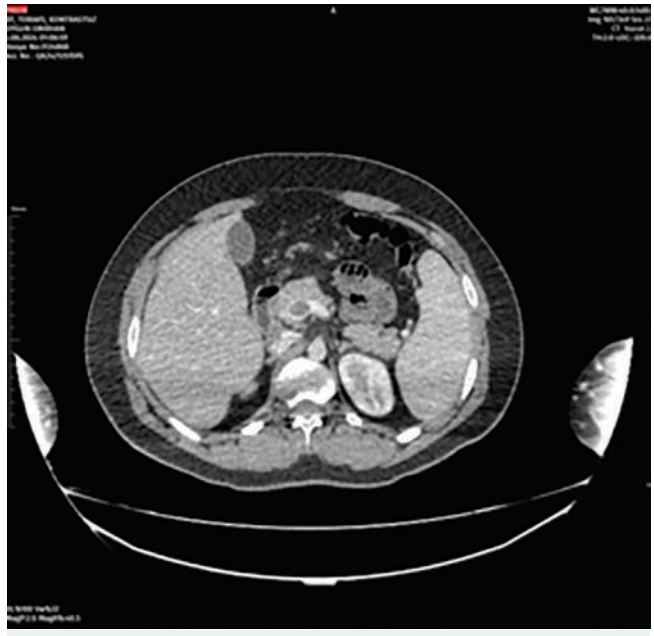

Figure 1. Contrast-enhanced abdominal CT showing superior mesenteric vein thrombosis (axial).

CT: Computed tomography.

[P-169]

Organoaxial gastric volvulus secondary to hiatal hernia: A case report

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Objective: Gastric volvulus is a rare clinical condition that occurs when the stomach loses its normal anatomical position and rotates around its axis, carrying a high-risk of morbidity and mortality if diagnosis is delayed. The organoaxial type develops as a result of rotation along the stomach's longitudinal axis and is most commonly associated with hiatal hernia. Because clinical findings are often non-specific, diagnosis may be delayed, leading to serious complications. In this case report, we present the diagnostic process and successful treatment of organoaxial gastric volvulus secondary to hiatal hernia using a laparoscopic approach.

Material and Methods: A 56-year-old female patient presented to the emergency department with sudden-onset abdominal pain and recurrent vomiting. Her medical history was unremarkable except for hypertension. Physical examination revealed mild abdominal tenderness and distension, with no signs of guarding or rebound. Laboratory evaluation showed a leukocyte count of 13,160/mm³, while other parameters were within normal limits. Contrast-enhanced abdominal computed tomography demonstrated marked gastric distension, displacement of the greater and lesser curvatures, and abnormal positioning of the antropyloric region and part of the duodenum in the right upper quadrant. These findings were consistent with organoaxial gastric volvulus.

Results: Gastric decompression was achieved by insertion of a nasogastric tube, draining approximately 1600 cc of bilious gastric content. Subsequent upper gastrointestinal endoscopy revealed findings supporting gastric volvulus, along with diffuse mucosal edema and focal superficial ulcerations. Based on the clinical and radiological findings, emergency surgical intervention was planned. The patient underwent laparoscopic surgery. Intraoperative exploration revealed herniation of the proximal stomach into the thoracic cavity through the esophageal hiatus, resulting in organoaxial volvulus. The stomach was reduced from the thorax and restored to its anatomical position. No evidence of gastric wall ischemia or necrosis was observed. Crural repair and Nissen fundoplication were performed to address the hiatal hernia and prevent reflux. The postoperative course was uneventful, and the patient was discharged on postoperative day four.

Conclusion: Although rare, organoaxial gastric volvulus is an important surgical emergency requiring rapid diagnosis and intervention. In the presence of hiatal hernia, acute upper gastrointestinal symptoms should be carefully evaluated for gastric volvulus. In appropriately selected patients, laparoscopic management is a safe and effective option, offering both diagnostic and therapeutic benefits.

Keywords: Gastric volvulus, hiatal hernia, organoaxial volvulus, laparoscopic surgery

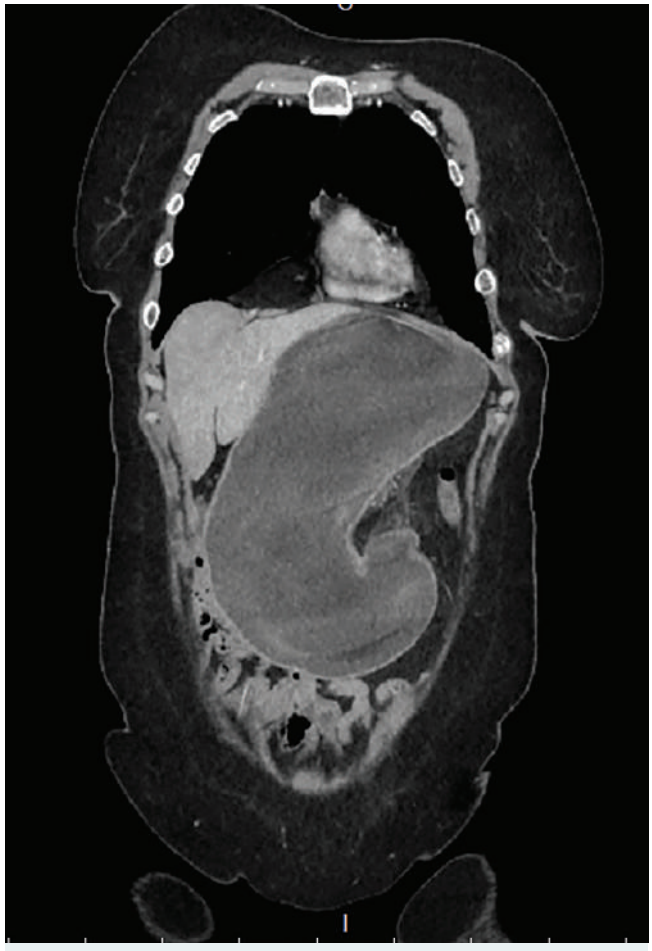

Figure 1. CT image showing gastric volvulus.

CT: Computed tomography.

Figure 2. Gastroscopic image.

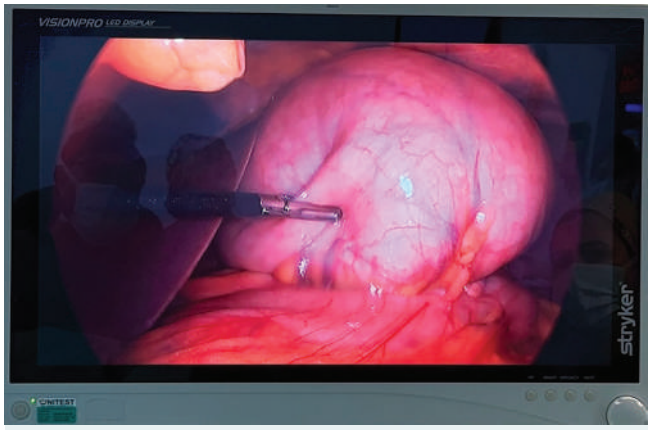

Figure 3. Intraoperative image of gastric volvulus.

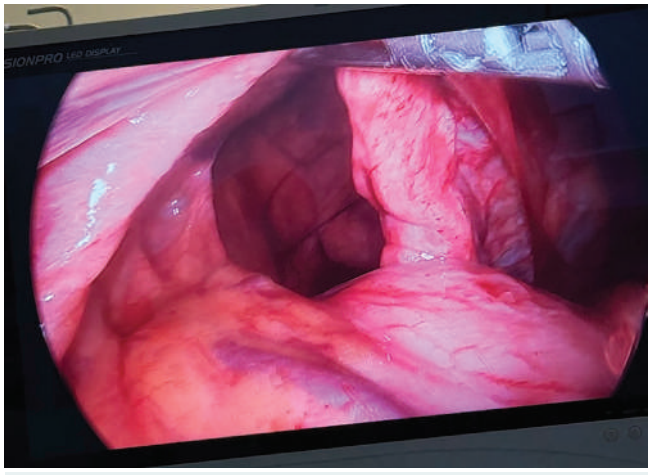

Figure 4. Image showing hiatal hernia.

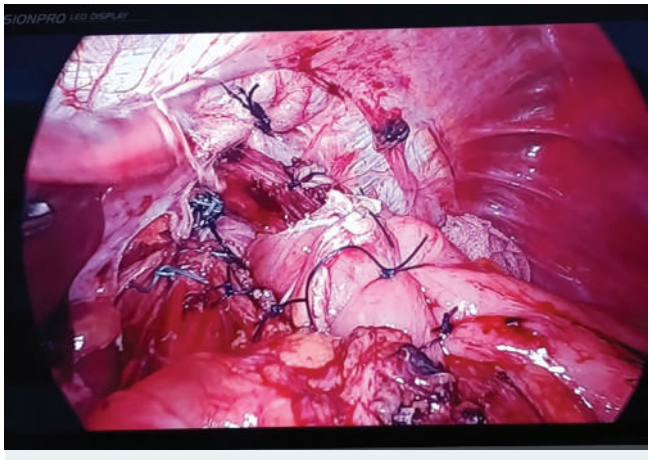

Figure 5. Crural repair and Nissen fundoplication.

Figure 6. xxxxxxxxxxx

[P-170]

A rare cause of ileus: Small intestinal involvement in Behçet's disease and ileus secondary to hematoma

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Objective: Behçet's disease is a chronic, relapsing multisystem vasculitis affecting both small and large vessels. Gastrointestinal involvement, reported in 3-25% of patients, represents one of the most serious complications and is associated with increased morbidity and mortality. The terminal ileum is the most commonly involved site, while isolated proximal small bowel involvement is rare. We report a case of a 49-year-old female with Behçet's disease who underwent segmental small bowel resection for ileus caused by an intramural hematoma.

Material and Methods: A 49-year-old female patient presented to the emergency department with complaints of abdominal pain, constipation, nausea, and vomiting persisting for approximately 10 days. The patient had a known diagnosis of Behçet's disease and a surgical history significant for total colectomy and cholecystectomy performed 10 years earlier. On physical examination, abdominal distension was noted, with tenderness on palpation in the right lower quadrant. Laboratory investigations revealed hemoglobin of 11.6 g/dL, leukocyte count of 18,180/µL, platelet count of 521,000/µL, and C-reactive protein level of 28.1 mg/L. Abdominal computed tomography demonstrated gastric and intestinal loop dilatation up to 42 mm, as well as millimetric air densities within the mesenteric fat tissue adjacent to small bowel loops in the right lower quadrant. Surgical exploration revealed a conglomerated small bowel segment with intramural hematoma and mass-like formation, starting approximately 110 cm distal to the ligament of Treitz and extending for nearly 40 cm. Segmental small bowel resection followed by side-to-side anastomosis was performed.

Results: Small bowel specimen: A resected small bowel segment measuring approximately 60 cm in length with a luminal diameter of 2.5 cm, collectively measuring 13×11.5×6 cm. Gross examination revealed multiple adhesions on the serosal surface, along with focal areas of hemorrhage. Histopathological evaluation demonstrated adhesions (macroscopic and microscopic), inflammatory granulation tissue, xanthomatous inflammation, and hemorrhage.

Conclusion: Gastrointestinal involvement in Behçet's disease is uncommon but may result in severe complications. Vasculitis-related intramural hematoma, although rare, can present with acute abdomen or mechanical ileus and lead to significant morbidity if not recognized early. In patients with Behçet's disease presenting with sudden-onset abdominal pain and obstructive symptoms, intestinal vasculitis–related complications should be considered. Early diagnosis and appropriate management are essential to reduce morbidity and prevent recurrence.

Keywords: Behçet's disease, hematoma, ileus

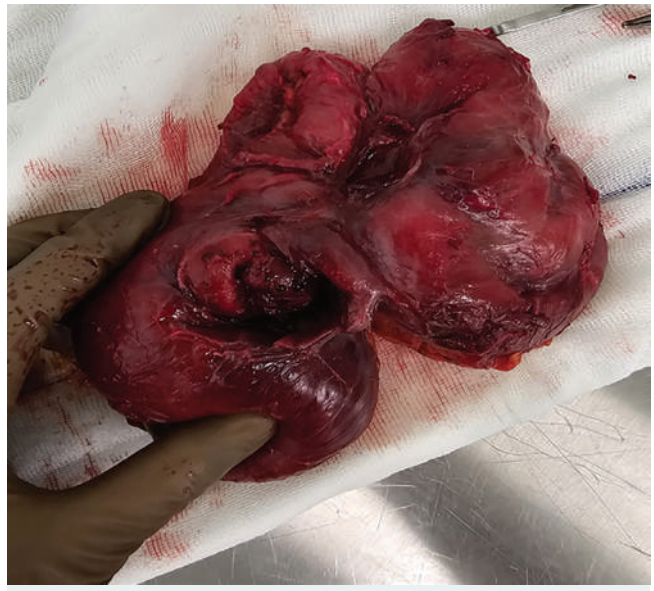

Figure 1. Behçet's secondary hematoma in the small intestine

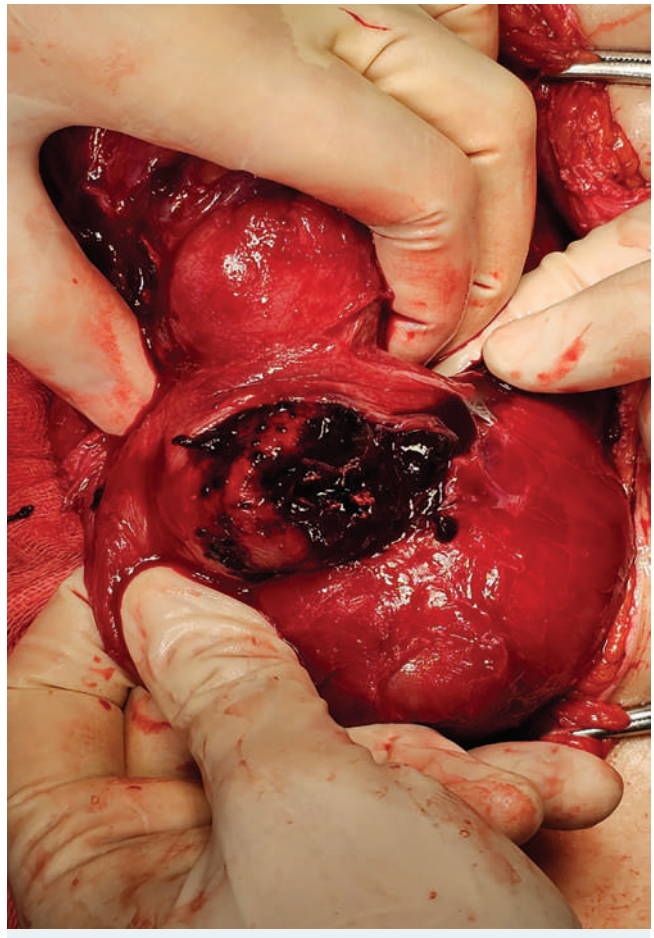

Figure 1. Behçet's secondary hematoma in the small intestine.

[P-171]

A rare cause of ileus; colon incarceration due to diaphragm rupture after right hepatectomy

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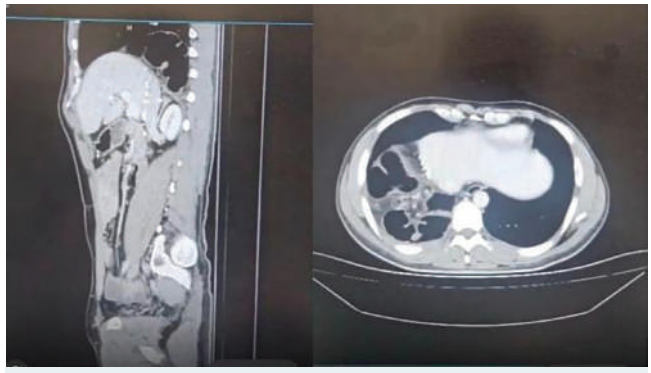
Objective: The diaphragm is a musculotendinous structure separating the thoracic and abdominal cavities and plays a key role in respiration. Diaphragmatic hernia is defined as herniation of intra-abdominal organs into the thoracic cavity through a congenital or acquired diaphragmatic defect. Most diaphragmatic ruptures are related to blunt or penetrating trauma and commonly occur on the left side, as the liver provides relative protection to the right hemidiaphragm. Delayed diaphragmatic rupture following trauma or upper abdominal surgery is uncommon and often presents with non-specific symptoms, leading to diagnostic delay and increased risk of complications such as organ incarceration, strangulation, and bowel obstruction. Diaphragmatic rupture after hepatectomy is rarely reported. This poster presents a case of delayed right-sided diaphragmatic rupture occurring two years after right hepatectomy and presenting with colonic obstruction.

Material and Methods: A 24-year-old male patient with a history of right hepatectomy for hepatocellular carcinoma two years earlier presented to the emergency department with a one-week history of abdominal pain and nausea. Physical examination revealed diffuse abdominal tenderness without signs of peritonitis. Contrast-enhanced computed tomography demonstrated a 4-cm defect in the right hemidiaphragm with herniation of colonic segments into the thoracic cavity and associated proximal bowel dilatation. Despite nasogastric decompression, the patient showed no clinical improvement during a 24-hour observation period. Based on radiological findings and persistent symptoms, emergency surgical intervention was planned.

Results: The patient underwent exploratory laparotomy under general anesthesia through a midline incision. Dense intra-abdominal adhesions related to the previous surgery were encountered. A diaphragmatic defect with surrounding deperitonized muscle tissue was identified on the right side, consistent with preoperative imaging. Incarcerated colonic segments were carefully reduced into the abdominal cavity. Due to an iatrogenic opening of the right parietal pleura during reduction, a closed underwater chest drainage system was placed. The diaphragmatic defect was repaired with a double-layer primary suture technique and reinforced with a composite mesh. The postoperative course was uneventful. Oral intake was initiated 24 hours after surgery, bowel function returned on postoperative day three, and the patient was discharged on postoperative day six without complications.

Conclusion: Delayed diaphragmatic rupture should be considered in the differential diagnosis of acute abdomen and intestinal obstruction, particularly in patients with a history of upper abdominal surgery. Following right hepatectomy, loss of the liver's protective effect and potential diaphragmatic weakening may predispose patients to late-onset rupture. Early recognition and prompt surgical repair are essential to prevent serious complications and ensure favorable outcomes.

Keywords: Colonic obstruction, diaphragmatic rupture, hepatectomy



Figures 1, 2. The patient's preoperative imaging studies.

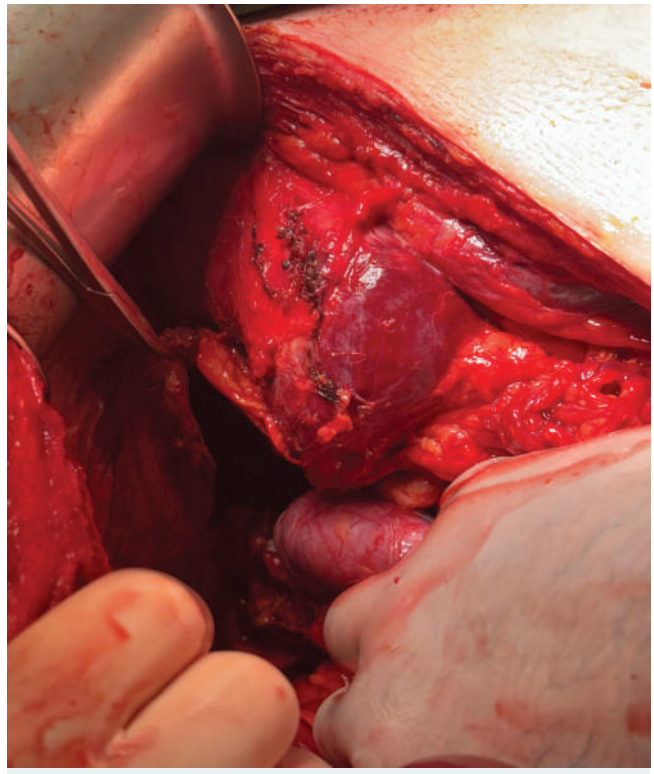


Figure 3. Intraoperative view of the diaphragmatic defect.

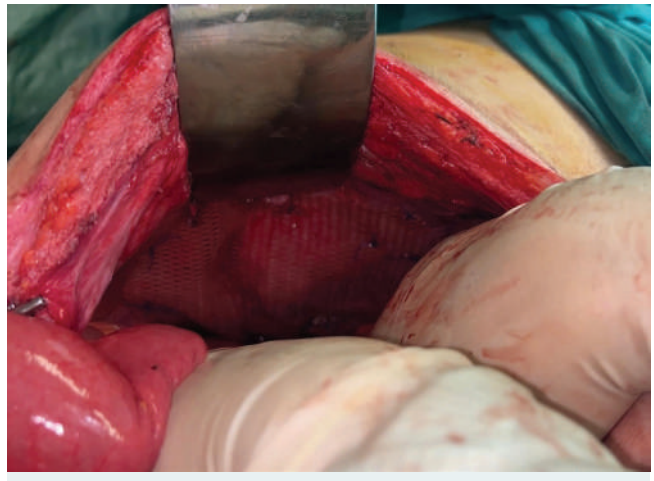


Figure 4. Post-repair view of the diaphragmatic defect.

[P-172]

Intra-abdominal hemorrhage due to ruptured HCC: A case report

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Objective: Hepatocellular carcinoma (HCC) is the most common primary malignant tumor of the liver and typically develops in the setting of cirrhosis or chronic hepatitis B infection. Spontaneous rupture of HCC is a rare but life-threatening complication associated with high mortality rates. In this case report, we present the diagnostic process and treatment of a hypotensive and tachycardic patient with no prior diagnosis of HCC who presented to the emergency department with syncope and abdominal pain, and whose management required a multidisciplinary approach across two centers.

Material and Methods: A 74-year-old male patient presented to an outside institution with complaints of syncope and epigastric pain. His medical history was significant for diabetes mellitus and chronic hepatitis B virus infection. On abdominal examination, tenderness was noted in the epigastric region and bilateral lower quadrants. No evidence of gastrointestinal bleeding was observed on nasogastric tube aspiration or digital rectal examination. Abdominal imaging performed due to decreased hemoglobin levels and the need for transfusion revealed a mass lesion in liver segment III and a large volume of free intraperitoneal fluid. Emergency laparotomy was performed, during which 1.700 cc of hemorrhagic fluid was aspirated. The source of bleeding was identified as the mass in liver segment III (Figure 1). As bleeding control was deemed unachievable at the referring center, intraoperative communication was established with our team. Perihepatic packing was applied, and following transfusion of six units of packed red blood cells, the patient was transferred to our center.

Results: The patient was admitted to the intensive care unit intubated and on low-dose inotropic support. A contrast-enhanced CT scan revealed a 48×40 mm heterogeneously enhancing hemorrhagic mass in liver segment III. Transarterial embolization of the hepatic artery branches via the celiac artery was performed (Figure 2), resulting in hemodynamic stability and no further hemoglobin decline. On postoperative day 1, the patient underwent removal of the packing and left lateral sectorectomy under low central venous pressure with a single 12-minute Pringle maneuver. The patient was extubated during follow-up and discharged on postoperative day 14.

Conclusion: Spontaneous rupture of HCC is a rare but potentially fatal clinical condition. Initial management must be systematic and rapidly implemented. In the present case, a favorable outcome was achieved through embolization at a tertiary referral center followed by elective surgical resection after initial surgical hemostasis.

Keywords: Hepatocellular carcinoma, spontaneous rupture, intraabdominal hemorrhage

Figure 1. Intraoperative appearance of the lesion.

Figure 2. Transarterial embolization.

[P-173]

A rare case of incidental colo-appendiceal fistula with appendiceal diverticulosis presenting as acute appendicitis: A case report

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Objective: Acute appendicitis is the most common surgical cause of acute abdominal pain, Delayed diagnosis may lead to serious complications such as abscess, perforation, peritonitis, sepsis, and fistula formation.Appendiceal diverticulitis is a rare condition and may clinically mimic acute appendicitis. Appendiceal diverticula may be congenital or acquired. Due to mild or atypical symptoms, diagnosis may be delayed and the risk of perforation increases. Additionally, appendiceal diverticula are associated with a risk of neoplasia, particularly carcinoid tumors and mucinous adenomas. Colo-appendiceal fistula is a very rare complication. It is most commonly associated with Crohn's disease, colorectal malignancy, complicated appendicitis, or diverticular disease. Appendiceal diverticulitis is a rare but clinically significant condition that may lead to fistula formation.

Material and Methods: Patient: 51-year-old male History: Abdominal pain for 2 days Past medical history: Unremarkable Physical Examination:• Localized tenderness in the right lower quadrant Laboratory findings: • WBC: 7500 • CRP: 149 Imaging: Contrast-enhanced CT revealed findings consistent with acute appendicitis. Intraoperative Findings During diagnostic laparoscopy: • The appendix was found to be fistulized to the ascending colon • Multiple nodular structures consistent with diverticula were observed along the appendiceal wall • No macroscopic findings suggestive of malignancy or inflammatory bowel disease were detected • Terminal ileum and cecum appeared normalSurgical Procedure • The appendiceal base was closed and transected using an endo-stapler • Wedge resection of the involved colonic segment was performed with an endo-stapler for the distal fistulized segment • Laparoscopic appendectomy was completed.

Results: Pathological Findings Macroscopic examination: • Thickened and edematous appendiceal wall • Multiple diverticular structures • Thin fistula tract along the distal stapler line Histopathological examination: • Acute appendicitis • No malignancy or chronic inflammatory disease detected. The patient was discharged uneventfully on postoperative day 2.

Conclusion: Surgical approach surgical treatment should be individualized according to: • Etiology • Extent of colonic involvement • Intraoperative findings segmental colectomy may be required in cases with suspected malignancy or extensive inflammation. However, in selected cases without malignancy or widespread inflammation, simple appendectomy and separation of the fistula tract may be sufficient. The laparoscopic approach offers advantages including: • Less postoperative pain • Lower morbidity • Faster recovery • Shorter hospital stay technical evaluation if hem-o-lok clips or sutures are used instead of an endo-stapler, the procedure can be performed through a 5-10 mm port instead of a 15 mm port. This minimally invasive modification may reduce the risk of port-site incisional hernia and provide technical improvement for future cases. Colo-appendiceal fistula is a rare finding encountered during acute appendicitis surgery. Intraoperative awareness is important. In selected cases without malignancy or extensive inflammation, laparoscopic appendectomy and fistula separation is a safe and effective treatment option.

Keywords: Acute appendicitis, appendiceal diverticulosis, colo-appendiceal fistula

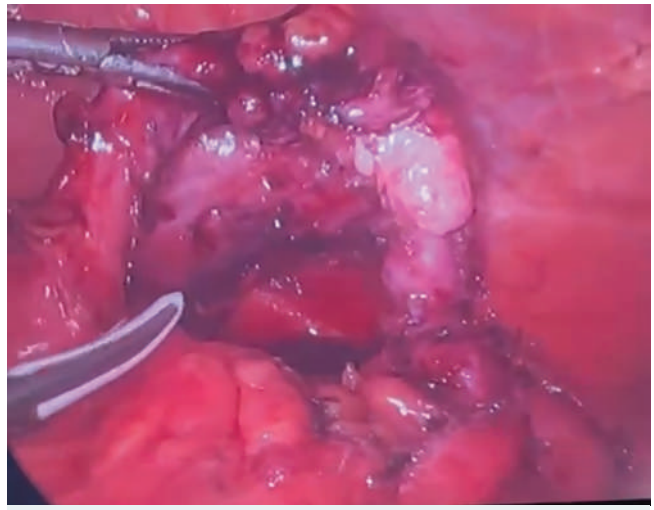

Figure 1. Laparoscopic wiew of colo-appendiceal fistula and appendiceal diverticulosis.

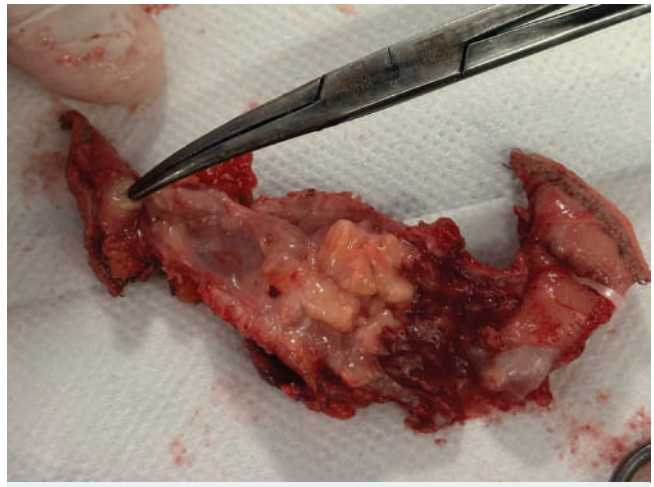

Figure 2. Gross examination of the specimen. Colo-appendiceal fistula and appendiceal diverticulosis shown in the specimen.

[P-174]

Giant Meckel's diverticulum causing adhesive small bowel obstruction with ischemia and inflamation: A case report

Elif Yılmaz

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Objective: Meckel's diverticulum is the most common congenital anomaly of the gastrointestinal tract, yet symptomatic disease in adults is uncommon. Most diverticula are <5 cm; truly giant diverticula are rare and can present as mechanical ileus—particularly in patients without prior abdominal surgery.

Material and Methods: A 67-year-old man presented with 3 days of nausea, vomiting, and obstipation. He had no history of abdominal surgery. Contrast-enhanced CT demonstrated markedly dilated small-bowel loops and a blind-ending, inflamed tubular structure (92×39 mm) in the right lower quadrant, separate from the cecum (Figure 1). Based on these findings, emergency laparotomy was performed.

Results: At exploration, the small bowel was diffusely dilated. A giant Meckel's diverticulum (approximately 14×4 cm) was identified about 50 cm proximal to the ileocecal valve on the antimesenteric border, with ischemic/necrotic changes and dense adhesions causing obstruction (Figure 2). Adhesiolysis and stapled diverticulectomy were carried out. Recovery was uneventful: Oral intake resumed on postoperative day 2, and the patient was discharged on day 4. Pathology confirmed transmural necrosis and intense neutrophilic inflammation, with no ectopic gastric or pancreatic mucosa.

Conclusion: Meckel's diverticulum is an uncommon but important cause of small bowel obstruction in adults. Keeping it in mind—especially when there is no surgical history—can speed up decision-making, and surgery remains definitive treatment.

Keywords: Meckel's diverticulum, small bowel obstruction, diverticulitis, emergency surgery

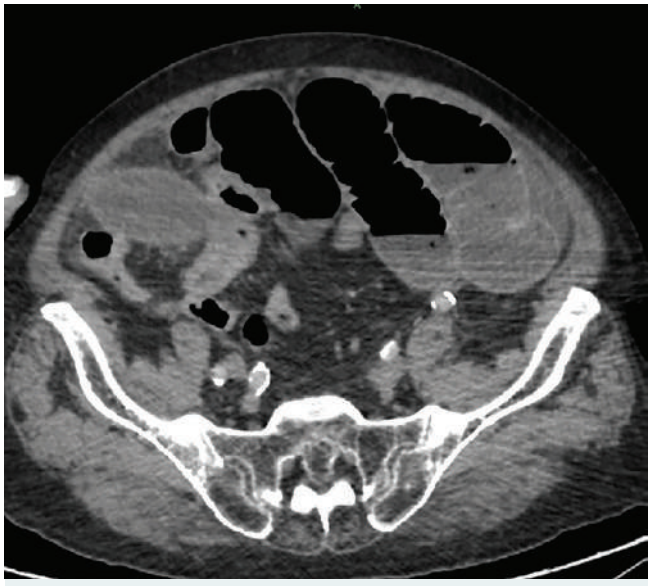

Figure 1. CT scan: Blind-ending inflamed tubular structure in the right lower quadrant (yellow circle) with dilated small-bowel loops.

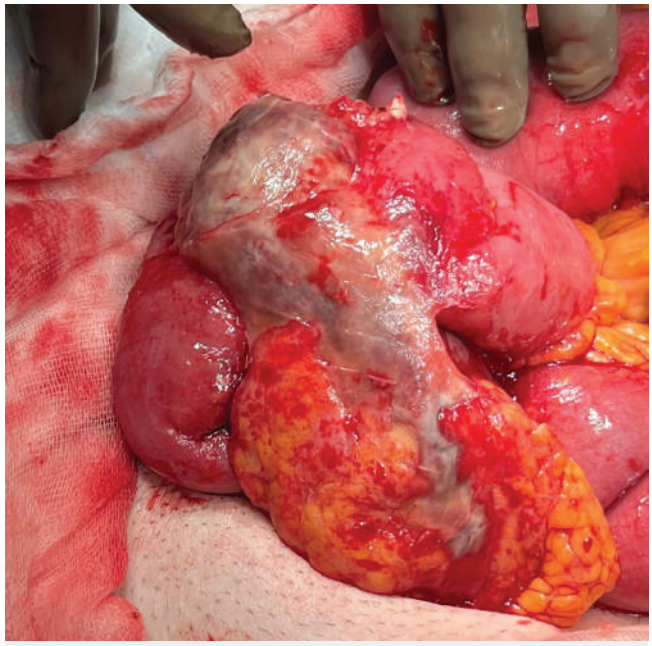

Figure 2. Inraoperative view: Giant Meckel's diverticulum with ischemic and inflammatory changes prior to resection.

[P-175]

Massive gastrointestinal hemorrhage due to splenic artery erosion in the setting of a pseudocyst: A rare vascular complication following necrotizing pancreatitis

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Objective: Acute pancreatitis is a heterogeneous disease whose clinical course can vary from a mild form to severe necrotizing pancreatitis, which carries a 20% mortality risk. Endoscopic and surgical drainage methods, such as cystogastrostomy or cystojejunostomy, are commonly used for the treatment of local complications, like pseudocysts and walled-off necrosis, in symptomatic patients following necrotizing pancreatitis. Complications such as infection, hemorrhage, and perforation may develop after these procedures. However, rare vascular complications following these interventions are of great clinical significance due to the difficulty in diagnosis and the high risk of mortality.

Material and Methods: This report presents a case of massive gastrointestinal hemorrhage due to vascular erosion at the junction of the splenic artery and celiac trunk, occurring late in a patient who underwent endoscopic cystogastrostomy and subsequent surgical cystojejunostomy for a pseudocyst that developed on the basis of necrotizing pancreatitis.

Results: A forty-nine-year-old male patient presented with a complaint of abdominal pain. His medical history included endoscopic cystogastrostomy and surgical cystojejunostomy for non-biliary necrotizing pancreatitis. The patient, who was being followed with medical treatment after an infected collection was detected in the pancreas body on imaging, developed hemodynamic instability with sudden syncope, hypotension, and massive hematochezia during follow-up. Active bleeding foci could not be demonstrated in upper and lower gastrointestinal endoscopies, CT angiography, or selective angiographies. Due to the continued clinical deterioration, the patient was taken for emergency laparotomy. During the exploration, it was found that the splenic artery was eroded in the setting of a pseudocyst at its junction with the celiac trunk, and the bleeding fistulized into the pseudocyst and from there into the stomach and small intestine, leading to massive gastrointestinal hemorrhage. Arterial repair was performed to control the bleeding, and the pseudocyst drainage tract was repaired.

Conclusion: In patients with a history of pancreatic drainage, vascular erosion and arterial rupture must be kept in mind as a possibility in the presence of unexplained massive gastrointestinal hemorrhage, even if endoscopic and radiological examinations are negative. Early surgical exploration and a multidisciplinary approach are of critical importance in reducing mortality.

Keywords: Necrotizing pancreatitis cystogastrostomy, pancreatic pseudocyst artery erosion

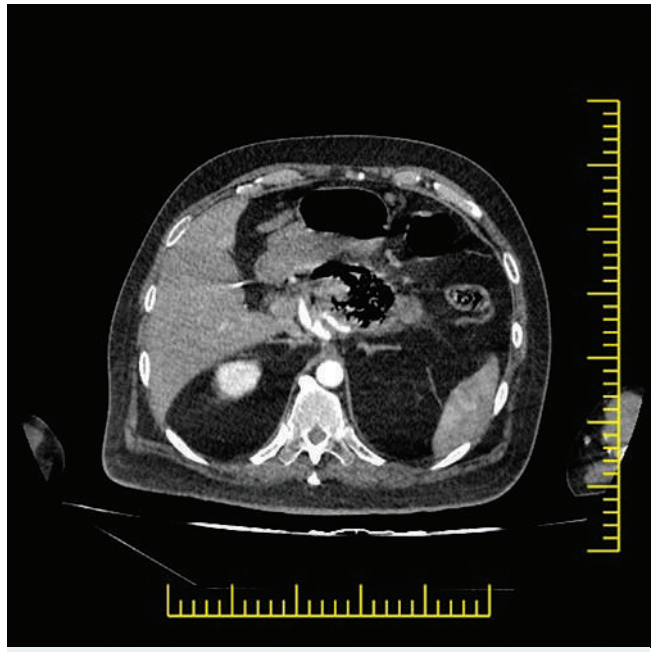

Figure 1. CT angiography. CT angiography showed irregularity at the splenic artery root.

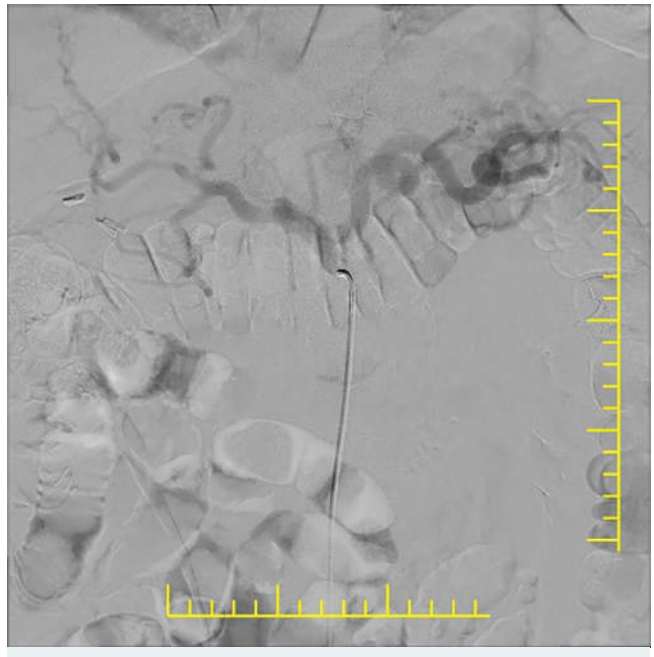

Figure 2. Selective arterial angiography. No extravasation was detected on the arterial angiography performed due to gastrointestinal bleeding.

[P-176]

Closed-loop obstruction from internal hernia caused by a peritoneal band: A case report

Ahmet Receb, Dilara Yılmaz Köse, Esmatullah Alizai, Muhammed Kerem Çolak, Berkan Acar, Ali Muhtaroğlu, Selahattin Vural, Tuğrul Kesicioğlu

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Objective: Internal hernias are an uncommon but high-risk cause of acute bowel obstruction; once a closed-loop forms, ischemia can develop quickly. We present a case of closed-loop obstruction caused by an internal hernia related to a peritoneal band in a patient with no prior abdominal surgery.

Material and Methods: A 41-year-old man presented with sudden-onset abdominal pain, nausea, and vomiting. He had no comorbidities, no regular medications, and no history of abdominal surgery. Because the examination suggested an acute abdomen, contrast-enhanced abdominal CT was obtained and an emergency laparotomy was performed.

Results: CT showed dilated jejunal loops consistent with a closed-loop obstruction and two contiguous internal hernias extending from a defect toward both sides of the abdomen. Bowel wall enhancement in the obstructed segments was reduced (Figure 1). At surgery, a peritoneal band extending from the transverse colon mesentery to the descending colon mesentery was identified (Figure 2). Proximal small-bowel loops were herniated and trapped through the space between this band and the small-bowel mesentery. The band was divided and the bowel was reduced. The involved loops appeared edematous with only minimal ischemia, and peristalsis was preserved. After warming, perfusion improved, so no resection was needed. A pelvic drain was placed. The patient resumed oral intake on postoperative day 1 and was discharged uneventfully on day 6.

Conclusion: Even without a surgical history, internal hernias and peritoneal bands can cause mechanical obstruction. Closed-loop features and reduced enhancement on CT should prompt timely surgery. Early reduction may spare the bowel and avoid resection.

Keywords: Mechanical ileus, internal herniation, ischaemia, emergency surgery

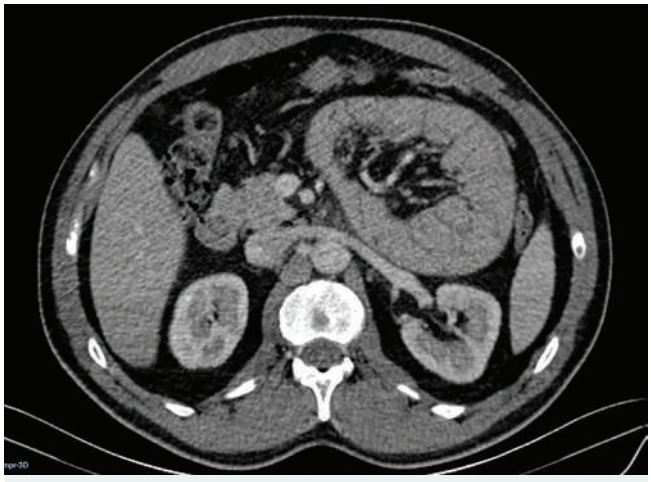

Figure 1. Contrast-enhanced CT: Closed-loop obstruction of jejunal loops with findings suggestive of internal hernia.

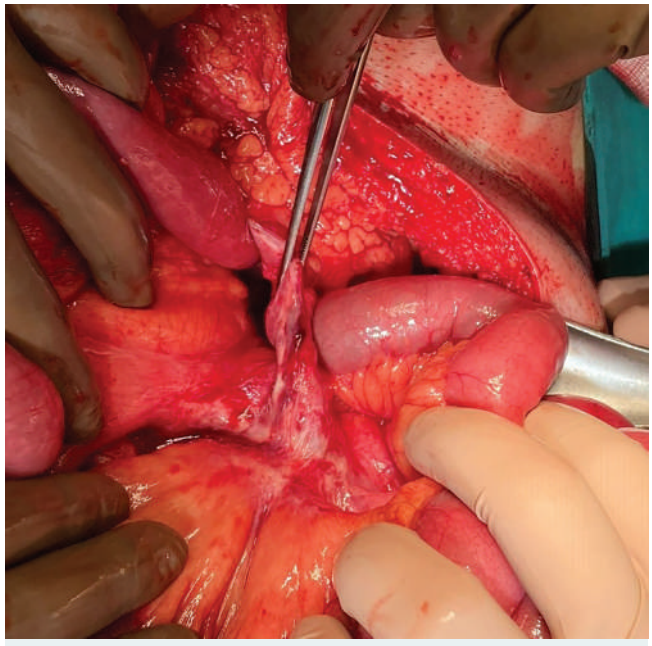

Figure 2. Intraoperative view: Peritoneal band and band/mesentery window.

[P-177]

A rare traumatic biliary complication after blunt abdominal trauma: Cystic duct stump rupture mimicking mesenteric hemorrhage

Banu Karapolat, Ahmet Yüğrük, Cennet Pınar Oymak, Selim Altındaş

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Objective: Extrahepatic bile duct injuries following blunt abdominal trauma are exceedingly rare and are often diagnosed late. The main reason for this delay is the lack of specific early clinical findings and the fact that imaging studies frequently appear normal or provide misleading results. In patients with a history of cholecystectomy, decreased mobility of the short and fibrotic cystic duct stump renders this structure more vulnerable to traction forces. Consequently, rare but potentially serious biliary complications may occur. In this presentation, we report a rare case of traumatic cystic duct stump rupture that was initially operated on with a presumptive diagnosis of mesenteric hemorrhage but was identified intraoperatively.

Material and Methods: The clinical findings, radiologic images, and surgical intervention of a 22-year-old female patient with a history of laparoscopic cholecystectomy four years earlier who presented after a fall from approximately three meters were retrospectively reviewed. The trauma computed tomography (CT) images obtained at the initial presentation were compared with the contrast-enhanced CT findings from the second admission. Intraoperative findings during emergency laparotomy and the surgical management were analyzed.

Results: No pathological findings were detected on the initial trauma CT, and the patient was discharged (Figures 1 and 2). She returned the following day with worsening abdominal pain, vomiting, and loss of appetite. Physical examination revealed diffuse abdominal tenderness and rebound. Laboratory evaluation demonstrated a 2 g/dL decrease in hemoglobin level. Contrast-enhanced CT showed extensive intraperitoneal free fluid, and mesenteric hemorrhage was suspected (Figures 3 and 4). During emergency laparotomy, bile-stained fluid was identified in the subhepatic region. Following a wide Kocher maneuver, no injury to the duodenum, pancreatic head, or major bile ducts was detected. Careful dissection toward the hepatic hilum revealed detachment of the cystic duct stump clip with active bile leakage from the open end (Figure 5). The cystic duct stump was securely ligated using a double-ligation technique, the abdominal cavity was irrigated, and drains were placed. No postoperative bile leakage occurred, and the patient was discharged without complications.

Conclusion: This case demonstrates that isolated cystic duct stump rupture following blunt abdominal trauma in patients with prior cholecystectomy, although rare, can result in a life-threatening condition. Normal findings on early imaging do not exclude severe biliary injury. When clinical findings are discordant with radiologic results, surgical exploration should not be delayed. Such an approach facilitates timely diagnosis and may significantly reduce morbidity and mortality.

Keywords: Blunt abdominal trauma, cystic duct stump rupture, biliary injury

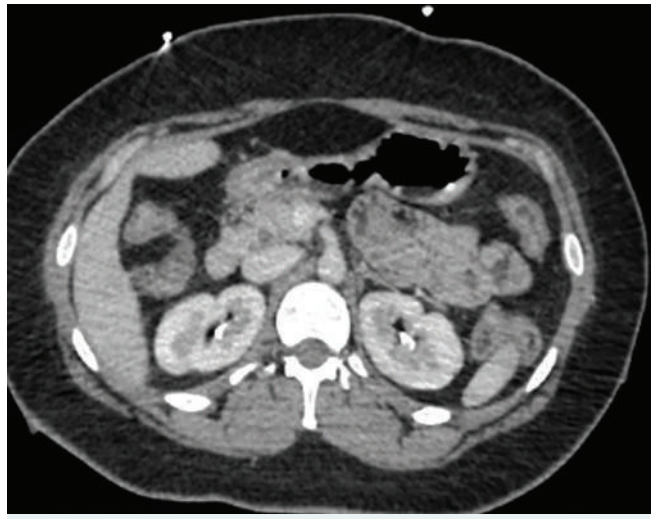

Figure 1. Initial axial trauma computed tomography (CT) image demonstrating no pathological findings.

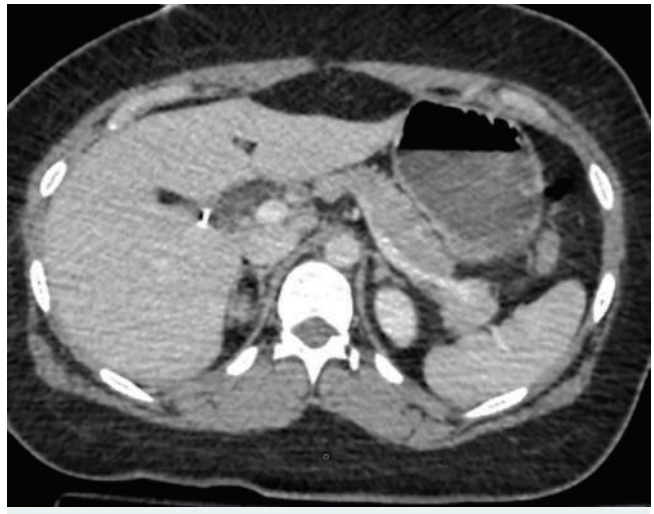

Figure 2. Initial trauma CT scan of the upper abdomen showing no evidence of free fluid or solid organ injury.

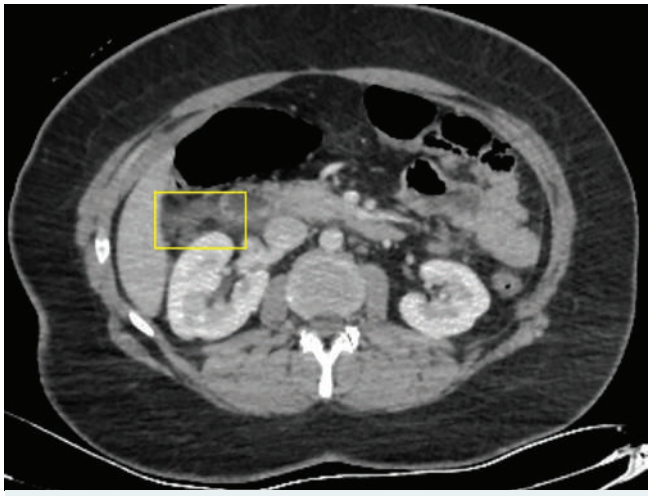

Figure 3. Contrast-enhanced CT obtained at the second admission demonstrating extensive intraperitoneal free fluid (arrows).

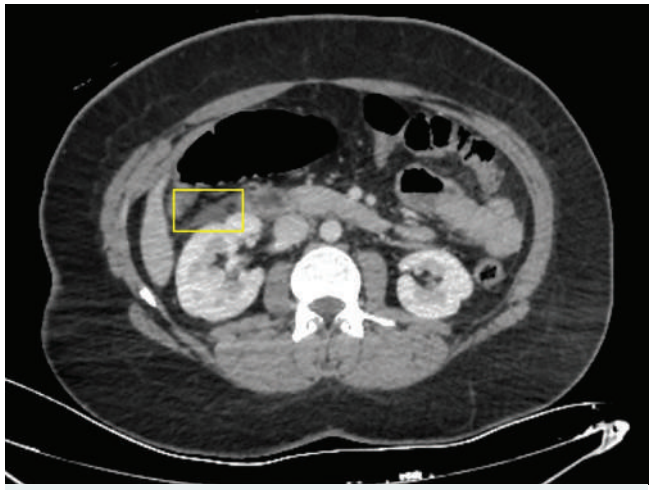

Figure 4. Contrast-enhanced CT showing free fluid collections initially suspected to represent mesenteric hemorrhage (arrows).

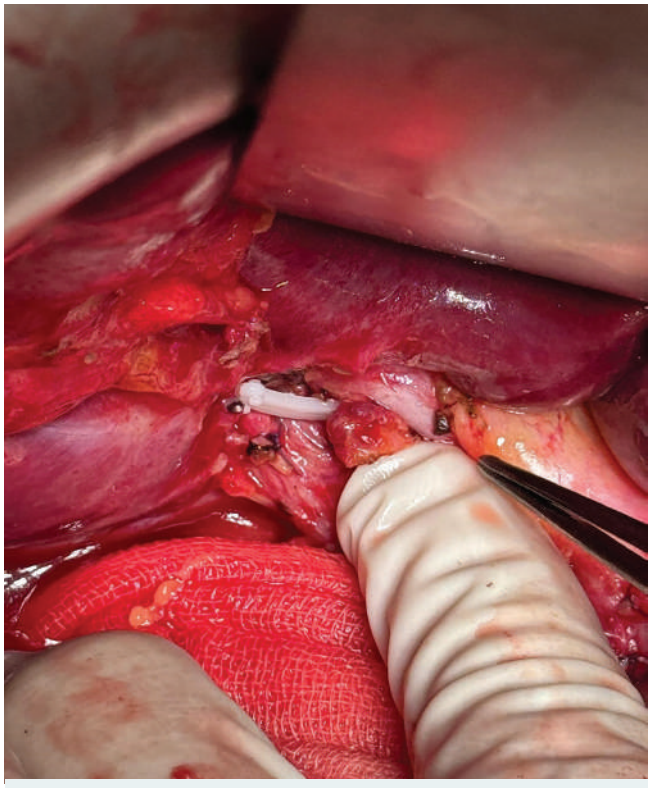

Figure 5. Intraoperative view demonstrating detachment of the cystic duct stump clip with active bile leakage from the open stump.

[P-178]

A jejunal diospyrobezoar causing complete small bowel obstruction in a patient with previous gastrojejunostomy: A case report and review of management

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Objective: Phytobezoars are an uncommon yet clinically significant cause of mechanical small bowel obstruction, accounting for 0.4-4.8% of all cases. In this case report, we aimed to evaluate the diagnosis and surgical management of acute small bowel obstruction caused by a "diospyrobezoar" (persimmon bezoar) in a patient with a history of gastric surgery, in light of current literature.

Material and Methods: In this study, the diagnosis, treatment, and follow-up processes of a 35-year-old female patient who presented with acute mechanical small bowel obstruction and had a history of gastrojejunostomy were retrospectively reviewed. The patient's dietary intake, surgical history, and duration of clinical symptoms were evaluated; physical examination and laboratory findings were recorded. The diagnosis was based on contrast-enhanced abdominal computed tomography (CT) findings, which have high sensitivity in detecting bezoars. For the surgical approach, a laparotomic enterotomy and extraction technique was performed, determined by the degree of bowel dilatation and the consistency of the bezoar.

Results: A 35-year-old female with a history of gastrojejunostomy presented with a 5-day history of complete small bowel obstruction. Focused anamnesis revealed the consumption of two persimmons (Diospyros kaki) 3 days prior to symptoms. Laboratory tests showed leucocytosis and prerenal acute kidney injury. Abdominal CT demonstrated 6 cm proximal bowel dilatation and a pathognomonic "mottled gas sign" in the jejunum, consistent with a phytobezoar. At laparotomy, a firm, impacted diospyrobezoar was identified in the mid-jejunum, 40 cm distal to the Braun's anastomosis. Due to the high risk of mural injury with manual milking, a longitudinal enterotomy was performed for intact bezoar extraction. The enterotomy was closed transversely in two layers. The patient had an uneventful recovery and was discharged on postoperative day 5.

Conclusion: Previous gastric surgery, hypochlorhydria, and impaired motility are primary risk factors for phytobezoar formation. Persimmons, high in tannins, polymerize in acidic environments into hard "diospyrobezoar" masses. CT remains the diagnostic modality of choice for identifying pathognomonic features and obstruction levels. While chemical dissolution may suit partial obstructions, complete obstruction with significant dilatation mandates emergency surgery. In proximal, firm bezoars, enterotomy is preferred over manual milking to prevent perforation. Ultimately, clinicians must maintain a high index of suspicion in post-gastric surgery patients and provide essential dietary counseling regarding high-fiber foods.

Keywords: Diospyrobezoar, small bowel obstruction, gastrojejunostomy

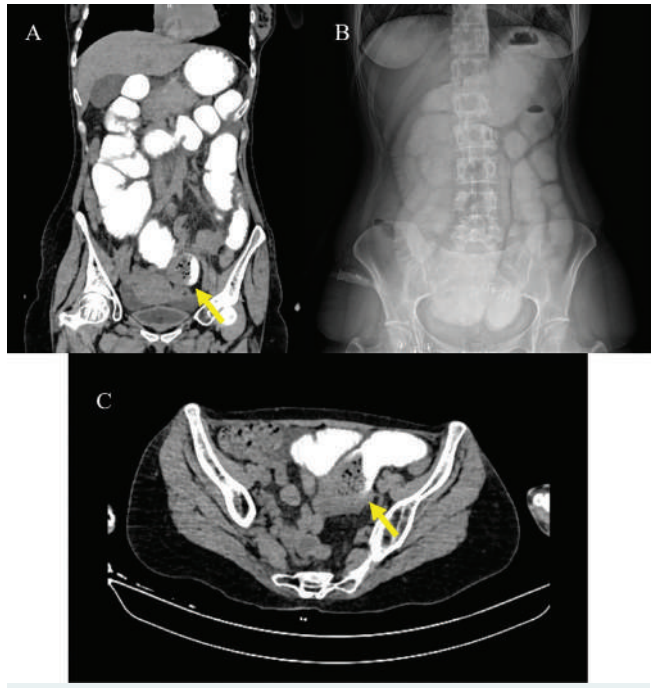

Figure 1. Preoperative imaging findings. (A) and (C) Coronal and axial CT images reveal a well-defined, mottled, gas-filled intraluminal mass within the small bowel (yellow arrows). Significant proximal bowel dilatation is present, consistent with a mechanical intestinal obstruction. (B) Upright abdominal X-ray reveals multiple dilated small bowel loops with a notable absence of distal gas, consistent with a mechanical obstruction.

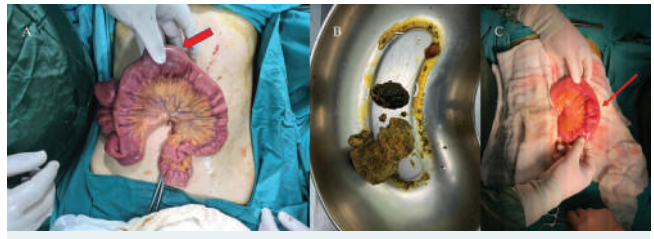

Figure 2. Intraoperative findings. (A) Intraoperative identification of the obstructive point (thick red arrow). (B) Subsequent delivery of the obstructing phytobezoar, a solid concretion composed of undigested persimmon fibers. (C) The longitudinal enterotomy was closed transversely in two layers to prevent luminal narrowing (thin red arrow).

[P-179]

Concurrent abdominal, upper extremity, and neck injuries associated with multiple stab-cut tool injuries: A case report

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Objective: Multiple stab-and-cut injuries are traumatic injuries that can lead to life-threatening bleeding and organ damage within a short period of time, requiring rapid decision-making and a multidisciplinary approach. This case presentation aims to present the diagnosis, treatment, and postoperative management of a patient who was hemodynamically unstable, underwent emergency surgery without preoperative imaging, and had simultaneous abdominal, upper extremity, and neck injuries.

Material and Methods: The literature has examined complex injuries resulting from multiple stab-and-cut injuries; in particular, the diagnostic and therapeutic role of emergency surgical exploration performed without preoperative imaging in hemodynamically unstable patients has been evaluated.

Results: A 57-year-old male patient presented to the emergency department with multiple stab and cut wounds following a suicide attempt. Physical examination revealed approximately 45 stab wounds on the body. Laboratory tests showed WBC: 26,000/µL and lactate: 3.72 mmol/L. Clinical evaluation revealed that the patient was hemodynamically unstable and therefore underwent emergency surgery without preoperative radiological imaging. During emergency surgical exploration; • Multiple tendon, nerve, and major vascular structure injuries in the left upper extremity, • Small intestine, stomach, liver, and colon injuries during abdominal exploration, • Penetrating-cutting instrument injury in the neck regionwere detected. Surgical procedures for abdominal and upper extremity injuries were performed simultaneously. The ear, nose, and throat team was involved in the operation due to a neck injury, and the Plastic Surgery team was involved due to a subtotal amputation of the left wrist. The surgical procedures were completed with the assistance of multidisciplinary teams. The patient was monitored in the intensive care unit during the postoperative period and hemodynamic stabilization was achieved. Further evaluation was performed when bile was observed in the surgical drains during follow-up. Magnetic resonance cholangiopancreatography revealed bile leakage, prompting the patient to undergo endoscopic retrograde cholangiopancreatography and biliary stent placement. Post-procedure drainage was observed to decrease. No other major surgical complications developed in the early postoperative period.

Conclusion: In cases of multiple stab and cut injuries with hemodynamically unstable course, emergency surgical exploration is life-saving even if preoperative imaging cannot be performed. Early diagnosis and management of complications that may develop in the postoperative period, such as bile leakage, using endoscopic methods reduces the need for additional surgery. This case highlights the importance of a multidisciplinary approach and close postoperative follow-up in cases of simultaneous abdominal, extremity, and neck injuries. After completing surgical treatment, the patient was transferred to the psychiatry department for further evaluation and treatment.

Keywords: Cutting-piercing instrument injury, multiple trauma, emergency surgery, bile leakage, multidisciplinary approach

Figure 1. Image of multiple injuries due to suicide in the abdomen. Multiple incisions made with the intent of suicide and the healed state three weeks later can be seen in the image.

[P-180]

Strangulated giant umbilical hernia with limited fecal contamination to the hernia sac: A rare cause of transverse colon perforation

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Objective: Adult umbilical hernias are associated with increased intra-abdominal pressure and impaired abdominal wall integrity, commonly seen in obesity, ascites, chronic cough, heavy and repeated physical strain, multiparity and chronic constipation.

Material and Methods: A 64-year-old male patient presented with abdominal swelling which increased in size since three days along with constipation for four days. Medical history included diabetes, hypertension, morbid obesity, and a sedentary lifestyle. He had been diagnosed with umbilical hernia four years ago, where surgical repair was recommended but declined by the patient. PE revealed a non-reducible giant hernia with tenderness in the supraumbilical region.The patient was hypotensive and tachycardic. Laboratory findings showed leukocytosis with elevated infective marker levels. CT demonstrated herniation of distal transverse colon segments through a 7-cm fascial defect at the umbilical level. Hernia sac reached approximately 22 cm in diameter and contained free fluid up to 14 cm in depth. Colonic loops proximal to hernia sac were dilated with air-fluid levels, and free air within the hernia sac was observed, consistent with perforation. The patient was underwent emergency surgery.

Results: On exploration, free colonic contents were found within the hernia sac, with a strangulation-related perforation of the transverse colon near the hepatic flexure. Severe edema, ischemia, and necrosis were present in the hernia sac, subcutaneous tissue, and anterior fascia. As contamination was limited to the hernia sac, temporary sutures were placed at the perforation site and irrigation was performed prior to entering the abdomen. No macroscopic intra-abdominal contamination was observed; only inflammatory fluid and dilation of the ascending colon were present. Right hemicolectomy and aggressive debridement of necrotic fascia and subcutaneous tissue were performed. Due to poor tissue quality and contamination risk, fascia was closed with interrupted non-absorbable sutures, and the skin was left for secondary healing. Patient developed respiratory failure, mixed acidosis, and oliguria peroperatively, and required mechanical ventilation for three days. Oral intake was resumed on postoperative day five. Secondary skin closure was performed on postoperative day eight. Combined broad-spectrum antibiotics were administered for 21 days. The patient was discharged on postoperative day 21 in stable condition. Histopathology revealed no malignancy.

Conclusion: Giant umbilical hernias can present with rare but life-threatening complications such as colonic perforation confined to the hernia sac. Early surgical intervention, meticulous contamination control, and careful abdominal wall management are crucial. This case highlights the importance of individualized surgical strategies in complex hernia emergencies, especially in patients with significant comorbidities.

Keywords: Hernia, strangulation, sepsis

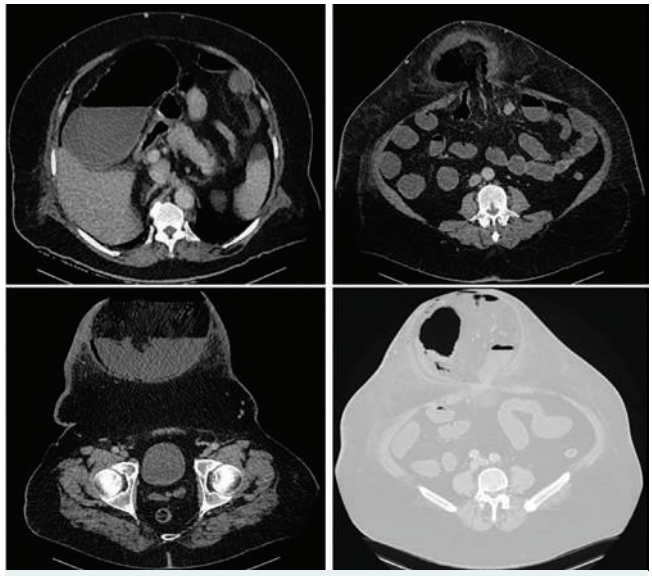

Figure 1. Computed Tomography (CT) images demonstrate herniation of the distal segments of the transverse colon through a defect at the level of the umbilicus, dilatation of the bowel loops proximal to the hernia sac with air–fluid levels, and the presence of free fluid and free air within the hernia sac.

Figure 2. Pre- and intraoperative images of the hernia sac, along with the resection specimen are shown.

[P-181]

Morel-Lavallée lesion following blunt abdominal trauma: A rare case report

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Objective: Although rare, Morel-Lavallée lesions (MLLs) typically occur following blunt trauma and result from the separation of the skin and subcutaneous tissue from the underlying fascial planes. This separation creates a potential space in which hematopoietic and lymphatic fluid accumulates, leading to clinical manifestations such as swelling, pain, fever, and tissue tension. Patients may receive a diagnosis within days of trauma; however, in some cases, symptoms may develop months or even years later, resulting in delayed diagnosis.

Material and Methods: The case was retrospectively evaluated, and management was determined based on the patient's clinical findings and the characteristics of the accumulated fluid.

Results: A 29-year-old male patient presented to the emergency department with fever, localized periumbilical swelling, and pain. Computed tomography revealed a cystic, hypodense fluid collection measuring 9 cm in diameter, located anterior to the rectus abdominis muscle in the anterior abdominal wall. The patient's medical history included a traffic accident (truck collision) one year prior, after which he had been observed in the emergency department for one day due to blunt trauma and subsequently discharged following non-operative management. During the post-traumatic period, it was noted that the patient had presented to the emergency department three times within one year with identical complaints. The MLL was first described in 1853 by the French physician Maurice Morel-Lavallée. This lesion represents a serous fluid collection that develops following closed degloving injuries and, in particular, after surgical procedures involving the pelvis and abdominal regions. Delays in diagnosis and treatment may lead to infection of the cystic cavity. Magnetic resonance imaging is considered the most reliable diagnostic modality. Treatment options include conservative management, percutaneous drainage, sclerosing agent injection, and open surgical debridement. The choice of treatment is guided by the patient's preference, clinical findings, and the characteristics of the accumulated fluid.

Conclusion: MLLs are rare entities that can develop following trauma, with potentially delayed diagnosis, and may present with symptoms even years after the initial injury. Awareness of MLLs is essential for emergency physicians and consulting surgeons to prevent delayed diagnosis and to avoid repeated surgical interventions.

Keywords: Morel-Lavallée, trauma, hematoma

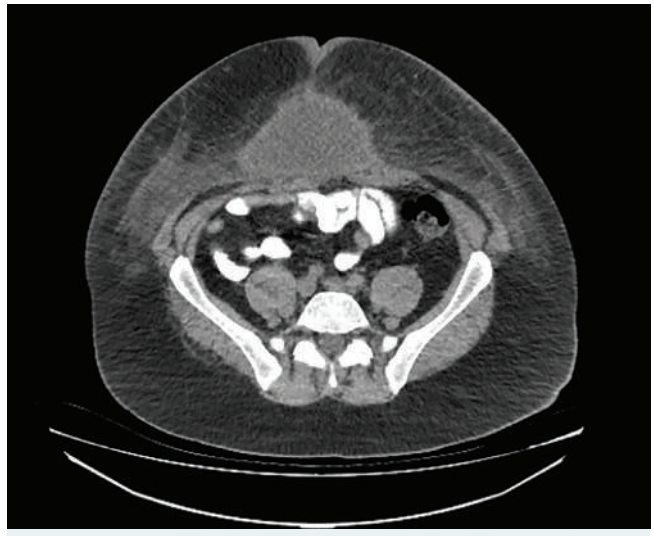

Figure 1. Oral contrast-enhanced CT scan section showing subcutaneous tissue collection.

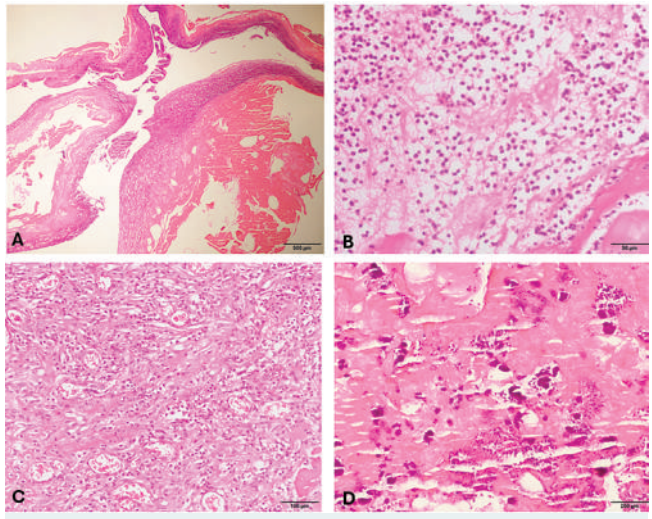

Figure 2. (A and B) Histopathological examination revealed fibrin deposition admixed with acute suppurative inflammatory cell infiltration (H&E X40, X400). (C) Granulation tissue with congested vascular proliferation and mixed inflammatory infiltrates was observed (H&E X200). (D) Focal areas of calcification within fibrotic tissue were identified (H&E X200).

[P-182]

Laparoscopic Meckel's diverticulum resection and hernia repair in an incarcerated Littre hernia: A case report

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Objective: Meckel's diverticulum is the most common congenital anomaly of the gastrointestinal tract, occurring in approximately 2% of the population. Although most cases are asymptomatic, they may present with clinical findings such as bleeding, diverticulitis, and intestinal obstruction. The presence of Meckel's diverticulum within a hernial sac is called Littre's hernia and is a very rare clinical condition. Littre's hernia usually presents with incarcerated or strangulated hernia and is difficult to diagnose in the preoperative period. The diagnosis is usually made during surgical exploration. This study aims to present a case of Meckel's diverticulum detected within a strangulated inguinal hernia and treated with a laparoscopic approach.

Material and Methods: A case of Meckel's diverticulum detected and treated using laparoscopic methods was retrospectively evaluated.

Results: A 30-year-old male patient presented to the emergency department complaining of pain and swelling in his right groin that had persisted for two days. Physical examination revealed an irreducible right inguinal hernia. Ultrasound revealed a herniated bowel loop through a fascial defect, a non-peristaltic appearance, and free fluid within the hernia sac, leading to a preliminary diagnosis of strangulated hernia. The patient underwent surgery. Exploration using the TAPP approach revealed a strangulated Meckel's diverticulum within the indirect inguinal hernia sac. After the diverticulum was reduced into the abdomen, the hernia sac was dissected, and the preperitoneal space was prepared. Subsequently, a 10x15 cm polypropylene mesh was placed and fixed in the preperitoneal space, and the hernia repair was completed by suturing the peritoneal defect. Then, the diverticulum was resected using a laparoscopic linear stapler. Intestinal integrity was preserved during the operation, and no additional resection was required. The patient was discharged on the third day without complications in the postoperative period. Histopathological examination revealed findings consistent with a Meckel's diverticulum without ectopic tissue.

Conclusion: Littre's hernia is a clinical picture that should be kept in mind in the differential diagnosis of incarcerated or strangulated inguinal hernias, despite its rarity. Due to the difficulty of preoperative diagnosis, surgical exploration plays a decisive role in diagnosis and treatment. In the presented case, the strangulated Meckel's diverticulum was safely resected using the TAPP approach, and hernia repair with mesh was successfully performed simultaneously due to the absence of contamination findings. The laparoscopic approach should be considered an effective and safe treatment option in selected cases due to its ability to provide intraabdominal exploration, its minimally invasive nature, and its advantages of rapid postoperative recovery.

Keywords: Littre's hernia, Meckel's diverticulum, laparoscopic hernia repair

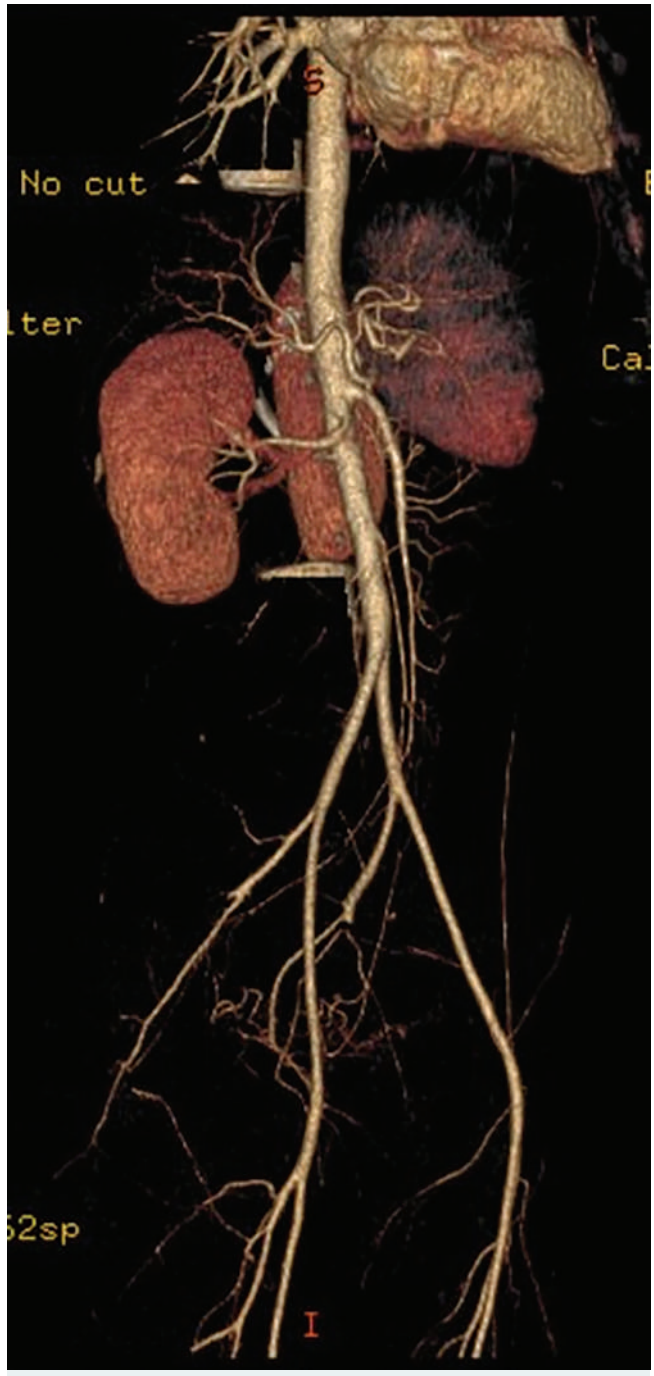

Figure 1. SMA blood flow appears normal.

[P-183]

Superior mesenteric venous thrombosis and small intestine necrosis in a young patient with protein S deficiency: A rare case

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Objective: This case study aims to highlight that protein sodium deficiency, a rare inherited thrombophilia, can lead to superior mesenteric vein (SMV) thrombosis and cause severe intestinal ischemia even under anticoagulation. Protein S deficiency is one of the inherited thrombophilias that disrupt the natural anticoagulant system and is quite rare in the general population. Although it poses a high risk for venous thromboembolic events, its association with mesenteric vein thrombosis has been reported in a limited number of cases in the literature. SMV thrombosis, while rare among the causes of mesenteric ischemia, can lead to serious morbidity and mortality if diagnosis and treatment are delayed. The non-specific nature of clinical findings can lead to delayed diagnosis, especially in young patients.

Material and Methods: A 28-year-old woman presented to the emergency department with abdominal pain. Her history included recurrent abortions, prior deep vein thrombosis, and known protein S deficiency, for which she was receiving regular low-molecular-weight heparin (LMWH). Physical examination revealed lower abdominal tenderness without signs of an acute abdomen. Laboratory tests showed normal lactate dehydrogenase, lactate, and creatine kinase levels. Contrast-enhanced abdominal CT angiography demonstrated normal opacification of the superior mesenteric artery; the main trunk of the SMV was patent, with filling defects consistent with thrombosis in the distal ileal branches.The patient was admitted for observation. Due to clinical progression despite anticoagulation, emergency surgery was performed. Laparoscopic evaluation revealed impaired bowel perfusion, necessitating conversion to laparotomy. A necrotic ileal segment approximately 40 cm in length was identified about 20 cm proximal to the terminal ileum. The affected segment was resected, and a primary ileoileal anastomosis was performed. Therapeutic-dose LMWH was continued postoperatively. Oral intake was initiated on postoperative day 2, and the patient was discharged uneventfully on postoperative day 5.

Results: A significant proportion of SMV thrombosis cases reveal underlying hypercoagulability. Although protein S deficiency is rare in the general population (0.03-0.13%), it poses a significant risk for venous thrombosis. This case is noteworthy because it demonstrates that SMV thrombosis and bowel necrosis can develop even with regular anticoagulation therapy. In young patients with a history of thromboembolic disorders, early imaging, close clinical monitoring, and timely surgical intervention significantly improve the prognosis.

Conclusion: Protein S deficiency is a rare cause of thrombophilia; however, it should be kept in mind that serious SMV thrombosis and intestinal necrosis can develop even under anticoagulation.

Keywords: Superior mesenteric vein thrombosis, protein S deficiency

Figure 1. Image of intraoperative bowel necrosis. A color difference is observed between the necrotic and healthy bowel loops.

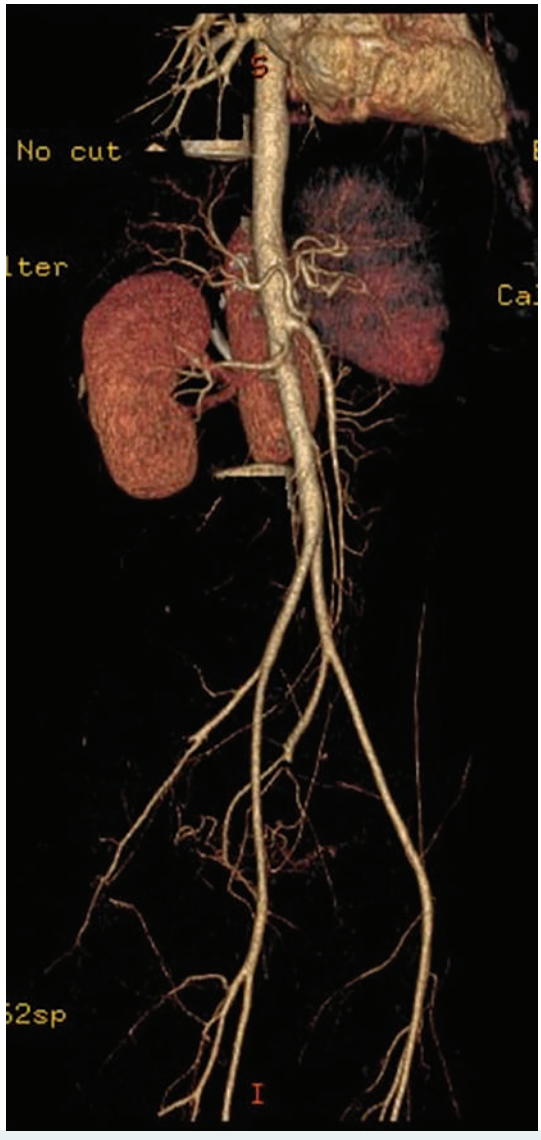

Figure 2. CT angiography image. SMA blood flow appears normal.

[P-184]

Chest compressions as an inadvertent maneuver for gastric detorsion: A rare case of spontaneous reduction during CPR

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Objective: Gastrik volvulus (GV) is a rare surgical emergency characterized by the rotation of the stomach more than 180 degrees around its own axis, posing a risk of vascular ischemia and perforation with high mortality. According to the anatomical axis of rotation, in the mesentero-axial type, the stomach rotates along its short axis (the perpendicular axis connecting the minor and major curvatures). This condition often results in the pylorus rising above the level of the esophagogastric junction and clinically mimics acute pyloric obstruction. The spontaneous resolution of this clinical picture—which usually requires emergency surgical or endoscopic intervention—during resuscitation (CPR) maneuvers is a mechanical phenomenon rarely encountered in the literature.

Material and Methods: A case of mesentero-axial gastric volvulus in an 84-year-old patient.

Results: An 84-year-old female presented with sudden severe epigastric pain, nausea, and inability to vomit for 24 hours. Medical history included hypertension and valvular heart disease. Physical exam showed epigastric tenderness, distention, and tympany. NG tube insertion failed due to resistance at the GE junction, confirming Borchardt's triad. Labs showed creatinine: 4.64 mg/dL and urea: 155 mg/dL, indicating secondary prerenal AKI. CT reported a massively dilated "upside-down stomach" with pylorus and duodenum herniated into the mediastinum, showing mesentero-axial rotation. Emergency endoscopy failed due to mucosal edema and anatomical distortion. During anesthesia induction for surgery, cardiac arrest occurred. After 2 minutes of CPR, spontaneous circulation returned. Upon laparotomy, the stomach—previously irreducible even by endoscopy—was found spontaneously reduced and detorsed due to intrathoracic positive pressure and mechanical maneuvers from chest compressions. Exploration confirmed preserved vascularity and no necrosis. The enlarged esophageal hiatus was repaired with primary sutures. Renal functions normalized rapidly, and the patient was discharged on day 8.

Conclusion: In the management of acute gastric volvulus, the primary goals are to restore the stomach to its anatomical position and prevent vascular damage. In cases where endoscopic interventions fail, surgical exploration is mandatory. The most unique aspect of this case is the unexpected mechanical effect of CPR maneuvers on herniated organs. High positive intrathoracic pressure generated during chest compressions acted as a "milking" maneuver, pushing the stomach trapped in the mediastinum back into the abdominal space and providing spontaneous reduction. Due to this phenomenon, it was observed peroperatively that the stomach was viable and the torsion had resolved. In conclusion, although perioperative mechanical events can instantaneously change the anatomical picture, surgical correction of the hiatal defect (crural repair) remains the mainstay of treatment to prevent recurrence.

Keywords: Gastric volvulus, borchardt triad, cardiopulmonary resuscitation

Figure 1. Sagittal CT scan showing herniation and rotation of the stomach into the mediastinum (red arrow).

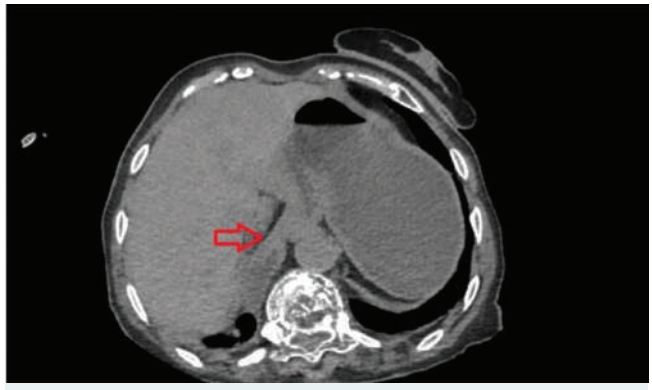

Figure 2. Axial CT scan showing herniation and rotation of the stomach into the mediastinum (red arrow).

[P-185]

A rare cause of acute abdominal disease; transmesenteric internal hernia

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Objective: Internal herniation is a relatively rare cause of acute abdominal pain. Its incidence is reported in the literature as 0.2-0.9%. Internal herniation is a difficult pathology to diagnose due to the lack of specific physical examination and laboratory findings. Subtypes of internal herniation include paraduodenal, foramen of Winslow, perisigmoid, transmesenteric, and transomental. This study aims to discuss the diagnostic difficulties and clinical approach to internal herniation pathology, accompanied by a case of transmesenteric subtype internal herniation in a patient with no prior history of intra-abdominal surgery.

Material and Methods: The diagnosis and treatment process of a 69-year-old male patient who presented to our clinic with complaints of inability to pass gas or stool and generalized abdominal pain for three days was evaluated.

Results:s A 69-year-old male patient presented with complaints of inability to pass gas or stool and abdominal pain for 3 days. His medical history revealed no other illnesses or previous surgeries. Physical examination revealed guarding, rebound tenderness, and tenderness. Vital signs: Temperature 36.5 °C, blood pressure 120/70 mmHg, pulse 83/min, and blood oxygen saturation (SpO_2) measured at 96%. Laboratory findings were: WBC 12.5 x 10^3/µL, CRP 1 mg/L, HGB 14 g/dL. A plain abdominal X-ray showed four air-fluid levels. An oral+iv-enhanced contrast abdomen CT scan was performed. The imaging revealed that the orally administered contrast medium did not reach the cecum and that there was dilation in the small bowel loops reaching a diameter of 4 cm. An emergency laparotomy was decided upon. Exploration revealed a herniation of the jejunal bowel loop through a 4 cm defect in the ileal mesentery, 50 cm proximal to the ileocecal valve, disrupting the continuity of bowel passage. The herniated segment was removed through the defect. No ischemia, infarction, or perforation was detected in the bowel. The mesenteric defect causing the internal herniation was repaired with primary simple sutures. No other pathology was found during the operation. Oral intake was gradually opened 24 hours after the operation, and the patient was discharged on the 4th postoperative day.

Conclusion: Internal herniation is a rare but significant cause of acute abdomen in patients. The lack of specific physical examination and laboratory findings makes diagnosis difficult. Internal herniation should always be considered in cases of acute abdomen with inconsistent clinical and laboratory findings. Early surgical intervention is vital in reducing morbidity and mortality, and the decision for laparotomy should not be delayed.

Keywords: Acute abdomen, internal herniation, transmesenteric

Figure 1. Transmesenteric hernia defect. A segment of the jejunal bowel herniated through a 4 cm defect in the ileal mesentery, approximately 50 cm proximal to the ileocecal valve.

[P-186]

Metabolic crisis in glutaric aciduria type II initially suspected as gastrointestinal perforation

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Objective: Glutaric aciduria type II (GAII), also known as multiple acyl-CoA dehydrogenase deficiency, is a rare inherited metabolic disorder characterized by impaired mitochondrial fatty acid and amino acid oxidation. Adult-onset or long-term asymptomatic cases may present with clinical manifestations mimicking surgical emergencies during periods of acute metabolic decompensation.

Material and Methods: A 25-year-old male with a childhood diagnosis of GAII had remained asymptomatic for approximately ten years without regular follow-up or pharmacological treatment. He presented with sudden-onset severe abdominal pain, nausea, and vomiting following a one-week history of dental infection treated with amoxicillin-clavulanate and non-steroidal anti-inflammatory drugs. Laboratory tests showed increased white blood cell count and eleveated C-reactive protein levels. Abdominal computed tomography performed at an outside institution revealed free air and fluid suggestive of gastric perforation. Consequently, the patient underwent emergency exploratory laparotomy.

Results: Intraoperative evaluation revealed no evidence of gastrointestinal perforation or other surgical pathology. During and after surgery, the patient developed profound metabolic disturbances, including severe high-anion-gap metabolic acidosis with arterial pH as low as 6.08, marked hyperlactatemia (maximum 11.8 mmol/L), hypoglycemia, hyperkalemia, and disseminated intravascular coagulation. Postoperatively, he required mechanical ventilation, vasopressor support, intensive bicarbonate infusion, and renal replacement therapy. The metabolic crisis was attributed to GAII, and treatment with high-dose riboflavin, carnitine supplementation, and continuous glucose infusion was initiated while lipid-containing solutions were avoided. Following targeted metabolic therapy, metabolic parameters gradually improved, and the patient achieved clinical stabilization. He was transferred to the ward and discharged on postoperative day 8.

Conclusion: This case demonstrates that GAII in adulthood may mimic an acute abdomen and that severe metabolic decompensation may be misinterpreted as surgical pathology. In patients presenting with acute abdomen accompanied by severe metabolic acidosis, hypoglycemia, and hyperlactatemia—particularly those with known or suspected metabolic disorders—metabolic crisis must be considered in the differential diagnosis. Early recognition and appropriate metabolic management are crucial to prevent unnecessary surgical interventions and serious morbidity.

Keywords: Metabolic crisis, negative laparatomy, glutaric aciduria type 2

[P-190]

Cyst of the canal of nuck treated with laparoscopic TEP: A case report

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Objective: Although inguinal and femoral hernias are the most common causes of palpable groin masses in women, a cyst of the canal of nuck is often overlooked because of its rarity. This cyst develops due to incomplete obliteration of the processus vaginalis during fetal life and may extend along the inguinal canal into the labium majus. Clinical findings are usually non-specific, and physical examination or ultrasonography may not provide a definitive diagnosis. In suspected cases, computed tomography (CT) or magnetic resonance imaging (MRI) helps define the lesion's location and confirm its cystic nature. Surgical excision is the standard treatment, with laparoscopic approaches considered safe and effective.

Material and Methods: A 41-year-old woman presented with left groin swelling. She had no comorbidities or prior surgical history. Physical examination revealed a palpable, non-reducible mass in the left inguinal region without a cough impulse. Due to persistent suspicion, contrast-enhanced abdominal and pelvic CT demonstrated a 7×3 cm cystic lesion extending from the left inguinal canal toward the labium majus. Based on its location and imaging characteristics, the findings were consistent with a cyst of the canal of nuck. No additional intra-abdominal pathology was identified (Figure 1). Surgery was performed using a laparoscopic totally extraperitoneal (TEP) approach. After entering the preperitoneal space, a cystic lesion in the left inguinal canal was identified, dissected in the preperitoneal plane, and reduced. After evaluation of the inguinal anatomy, a synthetic mesh was placed in the preperitoneal space to cover the myopectineal orifice and secured in position. No intraoperative complications occurred (Figure 2).

Results: Surgical treatment is recommended to relieve symptoms and prevent potential complications. Although open surgical methods have long been used, laparoscopic approaches offer advantages such as better anatomical visualization, detection of concomitant hernias, less postoperative pain, and faster recovery. The totally extraperitoneal (TEP) approach, in particular, has been reported as a safe method due to preservation of peritoneal integrity and low complication rates. In the present case, the lesion was successfully treated using the laparoscopic TEP approach, with no early complications or recurrence observed.

Conclusion: Cyst of the canal of nuck is a rare but important entity in the differential diagnosis of groin masses in female patients. Advanced imaging modalities play a decisive role in diagnosis when clinical suspicion persists. The laparoscopic TEP approach may be considered a safe and effective surgical option in appropriately selected patients.

Keywords: Nuck, TEP, laparoscopy

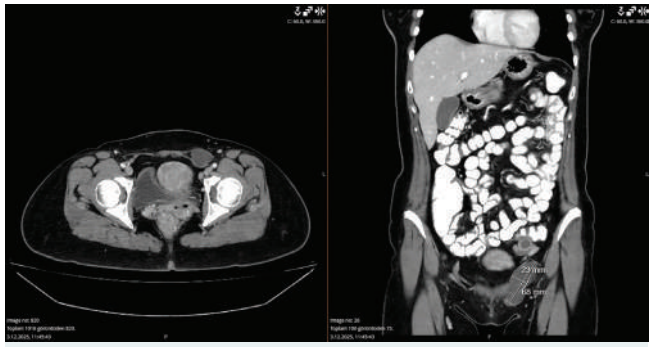

Figure 1. Preoperative computed tomography image of nuck canal cyst.

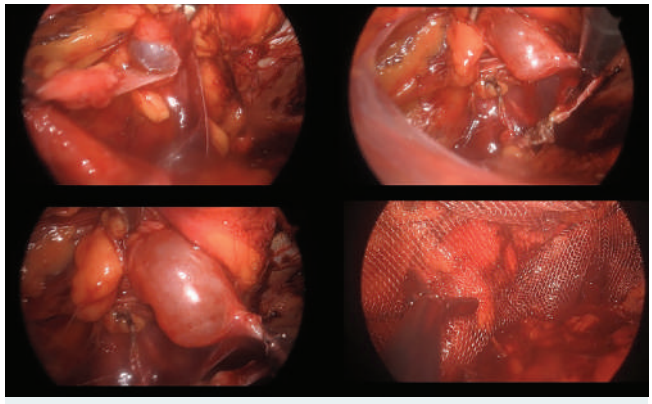

Figure 2. Intraoperative image.

[P-192]

Delayed multidisciplinary reconstruction of cervical esophageal transection following thyroidectomy: A case report

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Objective: Esophageal perforation is a rare but life-threatening surgical emergency associated with high morbidity and mortality. Although iatrogenic perforations most commonly occur during endoscopic procedures, they may rarely develop during cervical surgical interventions. Complete cervical esophageal transection following thyroidectomy has been reported only in a limited number of cases in the literature and, when not recognized early, may lead to mediastinal sepsis and the need for complex reconstructive surgery. In this study, we present the delayed multidisciplinary reconstruction of a cervical esophageal transection that developed after thyroidectomy at an external center, where primary repair had failed.

Material and Methods: A 38-year-old female patient underwent total thyroidectomy and neck dissection at an external center due to thyroid carcinoma. A cervical esophageal injury that occurred intraoperatively was recognized in the early postoperative period, and the patient was reoperated for primary repair and drainage. However, clinical follow-up revealed failure of the repair. Surgical exploration demonstrated complete transection of the cervical esophagus at the level of the hypopharynx-pharyngoesophageal junction, along with left recurrent laryngeal nerve injury. A proximal esophagostomy and feeding jejunostomy were subsequently performed. The patient was referred to our center for definitive reconstruction. Following multidisciplinary evaluation, partial esophagectomy and delayed reconstruction were performed using combined thoracoscopic and laparoscopic approaches. The thoracic and abdominal esophagus were mobilized, the stomach was advanced into the mediastinum, and a tension-free pharyngoesophagostomy was constructed at the cervical level.

Results: Postoperatively, the patient was monitored briefly in the intensive care unit and then transferred to the surgical ward. Enteral nutrition was initiated via jejunostomy, and gradual transition to oral intake was achieved. No anastomotic leak, mediastinal infection, or reoperation-requiring complication was observed during follow-up. After discharge, partial dysphagia was noted during outpatient follow-up. Endoscopic evaluation revealed a partial anastomotic stricture. The patient underwent two sessions of endoscopic dilatation, after which no further complications were observed. Contrast-enhanced sagittal CT imaging of the neck and upper thorax demonstrates a proximal cervical esophagostomy. The distal cervical esophageal segment is closed using a linear stapler, with interruption of esophageal continuity. A clear separation between the proximal and distal segments is observed.

Conclusion: Cervical esophageal transection following thyroidectomy is a rare but life-threatening complication. In cases where primary repair fails, delayed reconstruction performed at experienced centers using a multidisciplinary approach can achieve favorable clinical and functional outcomes. Appropriate surgical timing, institutional expertise, and coordinated team management play critical roles in treatment success.

Keywords: Cervical esophageal transection, thyroidectomy complication, delayed reconstruction

Figure 1. Cervical esophageal transection following thyroidectomy: computed tomography imaging of proximal esophagostomy and stapled distal esophageal closure.

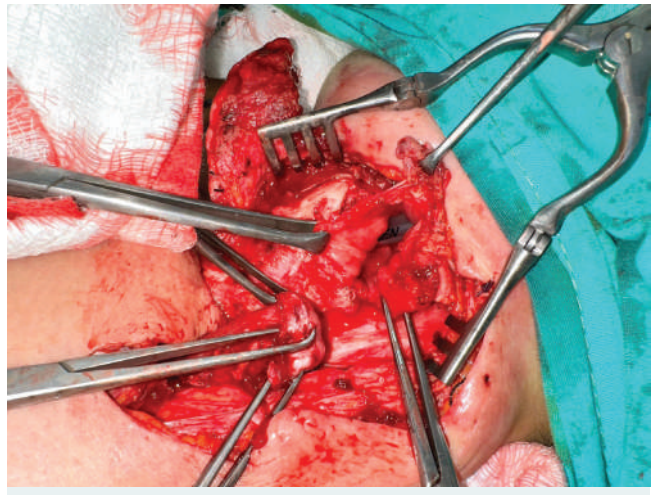

Figure 2. Intraoperative cervical exploration demonstrates loss of esophageal continuity, with the proximal esophageal segment remaining open. The distal cervical esophageal segment is noted to have been previously closed using a linear stapler. A clear gap is present between the proximal and distal segments.

[P-193]

Conservative management of a cecal perforation occurring during colonoscopic endoscopic submucosal dissection (ESD): A case report

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Objective: Endoscopic submucosal dissection (ESD) is an advanced endoscopic technique that enables en bloc resection of broad-based and superficial neoplastic lesions in the colorectal system. Perforation during colorectal ESD is a significant complication, particularly in the cecum, due to the thin structure of the colonic wall. Perforation rates in the literature have been reported to range between 4-10%. Perforations that are recognized early and closed during the procedure can often be successfully managed with conservative treatment. In this case, a cecal perforation that developed during the procedure was managed with endoscopic clipping and a conservative approach, resulting in recovery without the need for surgery.

Material and Methods: A 67-year-old female patient was evaluated with screening colonoscopy due to a positive fecal occult blood test. During colonoscopy, a 2.5×1 cm broad-based vegetative polyp was detected on a mucosal fold at the cecal base, located between the appendiceal internal orifice and the ileocecal valve. The polyp was removed en bloc by ESD. During the procedure, a cecal perforation occurred and the mucosal defect was closed using endoclips. Following the procedure, an oral and intravenous contrast-enhanced abdominal CT scan was performed. Widespread free intraperitoneal air was detected; however, no contrast extralumination was observed. On abdominal examination, distension and tenderness were present, but there were no signs of an acute abdomen, and vital signs were stable. Therefore, conservative management was planned: oral intake was discontinued and broad-spectrum intravenous antibiotics were initiated.

Results: During inpatient follow-up, the patient's abdominal tenderness decreased and she began to tolerate oral intake. As abdominal distension persisted, intraperitoneal air was evacuated using a 16 Fr intravenous catheter inserted at the level of the umbilicus, after which the distension regressed. Vital signs remained stable throughout follow-up and no complications developed. As the patient's general condition was good and oral intake was tolerated, she was discharged without any problems.

Conclusion: Cecal perforations that occur during colonoscopic ESD can be safely and effectively managed with conservative treatment when recognized during the procedure and closed with endoscopic clips. The presence of widespread pneumoperitoneum alone does not constitute an absolute indication for surgery. A conservative approach may be applied in patients without contrast extravasation, who are hemodynamically stable, and who do not exhibit signs of an acute abdomen. This case demonstrates that colon perforations can be managed without surgery through appropriate patient selection and close clinical follow-up.

Keywords: ESD, cecal perforation, conservative management

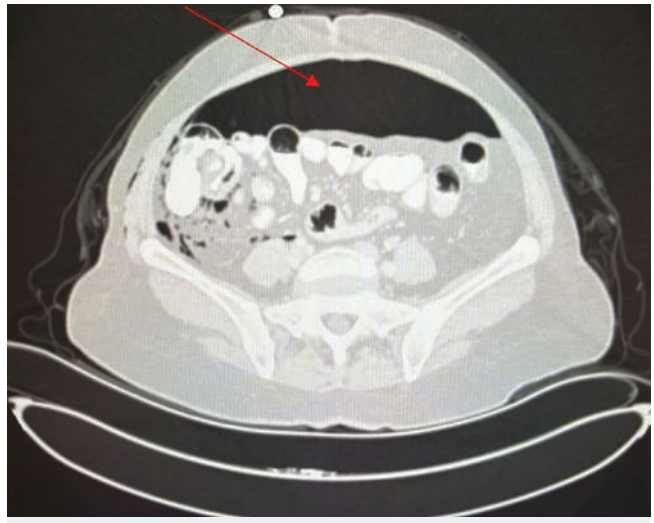

Figure 1. Computed tomography scan after the endoscopic submucosal dissection. (Red arrow) free air in the abdomen.

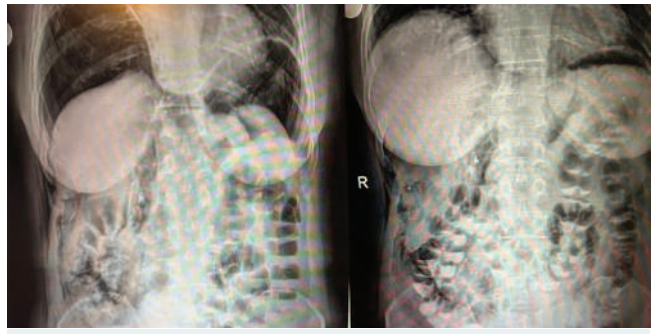

Figure 2. (A) Post-procedure upright abdominal radiograph, (B) Upright abdominal radiograph taken 1st and 3rd days.

[P-199]

Surgical management of fibrosis-related gastric obstruction in gastric lymphoma with complete response to therapy

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Objective: Primary gastric lymphomas account for only 3-5% of all gastric malignancies, and chemotherapy constitutes the mainstay of treatment. Surgical management in gastric lymphomas is reserved for patients who develop complications. In this case, we aimed to present the surgical management of gastric outlet obstruction caused by fibrotic pyloric stenosis that developed despite achieving a complete hematologic response after systemic therapy.

Material and Methods: A 39-year-old male patient presented to the internal medicine outpatient clinic with complaints of night sweats, weight loss, and epigastric pain. Upper gastrointestinal endoscopy revealed a nearly circumferential ulcerated lesion involving the distal greater curvature of the corpus and extending into the antrum (Figure 1). Biopsy of the lesion was consistent with B-cell non-Hodgkin lymphoma. Systemic therapy with rituximab, R-bendamustine, and R-CHOP was initiated.The patient's nausea and vomiting progressively worsened. Post-chemotherapy upper gastrointestinal endoscopy demonstrated edema and irregularity around the pylorus, and the pylorus could not be traversed (Figure 2). Biopsy specimens obtained from this area were interpreted as fibrosis secondary to chemotherapy. The patient's nausea and vomiting continued to increase. A contrast study with water-soluble contrast material showed complete gastric obstruction (Figure 3). As the patient was not suitable for percutaneous endoscopic gastrostomy, distal gastrectomy with Roux-en-Y gastrojejunostomy was performed. Histopathological examination of the gastrectomy specimen revealed no residual lymphoma; however, extensive fibrosis was observed. The patient tolerated oral intake in the postoperative period and was discharged uneventfully on postoperative day six. At the third postoperative month follow-up, the patient maintained a complete response in terms of lymphoma and had no nutritional problems.

Results: The role of surgery in gastric lymphoma is limited. Surgical intervention may be required only in cases of perforation, bleeding, obstruction, or treatment-resistant disease. Fibrotic pyloric stenosis following chemotherapy is a rare complication. This case is noteworthy because surgical intervention was required due to obstruction despite a complete response to systemic therapy.

Conclusion: Even in cases of primary gastric lymphoma with a complete response to systemic therapy, fibrosis-related gastric outlet obstruction may rarely develop. Therefore, in patients presenting with vomiting and obstructive symptoms after chemotherapy, not only residual disease but also treatment-related fibrotic stenosis should be considered in the differential diagnosis. In appropriate cases, surgical management is a safe and effective treatment option.

Keywords: Gastric outlet, lymphoma, surgery

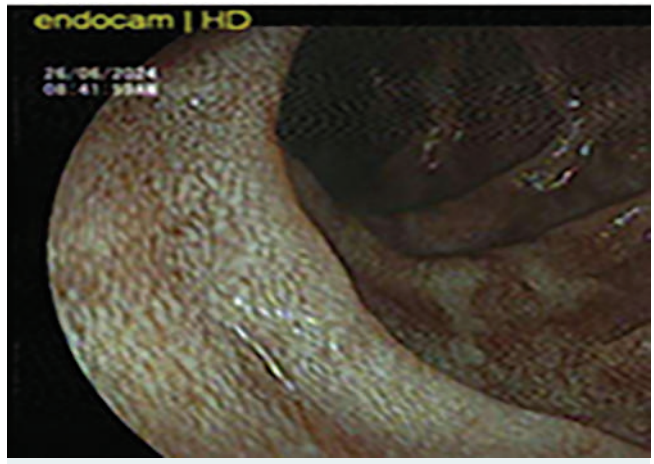

Figure 1.

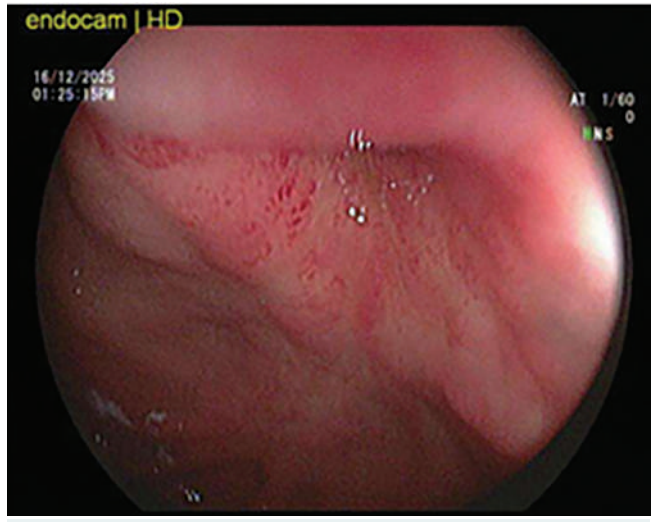

Figure 2.

[P-200]

Multivessel mesenteric artery involvement in a young age: A case report of chronic mesenteric ischemia

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Objective: Chronic mesenteric ischemia is a rare but serious cause of abdominal pain. Advanced age, atherosclerotic disease, diabetes mellitus, hypercoagulable states, and smoking are recognized risk factors. We present a young male patient with no known risk factors other than a long-standing history of cigarette smoking.

Material and Methods: A 44-year-old male patient with a 30 pack-year smoking history presented with postprandial abdominal pain, vomiting, and decreased oral intake that had persisted for four years and led to recurrent hospital admissions. He had experienced an unintentional weight loss of 10 kg over the last five months.

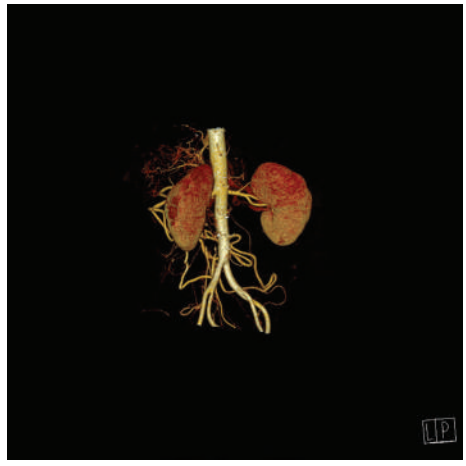
Results: Physical examination revealed epigastric tenderness without signs of an acute abdomen. Contrast-enhanced abdominal CT angiography demonstrated significant stenosis of approximately 2 cm in length beginning at the origin of the celiac trunk, followed by distal occlusion. The common hepatic artery and splenic artery were not visualized; arterial perfusion of the liver and spleen was maintained via collateral circulation. The left gastric artery origin appeared stenotic with post-stenotic dilatation distally. The superior mesenteric artery was not visualized. The inferior mesenteric artery showed marked proximal stenosis extending approximately 3 cm from its origin, with post-stenotic dilatation. The small bowel loops were observed to be supplied through extensive collateral circulation via the inferior mesenteric artery. The patient was referred to interventional radiology for advanced endovascular treatment.

Conclusion: Chronic mesenteric ischemia involving all three major mesenteric vessels at a young age is rare. In young patients presenting with longstanding postprandial abdominal pain and weight loss, particularly those with a significant smoking history, mesenteric ischemia should be considered in the differential diagnosis. In our patient, the presence of well-developed collateral circulation masked the clinical figure and contributed to delayed diagnosis, while simultaneously preserving intestinal perfusion and preventing the need for bowel resection. Early diagnosis with appropriate imaging modalities is crucial to prevent irreversible intestinal damage.

Keywords: Chronic mesenteric ischemia, smoker, young age

Figure 1. Sagittal section of contrast-enhaced abdomen CT angiography. 3D reconstructed CT angiography.

CT: Computed tomography.



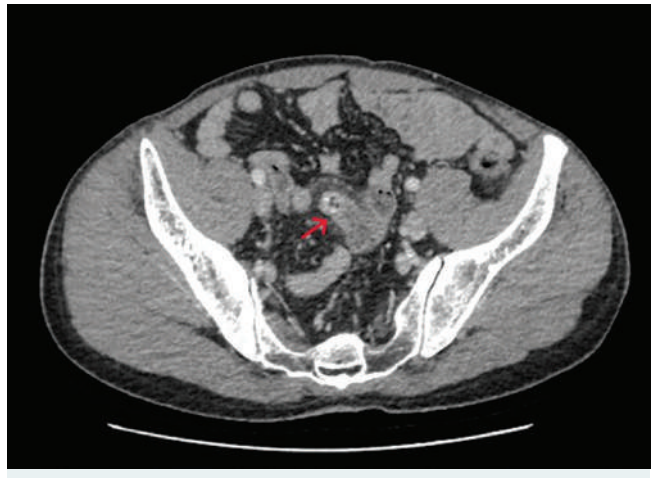


Figure 2. İleal anslardan kaynakladığı düşünülen, kör sonlanan intestinal ans görülmekte. Çevre yağ dokudaki enflamatuvar değişiklikler dikkat çekiyor. Laparoskopik eksplorasyon görüntüleri.

[P-202]

Meckel's diverticulum perforation, laparoscopic diverticulectomy

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Objective: Meckel's diverticulum is the most common congenital anomaly of the gastrointestinal tract. Its incidence is approximately 2%. This diverticulum originates from a remnant of the omphalomesenteric duct. It may be asymptomatic, but it can also lead to clinical conditions such as bleeding, intussusception, volvulus, intestinal obstruction, and perforation. Surgical intervention is required for symptomatic diverticula. Open or laparoscopic surgical approaches can be used for treatment. There is an increasing number of studies in the literature demonstrating the success of laparoscopic treatment. In this case presentation, we aim to present the treatment of a patient who presented to the emergency department with acute symptoms and was diagnosed with Meckel's diverticulitis.

Material and Methods: The patient's clinical observation notes, laboratory parameters, and imaging findings were reviewed. Images from the video recordings of the surgery were used.

Results: A 38-year-old male patient presented to the emergency department with abdominal pain in the umbilical region that had been present for a 48-hour period. A physical examination was performed, which revealed tenderness in the right lower quadrant. The WBC count was 7600/μL, and the CRP was 58 mg/L. Abdominal computed tomography revealed the presence of a blind-ended intestinal loop of approximately 2.5 cm in length, associated with the ileal and located at the pelvic inlet level. Additionally, contamination was observed in the surrounding mesentery. Radiological analysis revealed that the appendix appeared to be normal. Laparoscopic exploration was planned. A 10 mm camera port was inserted infraumbilically. A 12 mm port in the lower left quadrant and a 5 mm port in the suprapubic region were used. During exploration, a segment consistent with Meckel's diverticulitis was observed in the distal ileum, and perforation was seen at the distal end. The specimen was isolated from the surrounding mesentery, and laparoscopic diverticulectomy was performed using stapler. A drain was inserted into the pelvis. The surgical procedure was successfully completed. On the first day postoperatively, oral fluid intake was initiated and gradually increased. On the fourth day, the drain was removed, and the patient was discharged. The pathology findings were consistent with Meckel's diverticulum, and no evidence of malignancy was detected.

Conclusion: With the increase in laparoscopic experience in surgery and the development of instruments, the use of laparoscopy in emergency cases is also increasing. There may be reservations about the use of laparoscopy, especially in emergency cases where small bowel-related pathology is suspected. Selecting the appropriate patient is important in making this decision.

Keywords: Laparoscopic emergency surgery, Meckel's diverticulum

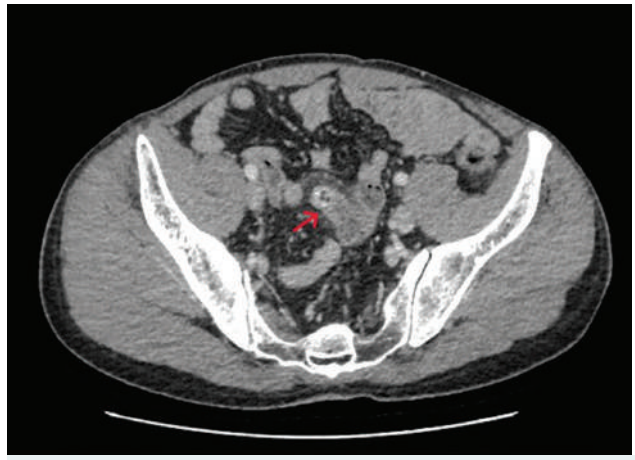

Figure 1. Abdominal CT scan. An intestinal loop with a blind end is observed, thought to originate from ileal loops. Inflammatory changes in the surrounding adipose tissue are also of note. Laparoscopic exploration images.

CT: Computed tomography.

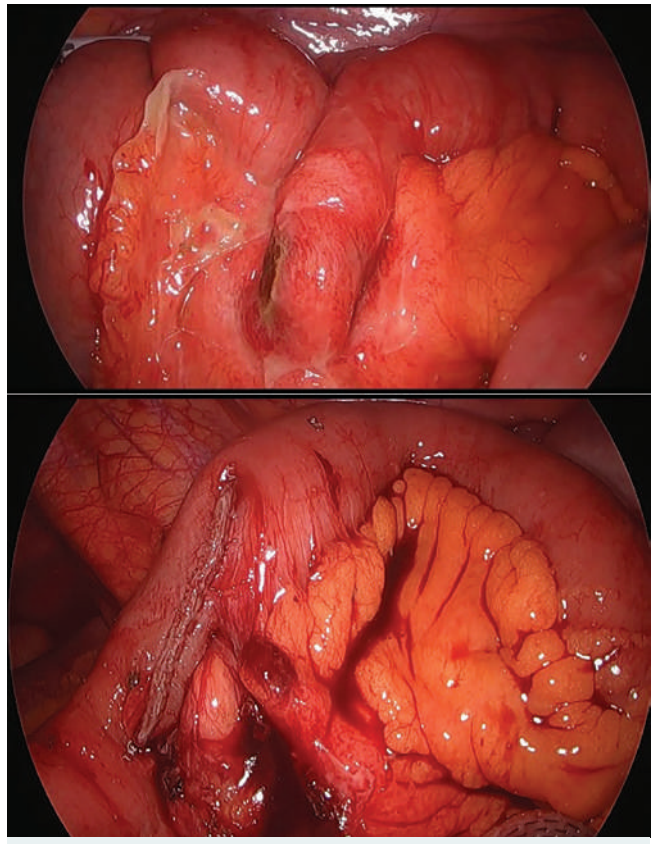

Figure 2. Meckel's diverticulum with necrosis and perforation observed at the distal end (above). It is seen that the diverticulum originates from the antimesenteric surface and that the inflammation is confined to the ileal mesentery. Ileal loop after diverticulectomy (below).

[P-203]

Enterobacter cloacae-associated necrotizing fasciitis following morsus insecti: Importance of early diagnosis and aggressive surgical debridement

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Objective: Necrotizing fasciitis (NF) is a rapidly progressive soft tissue infection with high mortality that develops following disruption of the superficial skin barrier and spreads along fascial planes. Minor skin entry lesions, particularly insect bites (morsus insecti), may serve as a portal of entry for infection. NF following insect bites is rare in the literature and is most commonly associated with Gram-positive pathogens; however, Gram-negative organisms may also be implicated. This study aimed to present a case of *Enterobacter cloacae*-associated NF following morsus insecti and to emphasize the critical role of early diagnosis and aggressive surgical debridement.

Material and Methods: Clinical, laboratory, imaging, surgical, and microbiological data of a 55-year-old female patient presenting with soft tissue infection after an insect bite were retrospectively evaluated. The patient underwent emergency surgical exploration and debridement with a preliminary diagnosis of NF. Deep tissue samples were obtained for culture, and broad-spectrum antibiotic therapy was initiated. The clinical course, need for repeated debridements, and reconstructive management were analyzed.

Results: The patient reported an insect bite in a rural area two days before admission. The lesion initially appeared as a small erythematous papule but rapidly enlarged despite drainage at an outside center, and septic progression prompted referral. Physical examination revealed extensive edema, hyperemia, and ecchymotic areas extending from the anterior abdominal wall to the right lumbar region. Fever (38.5 °C) and tachycardia were present. Laboratory tests showed leukocytosis, elevated C-reactive protein, and hyponatremia; the LRINEC score was 8. Computed tomography demonstrated fascial thickening and fluid collections consistent with fasciitis. Surgical exploration revealed typical NF findings, and extensive debridement was performed. Deep tissue culture grew Enterobacter cloacae. During follow-up, seven additional debridements were required. After infection control, the defect was closed with a split-thickness skin graft. The patient was discharged in good condition with no recurrence during follow-up.

Conclusion: NF should be considered a potential diagnosis in patients presenting with pain and erythema following morsus insecti. Disproportionate pain and rapid progression are key early warning signs. Early diagnosis and aggressive surgical debridement remain the most important determinants of prognosis in NF. Awareness of this rare Gram-negative etiology may prevent diagnostic delay and reduce mortality.

Keywords: Necrotizing fasciitis, insect bite, *Enterobacter cloacae*

Figure 1. Necrotizing fasciitis area and VAC application. Preoperative necrotizing fasciitis area and post-debridement defect treated with VAC.

VAC: Vacuum-assisted closure.

Figure 2. (A) Non-infected granulation tissue and skin graft application. (B) Granulation tissue after serial debridements and VAC therapy, and 3 month postoperative appearance after skin grafting.

VAC: Vacuum-assisted closure.

[P-204]

Rives-stoppa repair with Madrid modification in the treatment of incarcerated incisional hernia: Case report

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Objective: Emergency abdominal wall hernia repair remains challenging due to the absence of adequate preoperative optimization and the frequent presence of bowel obstruction or ischemia. In contaminated or potentially contaminated fields, many surgeons avoid mesh placement or prefer onlay repair techniques because of concerns regarding infection. However, sublay (retromuscular) repair has demonstrated superior long-term outcomes in elective settings. In the Madrid modification of the Rives-Stoppa technique, subxiphoid dissection is performed in the preperitoneal plane rather than directly over the posterior rectus sheath, reducing the risk of injury to the neurovascular bundles or pleura. We present a case of incarcerated incisional hernia with multiple previous onlay repairs, treated with emergency laparotomy and retromuscular mesh repair using the Madrid modification of the Rives-Stoppa technique.

Material and Methods: A case of incarcerated incisional hernia treated with the Madrid Modification of Rives-Stoppa repair will be presented.

Results: A 43-year-old male (BMI 31.8 kg/m^2) with a history of umbilical and incisional hernia repairs performed with the onlay technique presented with a midline incarcerated incisional hernia (EHS classification M2-4 W2). Preoperative computed tomography demonstrated a 55 mm fascial defect. The patient had mechanical bowel obstruction secondary to incarceration. Emergency exploration revealed multiple "Swiss cheese-like" midline defects and incarcerated small bowel loops with ischemic changes. After adhesiolysis, a 20 cm ischemic ileal segment located 70 cm proximal to the ileocecal valve, unresponsive to tactile stimulation, was resected, followed by side-to-side anastomosis. For hernia repair, the posterior rectus sheath was incised lateral to the linea alba. From the xiphoid process extending 6-7 cm caudally, the sheath was opened longitudinally and the retrorectus space was dissected laterally until the neurovascular bundles were identified. At 6 cm caudal to the xiphoid, the posterior sheath was transected transversely and the preperitoneal plane was entered. Subxiphoid dissection continued until visualization of the diaphragm's central tendon, allowing complete development of the retrorectus plane. The posterior sheath was closed with USP 2/0 PDS sutures. A 10×30 cm mesh was placed in the retrorectus space, and the anterior fascia was closed primarily. Postoperatively, the patient developed transient paralytic ileus and superficial surgical site infection not requiring invasive treatment. He was discharged on postoperative day 11. At two months, no recurrence or wound complications were observed.

Conclusion: Retromuscular repair using the Madrid modification of the Rives-Stoppa technique can be safely performed in selected emergency cases. Subxiphoid preperitoneal dissection provides technical advantages by protecting midline neurovascular structures while enabling durable mesh reinforcement.

Keywords: Incisional hernia, Rives-stoppa repair, sublay repair

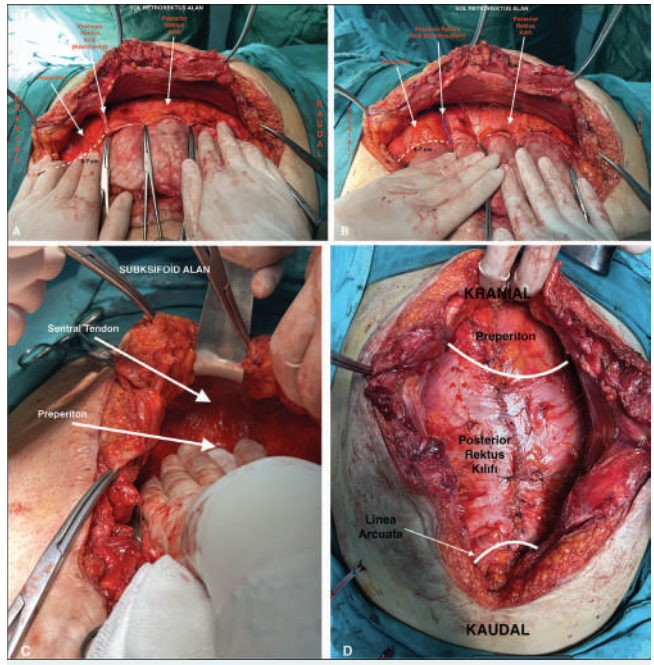

Figure 1. Retrorectus, subxiphoid dissection in Madrid modification.

[P-208]

Intraoperative fascial traction after prehabilitation in giant incisional hernia treatment: A case report

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Objective: In giant hernias primary repair is challenging because of loss of domain (LOD). While preoperative techniques like botulinum toxin A (BTA) and progressive pneumoperitoneum are used to reduce LOD, Intraoperative fascial traction (IFT) has recently gained popularity. We present a case managed with BTA followed by IFT and transversus abdominis release (TAR).

Material and Methods: A patient with a Carbonell index <2 and LOD >25% received preoperative BTA. A total of 300 U of BTA (Botox®, Allergan) diluted in 150 cc saline was injected into the lateral abdominal muscles at three points bilaterally under ultrasound guidance. IFT was performed using the Fasciotens® device.

Results: A 36-year-old male (BMI 30.8 kg/m^2) presented with a giant midline incisional hernia. Preoperative CT showed a defect width of 210 mm, an initial LOD of 45%, and a Carbonell index of 0.45. Thirty days post-BTA, the defect width was 190 mm, LOD 33%, and the Carbonell index 0.58. Surgery was performed 38 days after BTA. Following bilateral TAR, the anterior fascia could be approximated manually only to a gap of 8 cm. Consequently, IFT was applied for 30 minutes. Two 30x30 cm polypropylene meshes were placed in the retromuscular space, and the fascia was closed completely without tension. The patient was discharged on day 5 with no complications. On postoperative day 30, there was no complication and recurrence.

Conclusion: The combination of BTA & IFT eliminated the need for bridging or anterior component separation, enabling tension-free fascial closure. This multimodal approach is an effective strategy for managing complex abdominal wall hernias.

Keywords: Complex abdominal wall hernias, intraoperative fascial traction, transverse abdominis release

Figure 1. Preoperative vs. postoperative, intraoperative fascial traction.

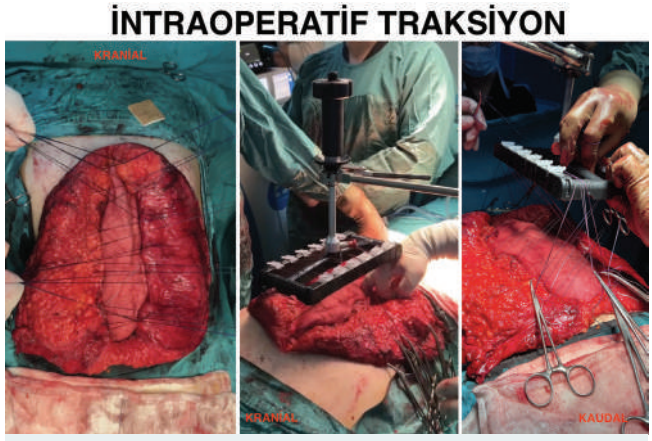

Figure 2. Intraoperatif traksiyon.

[P-234]

Videoscopic subcutaneous mastectomy with immediate implant reconstruction: A case report

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Objective: Although breast-conserving surgery is the preferred approach in the surgical management of breast cancer, mastectomy remains necessary in a substantial number of patients. Advances in oncoplastic surgery have introduced reconstructive options and nipple-areola-skin-sparing techniques for patients requiring mastectomy. Compared with conventional mastectomy, these approaches provide improved cosmetic outcomes and better quality of life. To further optimize cosmetic results, minimally invasive surgical techniques—particularly endoscopy-assisted subcutaneous mastectomy—have recently been incorporated into breast surgery practice. In this report, we present a case of videoscopic subcutaneous mastectomy with immediate implant-based reconstruction performed in our clinic.

Material and Methods: A patient who had previously undergone two breast-conserving surgeries in 2016 and 2023 at an outside center for triple-negative invasive ductal carcinoma located in different quadrants of the right breast presented with a third recurrence. Subcutaneous mastectomy with implant-based reconstruction was planned. A 3-cm skin incision was made approximately 4 cm lateral to the areola. After adequate subcutaneous dissection, a GelPOINT Mini Advanced Access Platform was inserted. Three 5-mm trocars were introduced through the platform, and a 5 mm 30° endoscopic camera was used. The breast tissue was dissected from the subcutaneous plane and over the pectoral fascia and removed through the incision. Immediate reconstruction was performed in the same session using a 460 cc round implant and titanium mesh in a prepectoral plane. A Voyant Maryland energy device was utilized for dissection.

Results: The procedure was completed without intraoperative complications. The postoperative course was uneventful, and the patient was discharged in good condition on postoperative day three. No early postoperative complications were observed.

Conclusion: Videoscopic subcutaneous mastectomy offers several advantages, including its minimally invasive nature, the ability to prepare healthier skin flaps without excessive traction, favorable cosmetic outcomes, and reduced sensory loss. However, a longer operative time during the early phase of the learning curve may be considered a limitation. With appropriate patient selection and surgical expertise, this technique appears to be a safe and effective alternative in selected cases.

Keywords: Implant reconstruction, minimally invasive, videoscopic subcutaneous mastectomy

Figure 1. Intraoperative view of videoscopic subcutaneous mastectomy.

[P-235]

Management of iatrogenic appendiceal perforation in a patient with a history of antegrade continence enema (ACE) procedure: A case report

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Objective: The antegrade continence enema (ACE) procedure is a surgical technique used for the management of bowel dysfunction associated with conditions such as Hirschsprung disease, myelomeningocele, spina bifida, quadriplegia, as well as idiopathic chronic constipation and fecal incontinence. It is primarily indicated in patients whose symptoms are refractory to conventional medical treatments. The main objective of the procedure is to achieve effective bowel evacuation by enabling antegrade colonic irrigation from the proximal to the distal colon. The ACE technique is based on mobilization of the appendix and its exteriorization as a stoma, referred to as an appendicostomy, usually positioned at the umbilicus or an appropriate abdominal quadrant. Lavage solutions administered through this channel create an antegrade flow within the colon, facilitating colonic cleansing. This method allows patients to control their defecation process, resulting in significant improvements in quality of life and social integration. Nevertheless, several complications have been reported, including stomal stenosis, leakage, channel obliteration, stomal prolapse, infection, bleeding, and perforation.

Material and Methods: A 27-year-old male patient who had undergone an ACE procedure at the age of seven due to Hirschsprung disease presented to the emergency department with severe abdominal pain following enema administration via the appendicostomy. Physical examination revealed diffuse abdominal tenderness and rebound tenderness in all four quadrants. Emergency imaging demonstrated diffuse intraperitoneal free fluid and free air, findings highly suggestive of intestinal perforation. Based on these findings, an urgent exploratory laparotomy was undertaken. During surgical exploration, approximately 200 mL of free intraperitoneal fluid was identified. All hollow visceral organs were systematically examined, yet no obvious perforation site was initially detected. Subsequently, methylene blue was administered through the umbilical ACE access. Extravasation of methylene blue was observed approximately two centimeters proximal to the appendicostomy, confirming the site of perforation. The appendicostomy was dismantled, and an appendectomy was performed.

Results: During the postoperative follow-up, the patient remained hemodynamically stable, exhibited no pathological drainage, and tolerated oral intake. Spontaneous passage of flatus and stool was observed. With normalization of clinical and laboratory parameters, the patient was discharged in good condition on postoperative day five, without complications observed.

Conclusion: The ACE procedure is relatively rare and is most often performed during childhood when suitable indications are present. Iatrogenic injuries occurring during lavage administration, as observed in the present case, represent one of the more common complications. In the majority of patients, these complications can be managed effectively with a simple appendectomy, leading to favorable clinical outcomes.

Keywords: ACE procedure, appendicostomy, perforation

Figure 1. CT imaging showing free intraperitoneal air and the appendicostomy.

CT: Computed tomography.

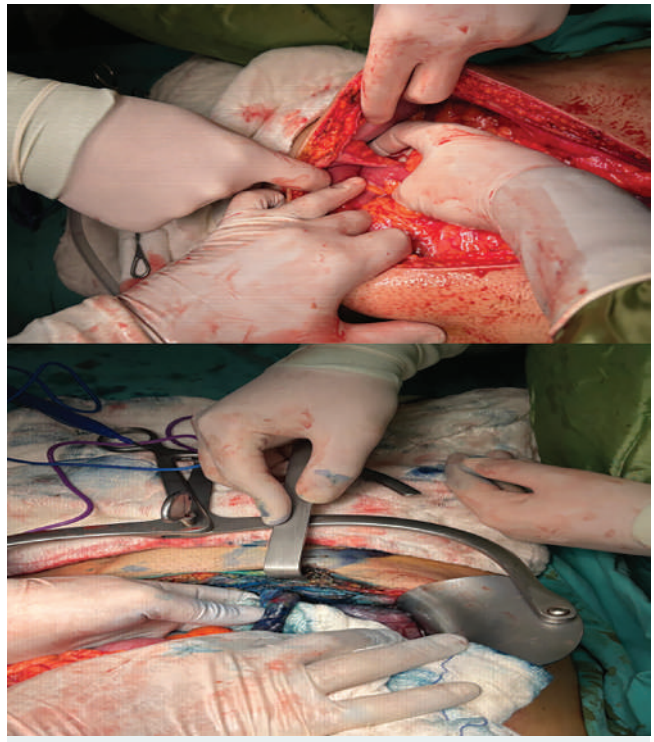

Figure 2. Extravasation of methylene blue administered through the appendicostomy.

[P-236]

Delayed breast reconstruction after mastectomy with lattisimus dorsi FLAP: Case report

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Objective: Breast cancer most commonly occurs between the ages of 50 and 69, but 5-7% of breast cancers are detected in women under 40. This highlights the importance of diagnosis and treatment management in younger breast cancer patients, given their longer life expectancy. Our case presentation aims to describe a 35-year-old patient who underwent mastectomy due to breast cancer and had late-stage reconstruction using a lattissimus dorsi flap.

Material and Methods: Case report.

Results: A 35-year-old female patient had a history of mastectomy and sentinel lymph node biopsy (SLNB) 3 years prior due to a 5 cm mucinous carcinoma in the right breast. She received adjuvant radiotherapy in the postoperative period. She presented at the 2nd postoperative year with no recurrence or metastasis detected and no additional adjuvant treatment planned. Since she had undergone mastectomy, a submuscular expander was initially placed. At 6 months postoperatively, due to insufficient skin width, reconstruction with a lattisimus dorsi flap and implant was planned. Because SLNB was performed during the first surgery, CT angiography was performed to evaluate the axillary region and the integrity of the lattisimus dorsi pedicle. No pathology was detected. Therefore, reconstruction with a lattisimus dorsi muscle-skin flap and implant was performed (Figures 1, 2). No pathology was detected during postoperative follow-up.

Conclusion: Oncoplastic surgery can currently be performed concurrently with mastectomy in suitable patients. However, late-stage reconstruction is also possible in patients for whom this is not feasible. In patients planned for this procedure, careful preoperative and multidisciplinary evaluation is crucial for the success of the surgery.

Keywords: Breast cancer, reconstruction, lattisimus dorsi flap

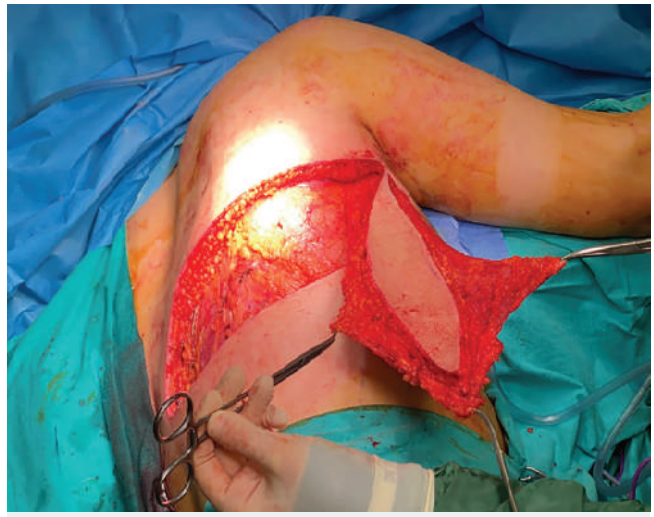

Figure 1. Prepared lattisimus dorsi muscle and skin flap.

Figure 2. Early postoperative image.

[P-237]

Papillary thyroid carcinoma associated with giant parathyroid adenoma: A case report introduction

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Objective: Primary hyperparathyroidism is a common endocrine disorder, most frequently caused by a parathyroid adenoma and characterized by hypercalcemia. Giant parathyroid adenomas are rare and are usually diagnosed with marked biochemical abnormalities. The coexistence of parathyroid adenoma and thyroid malignancy is a clinically important condition that requires careful evaluation. In this report, we present a case of a patient who underwent surgery for a giant parathyroid adenoma and was concomitantly diagnosed with papillary thyroid carcinoma.

Material and Methods: A fifty-year-old male patient was evaluated due to hypercalcemia and elevated parathyroid hormone (PTH) levels detected during routine examinations. Laboratory analysis revealed a serum calcium level of 12 mg/dL and a PTH level of 274 ng/L. Parathyroid scintigraphy demonstrated uptake consistent with a right inferior parathyroid adenoma. Neck ultrasonography showed a 1×1.2 cm solid nodule in the right thyroid lobe. Fine-needle aspiration biopsy was reported as benign. Neck and thoracic computed tomography revealed a 25×30 mm mass lesion in the right parathyroid region. The patient was scheduled for surgery.

Results: During surgery, a giant parathyroid adenoma weighing 13 grams and measuring 5.5×3×2 cm was excised. Right thyroid lobectomy was performed to allow complete removal of the parathyroid tissue. Histopathological examination confirmed the diagnosis of parathyroid adenoma. The thyroid lobectomy specimen revealed a 0.9 cm unifocal, classical-type papillary thyroid carcinoma. Surgical margins were negative, and no lymphovascular or perineural invasion was observed. Postoperatively, the patient was evaluated by general surgery and endocrinology departments, and completion thyroidectomy was not recommended.

Conclusion: Associated thyroid pathologies may be overlooked in cases of giant parathyroid adenoma. Therefore, careful evaluation of the thyroid gland is essential in patients undergoing surgery for primary hyperparathyroidism. Concomitantly detected papillary thyroid carcinomas may directly influence surgical strategy and follow-up planning. A multidisciplinary approach is crucial for optimal patient management.

Keywords: Primary hyperparathyroidism, giant parathyroid adenoma, papillary thyroid carcinoma, parathyroidectomy, thyroid malignancy

Table 1. Right thyroid; lobectomy

Papillary thyroid carcinoma, classic subtype
Tumor location: mid-pole
Tumor size: 0.9 cm
Tumor focality: unifocal
Lymphovascular invasion: not identified
Perineural invasion: not identified
Extrathyroidal extension: not identified
Surgical margins: negative

Table 2. Blood test result

Test	Results	Reference range	Unit
ALP	154	40-130	U/L
İron (serum)	56.76	33-193	µg/dL
Calcium	12.0	8.6-10.0	mg/dL
Phosphorus	3.29	2.5-4.5	mg/dL
Urea	32.4	16.6-48.5	mg/dL
Creatinine	1.21	0.70-1.20	mg/dL
PTH	274	15-65	bg/dL
25-hydroxy vitamine D	7.73	30-100	µg/dL
Calcium (spot urine)	21.38	0.9-37.9	mg/dL

ALP: Alkaline phosphatase, PTH: Parathyroid hormone.

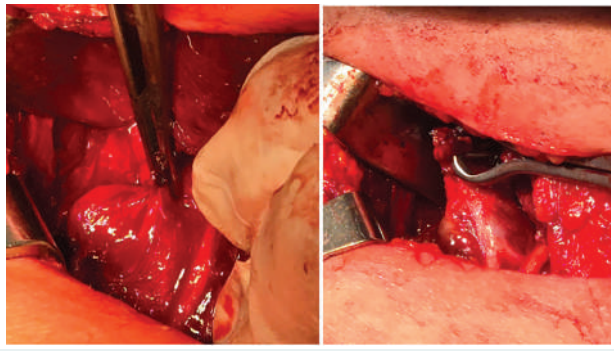

Figure 1. Peroperative imaging, preoperative radiologic imaging.

Figure 2. In neck and thorax CT perfomed 25x30 mm nodular lesion in right parathyroid lodge ehind the thyroid tissue.

CT: Computed tomography.

Figure 3. Pathological findings.

[P-238]

Rare coexistence of papillary and medullary thyroid carcinomas in a patient with Graves' disease

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Objective: Graves' disease (GD) is a common cause of hyperthyroidism and is occasionally associated with thyroid malignancies, particularly papillary thyroid carcinoma (PTC). Medullary thyroid carcinoma (MTC) rarely coexists with GD. The synchronous occurrence of multiple distinct thyroid carcinoma subtypes in a single patient is extremely uncommon.

Material and Methods: In this study, the clinical, laboratory, and imaging findings of a patient who underwent total thyroidectomy for GD were retrospectively analyzed. The surgical specimen was subjected to detailed histopathological and immunohistochemical examination, and tumor subtypes were classified according to established pathological criteria. Postoperative follow-up included clinical assessment and measurement of serum calcitonin and carcinoembryonic antigen (CEA) levels.

Results: A 36-year-old female with GD underwent total thyroidectomy. Preoperative ultrasound revealed multiple benign-appearing nodules (TI-RADS 2). Histopathology unexpectedly revealed three distinct malignancies: Well-differentiated high-grade thyroid carcinoma (7 mm, right lobe), classic PTC (4.8×2×2 mm, left lobe), and bilateral MTC (2 mm right, 4 mm left). Immunohistochemistry confirmed the distinct tumor subtypes. Postoperative recovery was uneventful, and the patient was discharged on the first day. Levothyroxine therapy was initiated. At 2-year follow-up, the patient remains disease-free with negative CEA and calcitonin levels. This case underscores that GD may coexist with multiple, histologically distinct thyroid malignancies, even when imaging suggests benign disease. The incidental detection of PTC, well-differentiated carcinoma, and MTC highlights the importance of thorough histopathological examination and consideration of total thyroidectomy, particularly in endemic regions. Postoperative follow-up must include surveillance for MTC via calcitonin and CEA monitoring.

Conclusion: Clinicians should be aware that GD does not exclude the presence of multiple thyroid cancers. Comprehensive surgical and pathological evaluation ensures accurate diagnosis and guides appropriate postoperative management.

Keywords: Graves' disease, papillary thyroid carcinoma, medullary thyroid carcinoma

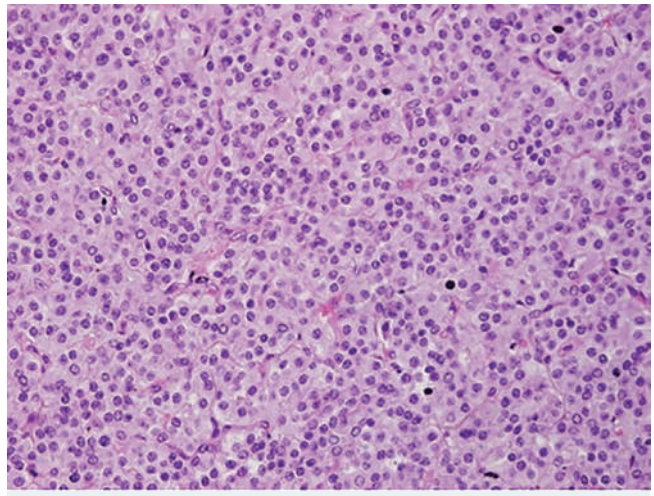

Figure 1. Papillary thyroid carcinoma.

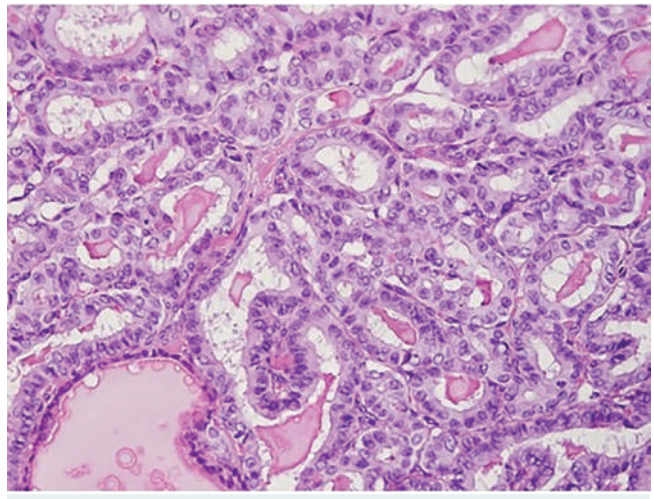

Figure 2. Medullary thyroid carcinoma.

[P-239]

Intraperitoneal migration of hepatic hydatid cyst with intact daughter cysts: Case report and systematic review translate to Turkish

Ferdi Cambaztepe, Alphan Toyran, Begüm Irmak Çoban, Mahmut Hüdai Demir

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Objective: Intraperitoneal "delivery" of an intact hepatic hydatid endocyst—also termed spontaneous exovesiculation or hydatid delivery—is an exceptionally rare complication of cystic echinococcosis. Because the laminated (germinative) membrane remains unbroken, the presentation may be deceptively indolent and lacks the dramatic anaphylaxis and diffuse peritoneal seeding seen with frank rupture. We report a contemporary case and summarise the available evidence through a PRISMA 2020-compliant systematic review.

Material and Methods: PubMed, Embase, Web of Science and Google Scholar were searched from inception to December 2025. We included peer-reviewed reports of hepatic hydatid cysts in which the pericyst failed but the endocyst migrated intraperitoneally intact; cases with spillage/disseminated peritoneal hydatidosis or alveolar echinococcosis were excluded. Of 38 records screened, 11 published cases (1998-2023) met inclusion criteria; together with the present case, 12 cases were analysed. Most originated from the right lobe and gravitated to the pelvis (approximately 5-20 cm). Across reports, anaphylaxis and secondary peritoneal implantation were not observed, and surgical management was uniformly curative with no reported mortality or recurrence.

Results: A 67-year-old woman with hypertension and advanced chronic kidney disease was found to have multiple hepatic cysts. Initial indirect haemagglutination assay (IHA) was negative (31.01.2025), and the lesions were followed as presumed benign. A CT scan dated 25.09.2025 demonstrated hepatic cysts but no pelvic lesion. In December 2025, a new cystic pelvic mass was detected during gynaecological follow-up. Repeat serology became strongly positive (IHA 1:2560). MRI on 10.12.2025 demonstrated a cystic lesion in the pouch of Douglas with a classic "water-lily" sign, alongside a collapsed hepatic cyst cavity, consistent with intraperitoneal migration of an intact daughter cyst. Albendazole was initiated and surgery was performed on 26.12.2025. Laparoscopic exploration was converted to open laparotomy due to dense adhesions. An intact free hydatid cyst adherent to the ileum was removed en bloc with a short ileal segment followed by primary anastomosis. Concomitant hepatic cyst cavities were unroofed, evacuated, irrigated with scolicidal solution, and obliterated with omentoplasty. Recovery was uneventful, and no recurrence was observed at 2-month follow-up under antiparasitic therapy.

Conclusion: In endemic settings, the combination of a new pelvic cyst and a collapsing hepatic cyst cavity should prompt consideration of intact hydatid migration, even with previously negative serology. Early definitive surgery, meticulous anti-spillage technique, and adjunct albendazole appear to confer excellent outcomes.

Keywords: Cystic echinococcosis, hydatid cyst, intraperitoneal migration

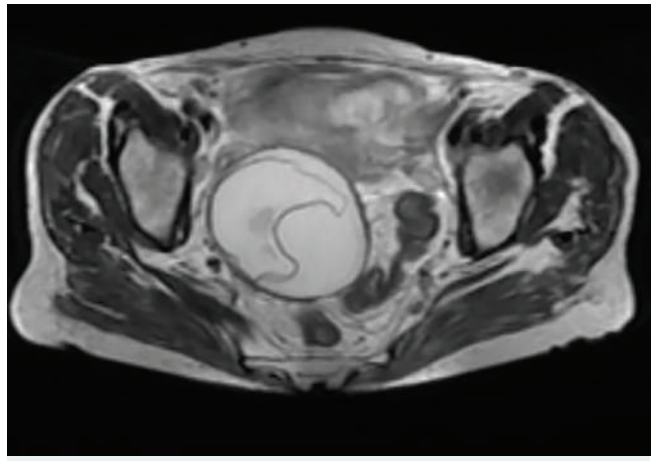

Figure 1. MRI image of hydatid cyst in the pouch of Douglas.

The cyst is seen as a rounded, well-defined fluid-filled structure situated between the uterus and the rectum in the cul-de-sac. It measures approximately 5 cm and has a multilayered appearance: note the detached parasitic membrane floating within the cyst (thin wavy hypointense line inside the cyst), a hallmark of hydatid cyst (sometimes referred to as the "water-lily sign"). The cyst exerts pressure on the uterus anteriorly and the rectosigmoid posteriorly. There is a mild rim of inflammatory reaction around the cyst, but no daughter cysts are obvious in the pelvis. This MRI conclusively demonstrates the secondary pelvic hydatid cyst that developed after the hepatic cyst rupture - a migration of hydatid elements leading to a new cyst implantation in the pelvic peritoneum peroperative view, *in situ*.

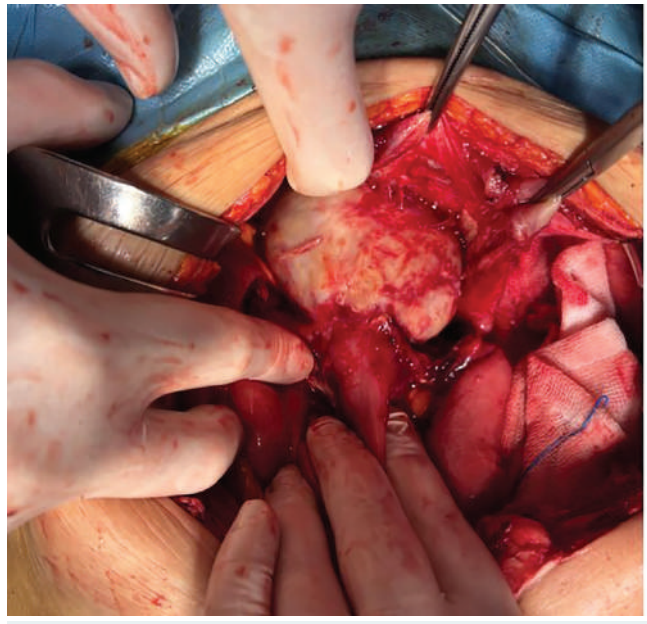

Figure 2. Intact pelvic hydatid cyst occupying the pouch of Douglas.

Table 1. Published cases of intraperitoneal migration of an intact hepatic hydatid cyst, with key features and outcomes

Case (year)	Age/sex	Liver cyst location	Cyst size	Migrated cyst location	Presentation	Management	Outcome
Arslan et al. (1998)	20 M	Left lobe (inferior surface)	~20 cm	Free in pelvis (causing bladder compression, ureteral obstruction)	Acute intestinal obstruction (bilateral hydronephrosis, uremia)	Laparotomy; intact cyst removal; hepatic pericyst left *in situ*	Recovered (no recurrence)
Sharma & Gupta (2000)	43 M	Left lobe	~20 cm	Free in peritoneum (pelvic)	Acute abdomen with peritoneal signs	Laparotomy; cyst excision; peritoneal washout	Recovered (no recurrence)
Karakaya et al. (2007)	35 F	Right lobe	~5 cm	Free in peritoneum (pelvis)	Mild abdominal pain only	Laparotomy; cyst removal	Recovered
Acer/Karnak et al. (2008)	10 F	Right lobe	~10 cm	Free in pelvis (POD)	Acute abdomen (sudden RUQ pain)	Laparotomy; cyst removal; liver repair	Recovered
Kahraman et al. (2016)	27 M	Right lobe	8 cm	Mobile in peritoneal cavity	Acute localized abdominal pain	Laparotomy; cystectomy; partial pericystectomy	Recovered
Idrissa et al. (2017)	6 M	Right lobe (segment VI)	7×5 cm	Free in pelvis (POD)	Acute pelvic pain & distension	Laparotomy; intact cyst removal; peritoneal lavage	Recovered
Ashebir et al. (2019)	25 F	Left lobe (with bile leak)	13×15 cm	Free in pelvis	Acute peritonitis (generalized pain, fever)	Laparotomy; cyst removal; lavage; omentoplasty	Recovered (albendazole given)
Markov et al. (2019)	30 M	Right lobe (+ small left lobe cysts)	10×13 cm	Free in lower abdomen (above bladder)	Subacute abdominal pain; mild hemoperitoneum	Laparotomy; cyst removal; plus aspiration of remaining liver cysts	Recovered (albendazole given)
Mehri et al. (2021)	85 M	Right & left lobes (multiple cysts)	10×13 cm	Free in pelvis (over bladder dome)	Dull generalized abdominal pain (chronic hydatidosis)	Laparotomy; intact cyst excision; drainage of liver cysts	Recovered (albendazole given)
Baccouch et al. (2021)	63 F	Left lobe (segment IV)	12×6 cm	Free in pelvis (POD)	2 months RUQ pain, acute exacerbation	Urgent laparotomy; hepatic pericyst resection; intact cyst removal	Recovered (no recurrence at 7 mo)
Ben Salem et al. (2023)	77 F	Left lobe	~10 cm	Free in peritoneum (bilobed cyst)	Acute RUQ pain (no trauma)	Laparotomy; intact cystectomy; partial pericystectomy	Recovered (albendazole 2 mo)
Present Case (2025)	67 F	Right lobe (segment VI; plus cysts in III, VII)	~7 cm (daughter cyst)	Free in pelvis (POD)	Chronic pelvic mass & pain (silent liver rupture)	Laparoscopy (converted to open); cyst resection with adherent ileal segment; liver cysts unroofed & omentoplasty	Recovered (albendazole given)

RUQ: Right upper quadrant, POD: Pouch of Douglas.

[P-240]

Mechanical ileus secondary to intestinal amyloidosis: A rare case report

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Objective: Amyloidosis is a heterogeneous disease characterized by extracellular deposition of misfolded protein fibrils in various organs. Although gastrointestinal involvement is rare, it may cause abdominal symptoms and motility disorders. Small bowel involvement due to submucosal and vascular amyloid deposition can lead to luminal narrowing and ileus. Only a few cases of mechanical obstruction secondary to intestinal amyloidosis have been reported.

Material and Methods: A 58-year-old woman presented with six days of abdominal pain, distension, nausea, vomiting, absence of flatus and stool, and syncope. Her history included hypertension. Physical examination showed a distended abdomen with diffuse tenderness and decreased bowel sounds, while laboratory tests revealed leukocytosis. Contrast-enhanced CT demonstrated marked jejunal distension with symmetrical wall thickening and partial asymmetry at the transition point. Wall thickening up to 1 cm was also observed in the ileal loops. The colon appeared collapsed, with mesenteric fat stranding and mild pelvic free fluid.Additionally, a suspicious 2.5 cm hypodense hepatic lesion and a 4 cm pathological right axillary lymphadenopathy were detected, suggesting metastatic malignancy. Emergency surgery revealed marked small bowel wall thickening and congestion. Approximately 100 cm of mechanically obstructed small intestine was resected starting 40 cm distal to the ligament of Treitz, followed by end-to-end anastomosis. Histopathology showed widespread amyloid deposits in the mesenteric tissue and intestinal wall, consistent with intestinal amyloidosis. The patient was followed for 20 days postoperatively and referred for systemic evaluation.

Results: Although gastrointestinal amyloidosis is rare, it can lead to serious complications. Amyloid deposition in the bowel wall causes rigidity, motility disturbances, and luminal narrowing, while vascular involvement may contribute to ischemia. Radiological findings are non-specific and often mimic malignant disease, as observed in our case.Treatment depends on clinical presentation. While supportive therapy may be sufficient in mild cases, surgical resection is required in patients who develop mechanical obstruction. Multidisciplinary evaluation is essential to assess systemic involvement.

Conclusion: Although intestinal amyloidosis is rare, it may present with serious surgical emergencies such as mechanical ileus. As it can radiologically mimic malignancy, it should be considered in the differential diagnosis. Definitive diagnosis is established by histopathological examination, and surgical resection is necessary in cases with obstruction.

Keywords: Amyloid accumulation, intestinal amiloidozis, mechanical obstruction

Figure 1. Macroscopic appearance of the resected small bowel segment causing mechanical obstruction secondary to intestinal amyloidosis.

[P-241]

Approach to the patient with superior mesenteric artery syndrome

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Objective: Superior mesenteric artery syndrome (SMAS) is a rare cause of upper gastrointestinal obstruction resulting from compression of the third part of the duodenum between the abdominal aorta and the superior mesenteric artery. Clinical symptoms are often non-specific and require high index of suspicion for diagnosis. This case report shares the successful management of SMAS-related obstruction with surgical bypass in an elderly patient with a history of prolonged oral intake disorder and weight loss.

Material and Methods: A 71-year-old female patient presented with long-standing oral intake disorder, weight loss, nausea, and vomiting. She sought emergency care due to a marked increase in symptoms over the past week and the development of severe oral intake disorder. Physical examination revealed abdominal distension. Computed tomography (CT) of the abdomen showed severe gastric distension extending into the pelvis. A nasogastric tube was inserted, and approximately 4000 cc of bilious contents were drained during the initial decompression. Upper gastrointestinal endoscopy performed to clarify the etiology revealed no significant pathology. However, an average of 1500 cc of bilious drainage continued daily from the nasogastric tube. An abdominal CT scan performed with oral contrast alone showed that the oral contrast progressed to the third portion of the duodenum but did not pass distally. A decision was made to perform surgical exploration with the differential diagnoses of obstruction/mass at the SMAS and Treitz levels.

Results: Intraoperative observation revealed that the SMA was compressing the third portion of the duodenum, causing mechanical obstruction. During surgery, an antecolic Roux-en-Y gastrojejunostomy was performed to restore passage by altering the Treitz anatomy. No complications were observed in the postoperative period. A liquid diet was started on postoperative day 4, and solid food was introduced on postoperative day 6 after the patient tolerated it well. The patient was discharged on postoperative day 8 with recommendations following an uneventful clinical course.

Conclusion: The absence of significant pathology on endoscopy and the continued high-volume bilious nasogastric drainage, along with contrast retention at the D3 level on oral contrast-enhanced CT, supported the diagnostic approach for SMA. The literature indicates that CT, along with SMA-aorta angle and distance measurement, is considered the gold standard. Conservative treatment aims for weight gain through decompression, postural therapy, and nutritional support. However, in selected cases, the conservative approach may fail, and surgical treatment becomes necessary. At this point, current sources emphasize that conservative treatment may fail and that surgery should not be delayed.

Keywords: Superior mesenteric artery syndrome, nasogastric drainage, vomiting

Figure 1. Contrast-enhanced abdominal tomography.

Figure 2. Contrast-enhanced abdominal tomography.

[P-242]

Case report: Gastric cellular angiofibroma

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Objective: Cellular angiofibroma (CAF) is a rare, generally considered to have a good prognosis, mesenchymal tumor. It is mostly found in the vulvo-vaginal region in women and in the inguino-scrotal region in men. Although extragenital localizations have been reported, there are no documented cases of CAF in the stomach in the literature. In this case presentation, we report a gastric CAF lesion detected in a patient who underwent laparoscopic gastric wedge resection with a preliminary diagnosis of gastrointestinal stromal tumor (GIST) originating from the stomach.

Material and Methods: A 75-year-old man with IgG kappa multiple myeloma was found to have a 2.5 cm submucosal gastric polyp during endoscopy for dyspepsia. Endoscopic ultrasonography showed a heterogeneous, hypoechoic lesion from the muscularis propria, measuring 23x20 mm. Biopsies revealed no diagnostic tissue. CT scan showed a 35x22x16 mm hypodense lesion in the stomach's small curvature, suggestive of GIST, with no metastasis. A type 3 hiatal hernia was also identified. The patient had laparoscopic wedge resection; a 2 cm polyp on the lesser curvature was excised. The hiatal defect was repaired with crurorrhaphy, mesh, and Toupet fundoplication.

Results: Pathology showed a 4x2.3x2.5 cm homogeneous, lobulated tumor 3 mm from the margin, consistent with CAF. Immunohistochemistry: Actin, desmin, h-Caldesmon, calponin negative; CD34, CD117 positive; DOG1, S100 negative; Ki-67 <10%; PR positive; SDH-B preserved.

Conclusion: CAF generally shows a good prognosis when excised with negative margins. To date, no studies reporting metastasis have been published in the literature. Nevertheless, cases of recurrence after excision with negative margins have been reported. Therefore, follow-up is important. In our case, the lesion was localized on the lesser curvature of the stomach and was identified as a subepithelial lesion, mimicking GIST on both CT and endoscopic imaging. In our case, DOG1 was negative, SDH-B was preserved, and CKIT was negative, but positive in mast cells. No signs of recurrence were observed during postoperative follow-up.

Keywords: Cellular angiofibroma, subepithelial lesion, gastric

[P-243]

Surgical management of superior mesenteric artery syndrome: A case series of 5 patients including a rare malignancy association

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Objective: Superior mesenteric artery syndrome (SMAS), also known as Wilkie's syndrome, is a rare cause of upper gastrointestinal obstruction characterized by the extrinsic compression of the third portion of the duodenum between the abdominal aorta and the superior mesenteric artery. Pathologically, defined by a significant reduction in the aortomesenteric angle (AMA) to below 25° (from a physiological mean of approximately 38°) and a decrease in the aortomesenteric distance (AMD) to less than 10 mm.

Material and Methods: This retrospective case series evaluated five patients surgically treated with a preliminary diagnosis of SMAS at a single center. Demographic characteristics, clinical presentation, radiological findings (AMA, AMD), surgical techniques, and postoperative outcomes were assessed.

Results: The study included five patients (3 females, 2 males) aged 19-45 years (mean age 29.6 years). All presented with gastrointestinal obstruction symptoms, including nausea, vomiting, abdominal pain, weight loss, and postprandial exacerbation. Postprandial nausea and vomiting were present in all cases; three also had preprandial nausea. Computed tomography (CT) confirmed SMAS, demonstrating an AMA of 14°-20.7° and a maximum AMD of 6 mm. Surgical management consisted of laparoscopic Strong's procedure (n=1), laparoscopic Roux-en-Y duodenojejunostomy (n=1), resection with duodenojejunostomy (n=1), laparoscopic side-to-side duodenojejunostomy (n=1), and combined laparoscopic Strong's procedure and duodenojejunostomy (n=1). One patient had concomitant Nutcracker syndrome. In another patient with a preoperative diagnosis of SMAS, an intraoperative malignant epithelial tumor was detected. Case 1: A 19-year-old female with a 5-year history of postprandial pain and vomiting, and recent hematuria, had a BMI of 15.22 kg/m². Imaging showed an AMA of 16° and AMD of 4 mm, with left renal vein compression consistent with Nutcracker syndrome. Laparoscopic duodenojejunostomy was performed. Case 2: a 38-year-old female with valvular heart disease presented with intermittent nausea and vomiting for one year and minimal weight loss (2.5 kg). CT demonstrated an AMA of 19° and AMD of 5.3 mm. Intraoperatively, a proximal jejunal mass not detected on preoperative imaging was identified; resection of the distal duodenum and proximal jejunum with side-to-side duodenojejunostomy was performed. Histopathology revealed adenocarcinoma with focal squamous differentiation, serosal invasion, and three metastatic lymph nodes (pT4N2).

Conclusion: SMAS should be considered in patients with rapid weight loss and upper gastrointestinal obstruction symptoms. Laparoscopic duodenojejunostomy remains the standard treatment, a single anastomosis is generally sufficient and Roux-en-Y diversion is usually unnecessary. Strong's procedure with Treitz ligament repositioning may be considered in selected cases. Even when radiologic criteria for SMAS are met, alternative causes, including malignancy, must be excluded.

Keywords: Wilkie syndrome, nutcracker, superior mesenteric artery syndrome

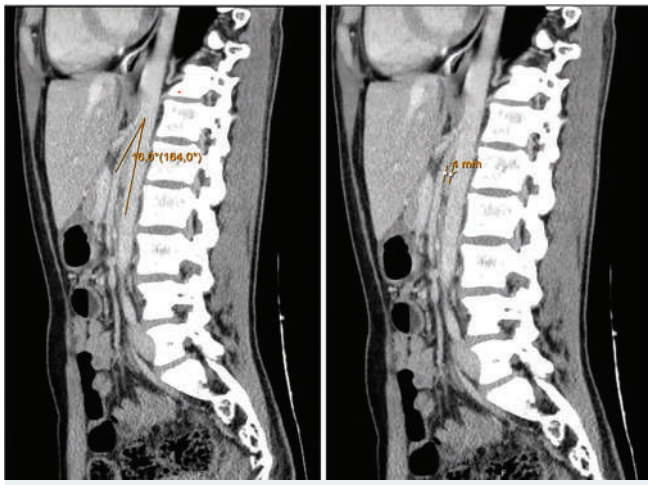

Figure 1. SMA syndrome; aortamesenteric angle and distance.

SMA: Superior mesenteric artery.

Figure 2. Nutcracker syndrome; left renal vein compression by the SMA.

SMA: Superior mesenteric artery.

[P-244]

Perforated jejunal adenocarcinoma arising in jejunal diverticulitis: A rare case report

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Objective: Jejunal diverticulosis is a rare pathology of the intestine, affecting elderly patients and usually remaining asymptomatic. However, it may lead to complications such as diverticulitis, perforation, bleeding, and obstruction. The diagnosis of acute jejunal diverticulitis is challenging due to non-specific onset and the limited sensitivity of imaging modalities, and it is often established during surgery. Small bowel adenocarcinomas account for only 1-3% of gastrointestinal malignancies, with jejunal localization being particularly rare. Adenocarcinoma arising from a jejunal diverticulum is exceedingly uncommon and presents with perforation or acute abdomen leading to delays in diagnosis and treatment. In this report, we present a rare case of jejunal adenocarcinoma presenting with diverticulitis and perforation, discussed in light of the current literature.

Material and Methods: This study is a case report of a patient presenting with acute abdomen and evaluated with a preliminary diagnosis of gastrointestinal perforation. Clinical findings, laboratory parameters, and radiological imaging (computed tomography) were reviewed. Intraoperative findings were recorded during surgery. Specimens were evaluated histopathologically and immunohistochemically.

Results: An 89-year-old male presented with a 10-day history of abdominal pain, worsening over the last two days, accompanied by oral intolerance and clinical deterioration. Associated symptoms included nausea, vomiting, and fever. Patient history included congestive heart failure, atrial fibrillation, hypertension, and type 2 diabetes mellitus. On admission, blood pressure was 90/50 mmHg, respiratory rate was 30/min, body temperature was 39 °C, and heart rate ranged 100-110 beats/min. Physical examination revealed generalized abdominal tenderness, rebound and signs of peritoneal irritation. Laboratory tests showed a CRP level of 350 mg/L and a leukocyte count of 23,000/mm^3. Computed tomography demonstrated diffuse free fluid and air throughout the abdomen (Figure 1). Emergency surgery was planned. Empirical intravenous piperacillin-tazobactam was administered. Exploration revealed generalized fecal peritonitis, a 7×7 cm tumoral mass in the cecum, and perforated jejunal diverticulum located 20 cm distal to the ligament of Treitz (Figure 2). Segmental small bowel resection with side-to-side anisoperistaltic stapled anastomosis was performed. Right hemicolectomy and end ileostomy were carried out for tumoral mass. The patient was under high-dose inotropic support postoperatively. Patient died on postoperative day 3 due to septic shock-related multiple organ dysfunction syndrome. Histopathology revealed moderately differentiated adenocarcinoma in both the cecum and the jejunal diverticulum.

Conclusion: Jejunal diverticulosis should be considered in cases of unexplained small bowel obstruction or perforation. In the presence of diverticulosis-associated masses detected intraoperatively, the possibility of malignancy should not be overlooked, and surgical resection should be performed with oncological principles.

Keywords: Acute abdomen, jejunal diverticulum, jejunal perforation, rare case, small bowel adenocarcinoma

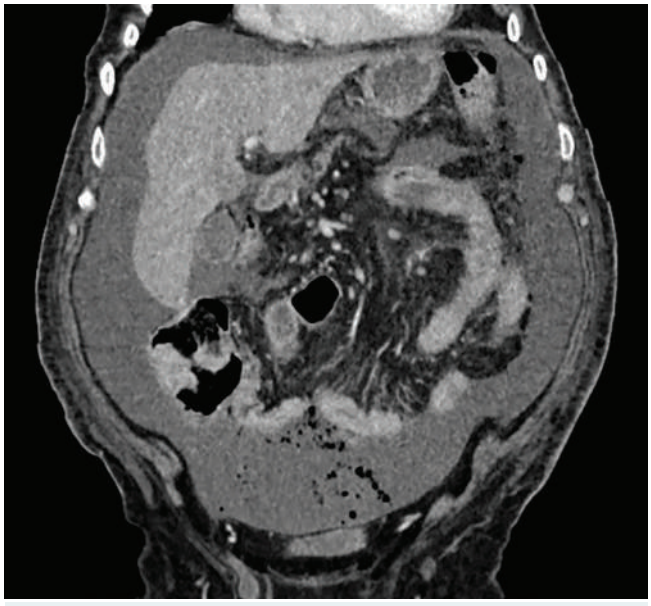

Figure 1. Preoperative CT.

CT: Computed tomography.

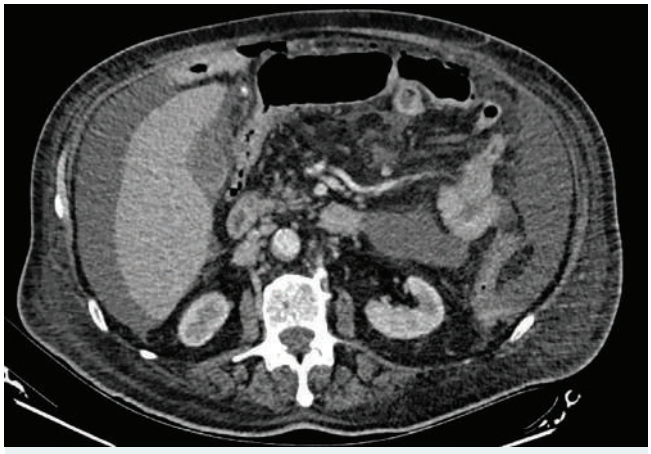

Figure 2. Preoperative CT.

CT: Computed tomography.

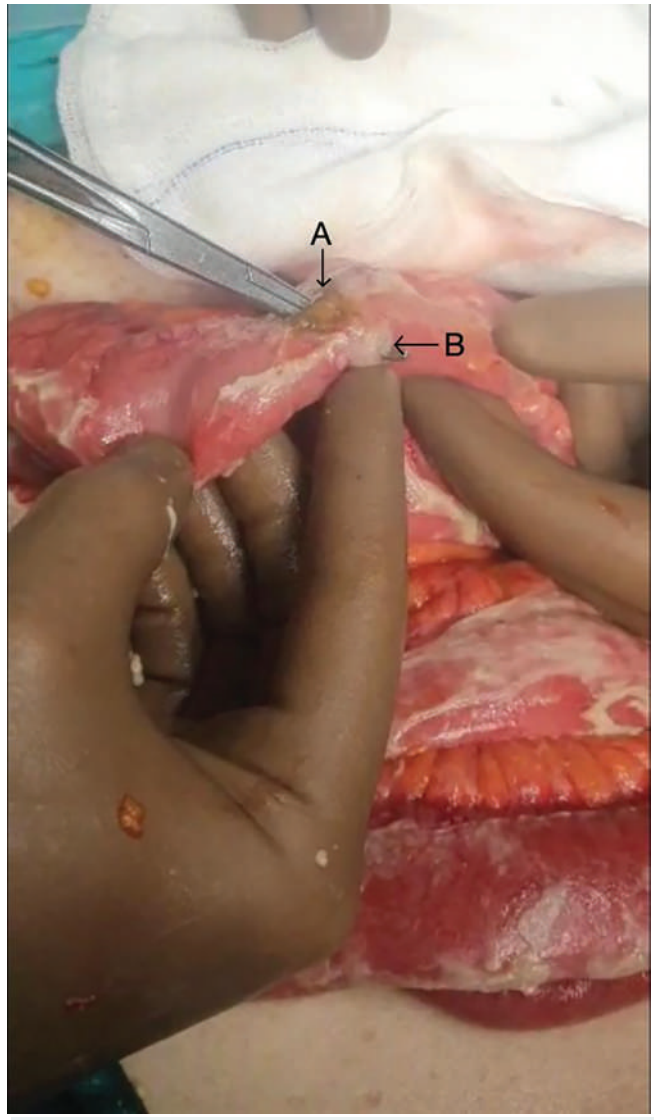

Figure 3. A: Intraoperatively identified perforated segment B: jejunal diverticulitis.

[P-245]

Spontaneous adrenal hematoma presenting with abdominal pain in an elderly patient and complicated by delayed adrenal insufficiency: A case report

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Objective: Spontaneous adrenal hemorrhage (adrenal hematoma) is a rare but potentially life-threatening condition associated with significant morbidity and mortality. It often presents with non-specific symptoms such as abdominal or flank pain, nausea, and fatigue, leading to delayed diagnosis. Reported etiologies include trauma, sepsis, coagulopathies, anticoagulant use, and underlying adrenal lesions, with increased risk in elderly patients due to comorbidities. Despite its rich arterial supply, the adrenal gland has limited venous drainage, predisposing it to hemorrhage under stress conditions. Computed tomography (CT) is the primary diagnostic modality. Conservative management is generally sufficient in hemodynamically stable patients without evidence of active bleeding. Recent reports have highlighted an association between spontaneous adrenal hemorrhage and direct oral anticoagulant (DOAC) therapy.

Material and Methods: An 80-year-old woman presented with a two-day history of diffuse abdominal pain. Her medical history included hypertension, diabetes mellitus, chronic kidney disease, and a prior ischemic cerebrovascular event. She was receiving rivaroxaban therapy. Physical examination revealed stable vital signs and a benign abdominal examination. Non-contrast CT performed at an outside facility demonstrated a large hematoma involving the left adrenal gland and perirenal region. The patient was admitted with a diagnosis of spontaneous adrenal hematoma and managed conservatively.

Results: Hemoglobin level decreased from 12 g/dL at initial presentation to 9 g/dL on admission but remained stable on serial measurements. Contrast-enhanced CT showed no evidence of active contrast extravasation, and the hematoma measured up to 8×15 cm. On hospital day eight, the patient developed acute mental status changes, hypotension, and tachycardia. Hemoglobin levels remained stable, and follow-up imaging showed no progression of hemorrhage. Endocrinology consultation raised suspicion for adrenal insufficiency secondary to adrenal hematoma. Intravenous hydrocortisone therapy was initiated, resulting in rapid clinical improvement. The patient was transferred from the intensive care unit back to the ward and subsequently discharged in good condition.

Conclusion: Spontaneous adrenal hematoma is a rare and diagnostically challenging cause of abdominal pain, particularly in elderly patients receiving anticoagulant therapy. Conservative management is safe and effective in hemodynamically stable patients, even in cases of large hematomas. However, clinicians should remain vigilant for delayed adrenal insufficiency. Prompt recognition and early corticosteroid replacement therapy are critical and may be life-saving.

Keywords: Adrenal hemorrhage, adrenal insufficiency, conservative management, direct oral anticoagulants (DOACS), spontaneous adrenal hematoma

[P-246]

Superficial abdominal venous thrombophlebitis: A rare clinical case

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Objective: Superficial thrombophlebitis most commonly affects the veins of the lower extremities, particularly the great saphenous vein. However, superficial abdominal veins—such as the thoracoepigastric and superior epigastric veins—are rarely involved. This condition is also described in the literature as abdominal Mondor disease. First reported by Mondor in 1939, it was most frequently described in the veins of the chest wall, whereas involvement of the abdominal wall is exceedingly rare. Risk factors include local trauma, surgical interventions, infection, malignancy, and hypercoagulable states. Clinically, it may present as a painful, cord-like lesion and can be misdiagnosed as an abdominal abscess, hernia, or intra-abdominal pathology. In this report, we present a case of superficial abdominal vein thrombophlebitis that developed following minor trauma.

Material and Methods: The clinical evaluation, laboratory tests, and imaging findings of a patient presenting with pain and swelling in the left upper quadrant were retrospectively reviewed. Superficial soft tissue and Doppler ultrasonography were used for diagnostic purposes. The treatment approach and short-term clinical course were also evaluated.

Results: A 51-year-old female patient presented to our outpatient clinic with complaints of pain and swelling in the left upper quadrant that developed after minor trauma caused by a branch strike approximately one week earlier. Her medical history was significant for hypertension and chronic hepatitis B infection, and she was receiving antiviral therapy (Viratt®). Physical examination: A linear, cord-like subcutaneous lesion with tenderness on palpation was detected in the left upper quadrant. No erythema or fluctuation was observed. Laboratory findings: hematological and biochemical parameters were within normal limits. Ultrasonography: Superficial soft tissue ultrasonography revealed a non-compressible millimetric superficial venous structure with increased surrounding echogenicity in the left upper quadrant, consistent with thrombophlebitis. No extension into the deep venous system was observed. Treatment and follow-up: Conservative treatment including non-steroidal anti-inflammatory drugs, local warm application, and rest was initiated. Anticoagulation therapy was not considered necessary. At the one-week follow-up, clinical findings had markedly regressed.

Conclusion: Superficial abdominal vein thrombophlebitis is a rare condition that can easily be misdiagnosed. It should be considered in the differential diagnosis, particularly in patients presenting with a cord-like lesion and a history of trauma. Doppler ultrasonography is indispensable for diagnosis. Most cases resolve uneventfully with conservative treatment.

Keywords: Abdominal Mondor disease, superficial venous thrombophlebitis, abdominal wall, minor trauma, Doppler ultrasonography

[P-247]

Giant infected thyroid mass complicated by vascular injury: A surgical challenge

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Objective: Thyroid gland pathologies are common diseases, but giant thyroid masses complicated by infection, skin penetration, and major vascular involvement are rare today. Large goiters or malignant thyroid lesions can lead to complications such as airway obstruction, vascular injury, and life-threatening postoperative neck hematoma. Here, we present a complex case of a patient who presented to the emergency department with necrosis and bleeding in a neck mass, underwent surgery for a giant thyroid mass.

Material and Methods: An 85-year-old female patient presented with a progressively growing and bleeding mass in the anterior neck region. Her medical history included hypothyroidism. A computed tomography scan of the neck revealed a mass lesion approximately 83×107 mm, extending anteriorly into the subcutaneous tissue and skin. The lesion contained scattered air densities and calcified foci. These findings were considered consistent with an abscess collection associated with malignancy.

Results: The patient underwent surgery for total thyroidectomy. The cystic components of the thyroid gland had penetrated the skin and showed significant inflammatory adhesions to surrounding tissues. During dissection of the right lobe of the thyroid, the internal jugular vein was injured due to the fragility of the tissues. The injury was primarily repaired. The parathyroid glands were preserved. Recurrent laryngeal nerve monitoring was performed intraoperatively. Total thyroidectomy was completed. In early postoperative period, the patient developed acute cervical swelling. Due to the patient's tracheotomy, airway security was ensured, and neck exploration was decided. Approximately 100 cc hematoma was drained. There was no active arterial or venous bleeding focus. Minimal leakage between tissue planes was controlled with electrocautery. The tracheotomy opening was repaired, and the patient was admitted to the intensive care unit.

Conclusion: In this case, despite successful vascular repair, the development of a postoperative hematoma without the detection of an active bleeding focus highlights the importance of diffuse capillary leakage in inflamed surgical areas. This case emphasizes the importance of careful dissection in infected and malignant thyroid diseases, being alert to the risk of tracheomalacia due to compression of giant thyroid masses, being prepared for vascular repair, close postoperative monitoring in high-risk patients, and the decision for early surgical re-exploration. Successful management was achieved through timely vascular repair, careful postoperative monitoring, and early re-exploration. Awareness of potential complications in such complex thyroid surgeries will improve surgical outcomes.

Keywords: Giant thyroid lesion, emergancy surgery, bleeding

Figure 1. An 85-year-old female patient presented with a progressively growing mass and bleeding in the anterior neck region.

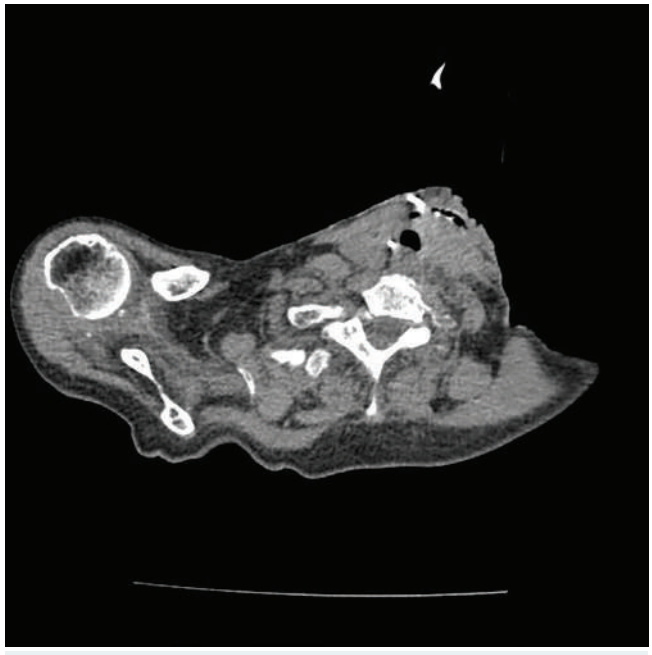

Figure 2. A contrast-enhanced neck computed tomography scan revealed a mass lesion approximately 83×107 mm in size, filling the thyroid gland lodge and extending anteriorly to the subcutaneous tissue and skin. The lesion contained scattered air densities and calcified foci. These findings were onsidered consistent with an abscess collection accompanying malignancy.

[P-248]

A rare cause of necrotizing fasciitis: Vaginal perforation

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Objective: Necrotizing fasciitis (NF) is a rare but life-threatening soft tissue infection affecting the skin, subcutaneous tissues, and fascia, characterized by rapid progression and high mortality. Early diagnosis and aggressive surgical treatment are critical for prognosis. This poster presents a case of extensive NF extending from the vagina to the subcostal space of the anterior abdominal wall, requiring repeated debridement.

Material and Methods: A 46-year-old female patient presented to our emergency department with pain and tenderness in the suprapubic area. Initial assessment revealed a moderate to good general condition and stable vital signs. Redness and foul-smelling discharge were present in the suprapubic area. History indicated that an abscess had been drained from this area a few days prior. Physical examination revealed tenderness in the suprapubic region and an opening approximately 4 cm in size. Digital examination showed that this opening extended from the anterior vaginal wall to the urethra. The urethra was assessed as intact. The patient showed elevated infectious markers and decreased albumin (WBC: 18.5 K/uL, Hgb: 13 g/dL, alb: 2.4 g/dL, CRP: 580 mg/L, proc: 2.03 ug/L). Computed tomography revealed subcutaneous emphysema starting in the suprapubic region, continuing under the skin along the muscle planes of the left lateral abdominal wall, and extending posteriorly into the lumbar region, along with accompanying increased density in the subcutaneous fatty planes. This appearance did not extend into the intra-abdominal area but did extend into the left inguinal region.

Results: The patient was found to have a fasciitis area extending from the left femoral head to the left subcostal space. After obtaining culture and pathology samples, the necrotic areas were debrided.In the postoperative period, the patient was empirically started on vancomycin/meropenem/metronidazole and frequent daily debridement and dressing changes were performed. Coryneform bacilli were cultured from the patient's blood. No growth was detected in cultures taken from the debrided areas. During this time, electrolyte imbalances and low albumin levels were treated with appropriate replacements. After the progression of necrosis was halted with frequent debridement and dressing changes, the patient was referred to plastic reconstructive and aesthetic surgery for appropriate flap surgery due to the very large area debrided. During follow-up with our team, a reduction in the size of the wound was observed.

Conclusion: This case highlights the rare but aggressive course of necrotizing fasciitis and the critical importance of early, repeated surgical debridement in treatment. A multidisciplinary approach and close follow-up improve patient survival.

Keywords: Necrotizing fasciitis, abdominal wall, repeated debridement

Figure 1. The patient, who underwent surgery with a diagnosis of necrotizing fasciitis, was found to have a fasciitis area extending from the level of the left femoral head to the left subcostal space.

Figure 2. After the progression of necrosis was halted with frequent debridement and dressing changes, the patient was referred to plastic reconstructive and aesthetic surgery for appropriate flap surgery due to the very large area of debridement performed.

[P-249]

A rare cause of acute mechanical intestinal obstruction: A case of ileocecal endometriosis

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Objective: Mechanical intestinal obstruction is a common cause of acute abdomen. However, intestinal endometriosis represents a rare etiological factor, particularly in women of reproductive age. Although endometriosis is predominantly confined to the pelvic organs, gastrointestinal involvement is less frequent, and terminal ileal or cecal localization may rarely present with obstructive symptoms. Herein, we report a case of cecal endometriosis presenting with acute mechanical intestinal obstruction, in which a scirrhous cecal mass was detected intraoperatively.

Material and Methods: A 40-year-old woman was admitted to the emergency department with nausea, vomiting, and abdominal pain, accompanied by the absence of flatus and stool passage. She was hospitalized with a preliminary diagnosis of mechanical bowel obstruction. Her past surgical history was remarkable only for a previous cesarean section. Due to the lack of clinical improvement under conservative management, diagnostic laparotomy was performed.

Results: Abdominal computed tomography demonstrated dilated bowel loops, diffuse air-fluid levels, and an image suggestive of nested bowel segments at the medial aspect of the cecum, raising suspicion of a cecal mass. Intraoperative exploration revealed endometriotic implants on the left ovary and peritoneal surfaces. Multiple lymphadenopathies were observed in the colonic mesentery. A well-demarcated polypoid mass causing obstruction was identified in the cecum, with marked dilatation of the proximal small bowel loops. In addition, a 15-cm segment of the terminal ileum exhibited cobblestone-like suspicious areas and luminal narrowing. The patient was also noted to have previously undergone appendectomy. An ileocecal valve resection was performed, and the specimen was sent for frozen section analysis, which reported the lesion as an endometrioma. Final histopathological evaluation revealed no evidence of inflammatory bowel disease; instead, the ulcerated areas were interpreted as subacute ischemic changes secondary to intussusception caused by endometriotic foci. The postoperative course was uneventful, and the patient was discharged on postoperative day 7.

Conclusion: Endometriosis is a common condition with a challenging diagnosis. Intestinal endometriosis should be considered a rare yet clinically significant cause of mechanical bowel obstruction in young female patients. When presenting as a scirrhous cecal mass, it may mimic malignancy or inflammatory bowel disease, making intraoperative pathological assessment essential for guiding surgical decision-making. In this case, endometriotic implantation in the ileocecal region, possibly related to the patient's previous cesarean section accompanied by appendectomy, was considered to have contributed to the pathogenesis of obstruction. Early recognition and timely surgical resection are crucial for achieving favorable clinical outcomes.

Keywords: Endometriosis, mechanical bowel obstruction, ileocecal resection

Figure 1. Macroscopic appearance of the ileocecal resection specimen; marked mural thickening and luminal narrowing are observed in the ileocecal region.

Figure 2. Macroscopic appearance of the ileocecal segment during intraoperative frozen-section evaluation; after sectioning of the bowel wall, a nodular lesion causing mural thickening is observed.

[P-250]

Gastrointestinal perforation due to foreign body

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Objective: Foreign body ingestion is more commonly encountered in the pediatric population; however, it also represents an important cause of emergency department admissions in adults. Ingestion may occur intentionally, such as in cases of self-harm or suicide attempts, although the majority of cases are accidental. In most instances, ingested foreign bodies pass through the gastrointestinal tract spontaneously. Nevertheless, perforation, bleeding, mechanical obstruction, impaction within the gastrointestinal tract, and chemical toxicity are among the most frequent complications. The size, shape, and material composition are considered the primary determinants of complication risk. To date, there is no clear evidence in the literature supporting patient-specific characteristics as independent risk factors.

Results: A 64-year-old female patient presented to the emergency department with abdominal pain and fever. Physical examination revealed abdominal guarding and rebound tenderness. A midline surgical scar and an incisional hernia were also noted. The patient had a history of endoscopic retrograde cholangiopancreatography (ERCP) and cholecystectomy. Review of the most recent ERCP report indicated distal migration of a biliary stent. Abdominal computed tomography performed in the emergency setting demonstrated small bowel loops within the hernia sac, along with free fluid and free air. The patient underwent emergency surgery with a preliminary diagnosis of acute abdomen. Intraoperative exploration revealed that the biliary stent had perforated the bowel wall within the herniated small bowel segment and had migrated extraluminally. A 44-year-old male patient presented with pain and swelling in the inguinal region. Physical examination demonstrated an incarcerated inguinal hernia, and ultrasonography raised suspicion for strangulation, prompting emergency surgical intervention. During exploration, a wooden toothpick was identified within the small bowel loop contained in the hernia sac, perforating the bowel wall from the mesenteric side and extending beyond the lumen. The patient reported no history suggestive of foreign body ingestion.

Conclusion: Although foreign body ingestion is relatively uncommon in adults, it may present with atypical clinical manifestations and lead to severe complications. Sharp, pointed, foreign bodies carry a substantial risk of gastrointestinal perforation. A notable challenge in such cases is the frequent absence of a clear history of ingestion, which may delay diagnosis and treatment. The presence of gastrointestinal segments within a hernia sac may represent a potential facilitating factor for perforation and other complications related to foreign bodies. While imaging modalities play a critical role in diagnosis, definitive diagnosis may often require surgical exploration. Further studies are needed to better explain the underlying pathophysiology and associated risk factors.

Keywords: Foreign body, gastrointestinal system, perforation

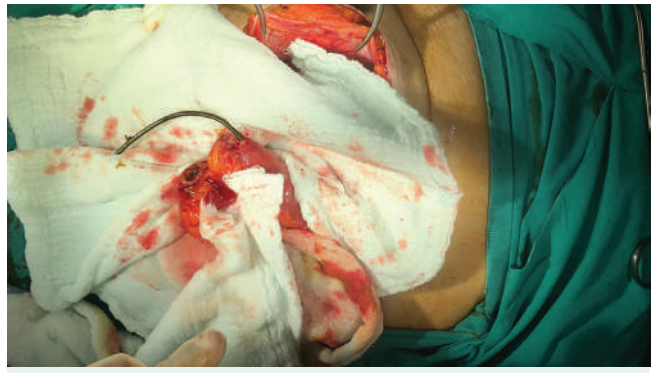

Figure 1. Biliary stent perforation.

Figure 2. Foreign body (toothpick) perforation.

[P-251]

De Garengeot hernia: An uncommon presentation of acute appendicitis

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Objective: De Garengeot hernia occurs in 0.5-1% of femoral hernia cases and is defined by the presence of the vermiform appendix within the femoral hernia sac. This emergency condition is typically diagnosed intraoperatively.

Material and Methods: This is a case presentation of De Garengeot hernia.

Results: A 76-year-old woman presented with a three-day history of pain and swelling in the right groin. Physical examination revealed an erythematous, edematous, and tender femoral mass. Laboratory investigations demonstrated leukocytosis and elevated C-reactive protein levels. Abdominal computed tomography confirmed the presence of the appendix within the right femoral hernia sac, accompanied by loculated fluid and inflammatory changes. Open femoral exploration identified the distal appendix incarcerated in the femoral ring, without evidence of perforation or abscess (Figure 1). Due to limited inflammation, mesh hernia repair and appendectomy were performed.

Conclusion: De Garengeot hernia remains challenging to diagnose. Preoperative computed tomography is essential for accurate identification and effective surgical planning. Early recognition and prompt surgical intervention are critical to achieving optimal patient outcomes.

Keywords: Femoral hernia, appendicitis

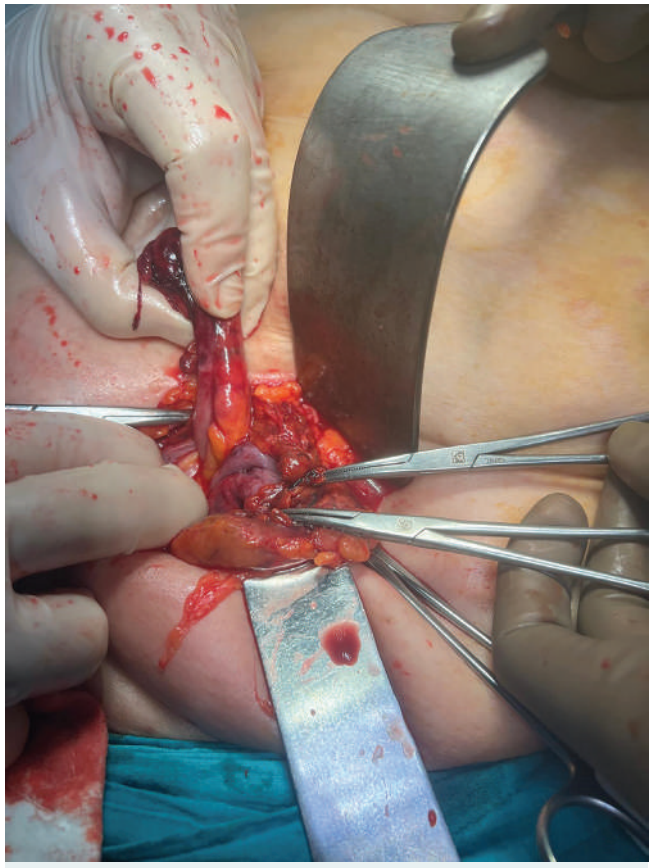

Figure 1. Intraoperative view of an appendicitis showing gangrene symptoms.

[P-252]

Migrated gastric balloon causing small bowel obstruction: Surgical milking and endoscopic extraction

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Objective: Obesity has become one of the most prevalent global health issues today. The quest to reduce morbidity in treatment has highlighted minimally invasive methods, which are more frequently preferred by patients. Among these methods, intragastric balloon (IGB) application holds a significant place. Although it has a safe profile, like every medical procedure, IGB application carries certain risks of complications. Spontaneous deflation of the balloon or migration to the small intestine due to volume loss is a serious condition that can lead to acute mechanical intestinal obstruction. In this study, we present our combined surgical and endoscopic management technique aimed at minimizing morbidity by avoiding enterotomy in a case of ileus caused by a migrated gastric balloon.

Material and Methods: A supraumbilical median laparotomy was performed under general anesthesia on a patient diagnosed with mechanical ileus. During surgical exploration, a mobile foreign body causing complete lumen obstruction was palpated approximately 60 cm distal to the ligament of Treitz. No ischemia or perforation was observed in the relevant bowel segments. Through a "Retrograde Milking" maneuver performed by the surgical team, the foreign body was manually pushed back proximally from the jejunum. Simultaneously, the duodenal lumen was visualized via gastroscopy; the balloon was grasped at the level of the bulb using endoscopic tripod forceps and extracted, thus terminating the procedure.

Results: A 43-year-old female, who had undergone IGB placement for weight loss 3 months prior, presented with abdominal pain, nausea, and vomiting lasting 8 days. Although she had visited emergency services previously, no diagnosis was made. Physical examination revealed abdominal distension and tenderness. Computed tomography confirmed mechanical ileus caused by a foreign body obstructing the small bowel lumen.

Conclusion: In patients with a history of gastric balloon, the risk of migration should be considered in the presence of abdominal pain and vomiting, even if the balloon appears to be in place. It is not essential for the balloon to rupture; loss of turgor and volume can also cause passage through the pylorus and subsequent small bowel obstruction. Preserving bowel integrity is essential in surgical treatment. The surgical retrograde milking and endoscopic extraction method we applied, as opposed to traditional enterotomy (bowel incision), is a safe and effective hybrid option that eliminates the risk of anastomotic leak and infection while shortening the length of hospital stay.

Keywords: Gastric balloon, ileus

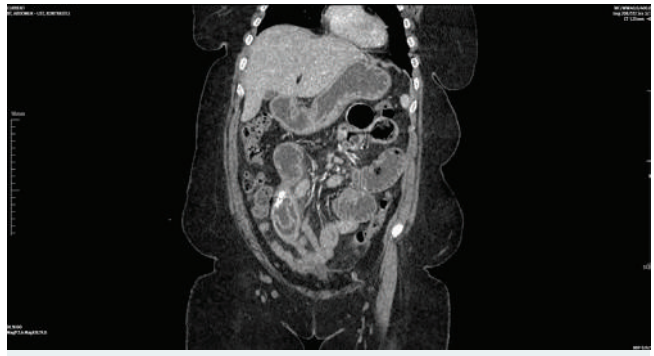

Figure 1. Computed tomography.

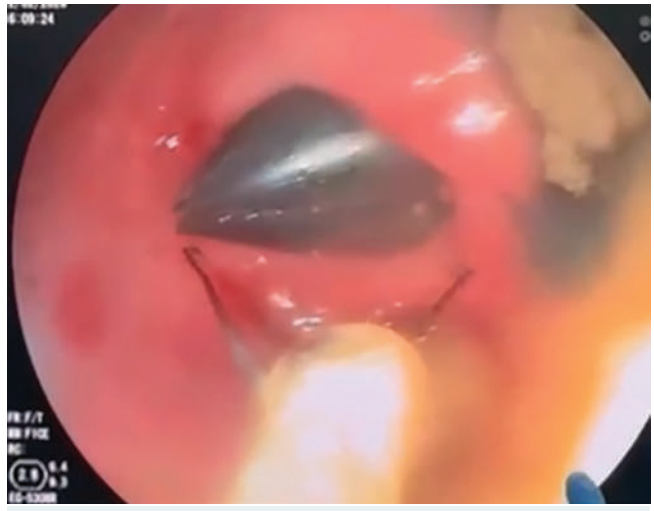

Figure 2. Endoscopic extraction.

[P-253]

Spontaneous rectus sheath hematoma: A case report

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Objective: Rectus sheath hematoma is a rare but clinically significant condition characterized by the accumulation of blood within the rectus sheath due to injury of the epigastric vessels or rectus muscle fibers, and it may mimic an acute abdomen. The most commonly associated factors include anticoagulation therapy, trauma, iatrogenic causes, and conditions that increase sudden abdominal muscle contraction; however, it may also develop spontaneously in patients without medication use. Contrast-enhanced CT provides high diagnostic accuracy by demonstrating the exact localization of the hematoma, its extent, and signs of active bleeding.

Material and Methods: Following is a case ropert regarding spontaneous rectus sheath hematoma.

Results: A 76-year-old male patient with no known comorbidities and no history of anticoagulant use presented to the emergency department with abdominal pain that had started the same day. Physical examination revealed tenderness and a palpable firm mass in the right upper quadrant of the abdomen. Ecchymosis was observed on the abdominal wall (Figure 1). Contrast-enhanced abdominal CT revealed a collection measuring approximately 90×48×92 mm within the right rectus abdominis muscle, consistent with a hematoma, and hyperdense areas within the collection suggestive of active extravasation (Figure 2). The patient was hospitalized for observation and treatment. During follow-up, his general condition remained stable, and he had adequate oral intake. Serial monitoring showed no decrease in hemoglobin levels. Control ultrasonography demonstrated no increase in the size of the hematoma. The patient was discharged on hospital day 5 with a stable clinical course.

Conclusion: Rectus sheath hematoma is an important differential diagnosis of acute abdominal pain in elderly patients, even in the absence of anticoagulant use. Contrast-enhanced CT plays a critical role in diagnosis. In hemodynamically stable patients without hemoglobin decline and without radiological progression, conservative management with close follow-up may be successful; in cases of instability or ongoing bleeding, endovascular embolization is an effective option. Conservative follow-up is often sufficient in stable cases, whereas embolization is prioritized in ongoing bleeding.

Keywords: Rectus sheath hematoma, spontaneous, acute abdomen, elderly

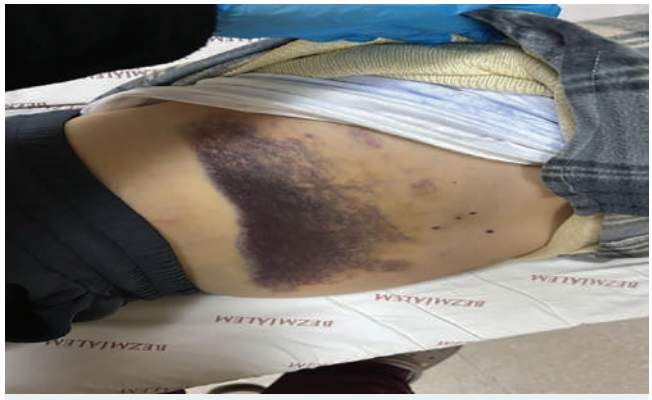

Figure 1.

Figure 2.

[P-254]

Aortoenteric fistula secondary to endovascular graft infection: Surgical management of a rare complication

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Objective: Fistulas between the aorta and surrounding organs are extremely rare; however, they can be fatal if not promptly recognized and treated. Primary aortoenteric fistula is a rare cause of gastrointestinal hemorrhage. Without treatment, the survival rate is 70% within the first 6 hours, dropping to 50% after 24 hours. Its classic triad consists of abdominal pain, gastrointestinal hemorrhage, and a pulsatile abdominal mass. This triad is observed in only 10-23% of cases. Secondary aortoenteric fistula (SAEF) is a rare but potentially fatal complication of aortic reconstructive surgery. The incidence of SAEF has increased as a result of advances in vascular surgery and aggressive surgical treatments.

Material and Methods: Surgical management and follow-up: Operation: The patient underwent surgery with a diagnosis of aortobiiliac graft infection. Erosion of the duodenum wall by the graft was observed. Procedure: Excision of the infected graft, new graft anastomosis (*in situ* reconstruction), duodenal resection, and gastrojejunostomy were performed. Outcome: After postoperative intensive care follow-up, the patient was transferred to the ward on day 5. During an endoscopy planned due to vomiting that developed on day 14, cardiac arrest occurred following sedation, and the patient died.

Results: Patient: 68-year-old male. Chief complaint: Fever of 38.6 °C and hematochezia. Medical history: Emergency EVAR due to ruptured abdominal aortic aneurysm 7 years ago. Embolectomy 3 years ago. Under follow-up for suspected graft infection due to recurrent febrile episodes. Diagnostic findings: Laboratory: Leukocytosis (17,000/mm³) and elevated CRP. Computed tomography: Diffuse thickening of the graft wall, air densities, and obliteration of the fat planes between the duodenum and the graft. Endoscopy: Migration of the graft into the duodenum was observed.

Conclusion: The operative and postoperative mortality rates of SAEF are extremely high, averaging around 50-60%. Various surgical strategies have been reported for the management of SAEF. Typical treatment consists of graft excision, debridement of infected tissues, revascularization, and repair of the intestinal fistula. In recent years, endovascular treatment has also gained prominence. In conclusion, SAEF should be the primary suspicion in any patient with a history of aortic reconstructive surgery presenting with gastrointestinal hemorrhage, abdominal pain, and sepsis; the diagnosis must be confirmed as soon as possible. Even in the absence of abdominal pain and sepsis, it is crucial to promptly determine whether the bleeding is caused by SAEF in patients with a history of aortic grafting. Contrast-enhanced abdominal CT and upper gastrointestinal endoscopy can provide a rapid and effective diagnosis. Early diagnosis and timely surgical intervention are life-saving for this patient group.

Keywords: Aortoenteric fistula, complication, surgery

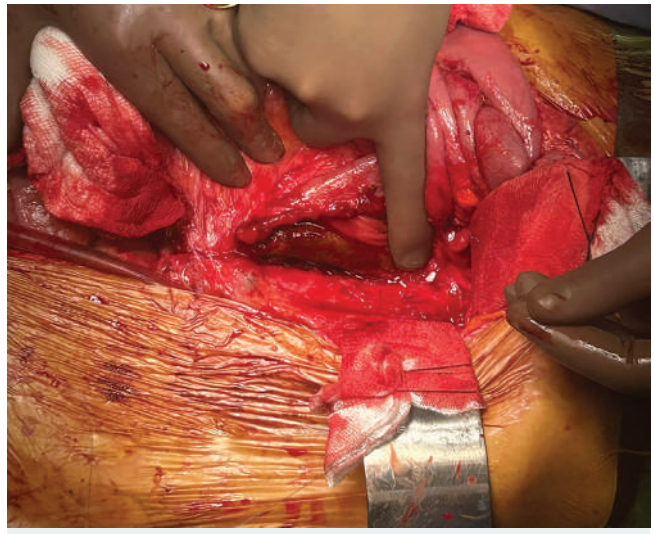

Figure 1. Intraoperative view showing the area where the graft eroded the duodenal wall and penetrated into the lumen.

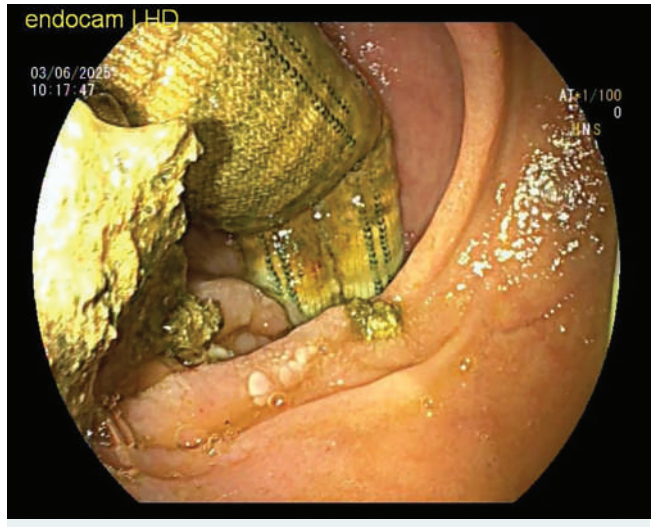

Figure 2. Graft migration into the duodenum observed in upper gastrointestinal endoscopy.

[P-255]

Recurrent psoas abscess

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Objective: Psoas abscess's a rare clinical condition, can lead to serious morbidity and mortality if not diagnosed and treated promptly. It's formed by collection of purulent fluid in the iliopsoas muscle. The infection may originate primarily from distant focus via the hematogenous route or develop secondarily as a result of direct spread from adjacent anatomical structures. The incidence has increased with development of imaging techniques, CT and MRI playing important role in this process. Our article aims to discuss diagnostic process, etiological causes, treatment approaches and mechanisms of recurrence based on a case of recurrent psoas abscess.

Material and Methods: Case report.

Results: 62-year-old woman developed recurrent right retroperitoneal abscess first detected in 2019, measuring 113×116 mm and initially treated with percutaneous drainage and antibiotics. After 15-day hospitalization, she was followed as an outpatient. One month later, 5 cm abscess recurred at same site, enlarged to 8 cm within six months, and required repeat drainage. Despite negative cultures and improvement in infection markers, abscesses continued to recur over subsequent years. Two years later, she presented with right-sided pain and 8.5 cm abscess, treated with drainage and antibiotics. One year later, MRI showed 10 cm abscess. Multiple additional drainages and antibiotic courses within a year failed to achieve durable resolution. In 2025, she presented to the ER with similar symptoms and underwent laparotomy. Exploration revealed a retrocecal appendix tip within the psoas muscle beneath migrated omental adhesions. Appendectomy, abscess drainage, and debridement were performed. The postoperative course was uneventful. She was discharged.

Conclusion: Psoas abscess is a rare clinical condition, can lead to serious complications if not diagnosed and treated promptly. Determining the etiology in recurrent cases is important for treatment success. In this case, despite repeated percutaneous drainage and antibiotherapy, the abscesses couldn't be controlled; surgical exploration revealed that the infection was associated with retrocecal appendicitis. Retrocecal appendicitis can be overlooked due to the absence of classic symptoms and difficulty in diagnosis by imaging. Due to its proximity to the psoas muscle, it can cause recurrent abscesses. This case emphasizes the need to investigate secondary causes with atypical anatomical localizations in cases of recurrent psoas abscesses with negative cultures and lack of response to treatment. It also demonstrates that surgery can be both diagnostic and therapeutic when conservative approaches fail. Treating patients who absolutely require surgery with non-surgical methods and delaying necessary surgical intervention leads to repeated patient visits, increased treatment costs and patient suffering.

Keywords: Appendicitis, psoas abscess, recurrent

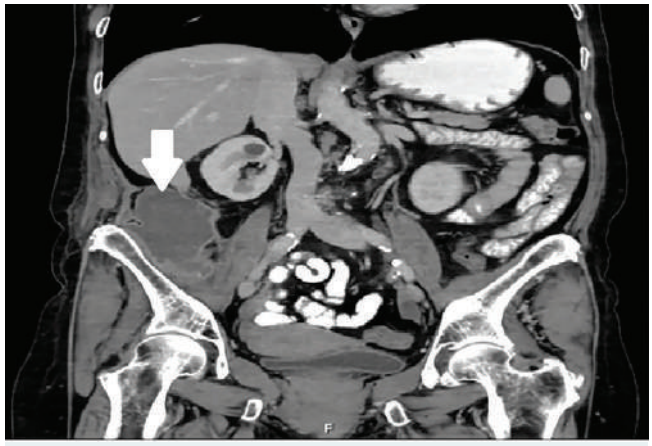

Figure 1. Image 1- CT imaging. Right iliopsoas abscess.

[P-256]

Gastric perforastion secondary to strangulated hiatal hernia: A rare case report

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Objective: Hiatal hernias are commonly encountered in clinical practice; however, strangulation and subsequent gastric ischemia with perforation are rare but life-threatening conditions associated with high morbidity and mortality. Clinical presentation is often nons-pecific, typically including epigastric pain, nausea, and vomiting, which may delay diagnosis. In some cases, patients may present with signs of an acute abdomen. The presence of mediastinal free air on imaging is usually suggestive of esophageal perforation, yet in rare instances it may also indicate gastric perforation secondary to a strangulated hiatal hernia. Therefore, careful correlation of clinical and radiological findings is crucial for timely surgical intervention.

Material and Methods: A patient presenting to the emergency department on the 24th with sudden-onset epigastric pain, nausea, and vomiting was evaluated. Physical examination findings were consistent with an acute abdomen, demonstrating diffuse abdominal tenderness, guarding, and rebound tenderness. Laboratory investigations revealed leukocytosis. Contrast-enhanced thoracic and abdominal computed tomography (CT) was performed. Based on clinical and radiological findings, the patient was taken to emergency surgery. Intraoperative exploration guided the decision for resection and gastrointestinal reconstruction.

Results: Contrast-enhanced thoracoabdominal CT demonstrated prominent mediastinal free air along with intra-abdominal free air and free fluid. Herniation of the gastric fundus into the thoracic cavity and thickening of the gastric wall were also observed. During surgery, severe ischemic changes were noted in the herniated gastric segment. A 6×3 cm perforation with extensive necrosis on the anterior wall of the gastric fundus was identified. Due to the wide necrotic area and the unsuitability of primary repair, a total gastrectomy with Roux-en-Y esophagojejunostomy reconstruction was performed. No major postoperative complications occurred.

Conclusion: Although rare, strangulated hiatal hernias may lead to life-threatening complications such as gastric ischemia and perforation. The coexistence of mediastinal free air with intra-abdominal free air and fluid should strongly raise suspicion for gastric perforation. Early diagnosis, prompt surgical decision-making, and appropriate resection with reconstruction significantly improve patient outcomes. In this case, the postoperative course was uneventful, and the patient was discharged on postoperative day seven. This report highlights the importance of considering gastric perforation secondary to strangulated hiatal hernia in the differential diagnosis when mediastinal free air is detected.

Keywords: Strangulated hiatal hernia, gastric perforation, mediastinal free air

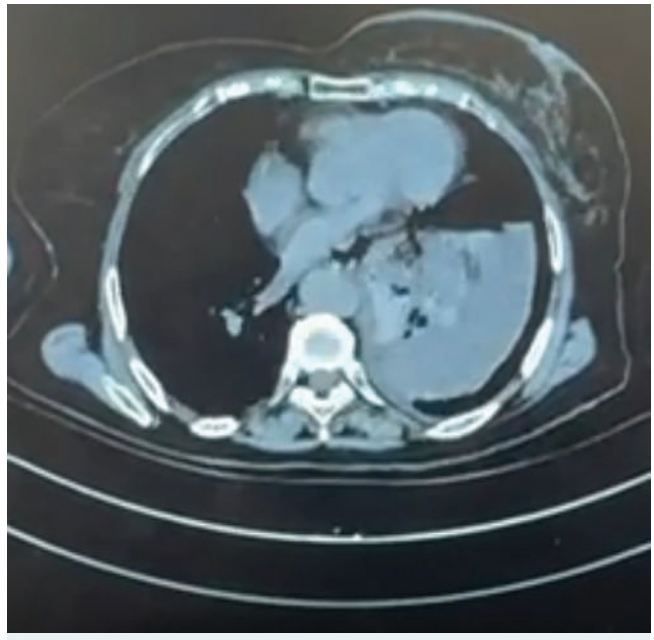

Figure 1. CT image; hiatal hernia and mediastinal free air and fluid.

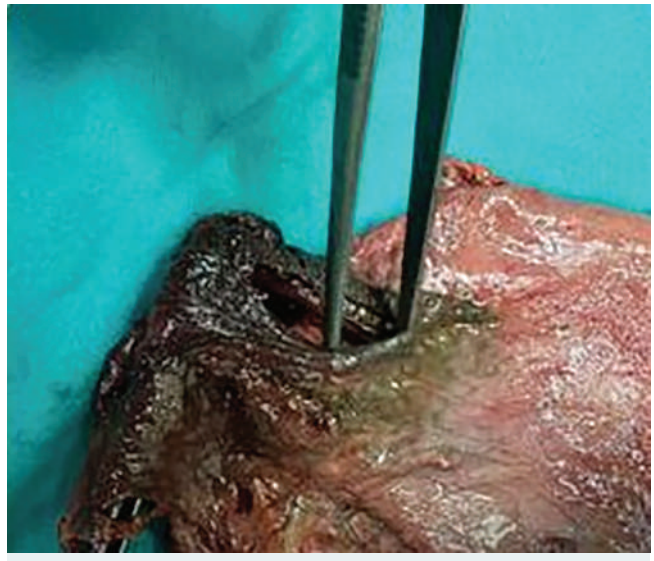

Figure 2. Image of the specimen; perforation focus on the gastric fundus with extensive necrosis.

[P-257]

Abdominal evisceration and multiple organ injuries secondary to shotgun trauma: A damage control surgery approach

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Objective: Firearm injuries, particularly shotgun-related trauma, represent severe clinical entities due to the wide dispersion of pellets and the extensive tissue destruction they may cause. Such injuries frequently result in multiple organ damage. In penetrating abdominal trauma, hemodynamic status is the primary determinant of surgical strategy. In the presence of hemodynamic instability or ongoing hemorrhage, damage control surgery (DCS) is widely accepted as an effective staged approach aimed at reducing mortality. This study presents the management of abdominal evisceration and multiple organ injuries secondary to shotgun trauma using a DCS strategy.

Material and Methods: A 22-year-old male was admitted to the emergency department following a shotgun injury. On initial evaluation, he was conscious, cooperative, and oriented, with a Glasgow Coma scale score of 15. His arterial blood pressure was 100/53 mmHg. Physical examination revealed a midline abdominal wall defect above the umbilicus with evisceration of the stomach and intestinal segments. Contrast-enhanced abdominal computed tomography demonstrated multiple metallic pellet fragments in the vicinity of the liver, spleen, and stomach, along with diffuse hemoperitoneum and free intraperitoneal air. The patient was diagnosed with penetrating abdominal trauma and was taken emergently to the operating room.

Results: Exploratory laparotomy revealed approximately 1000 mL of hemorrhagic fluid within the abdominal cavity. A 10 cm actively bleeding laceration was identified in segment IV of the liver, and a pellet fragment was removed. A 0.5 cm perforation on the anterior wall of the gastric corpus was repaired primarily in two layers. No additional intra-abdominal organ injuries were detected. Due to persistent oozing from the hepatic laceration, perihepatic packing and temporary abdominal closure were performed as part of a damage control strategy. A planned second-look operation 48 hours later demonstrated no active bleeding or bile leakage. Definitive repair was completed with topical hemostatic application, omentopexy, and suturing of the liver laceration. The patient was monitored in the intensive care unit postoperatively and was discharged uneventfully on postoperative day 19.

Conclusion: In shotgun-related penetrating abdominal trauma, rapid surgical intervention and appropriate patient selection are crucial. In patients at risk of ongoing hemorrhage and physiological deterioration, DCS represents a safe and effective treatment strategy. This case highlights the importance of a staged surgical approach in achieving favorable clinical outcomes in complex multi-organ injuries.

Keywords: Firearm injury, penetrating abdominal trauma, damage control surgery

Figure 1. Evisceration of the stomach and intestinal segments through a midline abdominal wall defect above the umbilicus.

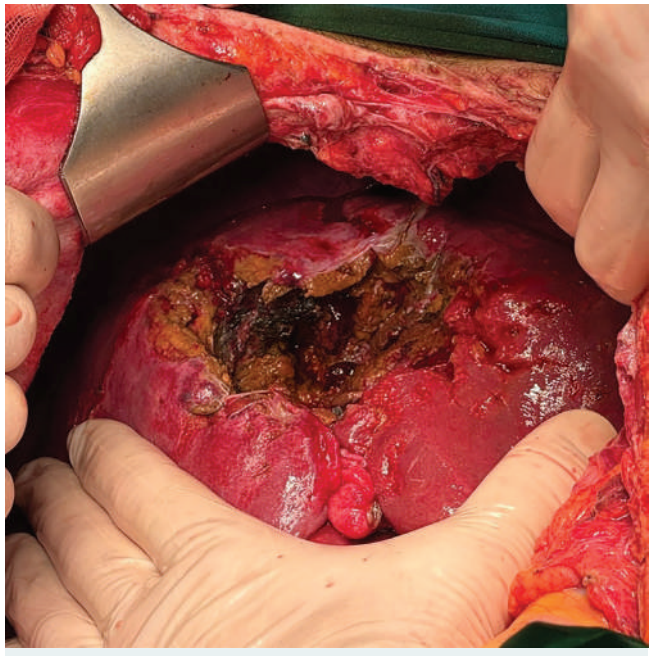

Figure 2. Approximately 10 cm actively bleeding laceration in segment IV of the liver.

[P-260]

Perforation secondary to incarceration of an umbilical Littre's hernia: A rare case

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Objective: Meckel diverticulum is a congenital anomaly resulting from the persistence of the vitelline duct and is usually asymptomatic. The most common complications include mechanical intestinal obstruction, bleeding, perforation, and diverticulitis. The presence of a Meckel diverticulum within any hernia sac is defined as a Littre's hernia. Littre's hernia is most frequently observed in the inguinal region, whereas umbilical localization with perforation secondary to incarceration is extremely rare. In this report, we present a case of perforation caused by incarceration of an umbilical Littre's hernia.

Material and Methods: An 18-year-old male patient was admitted to the emergency department with a one-day history of abdominal pain. Physical examination revealed tenderness in the umbilical region without guarding or rebound tenderness. Computed tomography demonstrated a 28×12 mm blind-ending tubular structure adjacent to the ileal loops at the level of the umbilicus. A 9 mm peripherally enhancing collection consistent with an abscess was observed in the surrounding area. Heterogeneity in the adjacent fatty tissue and millimetric air densities were also noted. These findings were suggestive of a perforated Meckel diverticulum. The patient was taken to emergency surgery.

Results: The procedure was initially started laparoscopically; however, conversion to laparotomy was required after identifying a Meckel diverticulum adherent to the umbilical hernia sac. A perforated Meckel diverticulum secondary to incarceration within the umbilical hernia sac was detected. A localized abscess formation was present around the perforation site. Diverticulectomy was performed using a surgical stapler, and simultaneous mesh-free umbilical hernia repair was carried out. Following appropriate medical management, the patient was discharged uneventfully on postoperative day six. Histopathological examination confirmed the diagnosis of Meckel diverticulum.

Conclusion: In patients presenting with acute abdominal pain accompanied by umbilical tenderness, an umbilical Littre's hernia, although rare, should be considered as a clinically significant differential diagnosis. In the present case, the perforation was noteworthy in that it resulted from incarceration within the umbilical hernia sac rather than from inflammation secondary to ectopic mucosa, which may be associated with Meckel diverticulum. It should be kept in mind that incarceration in umbilically located Littre's hernias may predispose to perforation.

Keywords: Incarceration, Littre's hernia, Meckel's diverticulum

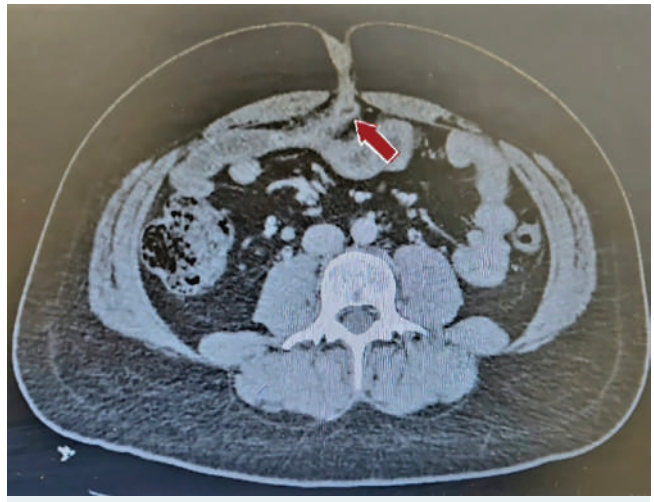

Figure 1. Preoperative abdominal CT. On abdominal CT, a blind-ending tubular structure at the level of the umbilicus with surrounding abscess is observed, consistent with a perforated Meckel's diverticulum.

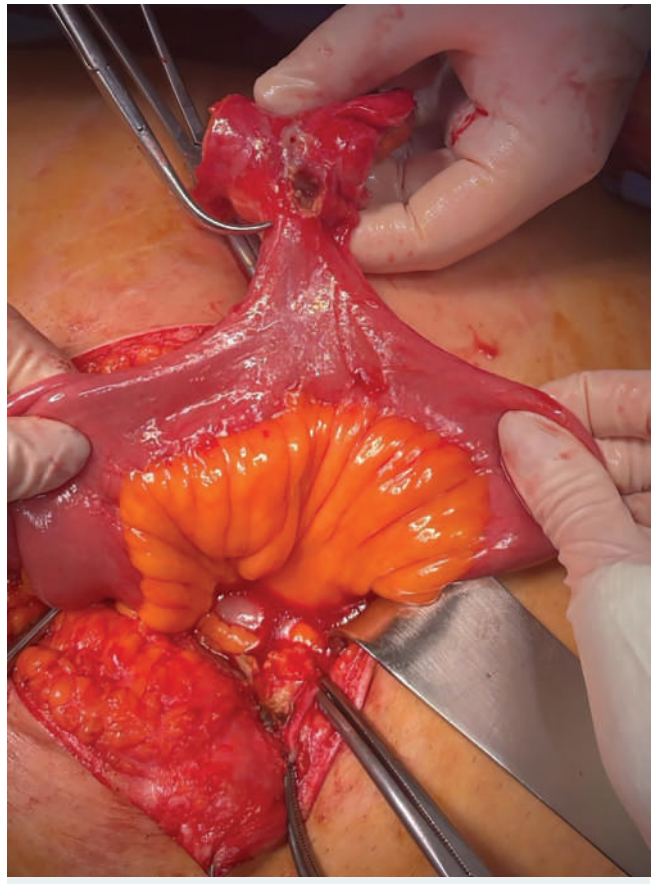

Figure 2. Perforated Meckel's diverticulum-intraoperative view. A perforated Meckel's diverticulum was identified within the umbilical hernia sac during intraoperative evaluation.

[P-261]

Recurrent inguinal hernia with bladder herniation: Laparoscopic TAPP experience

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Objective: Although inguinal hernias are a common pathology in general surgical practice, the presence of the urinary bladder within the hernia sac is a rare clinical condition. In the literature, bladder herniation has been associated with advanced age, male sex, obesity, and a history of recurrent inguinal hernia. A significant proportion of cases may be asymptomatic or may mimic lower urinary tract symptoms, leading to delays in diagnosis. Bladder herniations that are not recognized preoperatively may result in serious complications during surgery, such as bladder injury, urinary leakage, and infection. This risk is further increased in long-standing and recurrent hernias due to disruption of anatomical planes caused by previous surgeries. Although the widespread use of imaging modalities has increased preoperative diagnostic rates, clinical awareness remains crucial. In this case report, we present the diagnostic process and surgical management of bladder herniation in a patient with a long-standing recurrent direct inguinal hernia, treated with a laparoscopic TAPP approach, in light of the literature.

Material and Methods: A 77-year-old male presented with persistent left groin pain and swelling. He had a history of open, non-mesh, tension-free repair performed abroad 40 years ago, with recurrence about 10 years later. The patient reported manually reducing the hernia during urinary urgency. Physical examination revealed a reducible direct hernia and a previous incision scar. Abdominal CT showed herniation of the left anterior bladder into the left inguinal canal, with a stone-density image in the bladder lumen, likely due to residual urine. Laparoscopic TAPP herniorrhaphy was planned.

Results: Intraoperative evaluation confirmed the presence of the bladder within the hernia sac. Following careful dissection, the bladder was safely reduced, and an anatomical mesh was placed in the left inguinal region. Laparoscopic TAPP herniorrhaphy was successfully completed. No intraoperative or postoperative complications occurred. The patient was discharged uneventfully on the second postoperative day.

Conclusion: Bladder herniation should always be considered in the differential diagnosis of long-standing and recurrent inguinal hernias. Preoperative computed tomography is of critical importance for establishing the diagnosis and determining the surgical strategy. The laparoscopic TAPP approach is an effective and safe surgical option in recurrent inguinal hernias, as it provides a wide field of view, allows better evaluation of anatomical structures, and enables safe reduction of the bladder. This case demonstrates that recurrent inguinal hernias with bladder herniation can be successfully managed with appropriate preoperative assessment and meticulous laparoscopic dissection.

Keywords: Bladder herniation, hernia, recurrent inguinal hernia, TAPP

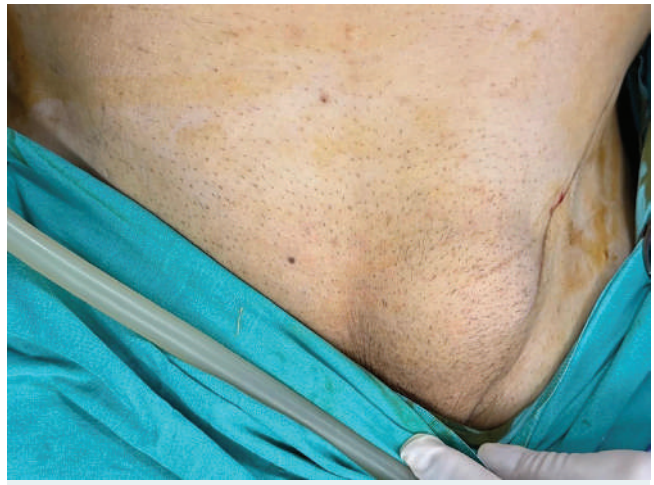

Figure 1. Preoperative physical examination. Physical examination image of a recurrent left inguinal hernia.

CT: Computed tomography.

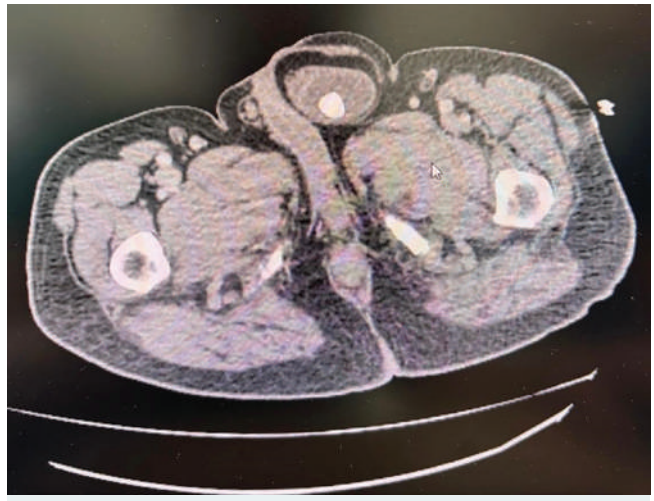

Figure 2. Preoperative abdominal CT. Herniation of the left anterior portion of the bladder into the left inguinal canal on abdominal CT, with a stone-density observed within the bladder lumen.

CT: Computed tomography.

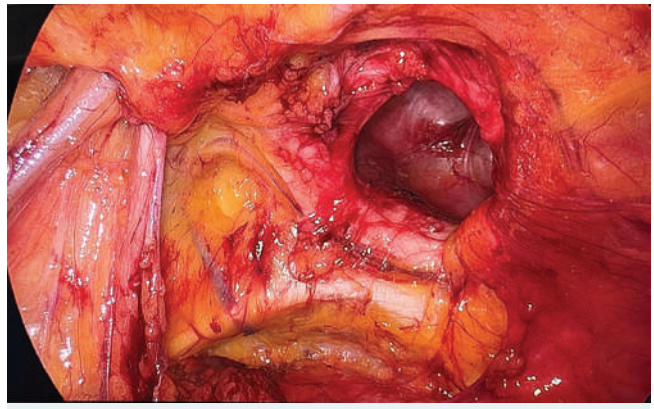

Figure 3. Intraoperative laparoscopic view. Intraoperative laparoscopic hernia defect.

[P-263]

Localized Boerhaave syndrome with spontaneous drainage via fistula to the gastric: A rare case

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Objective: Boerhaave syndrome is a rare clinical entity with high mortality, characterized by a full-thickness rupture of the esophagus, most commonly occurring after severe vomiting. In most cases, free perforation leads to mediastinitis and sepsis, whereas in some cases, a more subtle and atypical clinical course may occur due to localized perforation. The development of a mediastinal abscess following localized perforation and its spontaneous drainage into the stomach through fistulization is an extremely rare condition reported in the literature. In this study, we present a case that was initially evaluated with a preliminary diagnosis of subileus but was ultimately diagnosed as localized Boerhaave syndrome, demonstrating spontaneous drainage into the stomach via fistulization on endoscopic examination

Material and Methods: The clinical evaluation, laboratory findings, radiological imaging, and upper gastrointestinal endoscopy performed under emergency conditions of the patient who presented with epigastric pain, nausea, vomiting, and rapid weight loss were retrospectively reviewed. The clinical course, administered treatment, and referral process were analyzed in detail.

Results: A 33-year-old female patient with no known comorbidities presented with nausea, intermittent vomiting, epigastric pain, and approximately 10 kg of unintentional weight loss over the preceding week. Her medical history revealed a single episode of sudden-onset, painful vomiting 3-4 months earlier. Physical examination showed mild diffuse abdominal tenderness without guarding, rebound tenderness, or fever. Laboratory tests demonstrated a CRP level of 84 mg/L and a WBC count of 8.5×10^9/L, which decreased to 73 mg/L and 8×10^9/L, respectively, after seven hours. Contrast-enhanced abdominal CT revealed findings consistent with subileus. Due to significant weight loss and persistent symptoms, emergency upper gastrointestinal endoscopy was performed, demonstrating a pouch-like appearance in the distal esophagus, a fistulous opening into the stomach, and purulent material spontaneously draining through the fistula. These findings were consistent with localized distal esophageal perforation (contained Boerhaave syndrome) with fistulization into the stomach. Oral intake was discontinued, intravenous antibiotics and proton pump inhibitor therapy were initiated, and the patient was referred to a tertiary care center for further evaluation.

Conclusion: This case demonstrates that early gastroscopy can be diagnostic in patients initially evaluated with a preliminary diagnosis of subileus but presenting with significant weight loss and persistent vomiting. Since atypical and localized esophageal perforations may lead to serious morbidity and mortality when diagnosis is delayed, esophageal perforation should always be considered in the differential diagnosis, particularly in the presence of clinical-radiological discordance.

Keywords: Boerhaave syndrome, gastroesophageal fistula, spontaneous drainage

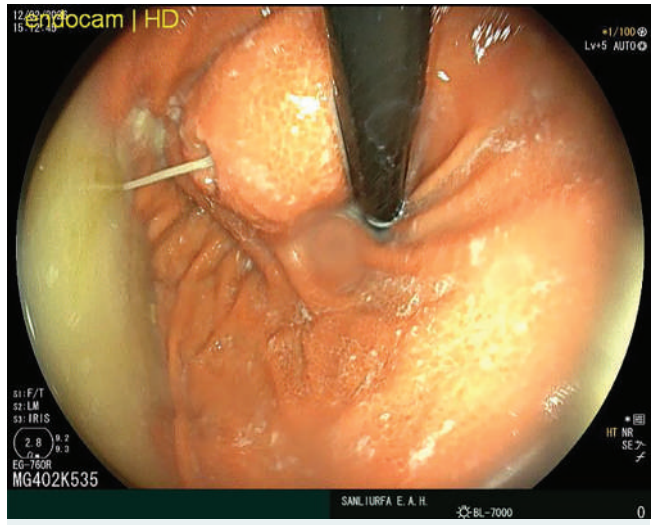

Figure 1. Gastric fistula.

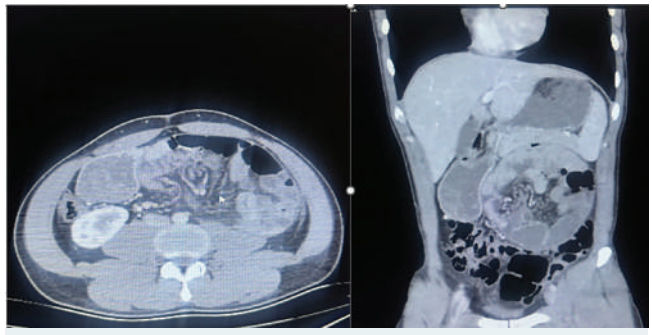

Figure 2. Hernia defect area. CT scan showing internal herniation.

CT: Computed tomography.

[P-265]

Acute small bowel obstruction caused by left paraduodenal hernia: A case report

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Objective: Paraduodenal hernias are the most common type of congenital internal hernias resulting from anomalies in midgut rotation and fixation. Left paraduodenal hernias account for approximately 70-75% of cases and often present with non-specific symptoms or remain asymptomatic for long periods. However, they may initially manifest with acute small bowel obstruction or other serious complications. In patients without prior abdominal surgery and unexplained small bowel obstruction, left paraduodenal hernia should be considered in the differential diagnosis. Contrast-enhanced computed tomography is the gold standard for diagnosis, and early surgical intervention is crucial to prevent complications. This report presents a rare case of left paraduodenal hernia presenting with acute small bowel obstruction.

Material and Methods: Case a 27-year-old male patient presented to the emergency department with intermittent abdominal pain lasting for two weeks. He had no significant past medical history and no previous history of abdominal surgery. Physical examination revealed diffuse abdominal tenderness without guarding or rebound tenderness. Digital rectal examination showed stool contamination and diarrheal discharge. Biochemical parameters were within normal limits, and complete blood count revealed leukocytosis with a white blood cell count of 11,000/mm³.

Results: A contrast-enhanced abdominal computed tomography scan performed in the emergency department demonstrated clustered small bowel loops with mesenteric edema in the left quadrant, suggestive of internal herniation, along with free pelvic fluid (Figure 1). Based on the clinical and laboratory findings, the patient underwent emergency surgery. Intraoperatively, the entire small bowel up to the terminal ileum was found herniated into a sac adjacent to the duodenum (Figure 2). The bowel loops were reduced, and the defect was closed without causing luminal narrowing (Figure 3). Oral intake was initiated on postoperative day 1 and advanced as tolerated. The patient was discharged in good condition on postoperative day 4 after the return of bowel function.

Conclusion: The literature indicates that left paraduodenal hernia is the most common form of internal hernia and that diagnosis is often delayed due to non-specific clinical findings. In young adults without a history of abdominal surgery presenting with unexplained abdominal pain or small bowel obstruction, left paraduodenal hernia should be considered in the differential diagnosis. Contrast-enhanced computed tomography is the gold standard for diagnosis, and early surgical intervention can prevent serious complications such as strangulation and bowel ischemia. In the present case, early surgical management resulted in a favorable outcome without postoperative complications.

Keywords: Small bowel, paraduodenal hernia, internal hernia

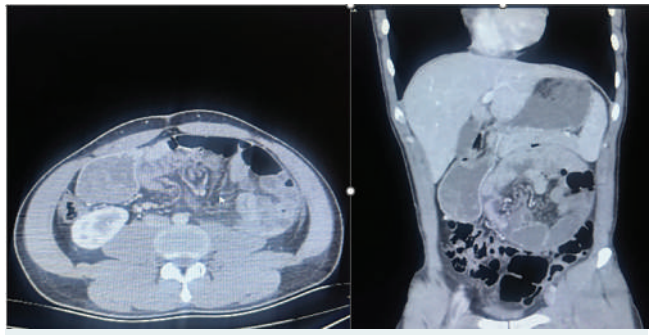

Figure 1. Abdominal CT scan. CT image of internal herniation.

CT: Computed tomography.

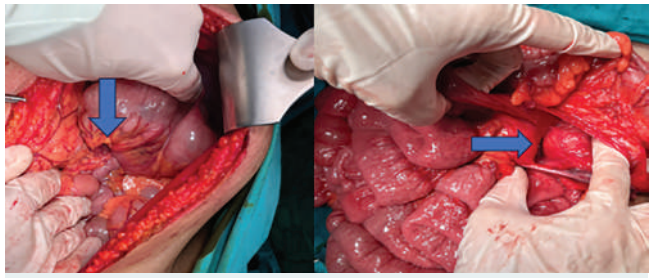

Figure 2. Hernia defect. Arrow in the first image: The sac from which the small bowel loops emerged Arrow in the second image: The wide defect observed after complete reduction of the small bowel loops from the sac.

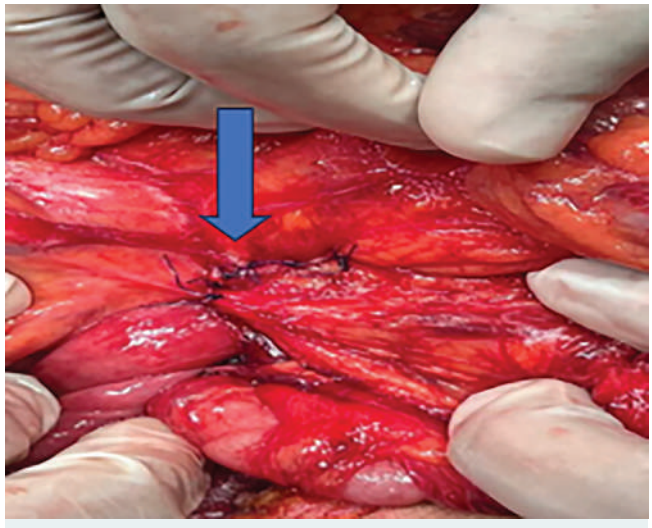

Figure 3. Repair of the defect. Closure of the large defect area.

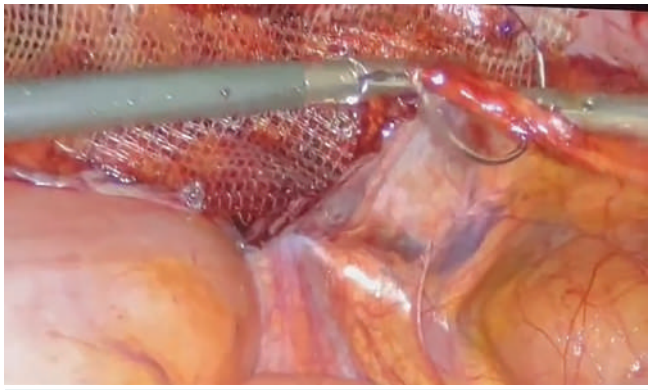

Figure 4. During peritoneal suturing.

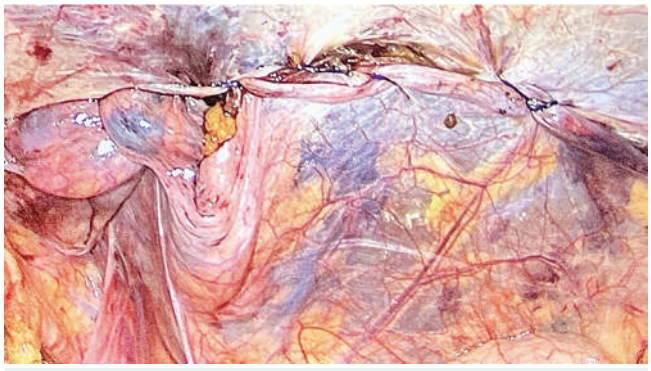

Figure 5. End of peritoneal closure.

[P-267]

Superficial abdominal vein thrombophlebitis – a rare clinical case

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Objective: Superficial thrombophlebitis most commonly affects the veins of the lower extremities, particularly the great saphenous vein. However, superficial abdominal veins—such as the thoracoepigastric and superior epigastric veins—are rarely involved. This condition is also described in the literature as abdominal Mondor disease. First reported by Mondor in 1939, it was most frequently described in the veins of the chest wall, whereas involvement of the abdominal wall is exceedingly rare. Risk factors include local trauma, surgical interventions, infection, malignancy, and hypercoagulable states. Clinically, it may present as a painful, cord-like lesion and can be misdiagnosed as an abdominal abscess, hernia, or intra-abdominal pathology. In this report, we present a case of superficial abdominal vein thrombophlebitis that developed following minor trauma.

Material and Methods: Case presentation.

Results: A 51-year-old female patient presented to our outpatient clinic with complaints of pain and swelling in the left upper quadrant that developed after minor trauma caused by a branch strike approximately one week earlier. Her medical history was significant for hypertension and chronic hepatitis B infection, and she was receiving antiviral therapy (Viratt®). Physical examination: A linear, cord-like subcutaneous lesion with tenderness on palpation was detected in the left upper quadrant. No erythema or fluctuation was observed. Laboratory findings: Hematological and biochemical parameters were within normal limits. Ultrasonography: Superficial soft tissue ultrasonography revealed a non-compressible millimetric superficial venous structure with increased surrounding echogenicity in the left upper quadrant, consistent with thrombophlebitis. No extension into the deep venous system was observed. Treatment and follow-up: Conservative treatment including nonsteroidal anti-inflammatory drugs, local warm application, and rest was initiated. Anticoagulation therapy was not considered necessary. At the one-week follow-up, clinical findings had markedly regressed.

Conclusion: Superficial abdominal vein thrombophlebitis is a rare condition that can easily be misdiagnosed. It should be considered in the differential diagnosis, particularly in patients presenting with a cord-like lesion and a history of trauma. Doppler ultrasonography is indispensable for diagnosis. Most cases resolve uneventfully with conservative treatment.

Keywords: Superficial thrombophlebitis, abdominal wall, Mondor disease, minor trauma, Doppler ultrasonography

[P-268]

Giant inguinal hernia containing stomach, small and large bowel: A rare case report

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Objective: Inguinal hernias are among the common causes of emergency department admissions. Today, many different surgical approaches have been defined for inguinal hernia repair. The most commonly herniated abdominal structures are the omentum and small intestine. In long-standing and large indirect hernias, herniation of organs such as the colon, bladder, ovary, spleen, and rarely the stomach has been reported.

Material and Methods: A 75-year-old male patient with a history of inguinal hernia for approximately 30 years presented to the emergency department with complaints of nausea and vomiting lasting for three days. Computed tomography (CT) performed in the emergency department revealed herniation of a portion of the stomach together with small and large bowel loops within the hernia sac. The patient was taken to emergency surgery with a diagnosis of incarcerated hernia.

Results: Exploration revealed that the gastric antrum, all small bowel loops starting from the mid-jejunum, the cecum, and the sigmoid colon had herniated through an approximately 6 cm defect in the inguinal region. After adhesions within the hernia sac were dissected, the contents were reduced into the abdominal cavity. A serosal injury of the stomach secondary to herniation was detected and repaired primarily. The hernia defect was repaired using mesh with a preperitoneal approach.

Conclusion: The number of reported cases in the literature describing the presence of the stomach within the inguinal hernia sac is quite limited, and gastric injury related to herniation has been reported in only 10 of these cases. To date, only one case has been reported from Türkiye. In long-standing and incarcerated inguinal hernias, CT imaging is an important diagnostic tool for evaluating herniated organs and possible complications. Although conservative management may be possible in selected cases, surgical treatment is required in most patients.

Keywords: Inguinal hernia, gastric herniation, incarcerated hernia, computed tomography

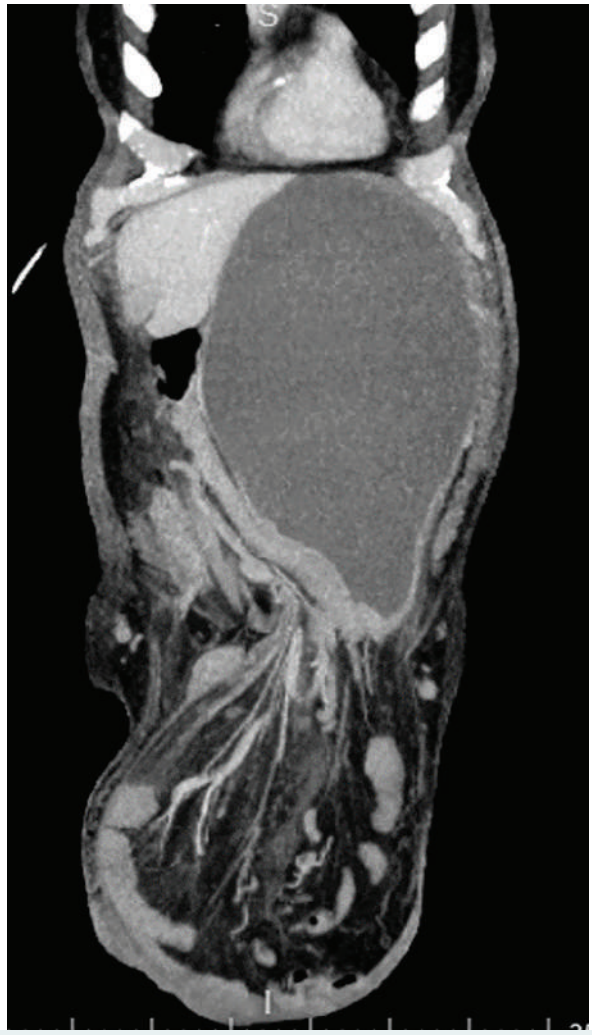

Figure 1. CT image.

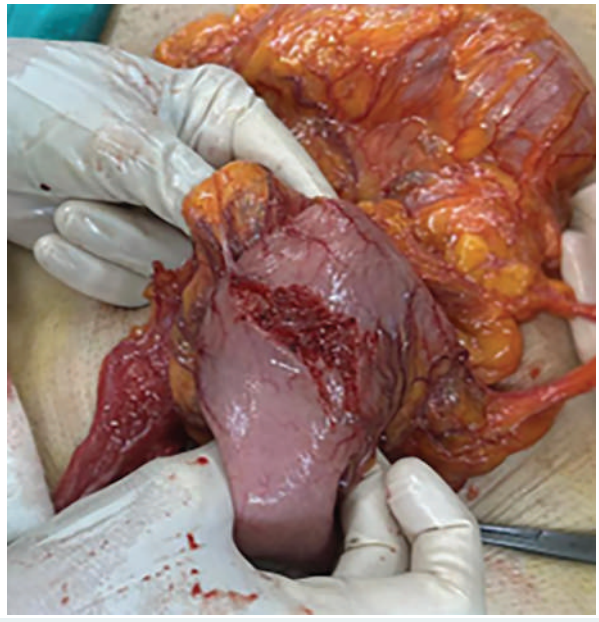

Figure 2. Stomach injury.

[P-269]

Recurrent severe foul-smelling diarrhea after Roux-en-Y gastric bypass with reproducible response to an antiparasitic herbal combination a case report

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[2]*Medicana Hospital, Bursa*

Objective: Foul-smelling diarrhea after Roux-en-Y gastric bypass (RYGB) is frequently attributed to fat malabsorption, bile acid–related diarrhea, or postoperative microbiota changes. However, early-onset, socially disabling malodor with nocturnal symptoms may suggest additional etiologies. This case highlights a reproducible dechallenge–rechallenge response to an over-the-counter herbal combination with traditionally antiparasitic components, raising the possibility of an infectious or parasitic contribution in selected post-RYGB patients.

Material and Methods: Clinical data were obtained from structured patient interview focused on bariatric timeline, stool characteristics, associated gastrointestinal symptoms, exposure risks, and patient-reported outcomes. The temporal relationship between symptom onset and interventions was documented. The patient had undergone sleeve gastrectomy in February 2010, followed by weight regain after four years. RYGB was performed in September 2025. No stool microscopy, antigen testing, or polymerase chain reaction panel had been performed at the time of symptom onset. The patient self-initiated a short course of three products used concurrently. Clove capsules (*Eugenia caryophyllata*). Green black walnut hull tincture (*Juglans nigra*). A wormwood-containing blend (*Artemisia absinthium*).

Results: Two weeks after RYGB, the 56 years old patient developed constant, highly distressing stool malodor described as a mixture of rotten and sulfuric smell, particularly worse after meals. She reported watery, pale stools with marked oiliness, 7 to 9 bowel movements daily, relief after defecation, abdominal bloating, and nocturnal diarrhea. Dysphagia was also reported. The symptom had never occurred after sleeve gastrectomy despite prior weight loss and subsequent weight regain. Dietary measures provided minimal benefit. The patient had household exposure to three cats for five years and traveled to Saudi Arabia for Umrah one week after the bypass operation. After starting the herbal combination, she reported complete resolution of malodor and diarrhea within days. Symptoms recurred after discontinuation with lower intensity and resolved again promptly after re-challenge, reproducing the initial effect. The condition had caused severe stress, avoidance behavior, and significant impairment of social and working life, all of which improved after symptom resolution.

Conclusion: This case suggests that, beyond malabsorption, infectious or parasitic contributors should be considered in severe, early-onset, persistent malodorous diarrhea after RYGB, especially when a reproducible response to antiparasitic exposure is observed. Systematic stool testing and targeted evaluation may prevent prolonged morbidity and guide appropriate therapy.

Keywords: Bariatric surgery complications, foul-smelling diarrhea, Roux-en-Y gastric bypass

[P-270]

Brachial artery aneurysm secondary to a hemodialysis arteriovenous fistula: A case report

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Objective: Arteriovenous fistulas (AVFs) created for hemodialysis (HD) may cause rare but clinically significant complications due to long-term high-flow-related hemodynamic stress on the arterial system. In this report, we present the surgical management of a brachial artery aneurysm secondary to a previously created and subsequently closed left brachiocephalic AVF following renal transplantation.

Material and Methods: The patient's medical records, clinical data, and imaging findings were retrospectively reviewed. Demographic characteristics, medical history, previous hemodialysis AVF, renal transplantation details, clinical presentation, and surgical course were evaluated. Preoperative physical examination and imaging studies were used to determine the location and size of the brachial artery aneurysm. The surgical procedure was performed under elective conditions. Surgical technique, intraoperative findings, vascular reconstruction method, and early postoperative outcomes were analyzed. Postoperative anastomotic patency and distal limb perfusion were assessed by clinical examination and duplex ultrasound.

Results: A 65-year-old male patient presented with pain and a palpable pulsatile mass in the left upper extremity. His medical history included a left brachiocephalic arteriovenous fistula created for HD and a cadaveric renal transplantation performed in 2015. The AVF had been closed after successful renal transplantation. Physical examination and imaging studies revealed an aneurysmal dilation measuring approximately 2×2 cm at the level of the left brachial artery. The patient underwent elective surgery. Intraoperatively, a brachial artery aneurysm was confirmed, and aneurysm resection was performed. Arterial continuity was restored with an end-to-end brachial artery anastomosis. In the postoperative period, the anastomosis was patent. Due to the development of a surgical site hematoma, hematoma drainage and surgical hemostasis were performed. Distal pulses remained palpable during follow-up, and no additional vascular complications were observed. The patient was discharged in stable condition on postoperative day three.

Conclusion: Although rare, upper extremity arterial aneurysms should be considered in patients with a history of HD arteriovenous fistula creation and closure after renal transplantation. In suitable cases, aneurysm resection with primary end-to-end anastomosis represents a safe and effective surgical treatment option. Early diagnosis and timely surgical intervention are crucial to prevent potential rupture and thromboembolic complications.

Keywords: Arteriovenous fistula, brachial artery aneurysm, renal transplantation, end-to-end anastomosis

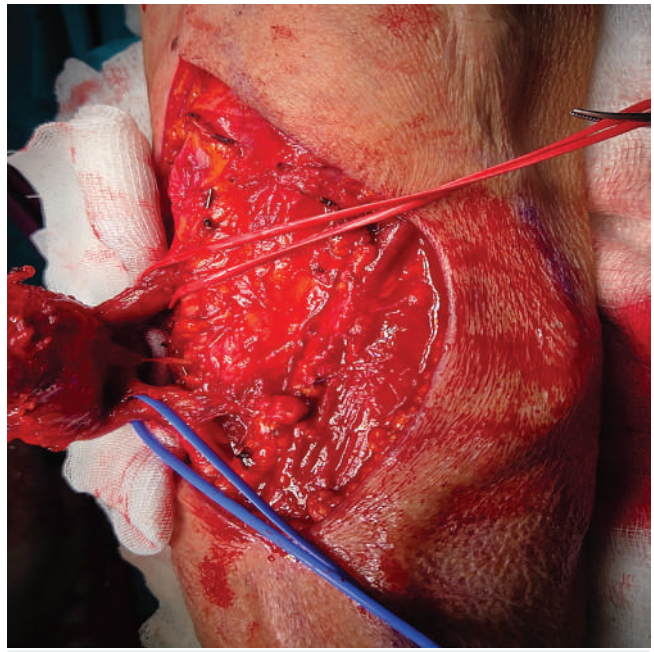

Figure 1. Isolated brachial artery and arterial aneurysm.

[P-271]

Large and vascular mass in the rectus abdominis muscle of a young male patient: A case of intramuscular angioma

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Objective: Abdominal wall tumors constitute a rare subgroup of soft tissue tumors. Lesions originating from the rectus abdominis muscle are particularly infrequent. Masses seen in this region include desmoid tumors, soft tissue sarcomas, and vascular lesions. Intramuscular angiomas belong to the group of benign vascular tumors and constitute less than 1% of all hemangiomas. They are usually seen in young adults and most often occur in the extremities; abdominal wall localization is quite rare. When they are large and have a dense vascular structure, they can mimic malignancy. Their etiology is still unknown 1. Pathogenic somatic mutations in the *MAP2K1* and *KRAS* genes have been identified in a subset of cases that overlap with mutations found in arteriovenous malformations.

Material and Methods: A 35-year-old male patient presented with a palpable mass in the right lower-middle quadrant. He had no history of trauma, anticoagulant use, or systemic disease. Physical examination revealed a deep-seated mass, approximately 8-10 cm in diameter, with restricted mobility, located at the level of the right rectus abdominis muscle. Laboratory findings were within normal limits.

Results: CT scan revealed: • Within the right rectus abdominis muscle • Approximately 73×78 mm in size • Showing heterogeneous signal characteristics • A solid mass expanding along the muscle • Significant contrast enhancement • Dilated tubular venous structures in the inferior section. Radiologically, a distinction could not be made between low-grade sarcoma and vascular malformation. Further evaluation was recommended due to the vascular character. No malignancy was detected in the initial core biopsy samples. Histopathological examination after surgical excision revealed: • Proliferation between striated muscle fibers • Dilated vascular channels the lesion was reported as an intramuscular angioma. No evidence of malignancy was found.

Conclusion: Intramuscular angiomas are rare and often misdiagnosed. Their large size, rapid growth, and dense vascularity may raise suspicion of malignancy. Abdominal wall localization is quite rare, and there are a limited number of cases in the literature. Especially in lesions ≥5 cm and with significant vascularity: Tru-cut biopsy is prone to sampling error. They may be radiologically confused with sarcoma.The vascular structure should be carefully evaluated before surgical planning. Complete surgical excision is curative, but incomplete excision may lead to local recurrence. While malignancy is primarily considered in the presence of a large, vascular mass in the rectus abdominis muscle, intramuscular angioma must be included in the differential diagnosis. In cases with imaging-pathology discrepancies, a multidisciplinary approach and careful surgical planning are critically important.

Keywords: Rectus abdominis, abdominal wall tumor, intramuscular angioma

Figure 1. Reoparative CT scan.

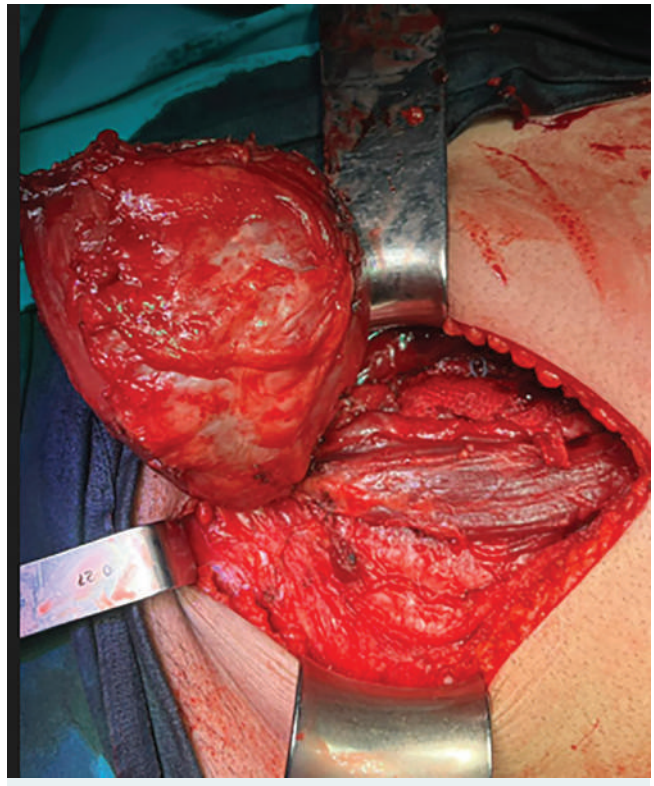

Figure 2. Intraoperative rectus mass.

[P-274]

Small cell neuroendocrine carcinoma of the breast: Experience of two cases following neoadjuvant therapy

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Objective: Primary neuroendocrine carcinomas (NEC) of the breast are exceptionally rare, accounting for less than 0.1% of all mammary malignancies. According to the 2019 WHO classification, the small cell subtype is characterized by high proliferative activity and an aggressive clinical course. To diagnose primary breast NEC, other organ metastases must be ruled out. Due to the paucity of reported cases in the literature, data regarding definitive therapeutic strategies remain limited. This study presents the clinical and histopathological characteristics of two rare cases referred for surgery following neoadjuvant chemotherapy (NAC).

Material and Methods: A retrospective analysis was conducted on two female patients diagnosed with small cell NEC via biopsy between 2023 and 2024. Systemic staging was performed in both patients using positron emission tomography-computed tomography. The pathological responses of patients who underwent curative surgery after NAC, as decided by a multidisciplinary council, were evaluated using the Residual Cancer Burden (RCB) score.

Results: Case 1: A 45-year-old female patient presented with a 10.5 cm mass in the right breast and metastatic axillary lymph nodes. Tru-cut biopsy was reported as Grade 3 small cell NEC (ER-/PR-/HER2- (triple negative), Ki-67 100%). Clinical and radiological regression was observed after NAC. Right subcutaneous mastectomy, sentinel lymph node biopsy (SLNB), and axillary dissection were performed. Pathology revealed a 1.1 cm residual tumour focus (triple negative, Ki-67 4%), metastasis in 2/12 lymph nodes, and extranodal spread (ypT1cN1a, RCB-III). Case 2: A 50-year-old female patient presented with a 2.7 cm mass in the left breast. Tru-cut biopsy was reported as Grade 3 small cell NEC (ER-/PR 50% positive/HER2-, Ki-67 90%). Clinical and radiological regression was observed after NAC. Left simple mastectomy and SLNB were performed. Pathology revealed a 0.5 cm residual tumour focus (triple negative, Ki-67 40%). No lymph node metastasis was detected (ypT1aN0, RCB-I). Patients are being followed up with disease-free survival for an average of 18 months.

Conclusion: Breast NECs may exhibit different clinical behaviour and treatment responses depending on their histological subtypes and immunophenotypes. While most primary breast NECs in the literature exhibit high ER and PR expression, the small cell subtype is generally triple negative. The dramatic decrease in the Ki-67 index after NAC is considered a strong predictor of chemosensitivity and survival prognosis. In these rare and aggressive cases, despite the heterogeneous pathological response, the combination of neoadjuvant therapies planned with a multidisciplinary approach and surgery is critical for local control and survival.

Keywords: Breast cancer, small cell neuroendocrine tumor, triple negative

Figure 1. A Meckel's diverticulum that cannot be reduced laparoscopically, with a lipomatous lesion at its tip.

[P-277]

A rare cause of adult intestinal intussusception: Meckel's diverticulum

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Objective: Meckel's diverticulum is one of the most common gastrointestinal tract anomalies, with an estimated prevalence of approximately 2% in the general population. In adults with symptomatic Meckel's diverticulum, obstruction occurs in 35.6% of cases, gastrointestinal bleeding in 27.3%, and inflammation in 29.4%. Imaging studies commonly reveal intestinal loop distension and intussusception, followed by free fluid, edematous thickening, and cystic lesions. Symptoms and imaging findings are not specific to Meckel's diverticulum, which poses a diagnostic challenge as other etiologies of acute abdomen must be considered. Therefore, diagnostic laparoscopy and intraoperative findings often lead to resection and primary anastomosis.

Material and Methods: A 30-year-old male patient presented to the emergency department with diffuse abdominal pain, mild nausea, and intermittent hematochezia. The patient had a history of intermittent chronic pain for six months. Abdominal ultrasound and laboratory tests performed in the emergency department were within normal limits. Abdominal computed tomography revealed an approximately 6 cm segment in the right lower quadrant with telescoping of intestinal loops consistent with intussusception. The patient showed no clinical signs of acute intestinal complications, and elective surgery was planned.

Results: The surgical procedure was performed under general anesthesia via videolaparoscopy. The intussuscepted small bowel loops were laparoscopically reduced. The segment containing the diverticulum could not be separated laparoscopically and was exteriorized through the trocar site. Meckel's diverticulum with a lipomatous lesion at its tip was identified. Resection and end-to-end anastomosis were performed. The postoperative period was uneventful, and pathology confirmed Meckel's diverticulum with a benign lipomatous lesion at the tip.

Conclusion: This report presents a case of intestinal intussusception secondary to invagination of Meckel's diverticulum. Considering that Meckel's diverticulum is a common intestinal malformation, this etiology should be considered an important differential diagnosis in patients presenting with abdominal complaints. Diagnostic laparoscopy and laparoscopic reduction of the intussuscepted bowel segment facilitate surgical management without the need for laparotomy.

Keywords: Meckel's diverticulum, small intestine, intussusception, laparoscopy

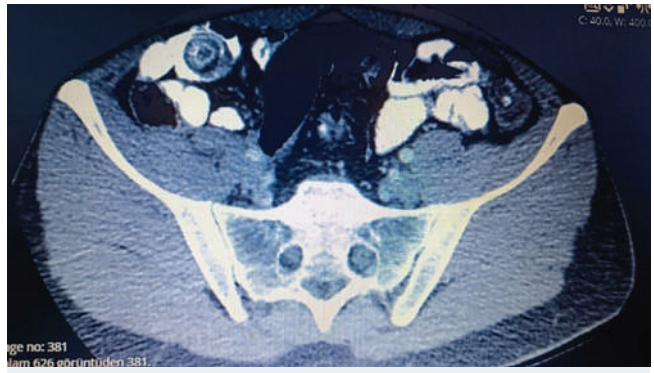

Figure 1. An approximately 6 cm segment of telescoping intestinal loops is observed in the right lower quadrant of the abdomen.

Figure 2. Meckel's diverticulum that could not be reduced laparoscopically, with a lipomatous lesion at its tip.

[P-278]

Acute appendicitis in trocar site herniation

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Objective: Trocar site hernias are rare but clinically significant complications following laparoscopic surgery. The hernia sac most commonly contains the small intestine and omentum, while the appendix is rarely found within the hernia sac. Acute appendicitis developing within the hernia sac has been reported in very limited numbers in the literature. This study presents an elderly female patient with a history of laparoscopic cholecystectomy who was found to have an incarcerated appendix and acute appendicitis within a trocar site hernia.

Material and Methods: 74-year-old female patient with a history of laparoscopic cholecystectomy presented with pain and swelling in the area of an old trocar scar in the inferior umbilicus. Physical examination revealed a lesion approximately 3×3 cm in size in the inferior umbilicus, accompanied by skin hyperemia, consistent with an incarcerated hernia. Laboratory investigations showed elevated acute phase reactants. Ultrasonography was reported as bowel loops and omental fat tissue visible within an approximately 3.5 cm defect consistent with an incarcerated herniation. Urgent surgery was performed. Exploration via a infraumblical incision revealed an incarcerated, edematous, hyperemic appendix within the hernia sac. It was diagnosed as acute appendicitis, and appendectomy was performed. Following excision of the hernia sac, the defect was repaired with prosthetic mesh due to the absence of perforation/contamination. Histopathological examination revealed findings consistent with acute appendicitis. The patient had an uneventful postoperative course and was discharged on the second day.

Results: Trocar site hernias are rare but potentially serious complications after laparoscopic surgery. Most cases develop at trocar insertions ≥10 mm, and failure to close the fascia is a significant risk factor. The presence of the appendix within a port-site hernia is extremely rare in the literature. Trocar site hernia should be considered in the differential diagnosis, especially in elderly patients and those with a history of abdominal surgery, in the presence of a painful, non-reducible mass at the incision site. The appendix's location within the hernia sac and the development of inflammation can be explained by extraluminal compression and impaired vascular circulation. Surgical treatment involves appendectomy along with hernia repair, and in appropriate cases, mesh use can reduce recurrence.

Conclusion: The presence of the appendix within a trocar site hernia and the resulting development of acute appendicitis is extremely rare. In patients presenting with pain at the incision site and a suspected incarceration mass, early imaging and surgical intervention are crucial for preventing complications.

Keywords: Acute appendicitis, hernia, trocar

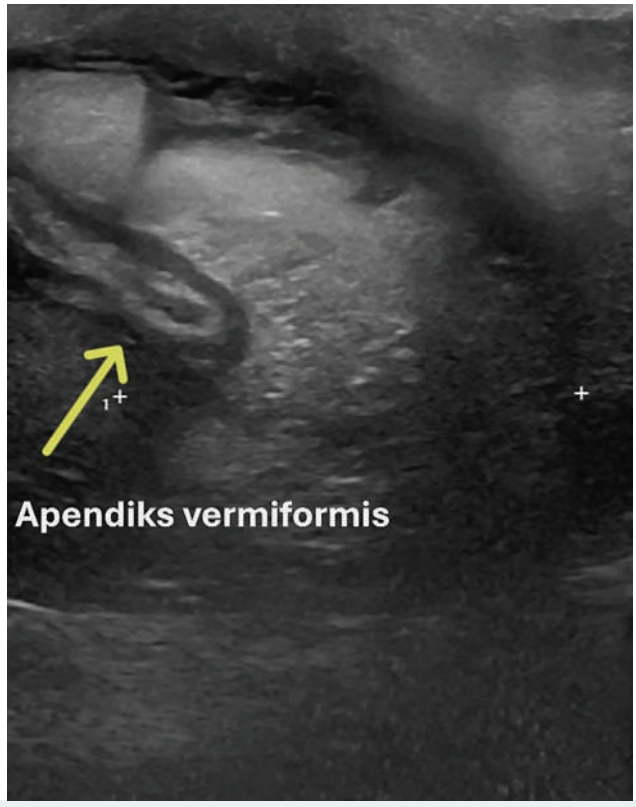

Figure 1. Appendix and bowel loop inside the hernia sac-ultrasonography. The image shows the intestinal loop and appendix within the hernia sac as viewed via ultrasound.

Figure 2. Acute appendicitis in a hernia-peroperative image. The photograph shows tissue consistent with acute appendicitis, which was exposed after the hernia sac was ruptured during surgery.

[P-279]

Chylous ascites following laparoscopic cholecystectomy: Successful management with conservative treatment- a case report

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Objective: Laparoscopic-cholecystectomy is considered the gold-standard-surgical-method in the treatment of symptomatic gallstone-disease. Chylo-ascites is a clinical condition characterized by the accumulation of triglyceride-rich-chylous-fluid originating from the intestinal-lymphatic-system in the peritoneal cavity. The development of chylous-ascites after laparoscopic-cholecystectomy is extremely rare,and only a limited number of case reports exist in the literature. This condition is due to damage to the lymphatic-structures around the hepatoduodenal ligament, portahepatis, and Calot's triangle during surgical dissection. This case report presents a patient who developed chylous-ascites after laparoscopic-cholecystectomy and was successfully treated with short-term total parenteral nutrition (TPN) initiated early, without the need for pharmacological or surgical intervention.

Material and Methods: A 74-year-oldfemale patient was admitted for elective-laparoscopic-cholecystectomy. Her medical history included diabetes mellitus, hypertension, and coronary artery disease. She had undergone endoscopic retrograde cholangiopancreatography (ERCP) one month prior. Laparoscopic-cholecystectomy was performed using the standard-four-trocartechnique, and the surgical procedure was completed without complications. The patient was transferred to the ward with a intra-abdominal drain. Postoperatively, approximately 500 mL of milky-white-fluid was observed draining from the drain. With a preliminary diagnosis of chylous-ascites, triglyceride levels in the drain fluid were measured at 466 mg/dL. Postop 2, the patient's oral intake was stopped, and TPN was initiated. Postop 3 the drain became serous in character. On postoperative days 4, 5 and 6, the drainage volume was observed as 300 mL of serous fluid,while TPN was continued. On postop 7, the drainage volume decreased to 200 mL. Controlled oral intake was initiated on the 8th postoperative day. Drainage continued at approximately 200 mL of serous character until the 11th postoperative day. One week later, minimal drainage was observed, and the drain was removed. No recurrence was detected during the follow-up period.

Results: Chylo-ascites is a complication-resulting from damage to the abdominal-lymphatic-system and is most frequently reported in the postoperative period after retroperitoneal and oncological-surgeries. The diagnosis is confirmed by detecting a triglyceride level above 110 mg/dL in the drainage-fluid. In our case, triglyceride level of 466 mg/dL. Conservative treatment is usually the first step; discontinuation of oral intake, TPN, medium-chain-triglyceride-diet, and somatostatin-analogs are recommended. In some cases, long-term TPN treatment, octreotide-use,or surgical-exploration has been required. In the case reported by Al Ghamdi et al., longer-term conservative treatment and different treatment strategies are included in the literature review for the management of chylousascites. In contrast, in our case,with the early initiation of TPN, the chylous character of the drainage disappeared within five days and progressively decreased. This suggests that early diagnosis and rapid intervention can shorten the treatment process. It is noteworthy that our patient had a recent history of acute pancreatitis and ERCP. It can be considered that peripancreatic inflammation and previous interventions may have affected lymphatic flow in the hepatoduodenal region and increased susceptibility to lymphatic damage during surgery.

Conclusion: Conclusion, although chylosacitis developing after laparoscopic-cholecystectomy is rare,it can be successfully managed with short-term conservative-treatment when diagnosed early. Early-initiation of TPN, in-particular, can reduce need for pharmacological/surgical intervention.

Keywords: Laparoscopy, cholecystectomy, chylous ascites

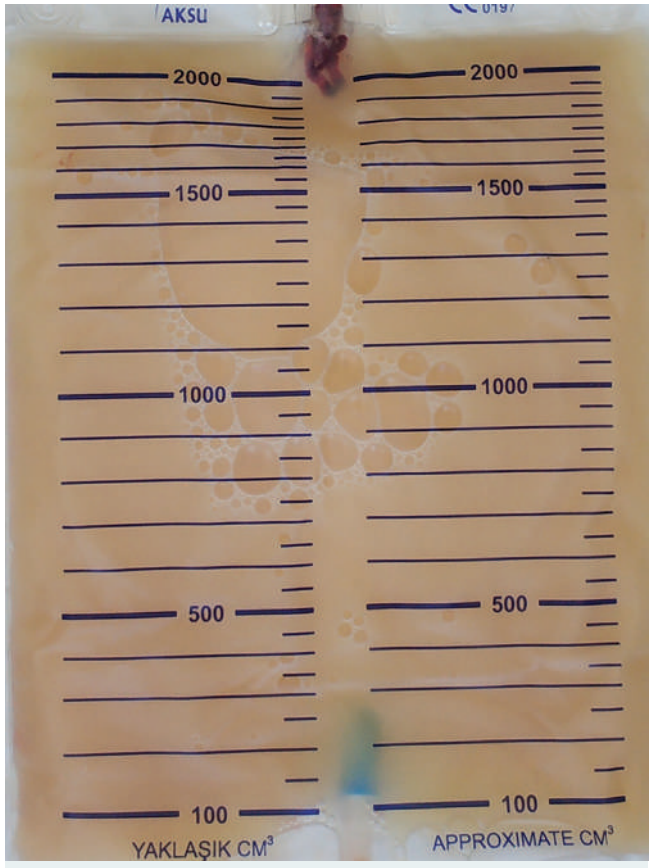

Figure 1. Postoperative 1.

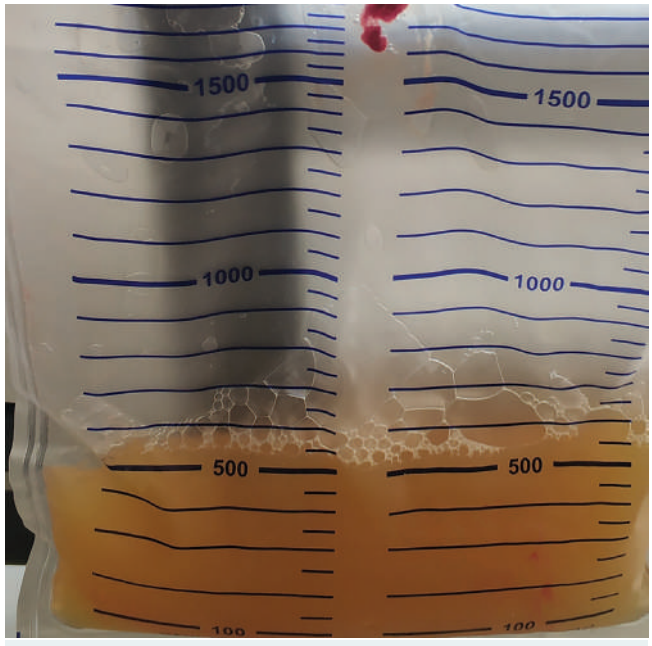

Figure 2. Postoperative 3.

[P-308]

Malignant gastrocolic fistula: Clinical course, surgical intervention, and pathological findings in two acute cases

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Objective: Gastrocolic fistulas represent a rare pathological occurrence, manifesting as fistulous connections between the stomach and the transverse colon. In Western societies, colorectal cancers are most commonly implicated in the etiology of cancer, while in Eastern societies, stomach cancers are typically held responsible. In the contemporary medical context, the implementation of screening programs has led to the ability to detect cases of colon cancer at an early stage, thereby reducing the prevalence of malignant gastrocolic fistulas. This study presents the surgical management of two cases presenting to the emergency department with acute fecal vomiting and abdominal pain, in whom malignant gastrocolic fistulas were identified.

Material and Methods: A retrospective review was conducted of two cases that presented to our clinic's emergency department with complaints of acute abdominal pain and fecal vomiting. The patients were subsequently diagnosed with malignant gastrocolic fistula based on the results of investigations. The patients' demographic data, diagnostic imaging findings (video/photographic documentation), surgical procedures performed, and histopathological results were compiled from hospital records.

Results: Case 1: A 56-year-old male with known synchronous adenocarcinoma of the colon and stomach presented with acute symptoms while awaiting neoadjuvant chemotherapy. Imaging confirmed a gastrocolic fistula. Following stabilization, the patient underwent en bloc resection comprising extended right hemicolectomy, distal gastrectomy, and D2 lymph node dissection. The hepatic flexure tumor had infiltrated the greater curvature of the stomach. Histopathology revealed pT4b colon adenocarcinoma invading the gastric wall, with one metastatic lymph node (pN1a/83) and clear surgical margins. Case 2: A 60-year-old female, treated conservatively for perforated diverticulitis six months prior, presented with abdominal pain and fecaloid vomiting. Imaging revealed a mass at the splenic flexure with a fistula tract. She underwent en bloc resection involving segmental colon resection, gastric wedge resection, and anterior abdominal wall resection. Intraoperatively, the mass invaded the stomach and abdominal wall. Histopathology confirmed pT4b adenocarcinoma, one metastatic lymph node (pN1a/14), and clear surgical margins.

Conclusion: Typically manifesting with chronic diarrhea and weight loss, malignant gastrocolic fistulas can rarely present as acute surgical emergencies. In locally advanced and fistulized tumors, aggressive en bloc surgical approach aiming for R0 resection remains the most effective modality for both cure and palliation.

Keywords: En bloc resection, gastrocolic fistula, colon cancer, multivisceral resection, pT4b

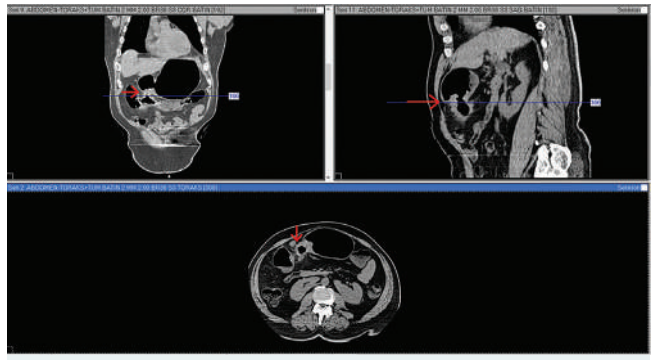

Figure 1. Emergency CT scan for case-1.

CT: Computed tomography.

Figure 2. Endoscopic image for case-1.

Figure 3. Case 1: Tumor image.

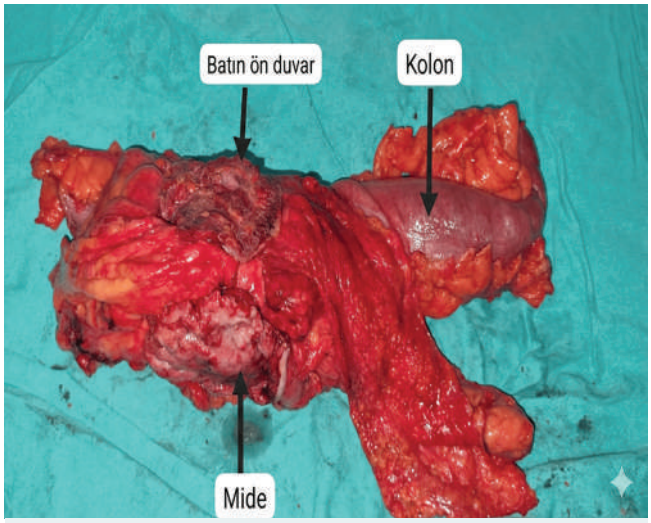

Figure 4. Case 2: Tumor image.

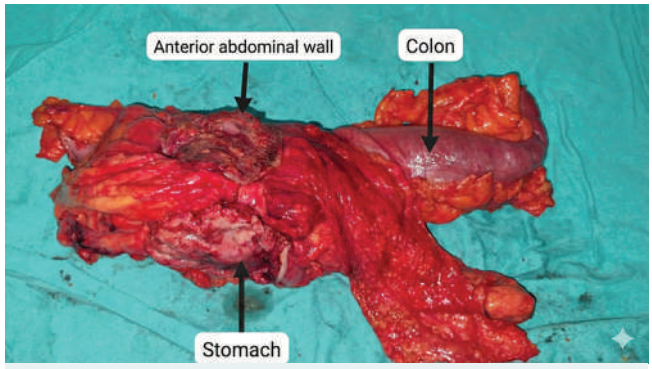

Figure 5. Case 2: Tumor image.

[P-309]

Isolated splenic sarcoidosis mimicking primary splenic angiosarcoma: Radiological misdiagnosis and surgical management

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[2]*İzmir Urla State Hospital, İzmir*

Objective: Sarcoidosis is a multisystemic non-caseating granulomatous disease of unknown etiology. The disease primarily affects the lungs and mediastinal lymph nodes,while isolated spleen involvement is a relatively uncommon complication (1-5%). Splenic sarcoidosis,when observed radiologically as multiple hypodense nodules in the spleen, can be misinterpreted as malignancies such as lymphoma, metastasis, or primary splenic angiosarcoma. The objective of this study is to present a case that initially raised suspicion of angiosarcoma radiologically, but was subsequently diagnosed with isolated splenic sarcoidosis following splenectomy.

Material and Methods: A 25-year-old male patient presented to our outpatient clinic, reporting a complaint of pain in the left upper quadrant. A thorough review of the patient's medical history did not reveal any additional complaints, such as weight loss, fever, or night sweats, other than the pain being experienced. A physical examination was conducted, yielding no pathological findings. Laboratory tests revealed normal hemogram and biochemistry parameters. A subsequent abdominal computed tomography (CT) scan revealed a hypodense lesion measuring approximately 3.5x4 cm in the spleen, containing calcifications in its periphery and interior. Thoracic CT, performed for systemic screening, revealed a normal appearance of the lung parenchyma and mediastinal lymph nodes. Abdominal magnetic resonance imaging performed for lesion characterization revealed a mass lesion with central cystic areas, appearing hypointense on T2-weighted sequences relative to the spleen parenchyma, and showing peripheral contrast enhancement after intravenous contrast material. Given the inability to exclude lymphoma or vascular malignancy (angiosarcoma) based on the available radiological findings, a decision was made to proceed with surgical intervention. The patient, who was scheduled for elective surgery, received the necessary vaccinations (Pneumococcal, Meningococcal, Hib) two weeks prior to the operation. The patient underwent an open splenectomy for diagnostic and therapeutic purposes and was discharged after a smooth postoperative follow-up.

Results: A macroscopic examination of the excised spleen material revealed numerous white-yellow nodules on the cut surface. The histopathological evaluation revealed no malignancy; however, non-caseating granulomas with epithelioid cells showing a tendency to coalesce were detected in the tissue. No bacilli were observed in the histochemical acid-resistant bacilli staining performed for the differential diagnosis of tuberculosis. The diagnosis of the case was determined to be "isolated splenic sarcoidosis," a determination that was made based on the findings that were available at the time of the diagnosis.

Conclusion: Isolated splenic sarcoidosis is a rare clinical condition that can be misdiagnosed as aggressive malignancies, such as angiosarcoma, due to the absence of specific radiological findings. In instances where imaging methods are inadequate for differential diagnosis and suspicion of malignancy persists, splenectomy is regarded as the gold standard approach for establishing a definitive histopathological diagnosis and providing curative treatment.

Keywords: Angiosarcoma, splenic mass, sarcoidosis, splenectomy

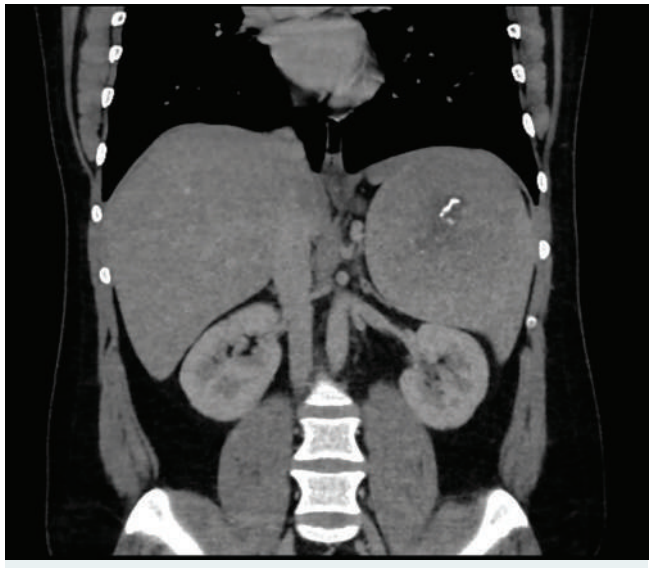

Figure 1. CT scan.

CT: Computed tomography.

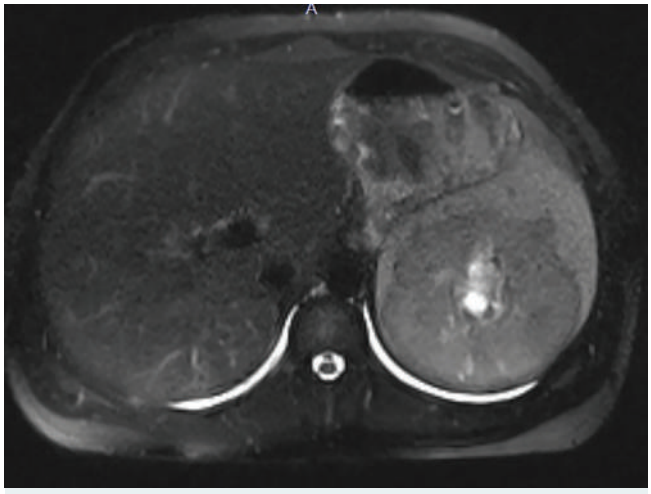

Figure 2. MR scan.

MR: Magnetic resonance.

Figure 4. Patology-X4 HE.

HE: Hematoxylin and eosin.

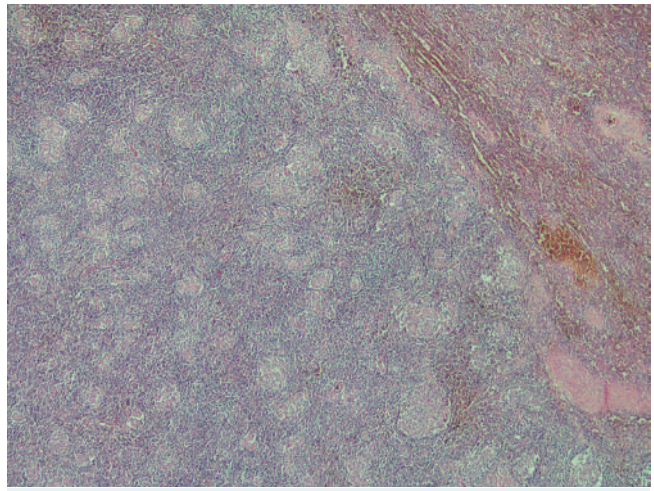

Figure 3. Surgical specimen.

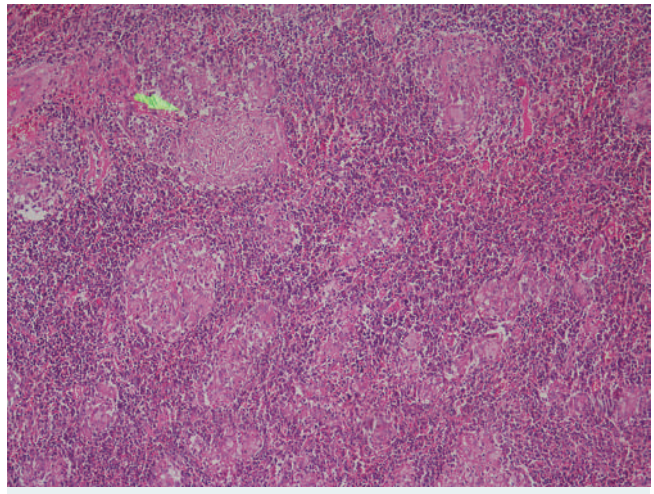

Figure 5. Patology-X10 HE.

HE: Hematoxylin and eosin.

[P-310]

A diagnostic pitfall in colorectal cancer surgery: Hepatic metastasis of uveal melanoma mimicking colorectal liver metastasis

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Objective: Acute appendicitis in elderly populations may serve as a sentinel clinical presentation for underlying right-sided colonic malignancy. Consequently, current literature supports colonic evaluation in selected patients following appendicitis to rule out occult pathology. In patients subsequently diagnosed with colorectal cancer, hepatic lesions identified during the staging process are predominantly interpreted as colorectal metastases, given that the liver is the most common site of spread. This presumption typically dictates surgical strategies, favoring synchronous or sequential resections in resectable cases. However, diagnostic pitfalls exist; limitations in oncologic imaging and the presence of "mimicker" lesions can lead to misclassification, particularly in patients with a history of malignancy. Uveal melanoma is distinct for its specific hepatic tropism and potential for metastatic recurrence many years after primary ocular treatment. This report discusses a rare instance where a presumed colorectal liver metastasis was histopathologically confirmed as late-stage uveal melanoma.

Results: A 68-year-old male presented with acute abdominal pain and generalized peritonitis, undergoing emergency appendectomy for perforated acute appendicitis. While the appendectomy specimen was benign, the patient's age and complicated presentation prompted a postoperative colonoscopy, which revealed a villous mass in the cecum diagnosed as adenocarcinoma. Staging imaging identified a solitary hepatic lesion, radiologically interpreted as a colorectal metastasis. Following multidisciplinary review, the patient underwent simultaneous right hemicolectomy and hepatic metastasectomy with curative intent. Intraoperative exploration showed no further dissemination. Although the colonic specimen confirmed primary adenocarcinoma, histopathological examination of the liver lesion unexpectedly revealed metastatic malignant melanoma. A detailed retrospective review disclosed that the patient had undergone ocular enucleation for uveal melanoma 15 years prior, with no intervening recurrence. The patient was diagnosed with synchronous primary colorectal cancer and late-onset metastatic uveal melanoma.

Conclusion: Not every hepatic lesion detected during colorectal cancer staging represents a colorectal metastasis. Uveal melanoma may clinically and radiologically mimic colorectal dissemination through late-onset hepatic metastases that develop years after primary treatment; this risk is particularly heightened in the presence of synchronous colorectal cancer. A detailed oncologic history and histopathological confirmation are of paramount importance for the prevention of misclassification and the optimization of appropriate multidisciplinary management

Keywords: Uveal melanoma, colorectal cancer, liver metastasis

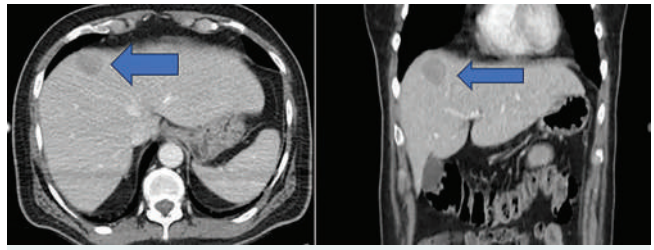

Figure 1. Solitary liver lesion detected on preoperative contrast-enhanced abdominal CT.

CT: Computed tomography.

Figure 2. Intraoperative view during right hemicolectomy.

[P-311]

A rare differential diagnosis in supraclavicular lymph node: Castleman disease or IgG4-related lymphoid proliferation?

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Objective: In supraclavicular lymph node pathology, metastatic solid tumors-particularly lymphoma and lung or thyroid malignancies-are the primary diagnostic considerations. However, viral infections, autoimmune disorders such as Hashimoto thyroiditis and Graves' disease, and rarer entities including Castleman disease (CD) and IgG4-related lymphoid proliferation (IgG4-RLP) should also be considered. Although CD and IgG4-RLP are generally regarded as benign or premalignant conditions, their overlapping histopathological and immunohistochemical features make accurate differentiation crucial, as management and therapeutic approaches differ. This case report presents a rare supraclavicular lymph node lesion and addresses the challenges encountered in the differential diagnosis within a multidisciplinary framework.

Material and Methods: A 39-year-old woman under follow-up for Hashimoto thyroiditis, without active symptoms,was found to have multiple pathological lymph nodes in the right supraclavicular fossa on routine ultrasonography,the largest measuring 36×18mm. Thoracic computed tomography revealed a 35×23 mm pathological lymphadenopathy in the right lower jugular chain-supraclavicular region. PET-CT demonstrated heterogeneous increased FDG uptake in a 17×21 mm lymph node at the same site (SUV_{max}:10.33). Targeted ultrasonography identified conglomerated lymph nodes at right level IV, posterolateral to the jugular vein,considered unrelated to thyroid pathology,and a tru-cut biopsy was performed. Histopathological evaluation revealed atypical lymphoid proliferation;due to suspicion of low-grade lymphoma,complete excision of the lymph node was subsequently performed.

Results: Microscopic examination showed follicular hyperplasia, regressive germinal centers, and focal follicular "twinning" consistent with features of hyaline-vascular type CD. Concentric mantle zone arrangement, perivascular hyalinization, and prominent capsular fibrosis were observed. Interfollicular areas demonstrated sheets of plasma cells and focal storiform fibrosis. Immunohistochemically, plasma cells were highlighted by CD138 and showed polyclonality on kappa and lambda *in situ* hybridization. CD20 and CD3 staining revealed preserved B-and T-cell compartments, while CD21 and CD23 highlighted intact follicular dendritic cell networks. CyclinD1, Bcl-2, CD30, HHV8, and EBV (EBER) were negative. Although focal areas showed an IgG4/IgG ratio exceeding 40%, the overall ratio was approximately 20%. Normal serum IgG4 levels and polyclonal plasma cells precluded a definitive diagnosis of IgG4-RLP.

Conclusion: Rare lymphoid proliferative disorders involving supraclavicular lymph nodes should be carefully considered in the differential diagnosis once malignant processes have been excluded.This case demonstrates that CD and IgG4-RLP may exhibit substantial overlap in histopathological and immunohistochemical features. While excisional biopsy plays a pivotal role in achieving definitive diagnosis and local disease control, pathological evaluation constitutes the cornerstone of a multidisciplinary approach. The integration of clinical findings, laboratory data, and detailed histopathological assessment enables accurate diagnosis and appropriate treatment planning. Systemic steroid therapy is generally effective in IgG4-RLP, whereas CD may require surgical excision or systemic immunomodulatory therapy. This case highlights the importance of close collaboration among surgery, pathology, and hematology disciplines in the management of rare lymphoid proliferations and underscores the critical contribution of excisional biopsy combined with immunohistochemical analysis in the diagnostic process.

Keywords: Castleman disease, IgG4-related lymphoid proliferation, rare lymphoid proliferations

[P-312]

It could not have been worse: Obstructive colonic malignancy on a background of Crohn's disease and a colon diverticulum perforated into the retroperitoneum

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Objective: Chronic inflammation is one of the fundamental mechanisms underlying the development of malignancy. Inflammatory bowel diseases (IBD) are also considered predictive factors for the development of colorectal cancer (CRC). Although the incidence of IBD-associated CRC has decreased with advances in diagnostic and therapeutic processes, its prognosis is known to be worse compared to sporadic CRC. As a result of chronic inflammation and obstruction, increased intraluminal pressure may create a predisposition for the development of diverticular disease of the intestine. Diverticular perforation and/or colonic perforation constitute a not-uncommon surgical emergency. In the present case, we report a patient in whom several colorectal pathologies—each not rare in isolation but seldom encountered simultaneously—coexisted, and we present the emergency surgical intervention performed along with the pathological findings.

Material and Methods: The present study is a case report.

Results: In the present case, we report the emergency surgical intervention performed in a patient in whom several colorectal pathologies—each not uncommon when considered individually but rarely encountered together—coexisted, along with the pathological findings.

Conclusion: CRCs arising in the setting of Crohn's disease are associated with aggressive histopathological features, advanced-stage disease at diagnosis, and poorer prognosis. Perforation is a rare but serious complication of Crohn's disease and is more likely in the presence of concomitant malignancy. Chronic transmural inflammation and tumor-related luminal narrowing predispose the colonic wall to perforation. In emergency settings, surgical management usually involves segmental resection or subtotal colectomy; however, chronic inflammation and poor nutritional status increase surgical morbidity. Because of the high risk of anastomotic leakage in cases with perforation, stoma formation is often preferred over primary anastomosis. Considering the increased risk of malignancy and perforation in Crohn's disease, resection should include the involved segment with its vascular and lymphatic drainage. In patients with suspected infection or high surgical risk, primary anastomosis should be avoided. Further multicenter studies with larger cohorts are needed to better define CRC management in patients with IBD.

Keywords: Chron's disease, divrticulosis, colorectal malignancy, perforation

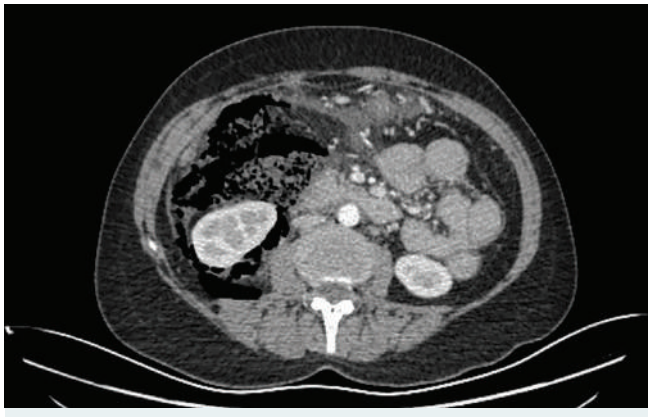

Figure 1. Cross-sectional imaging of retroperitoneal free air.

Figure 2. Extended right hemicolectomy specimen.

TANI

HİSTOPATOLOJİK TİP: ADENOKARSİNOMA
TÜMÖR BOYUTU: 3 X 2 CM
TÜMÖR YERLEŞİMİ: TRANSVERS KOLON
PERİTÜMÖRAL DESMOPLASTİK REAKSİYON: ORTA
PERİTÜMÖRAL LENFOSİTİK İNFİLTRASYON: BELİRGİN
LENFOVASKÜLER İNVAZYON: İZLENMEDİ
PERİNÖRAL İNVAZYON: İZLENMEDİ
TÜMÖR İNVAZYON SEVİYESİ: SUBSEROZAL İNVAZYON (pT3)
CERRAHİ SINIRLAR: İNTAKT
İNVAZYON DERİNLİĞİ: 1 CM
ÜLSERASYON: MEVCUT
NEKROZ: İZLENMEDİ
İNVAZYON SEVİYESİNİN MÜSKÜLARİS PROPRİA YA UZAKLIĞI: 0,1 CM
BENİGN LENF NODU SAYISI: 20 ADET
OMENTUM: KONJESYONE DAMAR YAPILARI İÇEREN LİPOMATÖ DOKULAR
TÜMÖR DIŞI ALANLAR: -PERFORASYON
-DİVERTİKÜL
-İNFLAMATUAR BARSAK HASTALIĞI (CROHN HASTALIĞİ İLE UYUMLU), İLEUM
YAPILAN İŞLEM: SAĞ HEMİKOLEKTOMİ

Figure 3. Pathological examination of the extended right hemicolectomy specimen.

Table 1. Literature comparison table

Study	Design / N	Typical Biology in MCC (MMR/MSI)	LN / Invasion Pattern	Clinical Message (Prognosis / Treatment)	Comparison With Our Case
Scott et al., 2021 (Histopathology; PubMed)	Single-center pathology audit; re-evaluation of 302 "poorly differentiated" CRCs	Majority of MCCs were dMMR; predominantly right colon/cecum localization	Lower LN metastasis and lower vascular invasion tendency compared with PD adenocarcinoma NOS	"MCC is frequently misclassified; MMR staining strengthens diagnosis"	Our case is consistent with right colon involvement + dMMR (MLH1/PMS2 loss) + MSI-H; however, LN (+) and LVI (+) were present → Stage III and high-risk features
Maung et al., 2024 (Open access; single-center series + literature review)	11 cases (2016–2023) + pooled literature data	MLH1/PMS2 loss in 11/11 cases (MSH2/MSH6 preserved)	LVI in 8/11 and PNI in 2/11; literature reports variable LVI/PNI rates	Authors emphasize similar demographic and tumor characteristics; longer follow-up needed for survival outcomes	MLH1/PMS2 loss consistent; LVI (+) consistent with series; PNI (-) closer to favorable profile
Netto, 2025 (Springer; case-based review and evidence summary)	Case-based review; hazard ratios from meta-analyses discussed	Predominance of MMRd MCC and importance of specific risk factors highlighted	Association of LVI and tumor size >7 cm with relapse discussed	Key message: MCC does not always demonstrate uniformly favorable outcomes; some series report lower 5-year OS compared with PDA (MSI-H)	Despite Stage III and LVI (+), our patient remains recurrence-free at 22 months, reinforcing "not all MCCs behave aggressively," while acknowledging existence of high-risk MCC subsets
Gómez-Álvarez et al., 2017 (Medical journal PDF; MSI-related MCC comparisons)	Comparative approach	MSI-associated MCC phenotype discussed	Stage-dependent differences in LVI, tumor size, and clinical course reported	"MCC is not universally advantageous; subgroups exist"	Our case represents the favorable outcome subgroup, but should be interpreted as a selected case due to LVI and LN positivity
Chen et al., 2019 (CRC biomarker practical guide)	Review/practical guideline	Prognostic and therapeutic importance of MSI/MMR testing in CRC	—	Emphasizes the role of dMMR/MSI-H in prognosis and treatment planning, particularly immunotherapy decisions	MMR/MSI reporting is central to the clinical message of our MCC case
Our case (Etlik City Hospital)	Single case	MLH1/PMS2 loss + MSI-H	pT3, pN1a (1/28), LVI (+), PNI (-)	22 months: no recurrence, no mortality	Consistent with literature on dMMR predominance; favorable short-to-mid-term outcome despite Stage III disease supports the prognostic "paradox"

[P-313]

Is poor differentiation always associated with poor prognosis? MSI-H colonic medullary carcinoma: clinical, pathological, and molecular evaluation (case report)

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Objective: Colonic medullary carcinoma is a rare subtype of colorectal cancer and is frequently associated with microsatellite instability (MSI) and loss of mismatch repair (MMR) proteins. Despite exhibiting poor histological differentiation, it has been reported to demonstrate a relatively favorable prognosis compared with conventional colorectal adenocarcinomas due to the prominent presence of tumor-infiltrating lymphocytes (TILs). This study aimed to present the clinical, pathological, and molecular characteristics of a patient diagnosed with colonic medullary carcinoma in the context of the current literature.

Material and Methods: A patient who underwent surgery with a diagnosis of colonic medullary carcinoma was retrospectively evaluated. Demographic data, mode of presentation, preoperative clinical and laboratory findings, surgical procedure, pathological examination results, tumor stage, lymph node status, TIL density, presence of lymphovascular and perineural invasion, as well as MMR immunohistochemical and MSI analyses were assessed. During the postoperative follow-up period, recurrence, metastasis, and mortality were recorded.

Results: The patient was of advanced age and presented with lower gastrointestinal bleeding. Histopathological examination following surgical resection revealed a prominent solid growth pattern, gland-poor architecture, and dense lymphocytic stromal infiltration consistent with medullary carcinoma. TIL density was markedly increased, suggesting the presence of an active immune response within the tumor microenvironment. No metastasis was detected in the dissected lymph nodes, and the absence of lymphovascular and perineural invasion supported limited local tumor aggressiveness. Surgical resection margins were reported as negative. Immunohistochemical analysis demonstrated loss of MLH1 and PMS2 protein expression, a finding consistent with MSI. Molecular analysis confirmed an MSI-H tumor phenotype. The patient received adjuvant chemotherapy, and no local recurrence, distant metastasis, or mortality was observed during a 22-month follow-up period. This clinical course is consistent with the relatively favorable prognosis of medullary carcinoma reported in the literature, despite its poor histological differentiation (Table 1).

Conclusion: Colonic medullary carcinoma is a distinctive colorectal cancer subtype that may lead to inaccurate prognostic assessment due to rarity and aggressive histological appearance. However, studies demonstrate frequent association with MSI-H phenotype and MMR loss, and improved outcomes related to immune cell infiltration.In this case, high TIL density, MLH1/PMS2 loss, nodal negativity, and recurrence-free follow-up support distinct biological behavior compared with conventional adenocarcinomas. These findings emphasize that poor differentiation alone should not indicate unfavorable prognosis.Routine MMR/MSI analysis in medullary morphology tumors is essential for prognostic assessment, individualized adjuvant treatment, and rational follow-up strategies. Accurate recognition and molecular evaluation can directly contribute to surgical clinical decision-making.

Keywords: Colonic medullary carcinoma, MSI-H, mismatch repair protein loss, poorly differentiated colorectal cancer, prognosis, tumor-infiltrating lymphocytes

[P-314]

Superior mesenteric vein injury occurring during right hemicolectomy

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Objective: Mesenteric vascular structures, particularly the superior mesenteric artery and vein, play a fundamental role in intestinal circulation. Although injury to these structures is rare, it carries a risk of massive bleeding and high mortality. Mezocolic dissection performed during right hemicolectomy can lead to serious vascular complications due to working close to central vascular structures. Superior mesenteric vein (SMV) injuries, reported in a limited number of cases in the literature, are generally related to anatomical variations and surgical traction. This case report presents an SMV injury that developed during right hemicolectomy and its management.

Material and Methods: A 76-year-old female patient presented to the general surgery outpatient clinic with complaints of abdominal pain and constipation. Colonoscopy revealed an ulcerative lesion at the hepatic flexure level, narrowing the lumen by approximately 40%. A biopsy was taken. Although the pathological examination reported adenocarcinoma, the patient and her relatives declined surgical treatment. Five months later, a follow-up colonoscopy revealed that the lesion was growing, and a decision was made to proceed with surgical treatment. Right hemicolectomy and mesocolic excision were planned.

Results: The patient was explored under general anesthesia via a midline median incision. Injury to the SMV occurred during mesenteric dissection. Venous bleeding was observed. Manual compression was applied to control the bleeding. With the help of a vascular clamp, proximal and distal control was achieved, and the damaged SMV segment was primarily repaired with non-absorbable prolene sutures. After abdominal irrigation, complete hemostasis was achieved. The operation was concluded with the placement of a drain to monitor the anastomosis line and repair site. The patient was extubated and transferred to the intensive care unit for monitoring. Clexane therapy was initiated at 12 hours postoperatively. Due to hemodynamic stability, the patient was transferred to the general surgery ward on the first postoperative day. No significant decrease was observed in postoperative hemogram follow-ups. The drain was serous in character. The regimen was started on the 4th postoperative day and gradually increased. The patient was discharged on the 9th postoperative day.

Conclusion: SMV injuries are rare during right hemicolectomy but carry a serious risk of morbidity and mortality. Early diagnosis, rapid control of bleeding, and appropriate surgical repair can successfully manage these potentially devastating complications. Thorough knowledge of vascular anatomy, careful mesenteric dissection, and avoidance of excessive traction on venous structures are critical in preventing such injuries.

Keywords: Superior mesenteric vein injury, mesocolic excision, intraoperative complication

Figure 1. Postoperative image of SMV injury developed during right hemicolectomy.

SMV: Superior mesenteric vein.

[P-315]

Isolated splenic metastasis from mucinous adenocarcinoma of the colon located at the splenic flexure: A case report

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Objective: Colorectal cancers most commonly metastasize to the liver and lungs. Mucinous adenocarcinomas may show more aggressive biological behavior and a tendency for peritoneal dissemination. Splenic metastasis in colorectal cancer is rare. This rarity may be explained by the sharp angulation of the splenic artery, the high phagocytic and immunologic activity of the spleen, and its limited lymphatic drainage.

Material and Methods: This study was designed as a single case report. Colonoscopy and biopsy were initially performed. In May 2019, the patient underwent left hemicolectomy, end colostomy, small bowel resection and anastomosis due to invasion, and peritonectomy for thoracic wall invasion. On postoperative day 2, hyperthermic intraperitoneal chemotherapy (mitomycin and carboplatin) was administered. The patient was diagnosed with T4bN0 mucinous adenocarcinoma and received adjuvant chemotherapy (5 cycles of FOLFOX and 1 cycle of FUFA) until January 2020. He was followed in remission. Two years later, Positron emission tomography-computed tomography revealed an 18×22 mm splenic lesion (SUV_{max}: 4.32) suspicious for metastasis. In June 2021, splenectomy and closure of the end colostomy were performed.

Results: A 45-year-old male patient presented with complaints of abdominal pain that began in 2018. Colonoscopy revealed a mass at the level of the splenic flexure. Macroscopic examination of the colectomy specimen demonstrated a malignancy measuring approximately 13×13 cm, consistent with mucinous adenocarcinoma. Pathological evaluation showed T4b disease (invasion of the abdominal wall, left thoracic wall, and small intestine) and N0 status (0/35 lymph nodes). There was no lymphovascular or perineural invasion. An R0 resection was achieved, and no tumor infiltration was observed at the surgical margins. Histopathological and molecular analysis revealed loss of *MLH1* and *PMS2* expression, MSI-H status, *KRAS* mutation, and HER2 negativity. After being followed in remission for two years, follow-up imaging revealed splenic metastasis. The patient underwent splenectomy, and pathological examination demonstrated a 2.5×2.5×2 cm metastatic lesion in the spleen, located approximately 0.1 cm from the surgical margin, consistent with metastatic mucinous adenocarcinoma.

Conclusion: This case is notable for the absence of lymph node metastasis despite T4b disease, mucinous histology, mismatch repair deficiency, and the development of isolated splenic metastasis after curative treatment. Although mucinous tumors typically spread intraperitoneally, this finding suggests a possible hematogenous route. Splenectomy is recommended as both a diagnostic and therapeutic approach in such cases. Although rare, splenic lesions detected during follow-up should be carefully evaluated for metastasis, and splenectomy remains an effective treatment option.

Keywords: Colorectal cancer, splenic metastasis, mucinous adenocarcinoma

Figure 1. Macroscopically, the mass was oval in shape, had a smooth surface and was firm. It measured 3.5 cm in diameter.

[P-316]

Case presentation: Incidentally detected peritoneal loose body in a patient undergoing surgery for Ileus

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Objective: Peritoneal loose bodies are usually asymptomatic and are found incidentally during abdominal surgery. Their size varies. They are generally thought to be caused by torsion and autoamputation of the appendix epiploica. Cases of peritoneal loose bodies larger than 2 cm are rare in the literature. We report the case of a patient who had difficulty in obtaining a diagnosis of tumor ileus.

Material and Methods: A 60-year-old male patient with hypertension and type 2 diabetes presented to our emergency department with abdominal pain and the absence of gas and stool passage for three days. On physical examination, he had generalized tenderness and distension in the abdomen. Rectal examination revealed no fecal contamination. An upright plain abdominal X-ray showed colonic distension but no air-fluid levels. Intravenous contrast abdominopelvic CT scan revealed fecalith at the level of the sigmoid colon and gas and stool distension proximal to this level. Laboratory findings showed no leukocytosis, no electrolyte imbalance, and normal renal function tests. Suspecting ileus due to fecalith, the patient was admitted to the general surgery ward for observation. Following symptomatic treatment and subsequent follow-up, the absence of gas and stool passage led to a planned colonoscopy. The colonoscopy revealed a mass encircling the lumen of the sigmoid colon and obstructing the passage. The patient was then taken to surgery. Anterior resection and anastomosis were performed due to a sigmoid colon mass. During the operation, a mass approximately 3.5 cm in diameter was detected in the peritoneal cavity and sent separately for histopathology.

Results: The mass detected intraoperatively was macroscopically oval-shaped, had a smooth surface, and was firm. Its size was 3.5 cm in diameter. Histopathological evaluation reported this mass as a peritoneal loose body. The patient's postoperative process was uneventful, and they were discharged.

Conclusion: In the case we present, imaging was insufficient to rule out fecaliths, peritoneal loose bodies, and malignant processes that could cause the patient's ileus, and the diagnosis was reached via colonoscopy. We encountered a peritoneal loose body in the patient, whom we operated on for tumor ileus. Peritoneal loose bodies can be confusing when investigating the pathology in a patient. Despite numerous examinations and imaging studies, they can be confused with both malignant and benign causes. Smaller ones are more common, but peritoneal loose body lesions larger than 2 cm are much rarer. The most optimal diagnostic and treatment option is surgery.

Keywords: Peritoneal loose bodies, calcified masses, colon malignancy

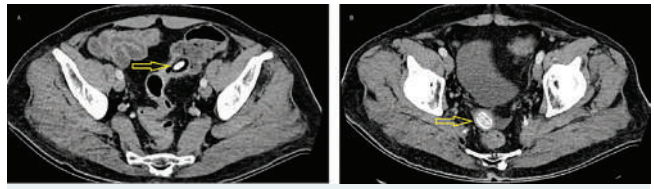

Figure 1. A) Contrast-enhanced abdominal CT scan shows fecalith in the sigmoid colon (arrow). B) Although not mentioned in the CT report, a calcified focus (arrow) was detected in the pelvis in the image.

Figure 2. Macroscopically, the mass was oval-shaped, had a smooth surface, and was hard. Its size was 3.5 cm in diameter.

[P-317]

Rectovaginal fistula after vaginal delivery: Diagnosis and surgical management

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Objective: Vaginal delivery can cause perineal trauma ranging from minor lacerations to obstetric anal sphincter injuries (OASIS) and, rarely, rectal injury leading to rectovaginal fistula (RVF). OASIS is strongly associated with postpartum anal incontinence and reduced quality of life, and reported rates vary by center due to differences in delivery practices and systematic postnatal examination. Although uncommon, RVF is a severe complication characterized by passage of flatus or feces per vagina, causing hygiene problems, infection risk, and psychosocial distress; it may occur even when the sphincter is intact and the perineum appears externally normal. Early, careful assessment is crucial for accurate anatomic diagnosis and appropriate surgical planning.

Material and Methods: A 23-year-old woman with no comorbidities or prior surgery underwent spontaneous vaginal delivery at an outside hospital on December 24 after onset of labor. Postpartum pelvic examination revealed a laceration on the lower posterior vaginal wall. Digital rectal examination raised suspicion of a rectovaginal defect when the examining finger was noted to pass into the vagina, and primary surgical repair was performed. She was referred to our clinic on January 10 due to development of a postoperative RVF. On examination in the lithotomy position, a RVF tract measuring approximately 1-3 cm was identified at the 12 o'clock position. Endorectal ultrasonography revealed disruption of the integrity of the internal anal sphincter and external anal sphincter along a line of approximately 150 degrees in the anterior region. Fecal passage from the anal canal to the vagina was observed in this region. The injury was classified as Type 4 according to the Sultan classification prior to repair. Although it was classified as Type 3c after surgical repair, the clinical presence of a RVF persists. A heterogeneous hyperechoic appearance was observed in the suture area, and these findings were considered to be changes secondary to hematoma or inflammation. In addition, disruption of the perineal body integrity and a distinct defect extending to the puborectal muscle were detected.

Results: Under spinal anesthesia in the lithotomy position, exploration revealed a previously sutured but dehisced ~4-cm rectovaginal defect consistent with Sultan type 4, with intact anal canal mucosa. The defect was closed with full-thickness continuous Vicryl sutures and the rectovaginal septum was reconstructed. Suspected internal and external sphincter fibers were repaired in an overlap fashion to reconstruct the perineal body, and the vaginal repair was completed by the obstetrics-gynecology team in separate planes. Oral intake (regimen 1) was started at postoperative hour 6, and the patient was discharged on postoperative day 5.

Conclusion: The main challenge in postpartum perineal trauma is missed injury in the early period; underdiagnosed OASIS may lead to anal incontinence and pelvic floor dysfunction. Systematic examination, standardized classifications, and—when suspicion persists—objective assessment of sphincter integrity with endoanal/endorectal ultrasonography can guide surgical planning. Although historical management of rectal injuries has emphasized diversion, repair, presacral drainage, and distal washout, selected patients may be successfully treated with primary repair without diversion. Surgical strategy should be individualized according to defect location and size, tissue quality, degree of contamination or infection, and the presence of sphincter injury.

Keywords: Rectovaginal fistula, obstetric anal sphincter injury, perineal trauma

Table 1. Sultan classification of obstetric perineal injuries

Degree	Injury description
Intact	No visible laceration.
First-degree	Limited to the perineal skin only.
Second-degree	Involvement of the perineal muscles; no anal sphincter involvement.
Third-degree	Injury involving the anal sphincter complex: 3a: <50% of EAS thickness involved. 3b: >50% of EAS thickness involved. 3c: Involvement of both EAS and IAS.
Fourth-degree	Injury involving the anal sphincter complex and the anal mucosa.
Rectal buttonhole tear	Isolated rectal buttonhole tear; may be observed with or without a third-degree injury.

EAS: External anal sphincter, IAS: Internal anal sphincter.

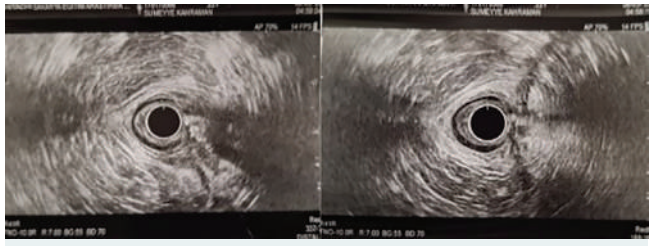

Figure 1. Endorectal ultrasound image compatible with Sultan Type 3c.

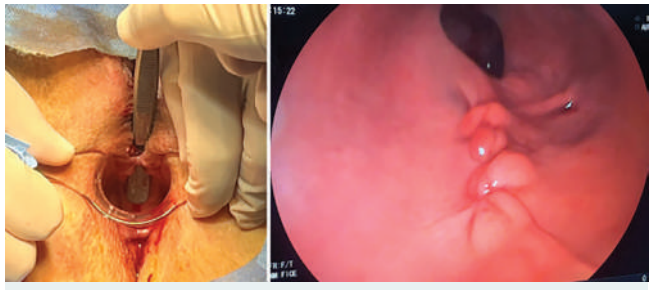

Figure 2. Intraoperatively observed rectovaginal fistula and rectoscopic image at 1-month follow-up.

[P-318]

A rare proctological case: Anal leiomyoma case report

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Objective: Leiomyomas are benign mesenchymal tumors of smooth muscle origin, most commonly found in the uterus, esophagus, and stomach. Perianal localization is quite rare and can often be confused with benign anorectal diseases. This case report presents a 65-year-old male patient who was followed for a long time with a diagnosis of hemorrhoids and was diagnosed with perianal leiomyoma after surgical excision. This case highlights the importance of considering rare tumor lesions in the differential diagnosis of perianal masses.

Material and Methods: A 65-year-old male patient presented to our clinic with a complaint of long-standing swelling in the anal region. Perianal examination in the knee-elbow position revealed a well-defined, non-pedunculated, elastic, and mobile mass approximately 3 centimeters in size, located at the 4-5 o'clock position. Preoperative perianal MRI was planned. The MRI showed a 2x2 cm solid lesion with diffuse homogeneous contrast enhancement and mild diffusion restriction at intermediate T2 intensity, resembling a GIST or leiomyoma. After clinical evaluation, surgical excision was planned for the patient. The mass was carefully dissected from the surrounding tissues and removed in its entirety.

Results: The excised material appeared as an oval-shaped, well-defined, cream-brown mass approximately 4 cm in diameter, with a slightly elastic consistency. A homogeneous solid structure was observed on the cut surface. Immunohistochemical staining was positive for Desmin and SMA, while S100 and DOG1 were partially weakly positive. No staining was observed with CD117. Although Desmin and SMA positivity suggested leiomyoma, the presence of partial DOG1 positivity did not rule out GIST. Pathology was reported as leiomyoma.

Conclusion: Although perianal leiomyomas are rare, they should always be considered in the differential diagnosis of perianal masses. Anal region diseases should also be considered during the preoperative examination.

Keywords: Anal leiomyoma, proctology

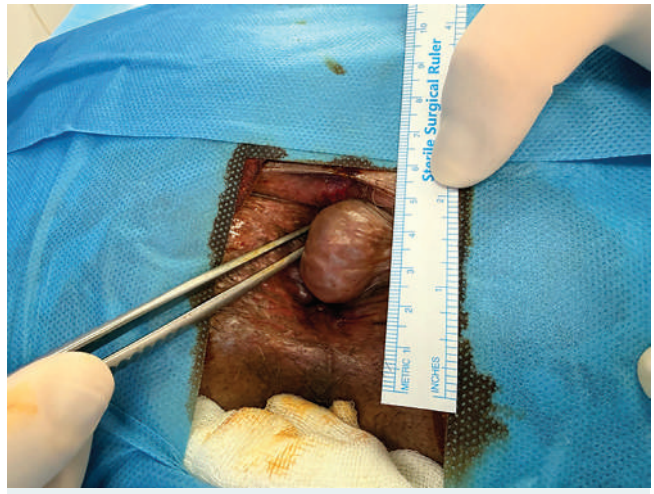

Figure 1. Preoperative image.

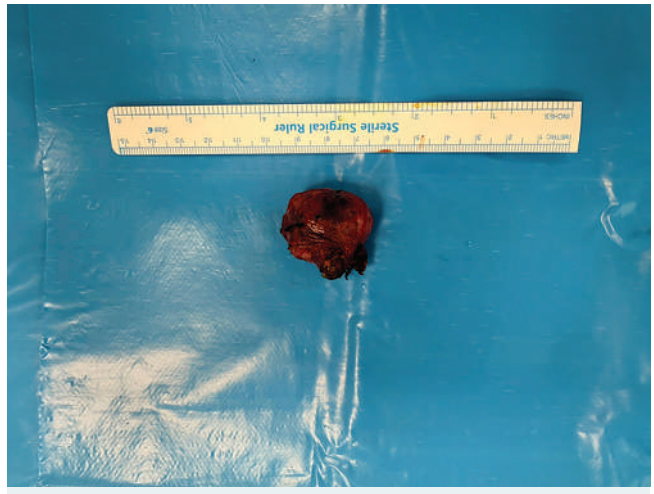

Figure 2. Spesmen.

[P-319]

Perineal scar endometriosis developing in an episiotomy scar: Case report

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Objective: Endometriosis is a chronic inflammatory condition characterized by the presence of functional endometrial glands and stroma outside the uterus. Scar endometriosis is rare and most commonly occurs following obstetric or gynecologic procedures. Perineal endometriosis developing in an episiotomy scar is an uncommon localization and diagnosis is often delayed. This report presents the clinical features, diagnostic process, and surgical management of a case of perineal scar endometriosis arising from an episiotomy scar.

Material and Methods: A 35-year-old woman presented with pain and swelling in the perineal region. She had a history of right mediolateral episiotomy during vaginal delivery in 2008. The patient reported a painful perineal mass for approximately 10 years, with symptoms increasing during menstruation. Physical examination revealed a tender subcutaneous mass adjacent to the episiotomy scar. The lesion was evaluated using ultrasonography and magnetic resonance imaging. Following clinical suspicion, surgical excision was performed and histopathological examination was conducted.

Results: Imaging demonstrated a solid lesion measuring approximately 3×3.5 cm beneath the episiotomy scar. No fistulous connection was identified and perianal fistula was excluded. Based on clinical findings and obstetric surgical history, scar endometriosis was suspected. The lesion was totally excised. Histopathological evaluation revealed endometrial glands and stroma. Immunohistochemistry showed diffuse CD10 positivity in stromal cells and cytokeratin-7 positivity in glandular structures, confirming the diagnosis of endometriosis.

Conclusion: Although rare, perineal endometriosis in an episiotomy scar typically presents with cyclical pain and a palpable mass. It should be considered in the differential diagnosis of perineal masses in patients with a history of obstetric surgery. Clinical suspicion is essential, and imaging supports the diagnosis. Definitive treatment is complete surgical excision with histopathological confirmation.

Keywords: Episiotomy, endometriosis, perineal mass

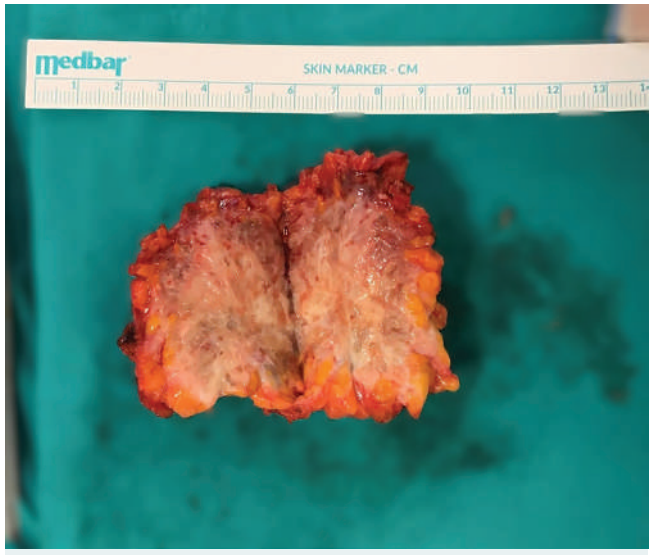

Figure 1. Macroscopic appearance of the excised endometriotic lesion.

Figure 2. Location of perineal endometriosis.

[P-320]

Extramedullary plasmacytoma of the breast mimicking primary breast carcinoma: A case report

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Objective: Multiple myeloma is a systemic plasma cell malignancy that may rarely present with extramedullary involvement. Breast plasmacytoma is extremely uncommon and often mimics primary breast carcinoma. This case highlights breast plasmacytoma as a rare initial manifestation of multiple myeloma and underscores the importance of accurate histopathological diagnosis.

Material and Methods: A 72-year-old woman was evaluated after bilateral suspicious breast masses were detected on routine screening mammography and breast ultrasonography. Imaging revealed irregular, solid, hypervascular lesions classified as BI-RADS 4C and BI-RADS 5, which were newly developed compared with prior examinations, prompting ultrasound-guided tru-cut biopsy. Subsequent PET/CT demonstrated intensely hypermetabolic breast lesions accompanied by widespread lymph node, soft tissue, and skeletal involvement. These findings were consistent with a systemic plasma cell neoplasm exhibiting extensive extramedullary and osseous disease involvement.

Results: Multiple myeloma is a systemic plasma cell malignancy that primarily involves the bone marrow but may rarely present with extramedullary disease. Extramedullary plasmacytoma of the breast is exceedingly rare and is most often reported in patients with known or relapsed multiple myeloma. Presentation as the initial manifestation of multiple myeloma is particularly uncommon. Clinically and radiologically, breast plasmacytomas frequently mimic primary breast carcinoma, representing a significant diagnostic pitfall. Definitive diagnosis relies on histopathological and immunohistochemical evaluation. Following diagnosis, comprehensive systemic assessment is essential to identify underlying multiple myeloma and to ensure timely initiation of appropriate hematologic management.

Conclusion: Extramedullary plasmacytoma of the breast, although rare, represents an important diagnostic pitfall as it can mimic primary breast malignancies. This case demonstrates that breast plasmacytoma may present as the initial clinical manifestation of multiple myeloma and highlights the necessity of combined histopathological evaluation and comprehensive systemic assessment to establish the correct diagnosis.

Keywords: Breast masses, breast plasmacytoma, differential diagnosis, extramedullary plasmacytoma, multiple myeloma

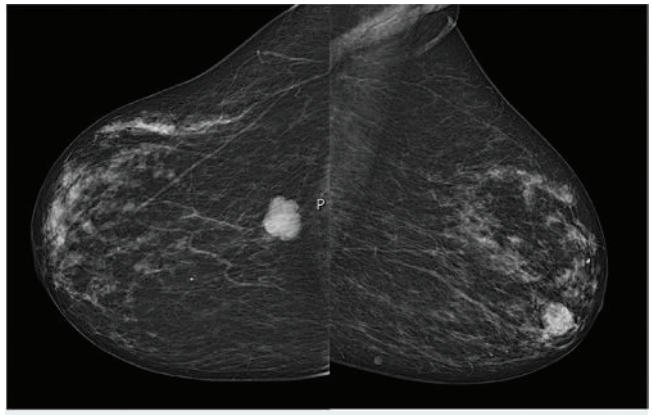

Figure 1. MLO mammographic image of breast plasmacytoma.

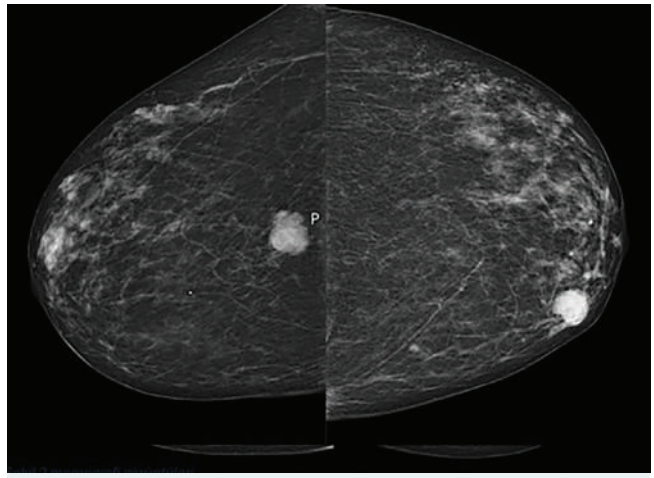

Figure 2. CC mammographic image of breast plasmacytoma.

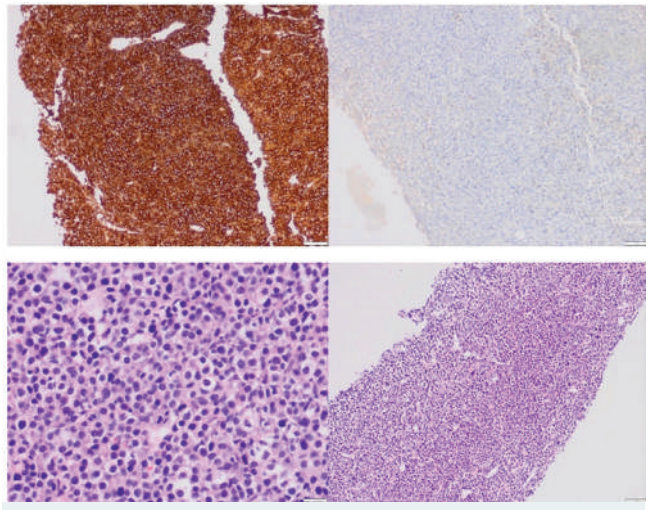

Figure 3. Pathology slides of breast plasmacytoma.

[P-321]

Skeletal recovery without biochemical cure in glucagon receptor-positive BMAH: Is unilateral adrenalectomy sufficient?

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Objective: Bilateral macronodular adrenal hyperplasia (BMAH) typically mandates bilateral adrenalectomy for cure, inevitably causing lifelong steroid dependency. While unilateral adrenalectomy (UA) has emerged as a cortisol-debulking strategy, its efficacy in reversing severe metabolic complications, particularly osteoporosis, in patients with mild autonomous cortisol secretion (MACS) remains debated. We evaluate UA's impact in a glucagon receptor-positive BMAH case.

Material and Methods: A 70-year-old female patient presented with uncontrolled hypertension, diabetes, and severe osteoporosis (lumbar T-score: -4.1). Computed tomography (CT) revealed bilateral giant adrenal masses (left: 60 mm, right: 50 mm). Although no overt cushingoid features were observed, MACS was confirmed (DST: 9.3 µg/dL). While genetic testing (*ARMC5*) was negative, aberrant glucagon receptors were identified. Following the failure of somatostatin analog therapy—intended to suppress glucagon—the patient underwent laparoscopic left adrenalectomy. The postoperative course was uneventful, and the patient was discharged on the 3rd day. Biochemical cure was not achieved due to the activity of the contralateral gland; 1 mg-DST levels remained non-suppressed (4.3 µg/dL). Despite this, the clinical outcomes are striking:

Steroid independence: During the 56-months follow-up, it was observed that the patient did not require any steroid replacement.

Hypertension management: Hypertension was successfully controlled with a reduced medication dosage.

Skeletal recovery: Most importantly, a dramatic improvement in bone mineral density was recorded, with the T-score rising from -4.1 to -1.6.

Clinical interpretation: This outcome indicates a significant improvement in osteoporotic changes, demonstrating that clinical benefits can be achieved through "cortisol debulking" despite persistent autonomous cortisol secretion.

Results: Biochemical cure was not achieved; the 1 mg-DST remained non-suppressed (4.3 µg/dL) due to contralateral gland activity. However, clinical outcomes were striking. At the 56-month follow-up, the patient required no steroid replacement. Hypertension was regulated with reduced medication. Most notably, bone mineral density improved dramatically (T-score -4.1 to -1.6), indicating significant skeletal recovery despite persistent autonomous cortisol secretion.

Conclusion: This case challenges the dogma of strict biochemical normalization. UA-mediated "cortisol debulking" successfully reversed severe osteoporotic changes associated with MACS. In elderly BMAH patients, preserving endogenous function through UA offers a superior balance between metabolic control and quality of life compared to bilateral adrenalectomy.

Keywords: Bilateral macronodular adrenal hyperplasia, mild autonomous cortisol secretion (MACS), unilateral adrenalectomy, cortisol debulking, osteoporosis

Table 1. Preoperative and postoperative comparison

Variable	Preoperative	Postoperative (56 months)	Outcome
Lumbar T-score	**-4.1 (severe osteoporosis)**	**-1.6 (osteopenia)**	**Major recovery**
DST (1 mg)	9.3 µg/dL	4.3 µg/dL	No biochemical cure
Anti-HT meds	1 (uncontrolled)	1 (regulated)	Improved control
HbA1c	6.1%	5.6%	Improved
Steroid need	-	None	Adrenal sufficiency preserved
Adrenal size	Bilateral (60 mm/50 mm)	Right only (50 mm)	Debulking achieved

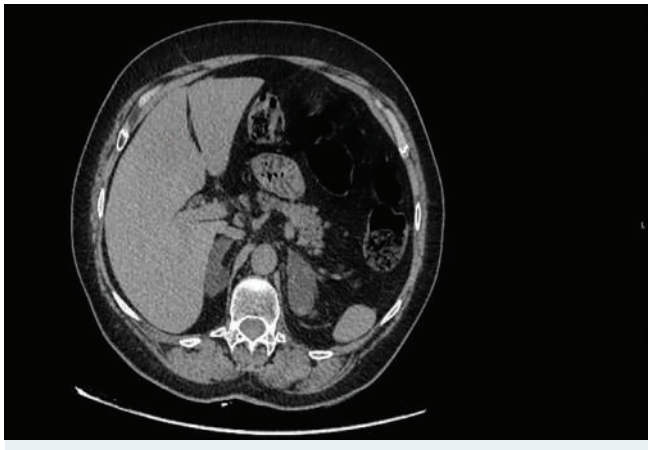

Figure 1. Preoperative CT scan.

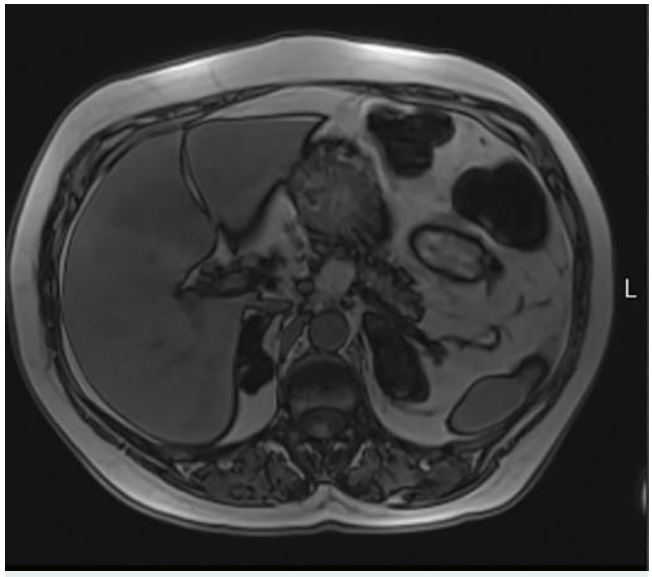

Figure 2. Preoperative MR scan.

[P-322]

Primary thyroid anjiosarcoma: A rare case report

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Objective: Primary angiosarcoma of the thyroid gland is an exceptionally rare and highly aggressive malignant tumor originating from endothelial cells, accounting for only a very small proportion of thyroid malignancies. Although it has been most frequently reported in the Alpine regions, it has been shown to be associated with a long-standing history of multinodular goiter; nevertheless, sporadic cases have also been described worldwide. Clinically, thyroid angiosarcoma typically presents with a rapidly enlarging neck mass accompanied by compressive symptoms, while radiological and cytological findings often mimic poorly differentiated thyroid neoplasms, thereby complicating early diagnosis.

Material and Methods: We evaluated of a 53-year-old male patient who presented with a six-month history of progressive neck swelling, dyspnea, and dysphagia.

Results: Neck ultrasonography revealed a large solid nodule measuring approximately 10 cm in the left thyroid lobe, characterized by a heterogeneous internal structure, hypoechoic appearance, areas of cystic degeneration, and coarse calcifications. Additionally, suspicious lymphadenopathies were detected at levels II-III, and fine-needle aspiration biopsy (FNAB) was performed. The initial FNAB result was reported as non-diagnostic. A second FNAB again yielded a non-diagnostic thyroid nodule biopsy; however, lymph node aspiration demonstrated very sparse malignant epithelial cells, favoring metastatic carcinoma. Nevertheless, the primary tumor origin could not be determined cytologically, and histopathological confirmation was recommended for definitive diagnosis. The patient subsequently underwent total thyroidectomy with left lateral and central neck dissection. No postoperative complications occurred, and the patient was discharged on postoperative day two. At follow-up, the patient was asymptomatic; however, histopathological examination revealed angiosarcoma measuring 5.5 cm in greatest diameter localized in the left thyroid lobe. Regarding lymph node findings, two reactive lymph nodes were identified in the right central compartment, while a total of 30 lymph nodes were dissected from the left central and lateral compartments, three of which demonstrated metastatic angiosarcoma. The patient was referred to medical oncology, and postoperative positron emission tomography/computed tomography (PET/CT) showed no evidence of distant organ metastasis.

Conclusion: This case highlights that repeated non-diagnostic FNAB results do not exclude malignancy in patients presenting with giant thyroid nodules, and that rare aggressive tumors should be considered, particularly in lesions demonstrating rapid growth, heterogeneous characteristics, and suspected invasiveness. Furthermore, early incorporation of endothelial markers into the immunohistochemical panel should be emphasized, as it may facilitate and expedite the diagnostic process.

Keywords: Total thyroidectomy, thyroid angiosarcoma, fine-needle aspiration biopsy (FNAB)

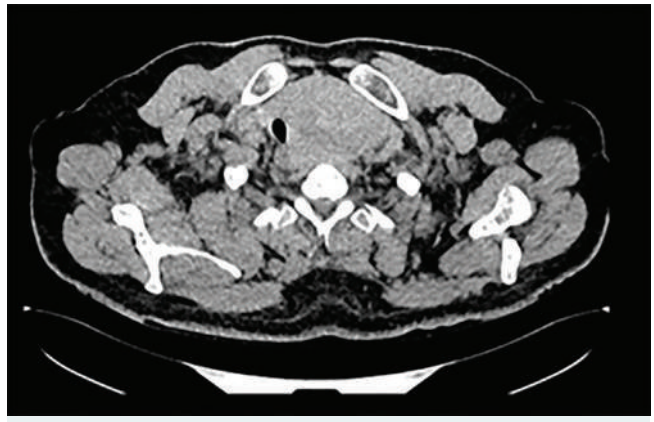

Figure 1. Computed tomography (CT) image demonstrating an approximately 10 cm mass in the left thyroid lobe.

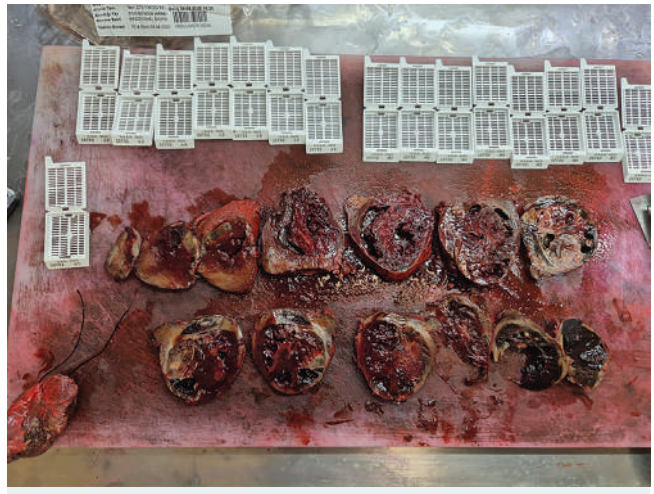

Figure 2. Surgical specimen.

[P-323]

Papillary thyroid carcinoma presenting with femoral fracture: A rare case report

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Objective: Papillary thyroid carcinoma (PTC) is the most common histological subtype of thyroid cancer and usually has a favorable prognosis. Distant metastases are rare, with bone involvement reported in approximately 4% of cases. Bone metastases may lead to pathological fractures and significantly worsen prognosis. We present a rare case of PTC diagnosed following a pathological femoral fracture.

Material and Methods: A 66-year-old female presented to the emergency department with right hip pain and limited mobility. Imaging revealed a pathological intertrochanteric fracture of the right femur. Open biopsy demonstrated metastatic carcinoma of thyroid origin. Following orthopedic resection, further evaluation of the thyroid gland was performed using ultrasonography and fine-needle aspiration biopsy.

Results: Thyroid ultrasonography revealed a 3 cm solid nodule in the right lobe, and fine-needle aspiration biopsy was classified as Bethesda category V. The patient underwent total thyroidectomy with bilateral central neck dissection. Intraoperatively, parathyroid glands were identified using a PT eye device, and intracapsular glands were autotransplanted into the sternocleidomastoid muscle. Histopathological examination confirmed invasive encapsulated follicular variant PTC, with no metastatic involvement of central lymph nodes (pT2N0M1).

Conclusion: This rare case highlights that PTC may present with aggressive behavior despite its generally favorable prognosis. Metastatic malignancy should be considered in patients presenting with atypical fractures, and a multidisciplinary approach is essential for optimal management.

Keywords: Bone metastasis, papillary thyroid carcinoma, pathological femoral fracture

[P-324]

Brachial cleft cyst: A rare case report

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Objective: Brachial anomalies result from changes in the development of the brachial apparatus during embryogenesis between the second and sixth to seventh weeks of fetal life. Persistence of brachial remnants can lead to the development of cysts, sinuses, fistulas, or cartilage islands. Secondary branchial cleft anomalies are the most common cause of this type of neck mass, accounting for approximately 90% of all cases. Although the masses are congenital, they are usually detected during the second to fourth decades of life when they enlarge due to infection or cyst rupture. They occur with equal frequency in men and women. Preoperative diagnosis requires precise determination of the lesion's location, with clinical and radiological findings being crucial.

Material and Methods: The patient was a 50-year-old woman with no significant medical history and no symptoms. She presented to our center with swelling in her right neck that had appeared approximately 6 months ago and had been progressively increasing since then. Physical examination revealed a 2 cm mass in the right submandibular area that was difficult to palpate and had well-defined borders. Ultrasonographic imaging revealed a hypoechoic lesion measuring 29x18 mm, located between the submandibular gland and the jugular vein in the right submandibular region, containing internal cystic areas in places, with no significant vascularization noted on Doppler evaluation. (Epidermoid cyst? Necrotic complicated LAP?) "Based on the MRI report stating," a lesion measuring approximately 25x20x28 mm, hyperintense on T1A and T2A, extending between the submandibular gland and the vascular bundle in the right submandibular region," surgery was planned for the patient. The pathology result was reported as a brachial cleft cyst.

Results: The vast majority of brachial anomalies (90%) originate from secondary clefts. These can be bilateral and present as soft, mobile, and asymptomatic masses under the skin. Depending on their size (ranging from 1 to 10 cm) and location, they may cause local symptoms such as dysphagia, dysphonia, dyspnea, and stridor. Cysts may become painful or tender due to infection, and abscess formation and fistula formation may occur. Sonographically, secondary brachial cleft cysts appear as well-defined, round-oval, hypo- to anechoic masses. Magnetic resonance imaging allows for better preoperative evaluation of the cyst.

Conclusion: Secondary brachial cleft cysts are rare and constitute the vast majority of brachial anomalies. They are usually asymptomatic but can become infected and lead to abscess and/or fistula formation. Clinical and radiological findings are valuable in preoperative evaluation. Treatment consists of surgical excision of the lesion.

Keywords: Brachial, cleft, cyst

[P-325]

Acute airway compression following thyroid fine-needle aspiration biopsy: A rare case requiring emergency lobectomy

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Objective: Thyroid fine-needle aspiration biopsy (FNAB) is a safe and minimally invasive diagnostic procedure widely used for the evaluation of thyroid nodules. Although complications are rare, cervical hematoma can occur and may lead to life-threatening airway compression. In this case report, we present our emergency surgical approach to a compressive thyroid hematoma that developed following FNAB and required urgent surgical intervention.

Material and Methods: A 72-year-old female patient underwent FNAB due to a nodule located in the left lobe of the thyroid gland. Approximately four hours after the procedure, the patient presented to the emergency department with shortness of breath. Physical examination revealed significant neck swelling and tachypnea. Neck computed tomography demonstrated a hematoma in the thyroid bed. Due to progressive respiratory distress, the patient was intubated in the critical care area and taken to emergency surgery. During the operation, active bleeding originating from the anterior thyroid artery of the left thyroid lobe was identified. A left lobectomy was performed to achieve definitive bleeding control. Postoperatively, the patient was admitted to the intensive care unit while intubated and was successfully extubated four hours later. On postoperative day one, the patient was transferred to the surgical ward, and calcium and parathyroid hormone levels were within normal limits. On postoperative day two, with no complications observed, the drains were removed and the patient was discharged.

Results: Although thyroid FNAB is considered a safe procedure with a low complication rate, rarely occurring cervical hematomas may result in life-threatening clinical conditions such as acute airway obstruction. The primary mechanism of hematoma formation is iatrogenic vascular injury, particularly damage to branches of the thyroid arteries, which may lead to rapid volume expansion. Due to the rapid progression of symptoms, early clinical recognition and prompt airway management are critical. Emergency surgical exploration may be required in the presence of progressive dyspnea and increasing neck swelling. In our case, early intubation was performed due to progressive respiratory distress, and active arterial bleeding was identified during surgical exploration, with definitive treatment achieved by lobectomy. This case demonstrates that although post-FNAB hematoma is rare, it may lead to rapid clinical deterioration, and early surgical intervention can be life-saving.

Conclusion: Cervical hematoma after thyroid FNAB is a rare but potentially life-threatening complication. Patients presenting with rapidly progressive neck swelling and respiratory distress require immediate evaluation, prompt airway management, and timely surgical intervention when indicated.

Keywords: Thyroid, FNAB, emergency surgery

[P-326]

Concomitant gallbladder hydatid cyst and Mirizzi syndrome: A rare case report

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Objective: Hydatid disease is a parasitic infection, most commonly caused by *Echinococcus granulosus*, and it predominantly involves the liver and lungs. Primary involvement of the gallbladder is extremely rare. Mirizzi syndrome (MS) is an uncommon but serious clinical condition secondary to cholelithiasis, characterized by obstruction and erosion of the main biliary ducts. The coexistence of a primary gallbladder hydatid cyst (PGHC) and type IV MS has been reported only in a very limited number of cases in the literature. In this poster, we aimed to present our case with this rare association.

Material and Methods: In a patient presenting with right upper quadrant pain and jaundice, physical examination and laboratory tests were performed. Ultrasonography and MRI were obtained. After an unsuccessful ERCP attempt, surgery was planned; intraoperative assessment was performed via laparotomy and the appropriate procedure was undertaken. Postoperatively, albendazole was initiated and long-term follow-up was performed.

Results: A 79-year-old male patient had a positive Murphy's sign on physical examination. Laboratory tests revealed leukocytosis and cholestasis (total bilirubin: 12.5 mg/dL). Ultrasonography and MRI demonstrated a stone in the gallbladder fossa, dense biliary sludge, and findings compatible with MS. Endoscopic retrograde cholangiopancreatography (ERCP) was unsuccessful. At laparotomy, the gallbladder was markedly inflamed and densely adherent to the common bile duct. During cholecystectomy, perforation of the gallbladder resulted in spillage of hydatid membranes and daughter vesicles. Concomitantly, full-thickness erosion of the common bile duct wall was observed. As no cyst was detected on preoperative imaging and no other focus was identified intraoperatively, the case was considered PGHC. Cholecystectomy and Roux-en-Y hepaticojejunostomy were performed. Albendazole therapy was initiated, and the patient was followed for 4 years without recurrence.

Conclusion: PGHC is a rare localization and is difficult to diagnose preoperatively; hydatid membranes and daughter vesicles may be mistaken for biliary sludge or gallstones on imaging. In our case, the finding interpreted as "biliary sludge" on ultrasonography and MRI was recognized intraoperatively as hydatid material. The coexistence of MS and PGHC is exceedingly rare. Although cholecystectomy with adjuvant albendazole is generally sufficient for PGHC, concomitant type IV MS in this patient required bile duct resection and Roux-en-Y hepaticojejunostomy, resulting in a successful clinical outcome during postoperative follow-up. Because this rare association may cause diagnostic confusion, primary hydatid disease should be considered in atypical cholecystitis and MS cases—particularly in endemic regions—and the surgical strategy should be planned to prevent parasitic dissemination while ensuring adequate biliary reconstruction.

Keywords: Primary hydatid cyst of the gallbladder, Mirizzi syndrome

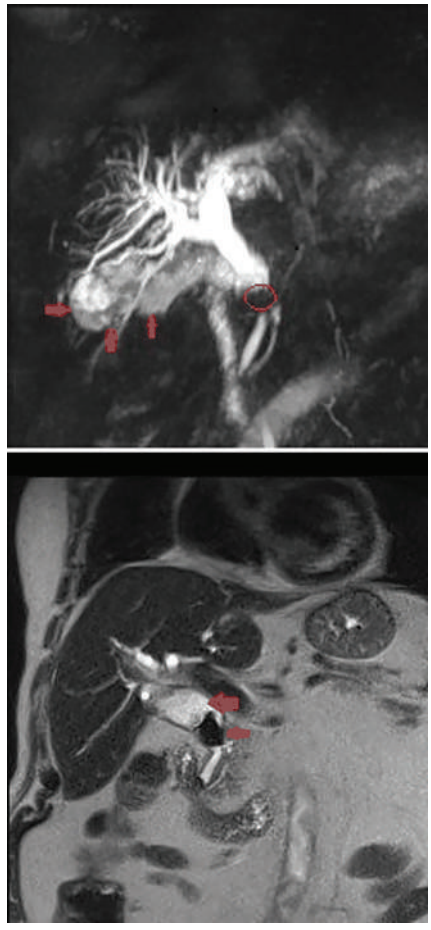

Figure 1. Preoperative MRCP image. Image of daughter cysts following intraoperative gallbladder perforation.

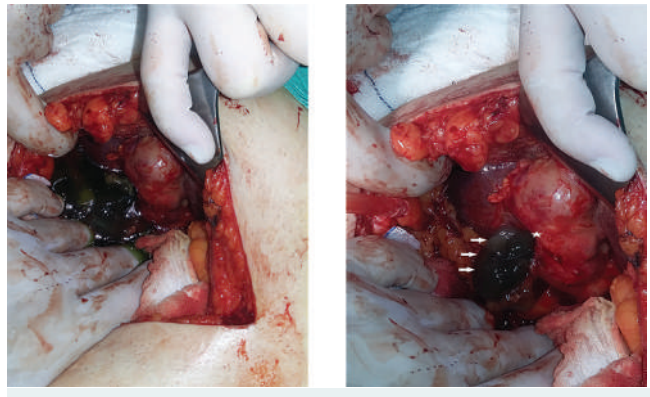

Figure 2. Image of daughter cysts following intraoperative gallbladder perforation.

[P-327]

Gallbladder torsion: A rare case report

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Objective: Acute cholecystitis is one of the most common surgical emergencies in patients presenting with acute abdomen; however, gallbladder torsion is reported as a rare condition. This rare pathology was first described in 1898, and since then, more than 500 cases have been reported. Although the exact etiology of gallbladder torsion is not fully understood, certain anatomical variations are thought to predispose patients to torsion. Preoperative diagnosis is challenging, and it is possible in less than 10% of cases. Gallbladder torsion is difficult to distinguish because its clinical and physical examination findings are similar to those of acute cholecystitis. While acute cholecystitis does not always require emergency surgery, delayed intervention in gallbladder torsion increases morbidity and mortality. The aim of this case report is to emphasize that gallbladder torsion should always be considered in the differential diagnosis of elderly patients presenting with clinical features of acute cholecystitis.

Material and Methods: An 82-year-old woman presented to the emergency department with sudden-onset right upper quadrant pain, nausea, and vomiting. Her medical history included Parkinson's disease, Alzheimer's disease, and hypertension. Laboratory tests and imaging studies raised the suspicion of gallbladder torsion, and the patient was admitted to the general surgery department for laparoscopic cholecystectomy. Intraoperatively, the gallbladder was found to be nearly detached from its posterior wall and displaced inferiorly. The hilum had rotated three complete turns, resulting in complete torsion, and the gallbladder was necrotic. The procedure was completed laparoscopically without complications.

Results: On physical examination, the patient had diffuse abdominal tenderness and a positive Murphy sign. Laboratory findings revealed elevated C-reactive protein (376.1 mg/L) and white blood cell count (12.25×10^3/μL), while other laboratory values were within normal limits. Hepatobiliary ultrasonography demonstrated inferior displacement of the gallbladder, with torsion of the neck and cystic duct. Further evaluation with computed tomography showed a hydropic gallbladder with torsion involving the cystic artery, confirming the diagnosis. Postoperatively, the patient's clinical and laboratory parameters normalized, and no complications occurred. She was discharged on the seventh postoperative day.

Conclusion: Although acute cholecystitis is a common cause of acute abdomen, gallbladder torsion is often overlooked preoperatively. In our case, the patient presented with typical acute cholecystitis symptoms, including right upper quadrant pain, nausea, and vomiting, along with elevated inflammatory markers. This case highlights the importance of considering gallbladder torsion in elderly patients, particularly women, who present with clinical signs of acute cholecystitis.

Keywords: Gallbladder, torsion, cholecystitis

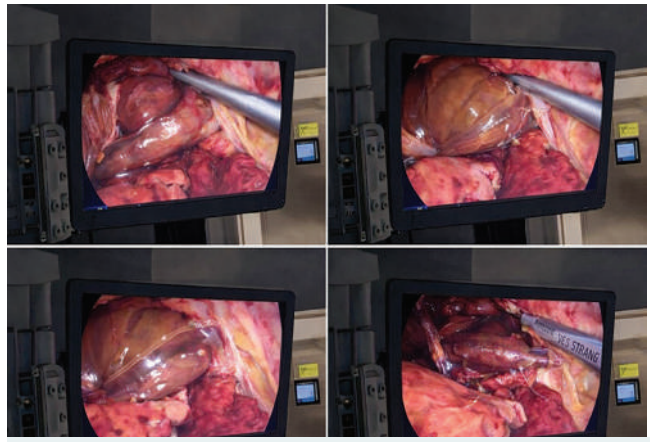

Figure 1. Intraoperative gallbladder images.

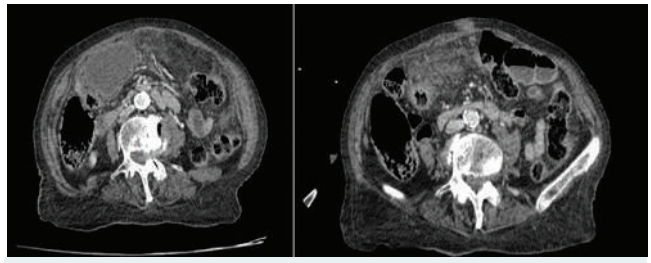

Figure 2. Preoperative CT images.

[P-328]

Is free intraperitoneal air always indicative of gastrointestinal perforation?

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Objective: Gallbladder perforation is a rare but potentially life-threatening complication of acute cholecystitis. The fundus, which has a relatively sparse vascular supply, is the most frequently affected anatomical site. While the presence of free intraperitoneal air (pneumoperitoneum) on computed tomography (CT) is typically associated with gastrointestinal (GI) perforation requiring urgent surgery, this case highlights that it can also arise from atypical etiologies such as a contained gallbladder perforation.

Material and Methods: A 75-year-old male presented with abdominal pain. One week prior, he had been managed for acute pancreatitis with elevated amylase (1089 U/L) and lipase (1814 U/L) levels, supported by CT findings. Following medical treatment, he was discharged. Upon re-admission, physical examination revealed no signs of peritonitis. Contrast-enhanced CT showed peripancreatic necrotizing collections and widespread pneumoperitoneum; however, no extraluminal contrast leakage was observed on oral contrast imaging. Laboratory follow-up showed a significant rise in CRP (from 18 mg/L to 138 mg/L) and leukocyte count (from 8.4 to 13.7×10^3/μL). Due to the clinicoradiological mismatch, a diagnostic laparotomy was performed. No GI perforation was found; instead, a contained perforation covered by the omentum was identified at the posterior fundus of the gallbladder. A cholecystectomy was performed. The postoperative course was uneventful, and the patient was discharged on day 6. No issues were noted at the one-month follow-up.

Results: Free intraperitoneal air is an important radiological finding most commonly associated with GI perforation. However, it has been reported that free air is not always secondary to luminal perforation and may rarely be related to alternative etiologies such as gallbladder perforation. Gallbladder perforations are classified according to the Niemeier classification as acute free perforation (type I), subacute localized perforation (type II), and chronic fistulized form (type III). The present case is consistent with a sealed (type II) perforation limited by the omentum. CT has high diagnostic value in suspected perforation for determining localization and evaluating accompanying intra-abdominal pathologies. In this case, despite the presence of widespread free air on CT, the absence of contrast extravasation and the lack of prominent clinical findings created a clinicoradiological discrepancy. This situation demonstrates that the etiology of free air should not always be considered GI perforation.

Conclusion: Although the detection of free intraperitoneal air is most commonly associated with GI perforation, rare but clinically significant etiologies such as sealed gallbladder perforation should also be considered in the differential diagnosis.

Keywords: Free intraperitoneal air, gallbladder perforation, pneumoperitoneum

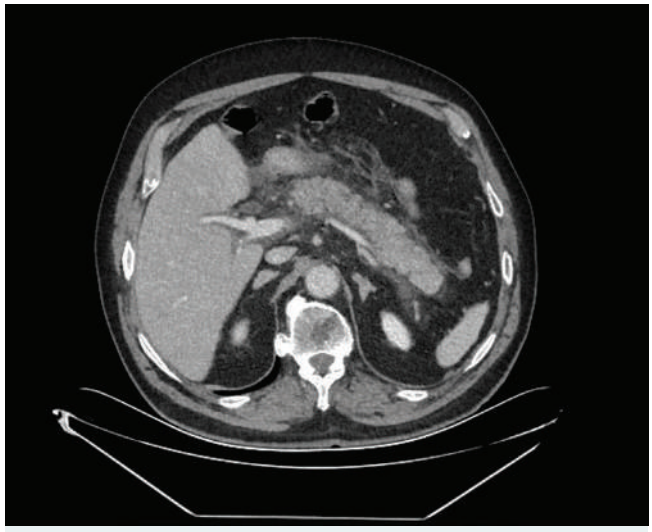

Figure 1. Contrast-enhanced abdominal CT demonstrating a bulky appearance of the pancreas and inflammatory changes in the peripancreatic fat planes; findings consistent with acute pancreatitis.

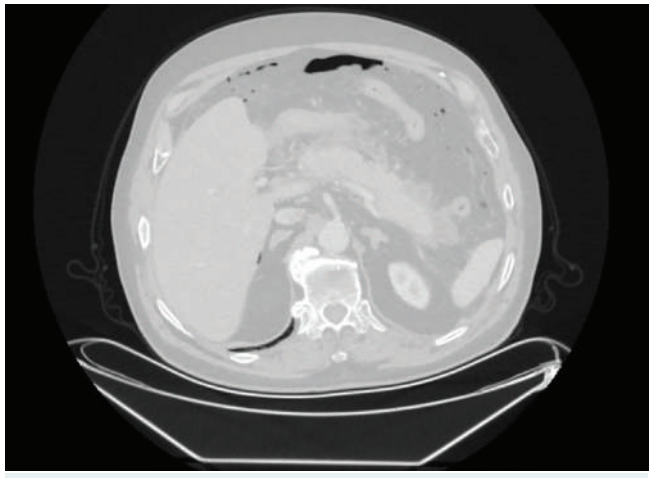

Figure 2. Contrast-enhanced abdominal CT demonstrating peripancreatic necrotizing collection areas and widespread free intraperitoneal air.

[P-329]

A rare cause of gastric outlet obstruction: A case of Bouveret syndrome

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Objective: Bouveret syndrome is a rare cause of gallstone ileus in which a gallstone passes through a bilioenteric fistula into the duodenum, leading to gastric outlet obstruction. In elderly patients with multiple comorbidities, delayed diagnosis may limit endoscopic treatment and increase surgical morbidity. This report describes the clinical, laboratory, imaging, and management features of an elderly patient with a high comorbidity burden diagnosed with Bouveret syndrome.

Material and Methods: A case presenting to the emergency department with signs of gastric outlet obstruction and diagnosed with Bouveret syndrome by USG/BT was retrospectively evaluated. Demographic data, comorbidity indices (ASA, Charlson), symptom duration, laboratory parameters (WBC, CRP, lactate), imaging findings, and characteristics of the ectopic gallstone (location, size, number, calcification, Hounsfield units), diagnostic delay, endoscopic interventions (endoscopy/ERCP), surgical approach, postoperative complications, intensive care unit and hospital length of stay, and follow-up outcomes were recorded.

Results: A 99-year-old female patient presented to the emergency department with a 19-days history of nausea, vomiting, and impaired oral intake. Owing to multiple comorbidities, the patient was classified as ASA-IV with a Charlson comorbidity index of 5 (BMI: 19). Laboratory evaluation revealed a marked inflammatory response (WBC: 23,960/mm^3, CRP: 146 mg/L), with a lactate level of 2 mmol/L. Abdominal ultrasonography and contrast-enhanced computed tomography demonstrated a single ectopic gallstone localized in the duodenum, measuring 52 mm in diameter, calcified, and of high density (617 HU). Based on these findings, together with signs of gastric outlet obstruction, a diagnosis of Bouveret syndrome was established. Due to a diagnostic delay exceeding 48 hours and the patient's high-risk profile, endoscopic interventions were limited. Following unsuccessful stone extraction after endoscopy and ERCP, the patient underwent surgical treatment. The obstructing stone was successfully removed via open enterolithotomy (operative time: 60 minutes). No additional surgical intervention was performed for the bilioenteric fistula. In the postoperative period, the patient developed surgical site infection and sepsis, requiring intensive care unit follow-up for 36-days; the total hospital stay was 60 days. The patient was discharged, and no mortality or recurrence was observed during a 12-months follow-up period.

Conclusion: Bouveret syndrome is prone to delayed diagnosis in elderly patients with multiple comorbidities and carries a high risk of morbidity. However, this case demonstrates that despite advanced age (99 years), ASA-IV status, a Charlson comorbidity index of 5, prolonged symptom duration, and a diagnostic delay exceeding 48 hours, a favorable clinical outcome can be achieved through accurate identification of a 52 mm calcified duodenal stone and performance of an open enterolithotomy aimed solely at relieving the obstruction, without fistula repair. Despite severe postoperative complications and prolonged intensive care unit stay, the patient was discharged without mortality, and no recurrence was observed during 12-months of follow-up. This case underscores the importance of early consideration of Bouveret syndrome in elderly patients presenting with gastric outlet obstruction and highlights that, in high-risk patients, the shortest, safest, and most targeted surgical strategy may be life-saving.

Keywords: Advanced age, Bouveret syndrome, enterolithotomy, gallstone ileus, gastric outlet obstruction

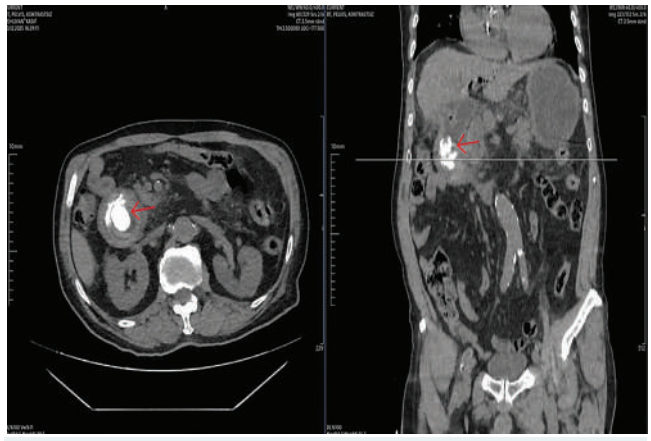

Figure 1. Axial and coronal CT images of the case.

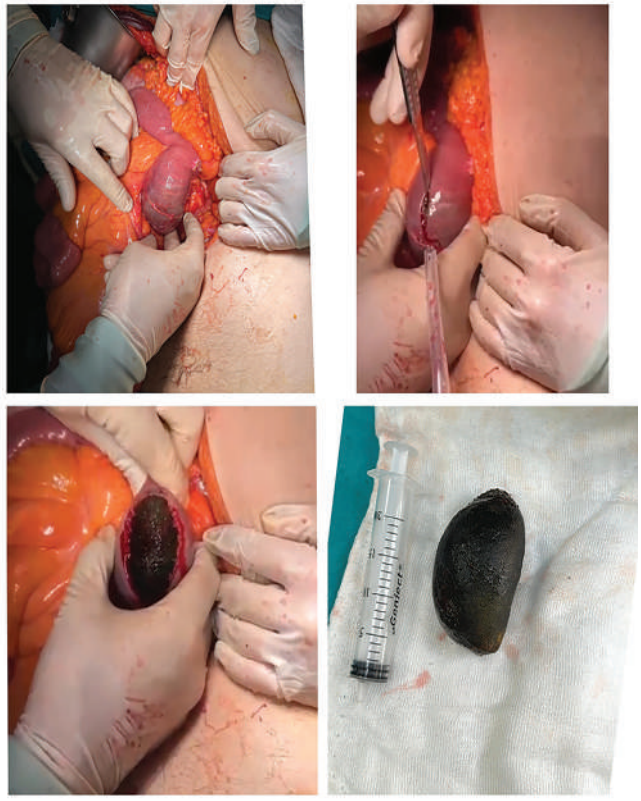

Figure 2. Operative images of the case.

Table 1. Comparison of the case with the literature

PARAMETRE	BİZİM OLGU	LİTERATÜR	YORUM
Yaş / cinsiyet	**99 / Kadın**	Çoğunlukla **yaşlı kadın** hastalar	Bizim olgu **uç yaş** grubunda; "kırılgan hasta" vurgusunu güçlendirir.
Klinik tablo	GÇO (bulantı-kusma, oral alım bozukluğu), semptom **19 gün**	En sık **gastrik çıkış obstrüksiyonu** semptomları; tanı gecikebilir (	Uzamış semptom süresi = tanı gecikmesi mesajını destekler.
Komorbidite / risk	**ASA 4, Charlson 5**, BMI 19	Olgular sıklıkla komorbid; standart kılavuz yok, karar bireyselleşir	"Yüksek riskte en güvenli strateji" temasına çok uygun.
İnflamasyon	WBC **23.960**, CRP **146**, laktat 2	Enfeksiyon/aspirasyon, sepsis gibi komplikasyonlar bildirilir	Bizde ağır inflamasyon + postop sepsis ile uyumlu.
Taş lokalizasyonu	**Duodenum**	Tipik olarak pylorus/duodenum	Klasik yerleşim.
Taş boyutu	**18 mm**	Çoğu olguda taşlar büyük/impakte; endoskopik çıkarım her zaman mümkün değil	18 mm görece "orta"; yine de çıkarılamaması "gecikme + impaksiyon" vurgusunu destekler.
Endoskopik tedavi	Endoskopi + ERCP yapıldı; **çıkarılamadı**	Endoskopik tedavi başarı oranı yaklaşık **%43**; cerrahi başarı **%94** civarı	Literatürle uyumlu: endoskopi ilk seçenek olsa da çoğu olgu cerrahiye gider.
Cerrahi yaklaşım	**Açık enterolitotomi**, süre **60 dk**	Cerrahi "kesin tedavi" olma eğiliminde; açık/lap yaklaşımlar mümkün	"Hedefe yönelik kısa cerrahi" mesajı burada çok güçlü.
Fistül onarımı	**Yapılmadı**, izlem	Yaşlı/kırılgan hastada fistül onarımı tartışmalı; basit taş çıkarımı sonrası nüks düşük bildirilebilir	Bizim olgu: "fistül onarımını zorlamadan başarı" vurgusu için ideal.
Postop komplikasyon	**CAE + sepsis**, YBÜ **36 gün**, yatış **60 gün**	Postop enfeksiyon/aspirasyon vs komplikasyonlar raporlanır; mortalite literatürde **%12–30** aralığına kadar bildirilebilir	Uzun YBÜ'ye rağmen sağkalım → olgunun çarpıcılığı artıyor.
Mortalitede durum	**Yok**	Endoskopi daha düşük mortalite ile anılsa da; cerrahide hasta profiline göre mortalite artabilir (seriler arası değişken)	Bizde "çok yüksek riskte mortalitesiz taburculuk" güçlü mesaj.
Takip / nüks	**12 ay, nüks yok**	Basit enterolitotomi sonrası nüks genelde düşük (bazı raporlarda <%5)	Takip verisi olguyu "tamamlanmış" ve daha değerli yapar.

[P-330]

Emergency management of jejunal perforations distal to gastrojejunostomy: A two-case series treated with Graham omental patch

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Objective: Marginal ulcers and jejunal perforations following bariatric surgery are rare but carry a significant risk of morbidity and mortality. In this study, we present the diagnostic approach, surgical management, and clinical outcomes of two patients who underwent emergency surgery due to perforation occurring distal to the gastrojejunostomy (GJ) anastomosis.

Material and Methods: Two patients with a history of bariatric surgery who presented with an acute abdomen between June and December 2024 were retrospectively evaluated. The patients' clinical findings, laboratory parameters, imaging results, intraoperative findings, and postoperative courses were reviewed. In both cases, jejunal perforations were repaired by primary suturing followed by the application of a Graham omental patch.

Results: Between June and December 2024, two patients with a history of bariatric surgery who presented with an acute abdomen were evaluated emergently. The first case was a 50-year-old female patient with a previous history of sleeve gastrectomy and Roux-en-Y gastric bypass; computed tomography revealed free air consistent with perforation. The second case was a 56-year-old male patient who had recently undergone Roux-en-Y gastric bypass; diffuse free air was observed on CT. In both cases, intraoperative exploration revealed jejunal perforations distal to the GJ anastomosis. The perforations were repaired by primary suturing and reinforced with a Graham omental patch. Leak tests were negative. No major postoperative complications occurred; one patient was discharged after short-term intensive care unit monitoring. The clinical course was stable in both patients, and the surgical repairs were deemed successful.

Conclusion: Marginal ulcers after Roux-en-Y gastric bypass are uncommon but may result in serious morbidity and mortality when complicated by perforation. Although computed tomography is considered the gold standard for diagnosis, perforation findings may be subtle due to altered postoperative anatomy, requiring high clinical suspicion. In this poster, two patients with a history of bariatric surgery who presented with acute abdomen were evaluated. In both cases, jejunal perforation distal to the GJ anastomosis was identified during emergency surgery. Perforations were repaired with primary suturing reinforced by a Graham omental patch. Despite minimal radiological findings in one patient, intraoperative exploration confirmed perforation, emphasizing the importance of early surgical intervention. No major postoperative complications occurred, and clinical outcomes were favorable in both patients. These cases demonstrate that Graham omental patch repair is a safe, effective, and easily applicable technique for distal GJ perforations. A low threshold for surgical exploration should be maintained in bariatric patients presenting with acute abdomen to prevent delayed diagnosis and outcomes.

Keywords: Bariatric surgery, marginal ulcer, jejunal perforation, gastrojejunostomy, emergency surgery

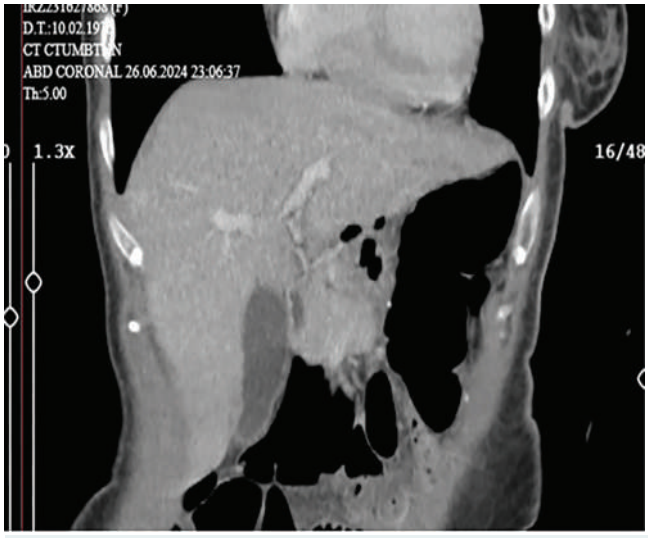

Figure 1. Case 1: preoperative contrast-enhanced CT image (coronal). Thin fluid-air levels consistent with perforation are observed in the hepatogastric region, along with localized millimetric free air foci at the level of the hepatogastric ligament and adjacent to the lesser curvature of the stomach.

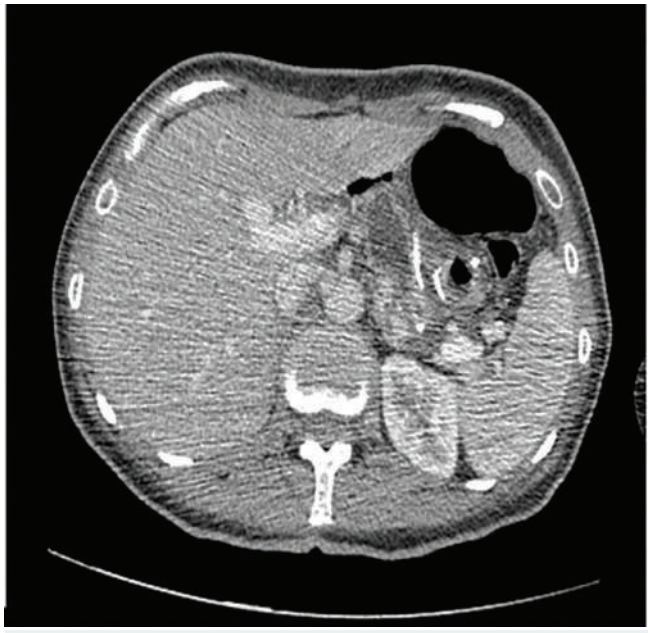

Figure 2. Case 1: preoperative contrast-enhanced CT image (axial). Minimal free fluid is observed in the pelvic cavity, along with metallic suture materials related to previous surgery. No obstructive pathology is identified.

Figure 3. Case 2: preoperative contrast-enhanced CT image (axial). Free air consistent with perforation is observed anterior to the liver, in front of the spleen, and surrounding the stomach.

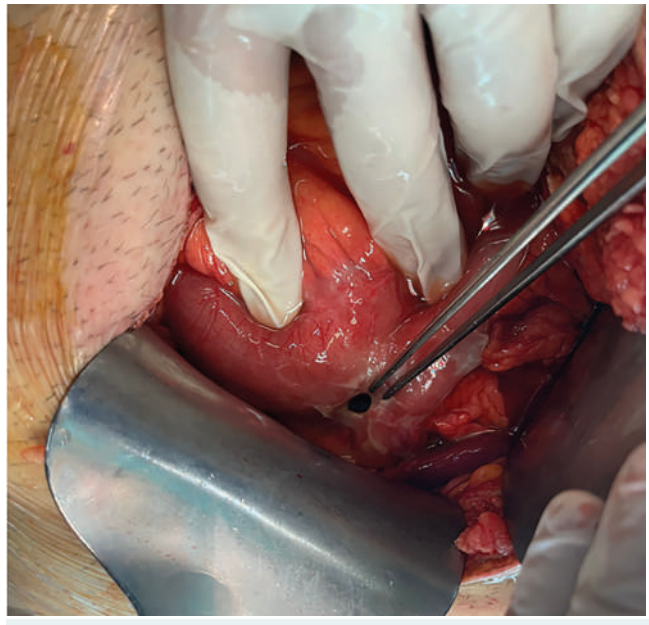

Figure 4. Case 2: Intraoperative image. Approximately 500 cc of free intraperitoneal fluid and a 1 cm perforation focus distal to the gastrojejunostomy anastomosis were observed.

[P-331]

Choice of surgical approach for gallstone ileus

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Objective: Gallstone ileus is the obstruction of the intestinal tract by stones due to gallbladder or biliary fistulas. Gallstone ileus accounts for 1-4% of all intestinal obstructions. Cholecystoduodenal fistula is frequently seen. Gallstone ileus occurs in 0.3-0.5% of all cases of cholelithiasis. Gallstone ileus develops when the gallstone is larger than 2.5 cm. Obstruction usually occurs in the terminal ileum (70%). Contrast-enhanced abdominal CT is the gold standard in imaging. Surgical treatment is performed as one-stage or two-stage.

Material and Methods: Case 1: a 54-year-old woman with no comorbidities or prior surgery presented with abdominal pain, nausea, and vomiting. Contrast-enhanced abdominal CT showed pneumobilia and small-bowel air-fluid levels, suggesting ileus. At laparotomy, a mass was palpated 170 cm distal to the ligament of Treitz; enterolithotomy was performed, the gallstone was removed, and the bowel was primarily repaired. Two cholecystoduodenal fistulas were identified, so cholecystectomy and fistula resection were performed in the same session. She was discharged uneventfully on postoperative day tenth. Case 2: An 87-year-old woman with comorbidities and known gallstones, with no prior surgery, presented with nausea, vomiting, abdominal pain, and constipation. Contrast-enhanced CT demonstrated pneumobilia and small-bowel intussusception in the left lower quadrant. At laparotomy, a mass was palpated 40 cm distal to the ligament of Treitz; the gallstone was removed via enterotomy and the bowel was repaired. Due to advanced age and comorbidities, cholecystectomy was deferred. She was discharged uneventfully on postoperative day sixth.

Results: Gallstone ileus is a rare cause of intestinal obstruction. In patients without prior abdominal surgery, Rigler's triad can aid diagnosis, and laparotomy may be required in up to 50% of cases. Surgical management may be one-stage (enterolithotomy with cholecystectomy and fistula repair in the same session) or two-stage (enterolithotomy alone initially). The choice depends on age, comorbidities, and obstruction site: one-stage surgery was preferred in the first case due to the absence of comorbidities, whereas advanced age and comorbidities led to a two-stage approach in the second case. In high-risk patients, two-stage surgery is associated with lower morbidity and mortality, supporting an individualized approach.

Conclusion: Although gallstone ileus is a rare condition, it should be kept in mind in the prediagnosis of elderly patients who do not have a history of previous abdominal surgery but present with signs of obstruction. Enterolithotomy, fistula repair and cholecystectomy can be performed in one or two surgical sessions in the treatment of these cases, or enterolithotomy may be sufficient in elderly and comorbid patients.

Keywords: Cholecysto-duodenal fistula, gallstone ileus, small bowel obstruction

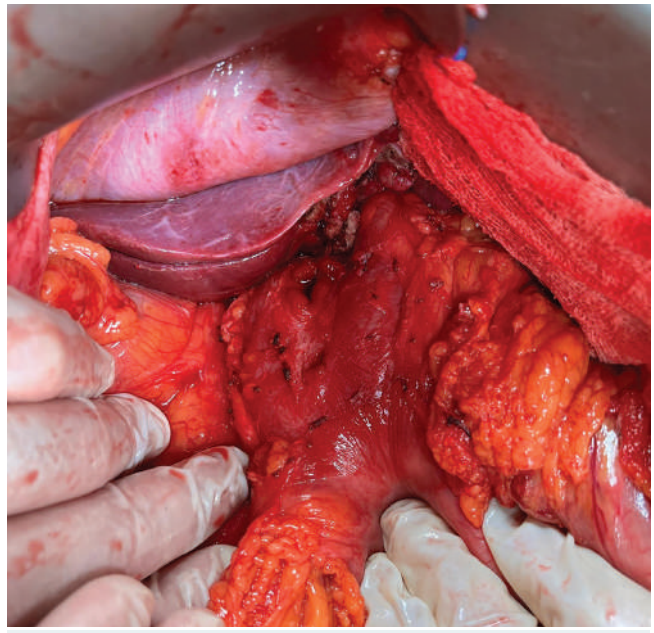

Figure 1. Cholecysto-duodenal fistula.

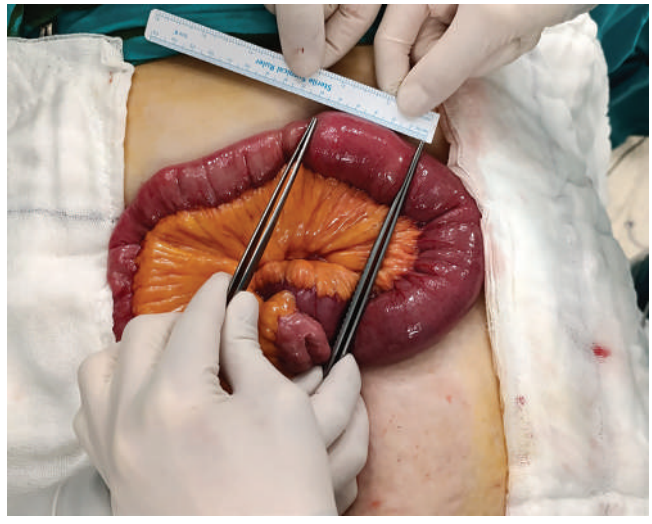

Figure 2. Obstruction of the small intestine segment due to gallstone.

[P-332]

Small bowel intussusception caused by cavernous hemangioma: A rare case

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Objective: Intussusception is a rare cause of mechanical intestinal obstruction, resulting from telescoping of one bowel segment into an adjacent segment. In adults, it accounts for less than 5% of all intussusception cases and is usually associated with an underlying structural lesion. Cavernous hemangiomas are rare benign vascular tumors of the gastrointestinal tract that are often asymptomatic but may require surgical intervention when obstruction occurs.

Material and Methods: A 35-year-old male presented to the emergency department with abdominal pain accompanied by nausea and vomiting. Clinical evaluation, laboratory findings, and radiological imaging were performed. Plain abdominal radiography and contrast-enhanced abdominal computed tomography suggested mechanical intestinal obstruction secondary to intussusception. Surgical exploration was planned accordingly.

Results: Intraoperatively, intussusception was identified approximately 60 cm proximal to the ileocecal valve in the terminal ileum. After manual reduction, a well-circumscribed solid intraluminal lesion measuring approximately 5-6 cm was detected as the leading point. Segmental ileal resection of approximately 10 cm with clear surgical margins was performed, followed by primary anastomosis. The postoperative course was uneventful. The patient passed flatus and stool on postoperative day 2, resumed oral intake on day 3, and was discharged without complications on postoperative day 5. Histopathological examination revealed a cavernous hemangioma.

Conclusion: Cavernous hemangioma is a rare cause of intussusception in adult patients. Although diagnosis in asymptomatic cases is challenging, surgical resection remains a safe and effective treatment option in patients presenting with intestinal obstruction. Adult intussusception cases should be managed with an individualized surgical approach, considering the high likelihood of an underlying organic lesion.

Keywords: Cavernous hemangioma, intussusception, small bowel obstruction

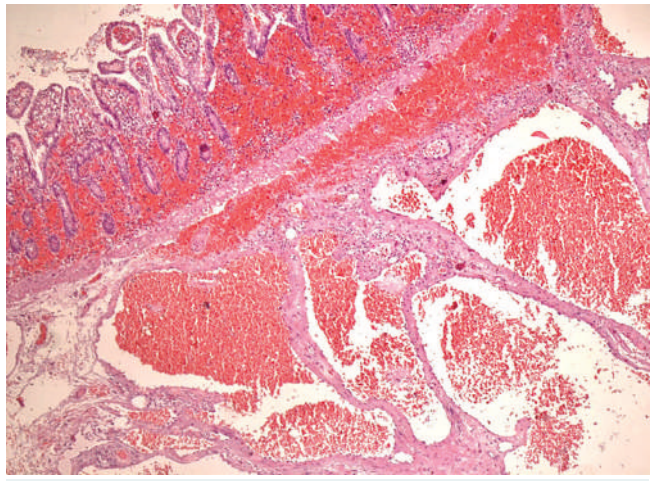

Figure 1. Cavernous hemangioma.

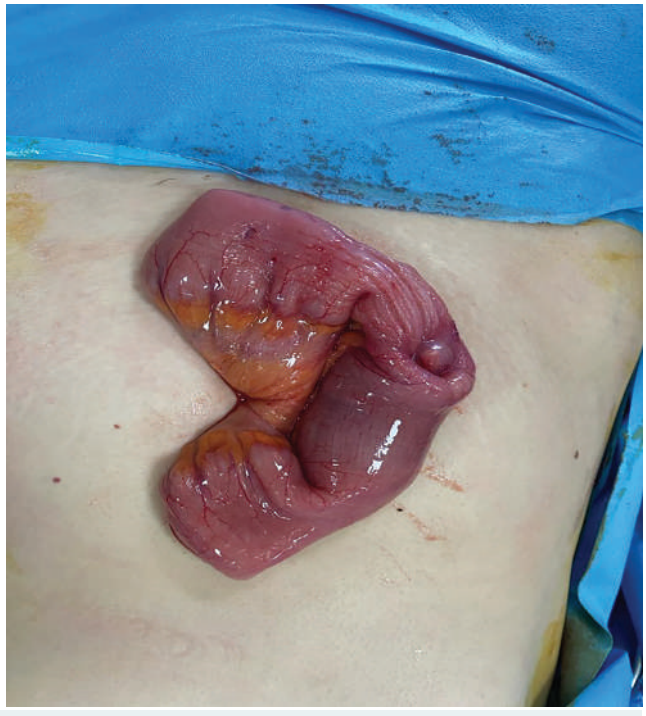

Figure 2. Intussusception.

[P-333]

A rare cause of ileus: Giant mesenteric cystic tumoral mass

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Alanya Alaaddin Keykubat University Faculty of Medicine, Antalya

Objective: Although giant mesenteric cysts are rare, they can present with acute surgical conditions such as ileus due to compression and invasion of adjacent organs. While imaging techniques guide the diagnostic process, definitive diagnosis in most cases is established through surgical exploration and histopathological examination.

Material and Methods: An 85-year-old male patient presented to the emergency department with complaints of abdominal pain, abdominal distension, and inability to pass gas or stool. Physical examination revealed abdominal distension and generalized tenderness. Abdominal ultrasonography detected a large soft tissue tumor, prompting an abdominal MRI. Magnetic resonance imaging revealed a large tumoral mass measuring approximately 28×18 cm, characterized by thick walls, septations, poorly defined margins, and diffusion restriction. The patient was admitted to the surgical ward for operative management.

Results: During emergency laparotomy, a giant tumoral mass measuring approximately 30×20 cm extending from the epigastric region to the pelvis was observed. The mass caused extensive adhesions to the small bowel and colon loops, invaded the appendix, and completely obstructed the intestinal passage due to compression. After adhesiolysis, the mass was completely resected along with the appendix. Other intra-abdominal solid organs were evaluated as normal. The patient had an uneventful postoperative course and was discharged with surgical cure. Histopathological examination revealed undifferentiated pleomorphic sarcoma (UPS), and the patient was referred to oncology for follow-up.

Conclusion: UPS, is a high-grade soft tissue sarcoma and one of the most common soft tissue sarcomas in adults. It is a rare and aggressive type of cancer that typically originates in the soft tissues of the body. These cancers often present with symptoms at a late stage and can reach advanced sizes by the time of diagnosis. In cases presenting with ileus (intestinal obstruction), emergency surgical intervention can be life-saving. Although imaging methods provide information about the size and spread of the mass, definitive diagnosis and treatment are often only possible through surgical exploration.

Keywords: Intra-abdominal mass, ileus, soft tissue tumor, emergency surgery

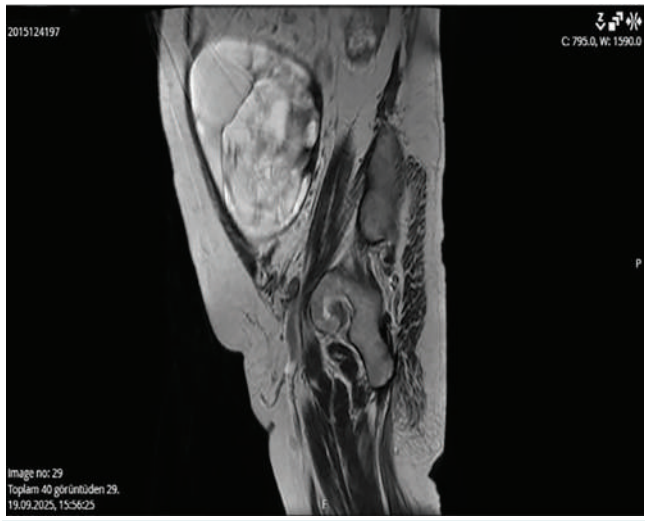

Figure 1. Pelvic MRI showing a solid-cystic, septated giant mass.

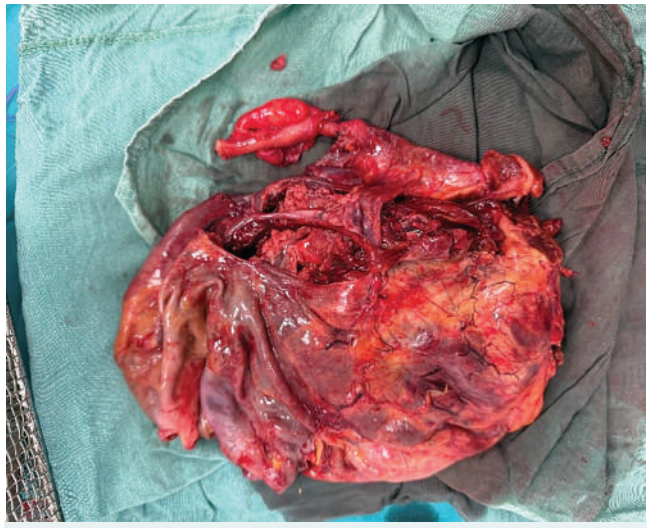

Figure 2. Giant cystic tumoral mass measuring 30×20 cm invading the appendix.

[P-334]

Abdominal cocoon syndrome presenting with illeus due to internal hernia (idiopathic sclerosing encapsulated peritonitis): Case report

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Objective: Abdominal cocoon syndrome (idiopathic sclerosing encapsulating peritonitis) is a rare cause of mechanical obstruction characterized by partial or complete encapsulation of small bowel loops within a fibro-collagenous membrane. Clinical findings are often non-specific, presenting as recurrent episodes of subileus/ileus, and preoperative diagnosis is difficult.

Material and Methods: A 53-year-old male patient with no known comorbidities or history of surgery presented with nausea-vomiting, abdominal pain, and inability to pass gas or stool. Contrast-enhanced abdominal CT revealed suspected internal hernia at the duodenal level and dilatation/air-fluid levels in the jejunal loops. Emergency surgery was planned with a preliminary diagnosis of mechanical obstruction; laparotomy was performed during laparoscopic exploration due to suspected abdominal cocoon.

Results: Approximately 80 cm distal to the Treitz ligament, segments of the small intestine extending to the terminal ileum were found to be trapped within a cocoon-like fibrous membrane, with dense adhesions between the loops. The membrane was carefully opened, and the intestinal loops were freed using careful enterolysis; resection was not performed as viability was preserved. Gas and stool passage began on postoperative day 2; oral intake was tolerated, and the patient was discharged on postoperative day 5.

Conclusion: Abdominal cocoon syndrome must always be considered in the differential diagnosis of patients presenting with recurrent ileus/intestinal obstruction attacks who have no prior history of abdominal surgery; this possibility should be considered, especially in the presence of clinical and radiological findings suggestive of internal herniation. The diagnosis is often made intraoperatively; the mainstay of treatment consists of opening/excision of the membrane and careful enterolysis.

Keywords: Abdominal cocoon, sclerosing encapsulating peritonitis, small bowel obstruction, internal hernia

Figure 1. Appearance suggestive of midline duodenal internal herniation on contrast-enhanced abdominal CT. Dilatation up to 3 cm and air-fluid levels are observed in the jejunal loops at the same levels, consistent with subileus.

Figure 2. The intraoperative view shows that the small bowel loops are encapsulated in a fibrous, thick membrane in a cocoon-like manner, and following the release of the loops, it is observed that this membrane is the mechanical cause of the obstruction (consistent with abdominal cocoon syndrome).

[P-335]

The role of inflammatory myofibroblastic tumor in adult intussusception: Clinical and pathological findings

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Objective: Intussusception is a condition in which segments of the intestine telescope into each other, creating a telescopic appearance and leading to transient or permanent gastrointestinal obstruction. It is less common in adults compared to children. Adult intussusceptions account for less than 1% of all cases of intussusception. Its incidence in adults is extremely rare and has been reported in fewer than one out of every 1,300 abdominal operations. Intussusception may cause ileus and bowel dilatation, which can subsequently lead to ischemia, necrosis, perforation, intra-abdominal sepsis, and mortality. Inflammatory myofibroblastic tumor (IMT) is an extremely rare neoplasm composed of myofibroblastic and fibroblastic spindle cells accompanied by a dense inflammatory infiltrate consisting of plasma cells, lymphocytes, and occasionally eosinophils. IMT may arise in almost any part of the body. In the gastrointestinal tract, IMT may be confused with inflammatory fibroid polyps (IFP). However, IFP can be distinguished histopathologically by the presence of stellate cells, reactive blood vessels, and a prominent infiltrate rich in eosinophils.

Material and Methods: A 50-year-old male patient presented to our emergency department with a five-day history of abdominal pain. The patient had no previous history of abdominal surgery, no known comorbidities, no regular medication use, and no history of drug allergy. He reported the onset of vomiting on the day of admission. Physical examination revealed a distended abdomen. Vital signs were stable. Due to persistent nausea, a nasogastric tube was inserted and oral intake was discontinued. Abdominal computed tomography was performed as an additional diagnostic evaluation. The presence of a target sign, which is pathognomonic for intussusception, was detected on computed tomography, and surgery was planned with a preliminary diagnosis of intussusception. Intraoperatively, an intussuscepted small bowel segment was identified 250 cm distal to the ligament of Treitz. The involved small bowel segment, including the intussusception site, was laparoscopically resected with proximal and distal margins, and primary anastomosis was performed. Figure 1: HE-stained section showing the relationship between intestinal mucosa and mass at 4x magnification, Figure 2: ALK-D5F3 positive staining area in the tumor during immunohistochemical examination at 10x magnification.

Results: The pathological examination revealed a submucosal, polypoid inflammatory mass measuring 5.5×3.5×3 cm, composed of spindle cells with focal myxoid and fibroid stroma. Immunohistochemical analysis demonstrated ALK positivity, and the lesion was diagnosed as an inflammatory myofibroblastic tumor.

Conclusion: Adult intestinal intussusception is a rare clinical condition. Contrast-enhanced computed tomography is a useful radiological modality and plays a crucial role in the diagnosis of the disease. IMT is a rare pathological entity with low rates of recurrence and metastasis after surgical resection. However, the diagnosis may be overlooked in the preoperative period.

Keywords: Intestinal obstruction, intussusception, inflammatory myofibroblastic tumor

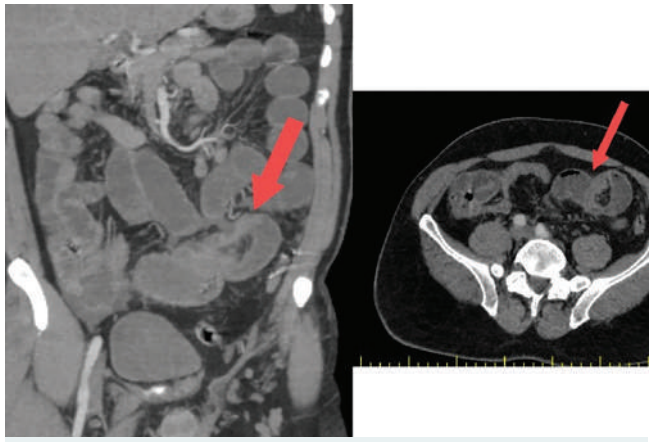

Figure 1. Imaging findings.

Figure 2. Surgical view.

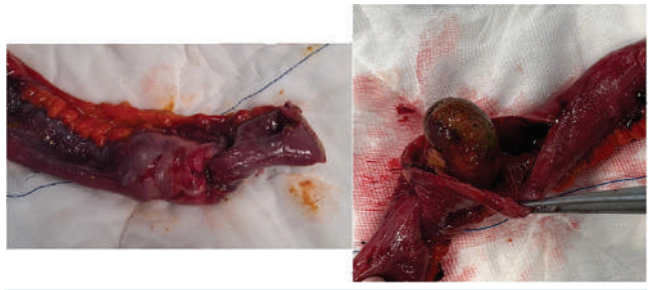

Figure 3. Pathological findings.

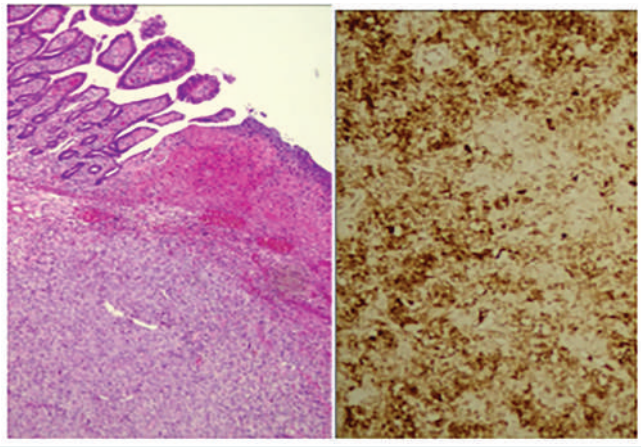

Figure 4. Pathological findings.

Table 1. Laboratory results

Parameter	Value	Unit
WBC	14.91	$\times 10^9$/L
RBC	5.39	$\times 10^{12}$/L
Hemoglobin	14.2	g/dL
Creatinine	0.83	mg/dL
e-GFR	103	mL/min
Sodium (Na)	135	mEq/L
Potassium (K)	3.74	mEq/L
Chloride (Cl)	98	mEq/L
Total Bilirubin	0.77	mg/dL
Direct Bilirubin	0.33	mg/dL
Indirect Bilirubin	0.44	mg/dL
ALT	17	U/L
AST	15	U/L
Amylase	46	U/L
Lipase	23	U/L
C-Reactive Protein (CRP)	148.4	mg/dL

[P-336]

A rare concurrence in acute abdomen: Simultaneous acute appendicitis, acute cholecystitis, acute pancreatitis

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Objective: Acute appendicitis, acute cholecystitis, and acute pancreatitis are common causes of acute abdomen; however, the concomitant occurrence of all three conditions is exceedingly rare. Overlapping clinical presentations may pose significant diagnostic and therapeutic challenges. This case report presents this uncommon coexistence.

Material and Methods: This case report describes the coexistence of acute appendicitis, acute cholecystitis, and acute pancreatitis in a patient presenting to the emergency department with acute abdomen. Clinical presentation, laboratory findings, and radiological imaging were retrospectively reviewed. Contrast-enhanced whole-abdominal computed tomography was used for diagnostic evaluation. Diagnostic laparoscopy was performed, and intraoperative findings were documented. The postoperative clinical course, laboratory parameters, and treatment response were assessed through review of the patient's medical records.

Results: A 48-year-old female patient with no known comorbidities presented to the emergency department with a two-day history of epigastric and lower quadrant abdominal pain accompanied by loss of appetite. Physical examination demonstrated tenderness in the epigastric region and right lower quadrant. Laboratory evaluation revealed the following values: leukocyte count, 12.82×10^3/μL; C-reactive protein, 2.2 mg/dL; aspartate aminotransferase, 107 U/L; alanine aminotransferase, 52 U/L; lipase, 5041 U/L; total bilirubin, 1.01 mg/dL; and direct bilirubin, 0.52 mg/dL. Contrast-enhanced abdominal computed tomography was performed at presentation. Imaging demonstrated fluid accumulation extending to the umbilical region at the level of the pancreatic head and body. The gallbladder appeared hydropic, with inflammatory wall thickening and pericholecystic fluid collection (Figure 1). A millimetric image suggestive of a gallstone was noted within the gallbladder lumen. The distal segment of the appendix measured approximately 10 mm in diameter and exhibited an inflammatory appearance, suggesting acute appendicitis (Figure 2). Based on the clinical, laboratory, and radiological findings, diagnostic laparoscopy was performed. Intraoperatively, the gallbladder was found to be edematous and inflamed, without evidence of necrosis (Figure 3). Appendectomy was performed due to the edematous and inflamed appearance of the appendix. Examination of the excised appendix revealed the presence of a fecalith (Figure 4). Postoperatively, the patient was managed with medical therapy and close monitoring. With improvement in clinical and laboratory parameters, the patient was discharged on postoperative day 4.

Conclusion: The simultaneous presence of multiple pathologies in acute abdomen is uncommon but may complicate diagnosis. In this case, contrast-enhanced abdominal CT was crucial in identifying concurrent acute pancreatitis, acute cholecystitis, and acute appendicitis. Successful outcomes were achieved with appropriate surgical and medical management. Clinicians should consider the possibility of multiple coexisting pathologies in patients presenting with acute abdomen.

Keywords: Acute abdomen, acute appendicitis, acute cholecystitis, acute pancreatitis, concurrent abdominal pathologies

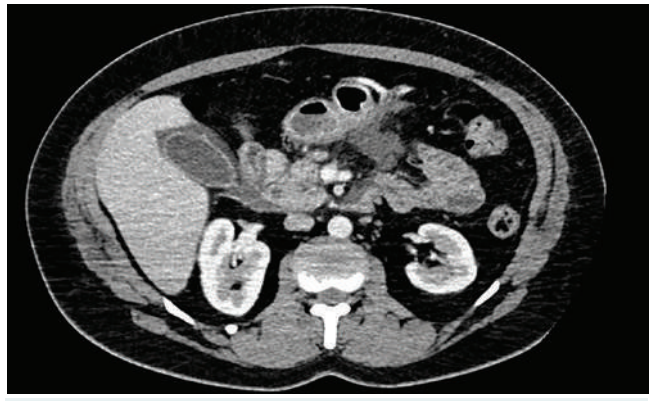

Figure 1. Computed tomography image of the gallbladder and pancreas. Contrast-enhanced CT image showing a hydropic gallbladder with wall thickening and pericholecystic and peripancreatic fluid collection, suggestive of acute cholecystitis and acute pancreatitis.

Figure 2. Computed tomography image of the appendix. CT image showing the appendix measuring 10 mm in diameter with an inflamed appearance.

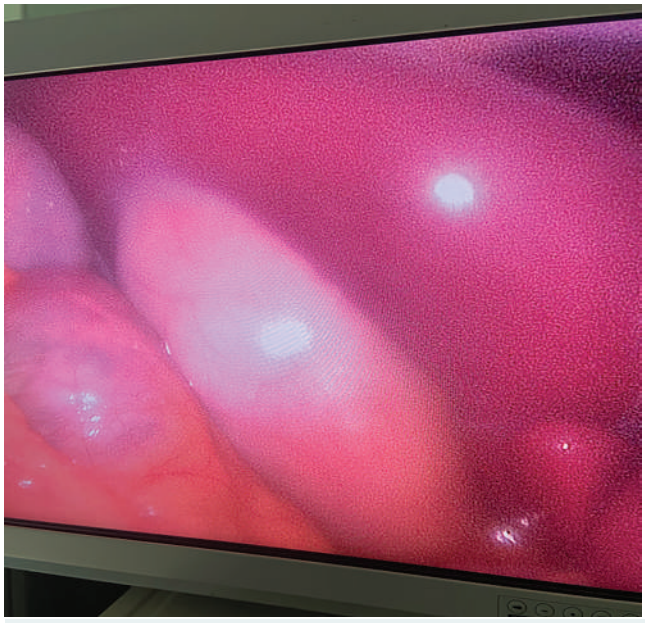

Figure 3. Laparoscopic view of the gall bladder. The gallbladder appeared edematous and inflamed, with no evidence of necrosis.

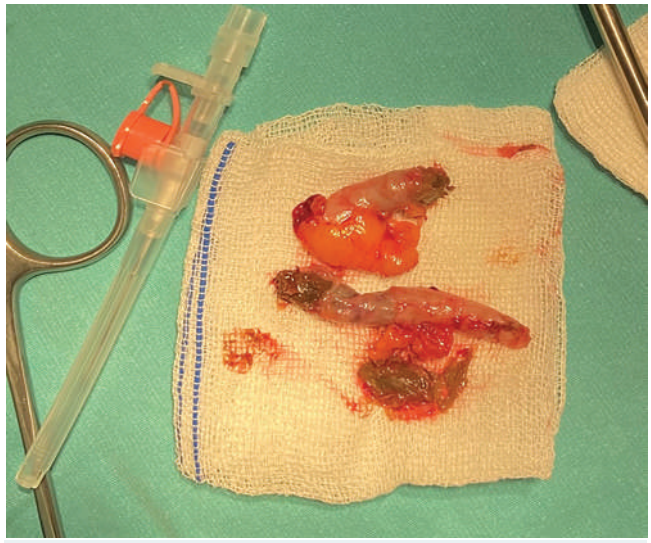

Figure 4. Resected bladder. The gallbladder appeared edematous and inflamed, with no evidence of necrosis.

[P-337]

Anterior abdominal wall necrosis following horse serum injection: A rare case

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Objective: To date, tissue necrosis following subcutaneous horse serum injection in humans has not been reported. However, immune-mediated reactions to heterologous sera, such as the Arthus reaction, a type III hypersensitivity response caused by immune complex deposition in small vessels, and systemic reactions including serum sickness after equine-derived rabies immunoglobulin have been described. In addition, Nicolau syndrome, a rare complication of parenteral drug administration characterized by pain, edema, erythema, and necrotic plaque formation, is well recognized. To the best of our knowledge, this case represents the first report of localized tissue necrosis following parenteral horse serum administration in humans.

Material and Methods: A 46-year-old woman with invasive carcinoma of the left breast was started on neoadjuvant doxorubicin-cyclophosphamide (AC) chemotherapy. Her medical history was significant for diabetes mellitus and obesity. During active chemotherapy, she reported self-administering a preparation containing equine serum, obtained from a veterinarian, without medical supervision, by subcutaneous injection into the abdominal wall at eight different sites, repeated weekly for a total of seven injections. Five days after receiving the third chemotherapy cycle, she presented with malodorous, exudative necrotic lesions on the anterior abdominal wall. Laboratory evaluation revealed leukopenia (4.530/µL), anemia (Hb 9.9 g/dL), and elevated inflammatory markers (CRP 65 mg/L). Abdominal computed tomography showed no intra-abdominal involvement. Early surgical debridement was performed, and eight separate necrotic/gangrenous lesions were excised and sent for histopathological analysis. Postoperatively, oral intake was resumed, antibiotic therapy was initiated, and chemotherapy was temporarily suspended due to infection. The patient was discharged on postoperative day 3 with outpatient wound care. Two sites developed superficial wound dehiscence during follow-up and were managed conservatively. Complete wound healing was achieved by postoperative day 21, after which the patient was referred back to oncology.

Results: Histopathological findings: All eight skin and subcutaneous tissue specimens showed epithelial ulceration, chronic inflammation, and fat necrosis, with no evidence of malignancy.

Conclusion: This case demonstrates that subcutaneous injection of horse serum into the abdominal wall, performed without medical supervision, can result in severe local soft tissue necrosis in an immunosuppressed breast cancer patient receiving active chemotherapy. Inappropriate use of heterologous animal sera may lead to rapidly progressive complications requiring surgical intervention, particularly in immunocompromised individuals. The clinical course and pattern of tissue injury in this case show similarities to Nicolau syndrome, a rare complication characterized by necrotic plaque formation following parenteral drug administration. This report highlights the potential risks associated with uncontrolled injections used for alternative treatment purposes.

Keywords: Horse serum, necrosis, nicolau syndrome, immunosuppression, case report

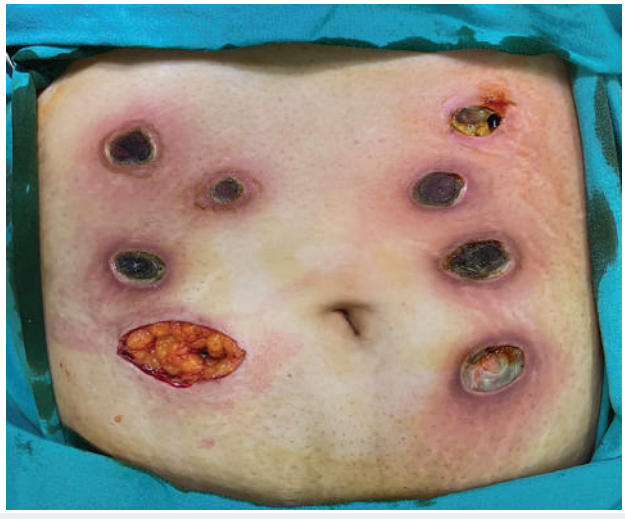

Figure 1. Necrotic lesions of the anterior abdominal wall. Necrotic lesions following repeated subcutaneous horse serum injections at eight sites of the anterior abdominal wall.

Figure 2. Wound appearance on postoperative day 21.

Figure 3. Necrotic skin and subcutaneous tissue specimens excised during surgery.

[P-338]

Gastric perforation secondary to incarcerated hiatal hernia associated with severe lactic acidosis in a 98-year-old patient

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Objective: Hiatal hernias are anatomical defects characterized by the displacement of the gastric fundus into the mediastinum. Paraesophageal hernias (types II-IV) may predispose patients to life-threatening surgical emergencies such as gastric volvulus and strangulation. In the literature, perforations due to gastric strangulation are associated with high mortality rates. This presentation discusses a case of hiatal hernia perforation at an extreme age, accompanied by a severe lactic acidosis profile.

Material and Methods: A 98-year-old female patient presented to the emergency department with sudden-onset, severe left-sided chest pain radiating to the back, dyspnea, and hematemesis. Initial examination revealed hypertension (140/85 mmHg), tachycardia (110 bpm), tachypnea (24 bpm), and hypoxia (SpO_2: 88%). Auscultation showed diminished breath sounds in the left lung; the abdomen was soft and non-tender.

Results: Chest X-ray revealed a widened mediastinum and a mass appearance with an air-fluid level in the left retrocardiac area (Figure 1). Arterial blood gas analysis demonstrated severe metabolic acidosis (pH: 7.23, lactate: 6.43 mmol/L). Thoraco-abdominal CT showed significant herniation of the stomach into the posterior mediastinum, 25 mm of free fluid, and free intraperitoneal air. The patient was taken for emergency surgery. Exploration revealed a strangulated gastric fundus herniated through a 4 cm hiatal defect. A 2 cm perforation was identified in the herniated fundus (Figure 2). Following irrigation and debridement, a wedge resection including the perforated area was performed, and the hiatal defect was repaired primarily. The patient, followed postoperatively in the intensive care unit under intubation, succumbed 48 hours later.

Conclusion: In elderly patients, strangulation of hiatal hernias may be masked by chest pain and respiratory distress instead of typical acute abdominal findings. As stated in the literature, lactate levels above 6 mmol/L are among the strongest predictors of tissue necrosis and poor prognosis. Despite early radiological diagnosis and surgical intervention, mortality may be inevitable in the presence of extreme age and profound acidosis. This case emphasizes the importance of considering hiatal hernia complications in the differential diagnosis of acute chest pain in the elderly.

Keywords: Incarcerated hiatal hernia, gastric perforation, lactic acidosis, incarcerated hiatal hernia, gastric perforation, lactic acidosis

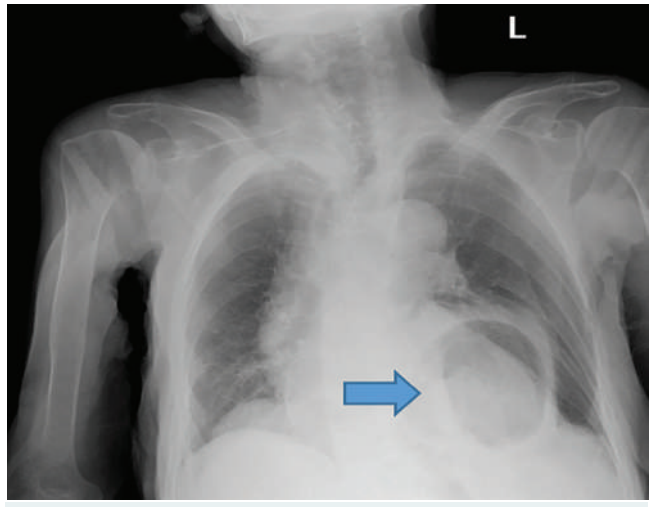

Figure 1. Chest X-ray showing a retrocardiac air-fluid level consistent with a hiatal hernia.

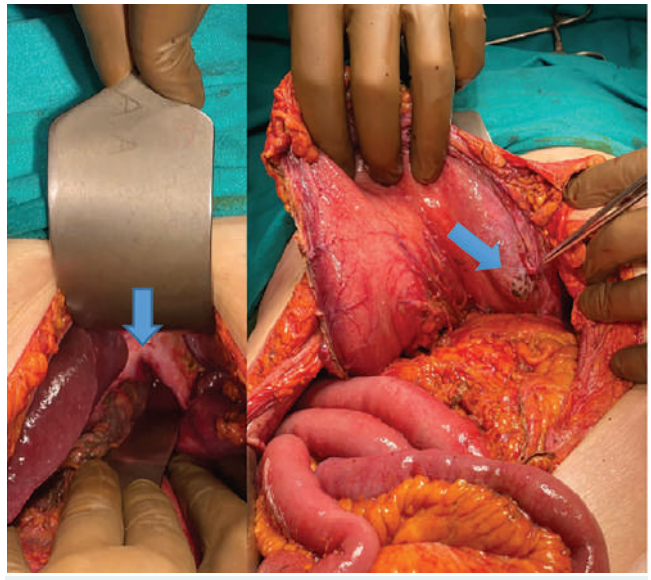

Figure 2. Intraoperative view of the 2 cm gastric perforation in the fundus after reduction from the hiatal defect.

[P-339]

A rare cause of acute abdomen: Spontaneus rupture of a splenic hydatic cyst

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Objective: Echinococcus, or hydatid disease, has four main subtypes: *Echinococcus granulosus, Echinococcus multilocularis, Echinococcus vogeli*, and *Echinococcus oligarthrus. Echinococcus granulosus* causes cystic echinococcosis (CE) and is the most commonly encountered clinical form. Although hydatid disease most commonly involves the liver and lungs, splenic involvement is reported in approximately 5% of cases. Cyst rupture in these patients is usually associated with trauma; however, spontaneous rupture may rarely occur. In this study, we aimed to increase awareness among general surgeons of a rare, life-threatening cause of acute abdomen.

Material and Methods: We present the case of a 45-year-old female patient who was admitted with sudden onset of severe abdominal pain and was diagnosed with spontaneous rupture of a splenic hydatid cyst.

Results: A 45-year-old female patient with no comorbidities presented with sudden, severe abdominal pain without any history of trauma. Physical examination revealed generalized abdominal guarding and rebound tenderness, more pronounced in the left upper quadrant. Contrast-enhanced abdominal CT demonstrated diffuse free intraperitoneal fluid in all quadrants and a splenic lesion consistent with a hydatid cyst. No hepatic lesions were detected. The patient presented within two hours of pain onset. Laboratory evaluation showed mildly elevated C-reactive protein and leukocyte levels. Emergency exploratory laparotomy was performed. Intraoperatively, widespread free fluid compatible with cyst contents, a perforated cyst capsule originating from the spleen, and germinative membranes were observed. Cystotomy and extensive peritoneal lavage were performed. No daughter cysts were identified. The postoperative course was uneventful. Albendazole therapy was initiated at a dose of 15 mg/kg/day divided into two doses. The patient was discharged in good condition on postoperative day four.

Conclusion: Although splenic hydatid cysts are rare, cyst rupture represents a life-threatening cause of acute abdomen and may lead to anaphylactic shock. Early recognition and prompt surgical management are crucial.

Keywords: Splenic hydatid cyst, acute abdomen, spontaneous rupture

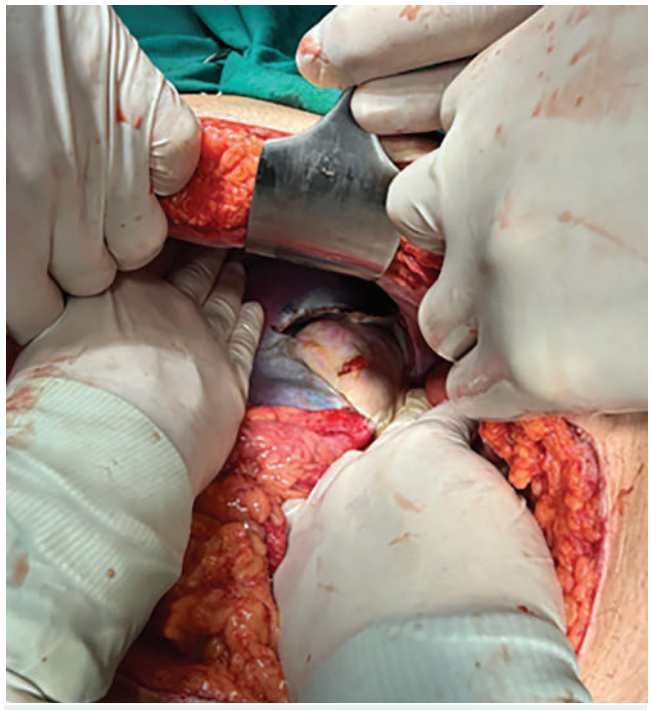

Figure 1. Perforated splenic hydatid cyst.

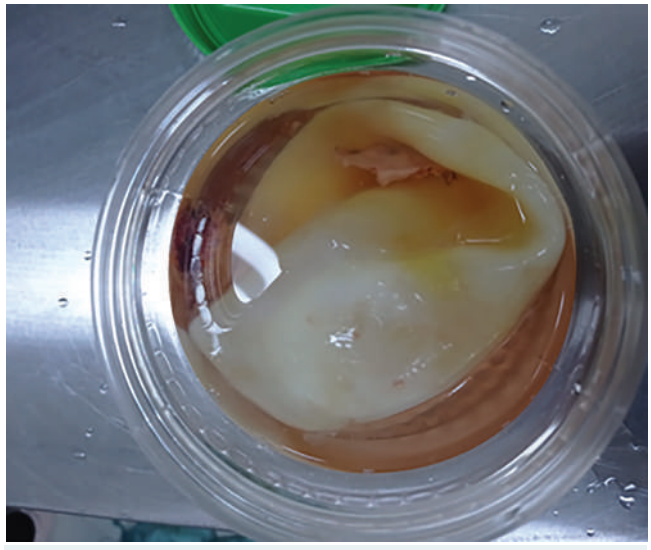

Figure 2. Germinative membrane.

[P-340]

Ileal ischemia due to superior mesenteric vein thrombosis: A case managed with emergency surgery

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Objective: Superior mesenteric vein (SMV) thrombosis is uncommon but can quickly progress to bowel ischemia if missed. This case highlights that symptoms mimicking obstruction may actually reflect mesenteric venous thrombosis.

Material and Methods: Sixty sevenyearold man presented with 3 days of obstipation, nausea, and vomiting. He had hypertension, cirrhosis, and peripheral arterial disease, with no prior abdominal surgery. After contrast-enhanced CT, emergency laparotomy was performed.

Results: CT showed marked small-bowel dilatation, diffuse wall thickening of ileal loops in the right lower quadrant, and mesenteric heterogeneity. A thrombus completely occluding the SMV with extension toward the portal vein was detected, and the liver had a cirrhotic appearance. At surgery, an approximately 100 cm ileal segment starting ~20 cm proximal to the ileocecal valve was ischemic/necrotic with absent peristalsis. Segmental small-bowel resection was performed and a Mikulicz (doublebarrel) ileostomy was created. The patient resumed oral intake on postoperative day 1 and was discharged uneventfully on day 7. Pathology confirmed transmural ischemia/necrosis with hemorrhage and edema.

Conclusion: In patients presenting with an ileus-like picture, SMV thrombosis should be considered-especially when cirrhosis or vascular disease is present. Prompt CT and timely surgery can limit bowel loss and improve outcomes.

Keywords: Ileal ischemia, mesenteric vein thrombosis, ileus, emergency surgery

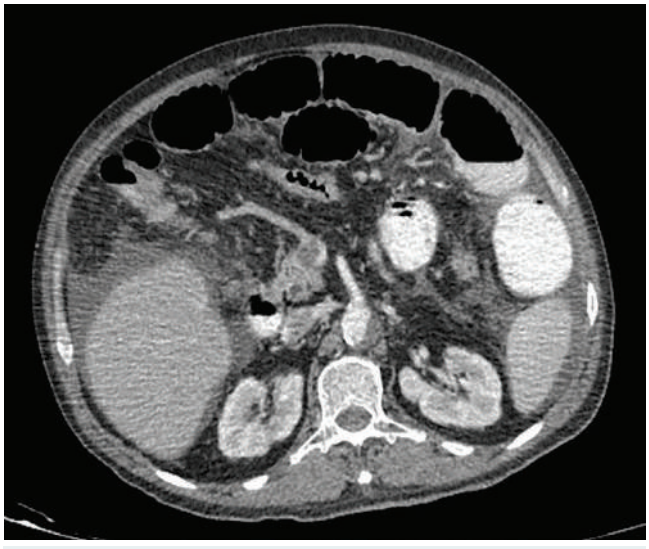

Figure 1. Computed tomography scan: superior mesenteric vein occlusion by thrombus with extension toward the portal vein; associated ileal wall thickening and dilatation.

Figure 2. Intraoperative view: ischemic/necrotic ileal segment and operative strategy with resection plus Mikulicz ileostomy.

[P-341]

Gas embolism following hydrogen peroxide ingestion: A case successfully treated with hyperbaric oxygen

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Objective: Hydrogen peroxide (H_2O_2) ingestion can result in gas embolism, a rare but potentially serious morbidity and mortality event. The extent of vascular involvement varies, and early diagnosis is crucial. Hyperbaric oxygen therapy (HBOT) is the primary treatment for gas embolisms.

Material and Methods: A 54-year-old male cleaning worker with no significant medical history presented to the emergency department with severe nausea and retrosternal pain after ingesting approximately 250 mL of 3% H_2O_2 orally. He was oriented, cooperative, vital signs were stable. Systemic examination was normal. Abdominal examination revealed no tenderness, guarding; rebound tenderness.Laboratory tests showed moderate leukocytosis ($12.68x10^3/\mu L$). Liver function parameters were normal. Contrast-enhanced abdominal CT scan revealed widespread gas emboli within the portal venous structures and mesenteric vascular structures but no perforation. Admitted to the ICU for close vital sign monitoring and systemic examination. Following a control CT, HBOT was administered. A subsequent CT showed a dramatic regression of the gas emboli. The patient was transferred to the ward for observation and continued monitoring with closed oral access. During follow-up, nausea subsided, abdominal examination was comfortable, and oral intake was gradually increased after symptomatic treatment. The patient was discharged in good health on the 7th day of follow-up.

Results: When H_2O_2 is ingested in high concentrations and large quantities, systemic effects can occur in addition to damage to the gastrointestinal and respiratory systems. In this case, the detection of widespread gas emboli in the portal venous system on CT findings indicates that the gas formed after H_2O_2 ingestion entered the systemic circulation. Even when H_2O_2 is ingested in low concentrations, it is rapidly broken down into water and oxygen by the catalase enzyme in the gastrointestinal system. The volume of released gas can increase; this can lead to the development of gas emboli in the portal venous system,mesenteric vessels,and even the cerebral circulation. Clinical findings can vary widely, from mild symptoms to fatal outcomes. If swallowed, 30 mL of 35% H_2O_2 is sufficient to produce 3.4 L of oxygen gas. In the literature, studies on the systemic effects of H_2O_2 and gas embolism frequently highlight the effectiveness of oxygen therapy and HBOT. The effectiveness of HBOT in the direct treatment of gas embolism has been proven in many studies. A review titled "Hyperbaric Oxygen Therapy for the Treatment of Decompression Sickness and Gas Embolism" reported that hyperbaric oxygen therapy improves patient outcomes in gas embolism by accelerating the dissolution of gases.

Conclusion: Gas embolism developing after H_2O_2 ingestion is a serious condition requiring urgent diagnosis and treatment. This case clearly demonstrates the effectiveness of HBOT in gas embolism management. Early intervention can improve the patient's prognosis and reduce the risk of complications. Monitoring and treating such conditions plays a crucial role in healthcare systems.

Keywords: Hydrogen peroxide, gas embolism, hyperbaric oxygen therapy

Figure 1. H_2O_2 portal gas embolism.

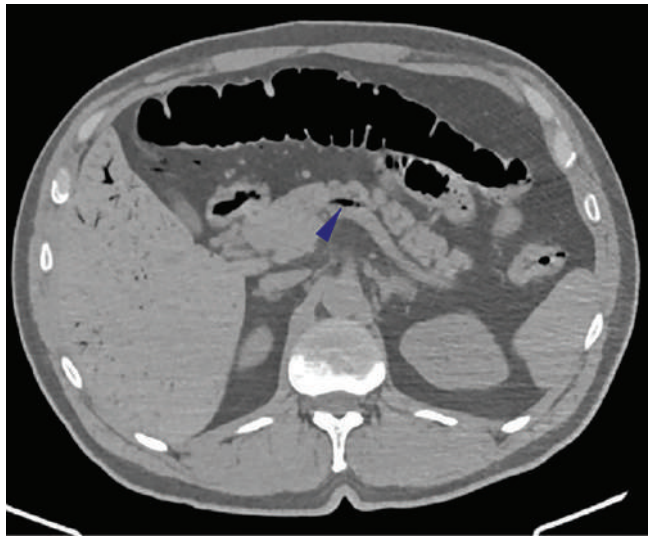

Figure 2. Mesenteric gas embolism.

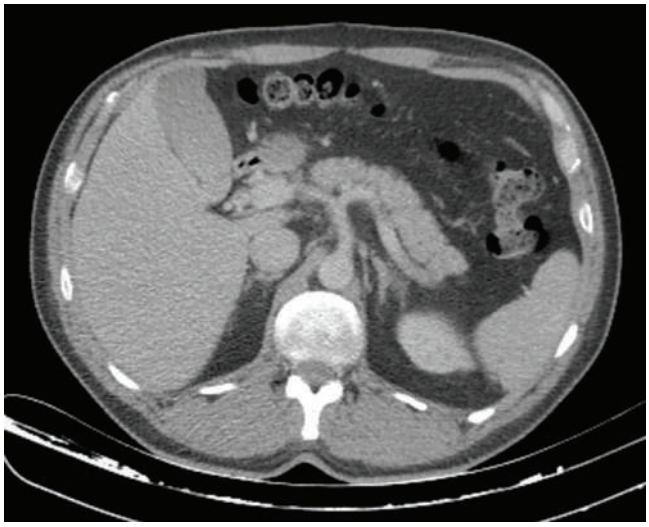

Figure 3. HBOT post-observation CT scan.

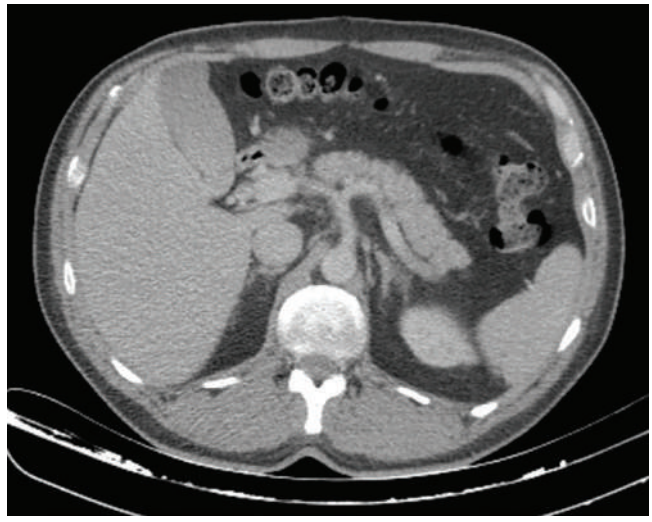

Figure 4. HBOT post-observation CT scan.

[P-342]

A rare cause of acute abdomen: Isolated mixed-type gastric volvulus unaccompanied by hiatal hernia

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Objective: Gastric volvulus is a rare but life-threatening surgical emergency resulting from abnormal rotation of the stomach. Although commonly associated with hiatal hernia, primary volvulus due to ligamentous laxity is infrequent. GV is classified as organo-axial, mesentero-axial, or mixed-type. While hiatal hernia or diaphragmatic defects accompany approximately 70% of cases, we aim to present a rare case of isolated mixed-type gastric volvulus without any anatomical defects.

Material and Methods: Ninety-one-year-old male with dementia presented to the emergency department with sudden onset abdominal pain and distension. Physical examination revealed severe abdominal distension. Contrary to Borchardt's triad, which typically includes the inability to pass a nasogastric (NG) tube, an NG tube was successfully inserted, and gastric content was drained. Although the initial non-contrast computed tomography (CT) did not explicitly report volvulus, the non-visualization of the spleen and high clinical suspicion prompted a contrast-enhanced CT. Imaging revealed massive gastric dilation with air-fluid levels. The orientation of the stomach and the medialization of the spleen were consistent with mixed-type volvulus. No hiatal hernia or diaphragmatic defect was identified, suggesting a primary etiology due to ligamentous laxity. Endoscopic detorsion was attempted but failed.

Results: The patient underwent emergency laparotomy. Intraoperative exploration confirmed the absence of a hiatal hernia and the presence of mixed-type rotation. The stomach was detorsed to its anatomical position, and the spleen was reduced. Serosal tears caused by distension were repaired primarily. A gastropexy was performed to prevent recurrence. Considering the patient's advanced age, dementia, and nutritional requirements, a Stamm gastrostomy was utilized. This procedure reinforced the gastropexy and established a secure route for enteral feeding. The patient was discharged on postoperative day 15 without complications.

Conclusion: The successful passage of an NG tube should not rule out gastric volvulus, especially in mixed-type or incomplete torsion cases where the gastroesophageal junction may remain patent. CT is the gold standard for diagnosis and surgical planning, particularly for identifying primary volvulus. In elderly patients with comorbidities, Stamm gastrostomy serves as a life-saving adjunct, providing both effective fixation and a reliable avenue for postoperative care.

Keywords: Gastric volvulus, volvulus

Figure 1. Axial plane computed tomography image. The NG tube have entered the stomach, and there was no diaphragmatic anomaly. The spleen was also observed to be retracted medially.

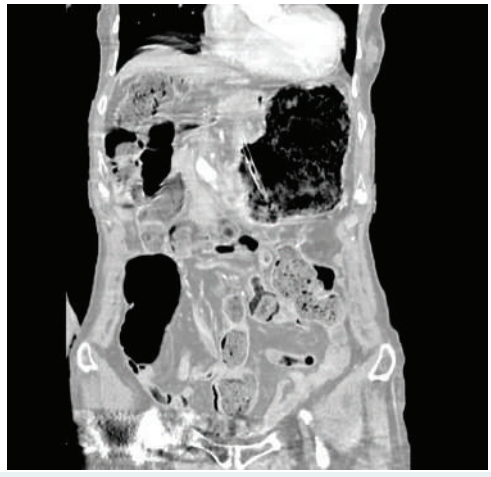

Figure 2. Coronal plane computed tomography image.

[P-343]

Complicated jejunal diverticular perforation: Our case experience

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Objective: Jejunal diverticular disease is a rare clinical entity with an incidence ranging from 0.06% to 1.3%. While the majority of cases remain asymptomatic, complications such as diverticulitis and, more rarely, perforation can develop. We aim to present two cases of complicated jejunal diverticular disease managed with emergency surgery.

Material and Methods: Case 1 A 94-year-old female with no known comorbidities presented with abdominal pain persisting for one week. Examination revealed bilateral spontaneously reduced inguinal hernias and generalized abdominal tenderness. Laboratory results showed CRP: 244.2 mg/L and procalcitonin: 3.3 µg/L. Abdominal CT suggested intestinal perforation with free air and fluid. During emergency laparotomy, diffuse purulent fluid was observed. Extensive jejunal diverticula were noted 30-100 cm distal to the ligament of Treitz, with a perforation identified at the 50 cm mark. Segmental small bowel resection and double-layer isoperistaltic side-to-side anastomosis were performed. The patient was transferred to the ICU but unfortunately developed cardiac arrest and passed away 6 hours postoperatively. Cultures grew *Klebsiella pneumoniae* and *E. coli*.

Results: Case 2 A 69-year-old male with hypertension and diabetes presented with generalized abdominal pain of one-day duration. Examination revealed generalized tenderness and rebound in the left lower quadrant. CRP was elevated (245 mg/L). CT imaging showed inflammatory density increases in the small bowel mesentery and diverticula in the colon. Upon exploration, purulent fluid and a perforated area with diffuse diverticula were found 20-60 cm distal to the ligament of Treitz. Segmental resection and double-layer isoperistaltic side-to-side anastomosis were performed. The patient recovered well, started oral intake on postoperative day 4, and was discharged on day 7. Pathology confirmed phlegmonous diverticulitis.

Conclusion: Jejunal diverticulitis is far less common than colonic diverticular disease and typically affects patients in their sixth and seventh decades. Consequently, jejunal diverticulitis, which can be life-threatening due to delayed diagnosis, must be considered in the differential diagnosis of acute abdomen, particularly in elderly patients.

Keywords: Jejunal diverticulitis, perforation

Figure 1. Perforated diverticulit area.

Figure 2. Widespread diverticular appearance.

[P-344]

Gastrointestinal manifestations of rheumatoid arthritis

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Sivas Cumhuriyet University Faculty of Medicine, Sivas

Objective: Rheumatoid arthritis (RA) and related spondyloarthropathies are primarily systemic inflammatory diseases affecting the joints; however, they may occasionally present with extra-articular involvement, including the gastrointestinal system and intra-abdominal tissues. The literature reports that such involvement can pose diagnostic difficulties and is often confused with infectious or malignant processes. Granulomatous and necrotizing lesions, in particular, require the exclusion of infectious causes, especially tuberculosis, in the differential diagnosis.

Material and Methods: Case A 30-year-old female patient had been followed up by rheumatology since 2019 with a diagnosis of ankylosing spondylitis. She presented to the emergency department on 31.01.2024 with acute abdominal pain. She reported pain in the right lower quadrant, suprapubic region, and left lower quadrant. Physical examination revealed acute abdomen. Laboratory findings: WBC: 8.03×10^9/L, neutrophils 43%, lymphocytes 49.4%, Hgb: 13.2 g/dL, PLT: 305×10^9/L, CRP: 2.2 mg/L, ALT: 43, AST: 33, LDH: 223, non-contrast upper abdomen CT scan revealed areas with fatty density and contamination in the surrounding fatty planes were detected at the umbilical level adjacent to the right anterior abdominal wall, and omental infarction was considered as the primary diagnosis. Based on the clinical and radiological findings, a decision was made to perform surgical exploration.

Results: During the operation, abnormal tissues were observed on the uterus and in the vicinity of the bladder, and excision was performed. Pathological examination revealed a necrotizing palisading granulomatous reaction in yellow-beige colored tissue samples. The pathology report stated that the findings were consistent with RA and extra-articular involvement of rheumatoid variants, and recommended further investigation for granulomatous diseases (especially tuberculosis). These findings are consistent with the literature on rare gastrointestinal and intra-abdominal involvement in rheumatological diseases.

Conclusion: The PPD (tuberculin) test and ARB staining microscopy performed on the patient were negative. Tuberculosis has been ruled out. This case highlights the rare extra-articular involvement that can present with an acute abdominal picture in inflammatory rheumatic diseases such as ankylosing spondylitis. In cases where granulomatous and necrotizing lesions are detected, infectious causes must be ruled out; however, the systemic effects of rheumatological disease should also be considered in the differential diagnosis. A multidisciplinary approach is critical for accurate diagnosis and appropriate management.

Keyword: Rhomatoid arthritis

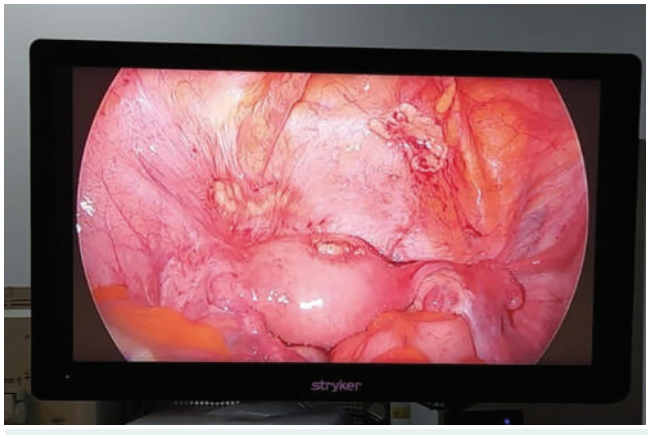

Figure 1. Surgery image.

[P-345]

Primary necrotizing fasciitis of the breast: Case report

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Objective: Necrotizing fasciitis is a life-threatening infection of the soft tissue and fascia, most often affecting the abdominal wall, extremities, and perineum. We aimed to present a case of primary necrotizing fasciitis with no identifiable risk factors, including trauma, surgery, insect bites, breastfeeding, diabetes, or immunosuppression.

Material and Methods: This is a case presentation of primary breast necrotizing fasciitis.

Results: A 60-year-old woman was treated with oral antibiotics for one week for pain, redness, and swelling in the left breast. She presented to the emergency department with worsening symptoms. Examination revealed erythema, edema, and severe tenderness in a 4x4 cm area from the inner quadrant of the left breast to the sternum (Figure 1A). Laboratory tests showed leukocytosis (17.970 103/mm^3, neutrophils 77%) and elevated C-reactive protein (143.7 mg/L). The LRINEC score was 7. Ultrasound revealed an abscess-like lesion measuring approximately 45×30 mm. Intravenous broad-spectrum antibiotics (piperacillin/tazobactam 3x4.5 g and clindamycin 3x900 mg) and fluid support were initiated. Under general anesthesia, multiple foul-smelling abscesses were drained. A wide surgical resection was performed to remove necrotic tissue extending to the pectoral fascia and sternum. No organisms grew in culture. Vacuum-assisted wound therapy began on postoperative day 5 (Figure 1B). On day 11 a partial-thickness skin graft from the right thigh was applied (Figure 1C-D). Pathology showed abscess and fat necrosis without malignancy. During two years of follow-up, no comorbidities or breast pathology were detected on examination or imaging.

Conclusion: Early diagnosis and combined treatment are essential to reduce mortality and morbidity in primary breast necrotizing fasciitis, due to its rarity and rapid progression.

Keywords: Breast, necrotizing fasciitis, primary

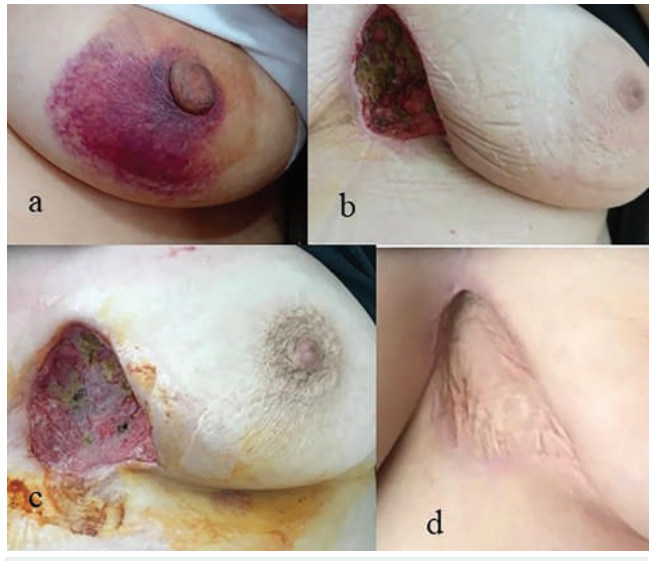

Figure 1. Case of primary necrotizing fasciitis of the breast. a. Necrotizing fasciitis was located in the inner quadrant of the left breast; b. Surgical debridement, 5th postoperative day; c. Partial-thickness skin graft, 11th postoperative day; d. Partial-thickness skin graft, 8th postoperative month.

[P-346]

Small bowel obstruction caused by a mesodiverticular band associated with Meckel's diverticulum: A rare cause of ileus

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Objective: Meckel's diverticulum is the most common congenital anomaly of the gastrointestinal tract, occurring in approximately 2-3% of the general population. It usually remains clinically silent throughout life and is often detected incidentally. Although most patients are asymptomatic, clinical symptoms develop in only about 16% of cases. The most common complications include gastrointestinal bleeding, small bowel obstruction, and diverticulitis. A rare cause of obstruction is the formation of a mesodiverticular band, which can lead to mechanical small bowel obstruction and acute abdomen. In this case report, we present the diagnostic process and surgical management of a rare ileus caused by a mesodiverticular band associated with Meckel's diverticulum.

Material and Methods: An 18-year-old female patient presented to the emergency department with sudden-onset abdominal pain that began in the morning and was accompanied by nausea and vomiting. She reported no passage of flatus or stool. The patient had no known comorbidities. Her surgical history included an appendectomy and an abdominal operation performed six years earlier for ileus. Physical examination revealed abdominal distension and diffuse tenderness without guarding or rebound tenderness. Digital rectal examination showed an empty rectal ampulla. Laboratory tests demonstrated a C-reactive protein level of 0 mg/L, a white blood cell count of 11.7×10^9/L, and a lactate level of 1.7 mmol/L. Contrast-enhanced abdominal computed tomography revealed dilated small bowel loops with air-fluid levels, reaching a maximum diameter of approximately 34 mm. A transition zone was identified at the ileal level, consistent with mechanical small bowel obstruction.

Results: Based on the clinical and radiological findings, surgical exploration was performed. Intraoperatively, a band originating from the Meckel's diverticulum and extending toward the anterior abdominal wall was identified. This mesodiverticular band caused adhesion and mechanical obstruction of the small bowel. An ischemic area was observed in the bowel segment distal to the diverticulum due to compression by the band. Consequently, segmental small bowel resection with side-to-side anastomosis was performed. The postoperative course was uneventful, and the patient was discharged without complications.

Conclusion: In conclusion, although Meckel's diverticulum is typically asymptomatic, it can rarely cause mechanical small bowel obstruction via a mesodiverticular band. In young patients presenting with acute abdomen, especially those with a history of adhesive ileus, this rare etiology should be considered. Early diagnosis and timely surgical intervention are crucial to prevent bowel ischemia and associated morbidity.

Keywords: Meckel's diverticulum, mesodiverticular band, small bowel obstruction

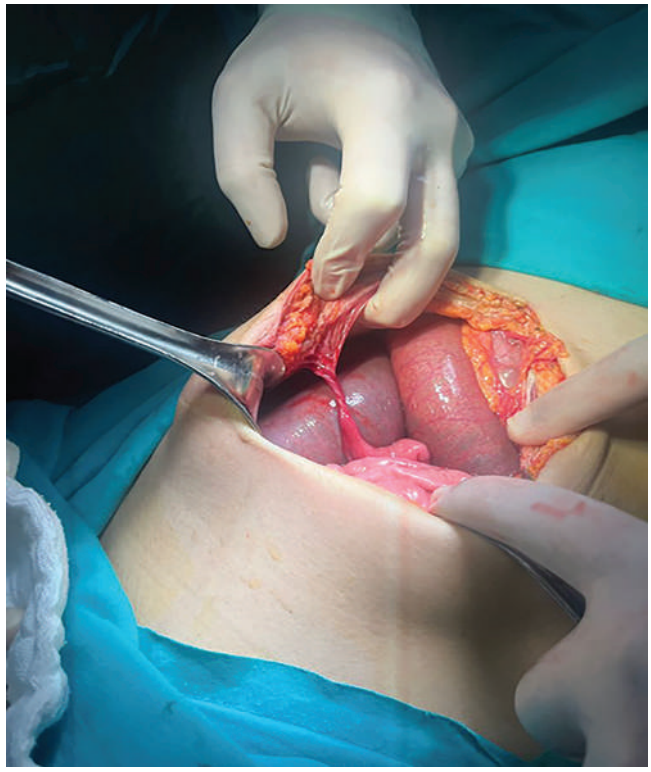

Figure 1. Intraoperative view of a mesodiverticular band arising from Meckel's diverticulum.

[P-347]

Laparoscopic repair of traumatic diaphragmatic injury with gastric incarceration: A rare case

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Objective: The incidence of diaphragmatic rupture following thoracoabdominal blunt trauma ranges from 0.8% to 5%. Acute gastric incarceration associated with diaphragmatic hernia in the early period after blunt trauma is exceedingly rare, and delayed diagnosis or treatment can be life-threatening. This report describes a case of traumatic diaphragmatic rupture with gastric incarceration, managed laparoscopically after hemodynamic stabilization in the acute phase in a patient with multiple traumatic injuries.

Material and Methods: This is a case presentation of laparoscopic repair of traumatic diaphragmatic injury with gastric incarceration.

Results: A 50-year-old woman was admitted to the emergency department following a non-vehicular traffic accident. On presentation, she was in poor general condition, intubated, hypotensive, and tachycardic. Laboratory evaluation revealed a hemoglobin of 7.79 g/dL, a creatinine of 0.53 mg/dL, and a C-reactive protein of 2 mg/L. Hemodynamic stabilization was achieved with intravenous fluid resuscitation. Chest computed tomography demonstrated gastric herniation and diaphragmatic rupture in the left hemothorax. Additional imaging identified multiple fractures of the pelvis and bilateral lower extremities. Laparoscopic abdominal exploration under general anesthesia confirmed a gastric herniation incarcerated into the thoracic cavity through an approximately 6x7 cm defect in the left diaphragm (Figure 1). The stomach was reduced into the abdominal cavity using an endo-grasper (Figure 2). Further exploration identified a collapse of the left lung, and a 28-French chest tube was inserted by a thoracic surgeon via the left mid-axillary line at the sixth intercostal space. The diaphragmatic defect was primarily closed with 2/0 polyglycolic acid sutures and reinforced with a 15 cm×10 cm piece of dual-mesh, which was fixed with an absorbable tacker. Orthopedic surgical intervention was subsequently performed for the extremity and pelvic fractures. The patient was discharged without complications at the end of the first postoperative month.

Conclusion: Gastric incarceration after diaphragmatic rupture is rare. Early diagnosis and prompt surgical intervention are essential once hemodynamic stability is achieved, and major injuries are excluded. Laparoscopic repair is a safe and effective treatment option.

Keywords: Trauma, diaphragm, incarceration

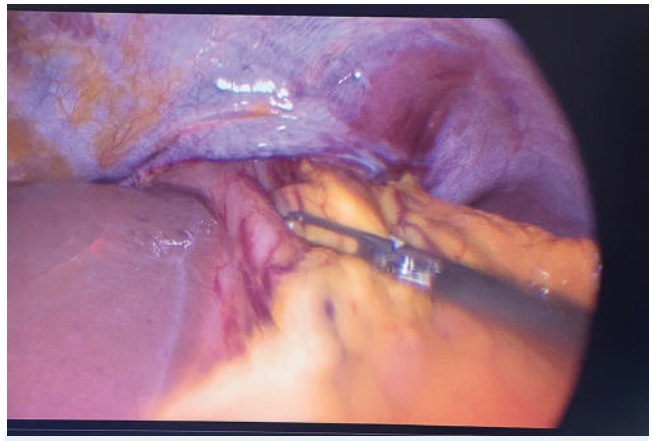

Figure 1. Laparoscopic view of gastric incarceration.

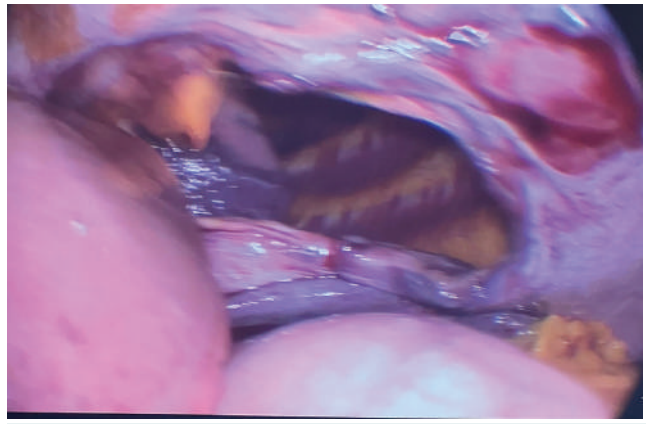

Figure 2. Laparoscopic view of the defect in the diaphragm after reduction of the stomach using an endo-grasper.

[P-348]

Diagnosis and management of esophageal injury in cervical gunshot wounds: A case report

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Objective: Cervical gunshot injuries are associated with a high risk of morbidity and mortality due to the close anatomical proximity of vital structures, including major vascular components, the trachea, and the esophagus. Although esophageal injuries are relatively uncommon, delayed diagnosis may result in severe and potentially life-threatening complications. In this case report, we present an esophageal injury secondary to a cervical gunshot wound, in which the diagnostic process was particularly challenging.

Material and Methods: This study comprises evaluation of a single patient managed with suspected esophageal injury following a cervical gunshot wound. The patient's clinical findings, imaging modalities, and endoscopic examination results were analyzed in detail. Following the diagnostic workup, surgical exploration was performed. A mucosal defect identified during intraoperative endoscopic assessment was primarily repaired. The patient was subsequently monitored in terms of postoperative clinical course, enteral nutritional management, and the development of potential complications.

Results: A 20-year-old male presented on February 2, 2026, with a gunshot wound to the neck. He was conscious (GCS: 15) and hemodynamically stable on admission. Physical examination revealed two entry wounds on the left cervical region and one exit wound over the left scapula. A bullet was palpated subcutaneously in the right cervical area. Minimal cervical and mediastinal emphysema were detected. Tetanus prophylaxis and intravenous antibiotics were initiated. A left clavicle fracture was identified, and the patient was admitted for observation. During follow-up, serous discharge from the cervical wound raised suspicion of esophageal perforation, and he was referred to a tertiary center. Imaging demonstrated pneumomediastinum without definitive evidence of perforation. Upper gastrointestinal endoscopy revealed a lesion in the cervical esophagus consistent with a fistulous opening, and surgical exploration was undertaken. Exploration via a left cervical oblique incision showed no clear transmural defect. Intraoperative endoscopy identified a blunt mucosal injury, which was repaired primarily. A drain was placed, a surgical gastrostomy was performed, and the retained bullet was removed. The postoperative course was uneventful. Enteral feeding was initiated via gastrostomy, oral intake was gradually resumed, and the patient was discharged without complications.

Conclusion: Despite two separate bullet penetrations to the cervical region, the absence of major vascular or vital organ injury is noteworthy. However, even in hemodynamically stable patients without major organ damage, esophageal injuries may lack clear clinical or radiological findings, leading to potential diagnostic delay. Early endoscopic evaluation in suspicious cases is therefore essential. When indicated, timely surgical exploration reduces morbidity. A multidisciplinary approach and early enteral support further improve clinical outcomes.

Keywords: Cervical gunshot wound, esophageal injury, penetrating neck trauma

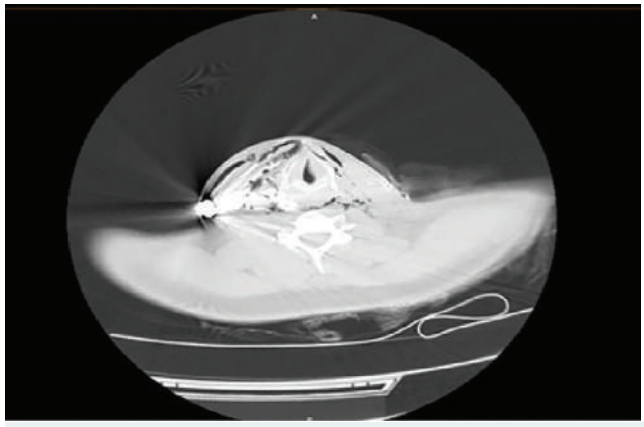

Figure 1. Contrast-enhanced cervical computed tomography demonstrating pneumomediastinum secondary to a cervical gunshot wound and a subcutaneously located bullet in the right cervical region.

[P-349]

Portal and mesenteric venous thrombosis following non-perforated laparoscopic appendectomy: Pylephlebitis in a thrombophilic patient

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Objective: Pylephlebitis is a rare and life-threatening form of septic thrombophlebitis involving the portal venous system, typically arising as a complication of intra-abdominal infections. While frequently associated with perforated appendicitis, its occurrence following non-perforated (suppurative) cases is exceptionally rare. It is hypothesized that the venous stasis induced by laparoscopic pneumoperitoneum, when combined with a genetic thrombophilic predisposition, may trigger thrombosis within the portal and mesenteric vascular beds. This report presents a unique case of extensive portal vein thrombosis (PVT) and superior mesenteric vein (SMV) occlusion following non-perforated laparoscopic appendectomy.

Material and Methods: A 39-year-old female (G6P5A1) with a medical history of type 2 DM, coronary artery disease, and recurrent pericardial effusion (on chronic colchicine therapy) underwent laparoscopic appendectomy for acute appendicitis. Preoperative contrast-enhanced computed tomography (CT) demonstrated normal portal and mesenteric vasculature. Following a non-perforated appendectomy, the patient was discharged on postoperative day one. On the second day, she developed nausea, vomiting, abdominal pain, and fever, eventually presenting to the emergency department one week later. Laboratory findings revealed leukocytosis and elevated CRP, along with increased ALP and GGT levels. Notably, AST, ALT, and lactate levels remained within normal limits throughout the clinical course. Contrast-enhanced CT revealed extensive thrombosis in the portal vein and total occlusion of the proximal SMV, though distal vascular perfusion was preserved. The patient was hospitalized and treated with intravenous broad-spectrum antibiotics and systemic anticoagulation. By day ten, biochemical parameters normalized, and she was discharged on anticoagulant therapy. Subsequent thrombophilia screening at a transplant center identified MTHFR C677T (heterozygous mutant) and PAI-1 (4G/5G) (heterozygous) mutations.

Results: Pylephlebitis can develop even in the absence of macroscopic perforation due to microscopic bacterial translocation triggered by increased intraluminal pressure. Laparoscopic pneumoperitoneum-induced stasis further facilitates the progression of this septic process into PVT and SMV occlusion. The preservation of normal transaminase and lactate levels, despite total proximal SMV occlusion, is attributed to maintained distal collateral perfusion preventing intestinal ischemia. The identified *MTHFR* and *PAI-1* mutations, exacerbated by surgical stress and systemic inflammation, likely catalyzed the coagulation cascade.

Conclusion: Pylephlebitis following non-perforated appendicitis is a silent, catastrophic vascular event that can be masked by normal transaminase and lactate levels. Surgeons must not be misled by a "false sense of security" provided by conventional laboratory findings; high clinical suspicion and early radiological evidence are paramount to prevent this surgical tragedy.

Keywords: Laparoscopic appendectomy, pylephlebitis, portomesenteric vein thrombosis

[P-350]

Necessity of endoscopic screening in liver donors: A donor diagnosed with rectal cancer

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Objective: Donor safety is maintained at the highest level during living-donor liver transplantation processes. Although donor candidates are routinely screened for malignancy, the scope of screening protocols—particularly the necessity of endoscopic imaging—remains a subject of debate. In this presentation, we aimed to discuss donor screening processes in light of the literature, based on a case diagnosed with advanced-stage rectal cancer one year after becoming a liver donor.

Material and Methods: This study presents a retrospective analysis of a patient managed in our clinic.

Results: A 42-year-old female patient, who had served as a living liver donor at an external center one year ago, presented to our clinic with the complaint of rectal bleeding. Rectoscopy revealed a mass encircling approximately 270 degrees of the lumen at a distance of 10 cm from the anal verge, and multiple biopsies were performed. The pathological examination reported a focus of adenocarcinoma *in situ* within an adenomatous polyp. No distant metastasis was detected on chest computed tomography and abdominopelvic magnetic resonance imaging. Since there was no diagnosis of invasive carcinoma, neoadjuvant therapy was not administered. The patient underwent a low anterior resection and a protective loop ileostomy. Following an uneventful postoperative period, the patient was discharged in good health. The final pathology was reported as adenocarcinoma (grade 3, pT3) with a tumor diameter of 5 cm and 13 tumor-free lymph nodes. The patient was referred for oncology follow-up to plan adjuvant therapy.

Conclusion: This case opens for discussion the necessity of endoscopic screening, particularly in donor candidates over the age of 40 or those with familial risk factors. To enhance donor and recipient safety, updating screening algorithms based on age and risk factors would provide a significant contribution to the literature.

Keywords: Living liver donor, rectal cancer, donor evaluation

[P-351]

Middle aortic syndrome (MAS)

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Objective: Middle aortic syndrome (MAS) is a rare vascular disorder characterized by segmental stenosis of the abdominal aorta and/or the distal descending thoracic aorta, frequently involving its major branches, and arising from either congenital or acquired etiologies. The condition predominantly affects young patients and typically manifests as refractory hypertension, lower extremity claudication, and signs of impaired end-organ perfusion. Owing to the non-specific nature of its clinical presentation, diagnosis is often delayed, thereby increasing the risk of severe cardiovascular complications. Herein, we report a case of MAS with delayed diagnosis in a young female patient.

Material and Methods: The clinical, laboratory, and imaging findings of a patient with a history of refractory hypertension, lower extremity claudication, and cardiac complications were retrospectively evaluated. The diagnostic workup included physical examination findings in conjunction with computed tomography angiography. The anatomical characteristics of the abdominal aorta and its major branches, as well as the presence of potential vascular anomalies, were examined in detail.

Results: The 24-year-old female patient initially presented with symptoms of claudication in 2019. In 2021, she required admission to the intensive care unit due to pulmonary edema secondary to heart failure. Between 2022 and 2023, she had recurrent hospitalizations for refractory hypertension. Computed tomography angiography demonstrated complete narrowing of the abdominal aorta. Marked anatomical variations were identified in the origin and course of the celiac trunk, superior mesenteric artery, and renal arteries. The left renal artery was not clearly visualized, and the distal segment of the celiac artery appeared short and hypoplastic. These findings were considered consistent with MAS.

Conclusion: MAS should be considered in the differential diagnosis of young patients presenting with refractory hypertension and lower extremity claudication. Early diagnosis is critical for preventing heart failure and other serious vascular complications. Appropriate imaging modalities and a multidisciplinary approach play a pivotal role in establishing the diagnosis.

Keyword: Middle aortic syndrome

Figure 1. Middle aortic syndrome.

[P-352]

Stoma management in a patient with high-output ileostomy following mesenteric ischemia: A case report

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Objective: Acute mesenteric ischemia caused by mesenteric artery thrombosis is a life-threatening condition associated with high morbidity and mortality. In emergency bowel resections, stoma site marking is often not feasible, increasing the risk of postoperative stoma-related complications. High-output ileostomy is a challenging clinical condition that may lead to severe fluid-electrolyte imbalance and peristomal skin complications, complicating postoperative management.

Material and Methods: This report retrospectively evaluates the clinical course and stoma care management of a patient who underwent emergency surgery for mesenteric ischemia with creation of a double-barrel ileostomy. Stoma characteristics, postoperative complications, nursing interventions, and medical management strategies were reviewed.

Results: A 74-year-old female patient with a history of diabetes mellitus and hypertension underwent emergency surgery due to extensive mesenteric ischemia. Necrotic segments of the small intestine were resected, and a double-barrel ileostomy was created under emergency conditions without preoperative stoma site marking. Postoperatively, the stoma was located in the left lower quadrant, close to the umbilicus, and was irregularly shaped and mildly retracted. Peristomal skin irritation developed due to exudate leakage from the surgical field. On postoperative day 11, the patient developed a high-output ileostomy with daily output exceeding 2000-2500 mL, accompanied by electrolyte imbalances. Management included fluid and electrolyte replacement, loperamide therapy, and dietary modification. Stoma care involved the use of a two-piece convex appliance, a drainable transparent pouch, skin barrier spray, stoma powder, and a stoma belt. Due to poor compliance of the patient and relatives with stoma care, frequent pouch changes were required. Despite the high surgical risk, ileostomy closure was performed at postoperative week five, and the patient was discharged without complications.

Conclusion: Emergency stoma creation without appropriate site selection increases the risk of high-output stoma and peristomal skin complications. This case highlights the critical role of experienced stoma and wound care nurses within a multidisciplinary team in achieving favorable outcomes in complex surgical patients.

Keywords: High-output stoma, ileostomy, stoma complications

Figure 1. Appearance of a double-barrel ileostomy following emergency surgery, showing stoma retraction and peristomal skin irritation associated with a high-output stoma.

View of a double-barrel ileostomy created after emergency surgery, showing a stoma located below the skin level with surrounding widespread erythema, moisture, and areas of impaired peristomal skin integrity due to leakage.

[P-360]

Mesh migration after graft-reinforced hiatal hernia repair: A case report

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Objective: Hiatal hernia is defined as the protrusion of the stomach or other abdominal organs into the thoracic cavity through the diaphragmatic hiatus. Hiatal hernias may be congenital or acquired, and their prevalence increases with age. Predisposing factors include conditions that increase intraabdominal pressure such as obesity, pregnancy, and chronic constipation. The most common presenting symptoms are reflux, dysphagia, and regurgitation; however, respiratory symptoms may also be observed in some cases. Treatment options vary depending on the severity of symptoms and the type of hernia.

Material and Methods: This case report presents the follow-up and treatment process applied after mesh migration that developed in the postoperative sixth month in a patient who had previously undergone grafted repair for hiatal hernia at our hospital.

Results: An 80-year-old female patient presented to the emergency department with complaints of nausea, vomiting, and dysphagia, including difficulty swallowing liquids. Chest radiography and computed tomography revealed a mixed-type giant hiatal hernia. Endoscopic evaluation was attempted but was unsuccessful. Due to persistent symptoms and the development of respiratory distress, the patient—who had a known history of coronary artery disease and hypertension—was taken to surgery under emergency conditions. After reduction of the stomach, duodenum, and colon from the hernia sac back into the abdominal cavity, graft-reinforced hiatal hernia repair was performed using a polypropylene (Prolene) mesh. The patient's postoperative course was uneventful, oral intake was tolerated, and she was discharged. At the sixth postoperative month, the patient re-presented with dysphagia. Contrast-enhanced computed tomography showed no evidence of recurrent hiatal hernia. Upper gastrointestinal endoscopy demonstrated a foreign body in the distal esophagus, which was primarily interpreted as mesh material. Endoscopic extraction attempts by the gastroenterology team and rigid bronchoscopy performed by the thoracic surgery team were unsuccessful. Consequently, the patient was re-operated on by our team. During gastrotomy, a polypropylene mesh protruding into the esophageal lumen was identified and excised. Intraoperative gastroscopy confirmed patency of the esophageal lumen. The patient tolerated an R3 diet on postoperative day 2 and was discharged.

Conclusion: The use of mesh in hiatal hernia repair remains controversial. In addition, biological mesh should be considered as an alternative to polypropylene mesh during mesh selection. Surgeons should be aware that early-term mesh migration may occur following mesh-reinforced hiatal hernia repair.

Keywords: Hiatal hernia, mesh migration

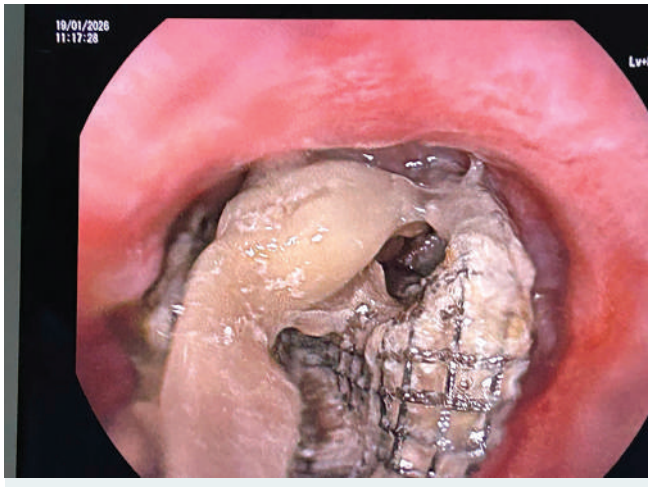

Figure 1.

[P-364]

A challenging situation during ERCP: Impacted dormia basket – what should be done?

Hasan Doğru, Müfit Şansal, Mehmet Can Aydın

University of Health Sciences Türkiye, Bursa City Hospital, Bursa

Objective: Since 1974, endoscopic retrograde cholangiopancreatography (ERCP) has been the standard technique for the removal of bile duct stones, achieving success rates of 85-90% using sphincterotomy followed by balloon or basket extraction. Although generally safe, ERCP is associated with complications such as pancreatitis, bleeding, cholangitis, and perforation. Impaction of a Dormia basket is a rare but challenging complication that requires prompt recognition and appropriate management.

Material and Methods: Case 1: An 80-year-old male with coronary artery disease and hypothyroidism presented with jaundice, fever, abdominal pain, nausea, and vomiting. Physical examination revealed icterus and a positive Murphy's sign. Laboratory findings showed elevated bilirubin levels. Imaging demonstrated gallstones up to 11 mm and a 7 mm stone in the common bile duct. During ERCP, a filling defect was observed, and an impacted Dormia basket was encountered. Balloon dilation of the papilla was attempted but unsuccessful, necessitating emergency surgery. Open exploration of the common bile duct was performed, and the impacted basket and stones were removed through a choledochotomy. The patient was monitored in intensive care postoperatively and discharged on postoperative day ten with a cystic duct drain, which was removed after 45 days. Case 2: A 61-year-old male with chronic obstructive pulmonary disease and hypertension presented with similar symptoms. Imaging revealed multiple gallstones, the largest measuring 20 mm, and suspected distal bile duct stones. ERCP demonstrated type I Mirizzi syndrome. Sphincterotomy and biliary stenting were performed, leading to clinical improvement. Twenty days later, the patient returned with recurrent symptoms. Repeat imaging showed stones in the common bile duct. During repeat ERCP, the stent was removed, and an impacted stone in the distal cystic duct was identified. Basket extraction failed, resulting in basket impaction and emergency surgery. Subtotal cholecystectomy and bile duct exploration were performed. As the basket could not be removed, a duodenotomy was required to extract the impacted basket and stones. A cystic duct drain was placed, and the patient was discharged on postoperative day seven.

Results: Dormia basket impaction is reported in 0.8-5.9% of ERCP procedures, usually caused by large or hard stones. Endoscopic techniques such as balloon dilation or mechanical lithotripsy may be attempted; however, surgical intervention becomes necessary when these methods fail. Early recognition and timely surgical management are essential to prevent serious complications.

Conclusion: While ERCP remains an effective method for treating biliary stone disease, clinicians must be prepared to manage rare complications such as Dormia basket impaction. Multidisciplinary approaches and surgical backup are crucial for optimal outcomes.

Keywords: Biliary complications, common bile duct stones, Dormia basket impaction, endoscopic retrograde cholangiopancreatography (ERCP), open surgical intervention

[P-365]

A rare intraoperative pathology in recurrent inguinal hernia: Amyand's hernia

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Objective: Amyand's hernia is an extremely rare clinical condition characterized by the presence of the vermiform appendix within an inguinal hernia sac, with an incidence reported between 0.19% and 1% in the literature. This condition may lead to acute appendicitis due to luminal obstruction, vascular compression, and inflammation resulting from the entrapment of the appendix within the hernia sac. Since clinical findings often overlap with incarcerated hernia, preoperative diagnosis is challenging, and definitive diagnosis is frequently made intraoperatively. The occurrence of Amyand's hernia in recurrent cases previously repaired with mesh is a phenomenon reported very limitedly in the literature. This report aims to discuss the management of an Amyand's hernia case detected in a recurrent site following laparoscopic surgery, in light of current literature.

Material and Methods: A 52-year-old male patient, who had undergone laparoscopic transabdominal preperitoneal repair for a right inguinal hernia six years prior, presented with pain and swelling in the right inguinal region for the last three months. Physical examination revealed a reducible mass in the right inguinal region; ultrasonography showed bowel loops and fatty tissue herniating through the fascial defect. The patient was operated on under spinal anesthesia with a preliminary diagnosis of recurrent inguinal hernia, utilizing an open anterior approach. During the dissection of the indirect hernia sac, it was observed that an edematous and hyperemic appendix formed one wall of the sac. According to the Losanoff-Basson classification, the clinical picture was evaluated as "type 2" (acute appendicitis confined to the sac). Following appendectomy, the hernia defect was repaired using the Lichtenstein technique with a self-gripping polypropylene mesh. The operation lasted 45 minutes; the patient had an uneventful postoperative course and was discharged at the 24th hour. Histopathological examination confirmed "acute suppurative appendicitis."

Results: The primary determinant in the surgery of Amyand's hernia is the degree of appendiceal inflammation and the presence of peritonitis. The Losanoff-Basson classification standardizes the surgical strategy at this point; in type 2 cases where contamination is limited, as in our patient, the use of polypropylene mesh alongside appendectomy is considered safe. Although adhesions from previous laparoscopic surgery may complicate dissection in recurrent cases, an open surgical approach allows for direct visualization of the sac and secure repair.

Conclusion: In conclusion, Amyand's hernia should be considered in the differential diagnosis of recurrent inguinal hernia cases. A personalized surgical approach guided by the Losanoff-Basson classification is the key to successful outcomes.

Keywords: Amyand's hernia, Losanoff-Basson classification, recurrent inguinal hernia

Figure 1. Amyand's hernia.

Appendix tissue within the hernia sac.

Figure 2. Amyand's hernia.

Appendix tissue within the hernia sac.

[P-368]

Recurrence of hepatocellular carcinoma after liver transplantation: Metastasis initially to the spleen followed by involvement of the pectoral muscle

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Objective: Hepatocellular carcinoma (HCC) is the most common primary liver malignancy and a leading cause of cancer-related mortality worldwide. Curative options include liver resection and transplantation, the latter offering lower recurrence rates, particularly in cirrhotic patients; however, recurrence occurs in 6-20% of selected cases. Most recurrences develop within the first two years (early recurrence). Extrahepatic recurrences most commonly affect the lungs, lymph nodes, bones, and adrenal glands, whereas late recurrences after two years are rare.

Material and Methods: A 66-year-old male presented in December 2018 with elevated AFP. Imaging revealed two nodules in liver segment VI consistent with HCC. At diagnosis, the patient was Child-Pugh A, and met Milan criteria; thus, a deceased-donor liver transplantation (LT) was performed in October 2019. Explanted liver pathology s howed no viable tumor. Sixty-six months post-transplant, late extrahepatic recurrence developed in the spleen and, eight months later, in the pectoral muscle. The splenic lesion was considered consistent with HCC recurrence, and splenectomy was performed in May 2025. Histopathology confirmed metastatic HCC (3×3×2.7 cm). Postoperative course was uneventful. Eight months after splenectomy, AFP rose to 1139.8 ng/mL. CT and PET/CT revealed a 3.1×2.5 cm lesion in the pectoral muscle with increased FDG uptake (SUV_{max} 4.8). Surgical resection was performed, and pathology confirmed metastatic HCC (4.8×2.3 cm). Early follow-up showed no evidence of further recurrence.

Results: With improved survival, extrahepatic metastases after LT have gained clinical significance. Management of post-LT HCC recurrence generally follows approaches used in non-transplanted patients. Surgical resection may be considered for resectable metastases, alongside systemic therapies, RFA, and TACE. Resectable recurrence is associated with better prognosis, though overall survival remains poor. Extrahepatic metastases usually occur as part of disseminated hematogenous spread, with isolated organ involvement being rare. In our case, late recurrence involved the spleen at 66 months and the pectoral muscle at 74 months post-LT. The impact of metastasectomy on survival remains unclear; however, aggressive approaches including surgical resection may improve outcomes. Disease control for the second pectoral recurrence after splenectomy is under ongoing follow-up.

Conclusion: The survival benefit of surgical resection for isolated extrahepatic metastases of HCC remains unclear; however, in selected patients, it may offer low morbidity and potential for long-term survival. Given the uncertainties in managing recurrent HCC, long-term follow-up and additional evidence are required.

Keywords: Hepatocellular carcinoma, liver transplantation, extrahepatic metastasis

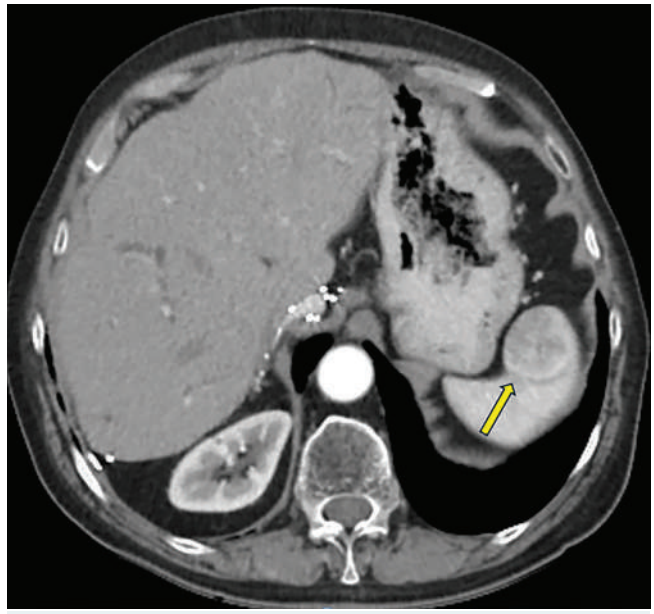

Figure 1. Splenic recurrence of HCC after liver transplantation: on contrast-enhanced axial CT, a splenic mass consistent with recurrent hepatocellular carcinoma is observed. The lesion is indicated by the yellow arrow.

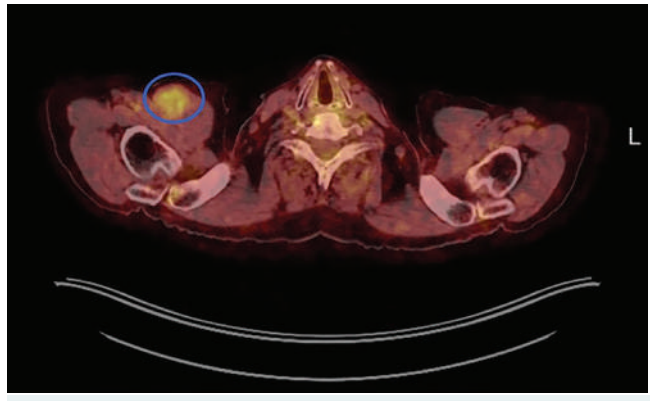

Figure 2. Mass in the pectoral muscle after splenectomy: PET/CT demonstrates uptake within the mass, which is outlined by the blue circle.

[P-369]

A rare case report: Primary lymphoma of the breast

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Objective: Breast lymphoma is a rare hematological malignancy. They are divided into two types: Primary and secondary. Its treatment and prognosis differ from other breast carcinomas. Primary breast lymphoma is rarer. In our case report, we aimed to present the diagnosis and treatment process of a rare primary breast lymphoma, along with a review of the literature.

Material and Methods: A 71-year-old female patient with no other medical conditions besides known hypertension presented with a mass in her right breast. Mammography and ultrasound imaging revealed a 3x2 cm lesion in the upper inner quadrant of the right breast, which was biopsied using a tru-cut biopsy. Pathology reports indicated findings suggestive of lymphoproliferative neoplasia, primarily low-grade follicular lymphoma. Peripheral blood smear, including complete blood count, came back negative for lymphoma. PET-CT scan revealed no other pathological FDG uptake in the body besides the primary tumor uptake in the breast. The oncology council recommended total excision of the lesion for histopathological typing, and the pathology result revealed a grade 1-2 follicular lymphoma. The patient has started chemotherapy.

Results: Breast lymphomas account for less than 1% of breast malignancies. The most common type is diffuse large B-cell lymphoma. It most often presents as breast involvement secondary to systemic disease. Primary and secondary breast lymphomas require different treatment regimens, making a clear distinction between them. Primary breast lymphoma is thought to originate from the lymphoid ducts in the breast, specifically from the intramammary lymph nodes. To be diagnosed as primary breast lymphoma, there must be no history of lymphoma or symptoms at the time of diagnosis, a close association between the lymphoma and breast tissue, and no involvement of organs outside the breast at the time of diagnosis. Based on these criteria, we can diagnose our case as primary lymphoma of the breast. Clinically, patients may exhibit B symptoms similar to those seen in hematological malignancies. There are no specific findings on radiological imaging. Treatment involves systemic chemotherapy and radiotherapy, depending on the histological subtype and stage of the disease. Due to the rarity of primary breast lymphoma, there are no definitive treatment guidelines yet. It is known that excision of the lesion does not contribute to the prognosis. Therefore, surgery is not recommended except for local control or diagnostic purposes. The 5-year survival rate is around 50% for primary breast lymphoma, while it is 25% for secondary breast lymphoma.

Conclusion: Breast lymphomas are clinically similar to other breast carcinomas, but their treatment differs from other breast carcinomas, and accurate diagnosis is crucial to avoid unnecessary surgery.

Keywords: Breast, lymphoma, hematology

[P-376]

A rare cause of asymptomatic spleen cyst: Spleen endometriosis mimicking hydatid cyst

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Objective: Spleen endometriosis is an extremely rare form of extragenital endometriosis. Diagnosis is difficult in the preoperative period because it often does not present specific clinical and radiological findings. This study aims to present a rare case diagnosed with spleen endometriosis following histopathological examination after surgery for a suspected hydatid cyst.

Material and Methods: A 39-year-old female patient with non-active complaints was evaluated after a cystic lesion was detected inthe upper pole of the spleen on abdominal ultrasound performed for suspected hydatid cyst. Ultrasound revealed a cystic lesion measuring 40×49 mm in the upper pole of the spleen, with smooth lobulated contours, septations, and calcified walls. Contrast-enhanced abdominal computed tomography revealed a cystic lesion measuring approximately 52×40 mm in the anterosuperior section of the spleen, which was multilocular and contained internal septa and calcifications; epidermoid and hydatid cysts were considered in the differential diagnosis. Upper gastrointestinal endoscopy revealed no findings suggestive of malignancy or extrinsic compression. The patient underwent planned laparoscopic splenectomy.

Results: Abdominal ultrasonography demonstrated a 40×49 mm cystic lesion with smooth lobulated contours, internal septa, and calcified walls in the upper pole of the spleen. Contrast-enhanced abdominal CT revealed a 52×40 mm multilobulated cystic lesion with internal septa and wall/septal calcifications in the anterosuperior splenic segment; the leading differential diagnoses were epidermoid and hydatid cysts with cystic neoplasm considered less likely. No free fluid, pathological lymphadenopathy, or additional solid organ pathology was identified, and upper gastrointestinal endoscopy showed no malignant or obstructive findings. Laparoscopic exploration identified an approximately 5 cm cystic lesion confined to the superior spleen without invasion of adjacent tissues, and laparoscopic splenectomy was performed uneventfully. Histopathological examination demonstrated a multilocular cyst with hyalinized walls and glandular structures lined by a single-layer epithelium within the splenic parenchyma, without evidence of malignancy; immunohistochemistry showed positivity for PAX8, ER, and PR and negativity for CA19-9 and CEA, consistent with splenic endometriosis. The postoperative course was uneventful.

Conclusion: Splenic endometriosis is an exceptionally rare form of extragenital endometriosis and is typically reported in association with symptomatic presentations or preoperative suspicion. In contrast, the present case was entirely asymptomatic, and the calcified, septated, multilocular splenic cyst was radiologically interpreted as a benign cystic lesion. The lack of endometriosis-specific findings on endoscopic, intraoperative, and laboratory evaluation further underscores the diagnostic challenge. This case highlights that, although rare, endometriosis should be considered in the differential diagnosis of splenic cystic lesions mimicking hydatid or epidermoid cysts, particularly in women of reproductive age. Consistent with the literature, definitive diagnosis relied on histopathological and immunohistochemical evaluation, emphasizing the need for a multidisciplinary approach in the assessment of splenic cystic lesions, even in asymptomatic patients.

Keywords: Case report, cystic spleen lesion, extra-genital endometriosis, laparoscopic splenectomy, splenic endometriosis

Table 1. Comparison of our case with the current literature (splenic endometriosis)

Kaynak (künyeli)	Hasta / Klinik	Görüntüleme (boyut–özellik)	Ayırıcı tanı / yaklaşım	Cerrahi	Patoloji–İHK	Seyir
Weyl A, Ulac C, Delchier MC, Suc B, Cuellar E, Chantalat E. (2020). *J Endometriosis and Pelvic Pain Disorders*. "Splenic lesion mimicking breast metastasis: the first description of splenic parenchymal endometriosis."	54 yaş, premenopozal; **asemptomatik**	13 cm, kompartmante kistik lezyon; FDG tutulumu (SUVmax 4.8)	Meme kanseri metastazı taklidi	Laparoskopik	ER+, PR+, HER2–, PAX8+	2 yıl sorunsuz
Krzeczowski RM, Jackson TN, Kabbani W, Grossman Verner HM, Sladek P. (2022). *Cureus*. "Splenic cysts and the case of mistaken identity."	36 yaş, premenopozal; **kronik LUQ ağrı + postprandiyal bulantı/kusma**	8 cm multiloküle kistik kitle + **duvar/septa kalsifikasyon**	Travmatik/iatrojenik/enfeksiyöz/pseudokist	Açık	Kronik hemoraji; PAX8+, ER+, PR+	Takip kayıp
Mills SEA, Bitar M, Mueller KH. (2022). *ACS Case Reviews in Surgery*. "Incidentally found splenic endometriosis during laparoscopic splenectomy for large splenic cyst."	26 yaş, premenopozal; **şişkinlik/erken doyma** (yakınmalar başka nedenle ilişkilendirilmiş)	10 cm splenik kist; mideye bası	Travmatik/vasküler/enfeksiyöz	Laparoskopik	Endometriotik kist (gland+stroma); ER/PR pozitifliği vurgulanır	Sorunsuz
Bilgin İAB, … (2022). *North Clin Istanbul*. "Endometriosis of the spleen." (Literatürde "4. olgu" olarak sunulur; Tablo 1'de önceki 3 olgu ile kıyas)	31 yaş, premenopozal; **sağ alt kadran ağrısı**	Üst polde 9 cm septalı kistik lezyon	İatrojenik/enfeksiyöz	Laparoskopik	Epitel döşenmesi yok + kist duvarında endometriozis odakları; ER/PR pozitifliği	Sorunsuz
Bu olgu (Ankara Etlik Şehir Hastanesi, 2024)	Kadın; BT isteminde "dalakta kitle"	**BT:** Dalak **superiorda 52×40 mm**, lobüle konturlu, multiloküle, internal septalı; **septa/duvar kalsifikasyonlu**; ayırıcı tanıda epidermoid/hidatik + düşük olasılıkla kistik neoplazm	Klinik–radyolojik olarak komplekskist nedeniyle cerrahi plan	**Laparoskopik total splenektomi**; bilus EndoGIA ile transeksiyon + JP dren	**Endometriozis (dalak, splenektomi)**: hyalinize duvarlı multiloküler kist; malignite yok. **İHK:** PAX8+, ER+, PR+; CA19-9/CEA negatif	Postop biyokimya/lab değerleri genel olarak stabil görünümde

[P-377]

Surgical management of a case of type 3 popliteal artery entrapment syndrome with acute thrombosis after decompression

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Objective: Popliteal artery entrapment syndrome (PAES) is a rare cause of lower extremity ischemia in young individuals without atherosclerotic risk factors. It is most commonly associated with anatomical variations of the medial head of the gastrocnemius muscle. In type 3 PAES, aberrant muscular slips compress the popliteal artery, leading to progressive intimal damage, thrombosis, and distal embolization. Delayed diagnosis may result in recurrent ischemic events and the need for complex revascularization procedures. We present a case of type 3 PAES requiring multistage surgical intervention following initial decompression and patch repair.

Material and Methods: A 26-year-old male with no significant cardiovascular risk factors presented with acute onset of right foot discoloration, coldness, and pain. Computed tomography angiography revealed intraluminal thrombus within the right popliteal artery. Diagnostic and therapeutic digital subtraction angiography was performed, and selective thrombolytic therapy was initiated. Magnetic resonance imaging of the knee demonstrated an abnormal superior origin of the medial gastrocnemius head compressing the popliteal artery, consistent with type 3 PAES. The patient underwent posterior surgical exploration with resection of the aberrant gastrocnemius muscle and saphenous vein patch angioplasty of the popliteal artery. Initial postoperative recovery was uneventful, and distal perfusion improved.

Results: Six months later, the patient presented again with acute limb ischemia. Angiography demonstrated occlusion of the superficial femoral artery with poor distal runoff. Thrombosis of the saphenous vein graft was identified, and thrombectomy with re-anastomosis was performed. Due to persistent perfusion impairment, femoro-distal bypass and thromboendarterectomy were subsequently carried out. Histopathological examination excluded vasculitis and revealed degenerative and inflammatory changes in the vascular wall. Following definitive surgical reconstruction, distal circulation improved clinically.

Conclusion: PAES may require more than simple decompression, particularly in cases with established arterial wall damage and thrombotic complications. Early recognition and appropriate surgical planning are essential to prevent recurrent ischemia and multiple revascularization procedures. PAES should always be considered in young patients presenting with unexplained lower extremity ischemia.

Keywords: Popliteal artery entrapement syndrome, acute arterial thrombosis, revascularization

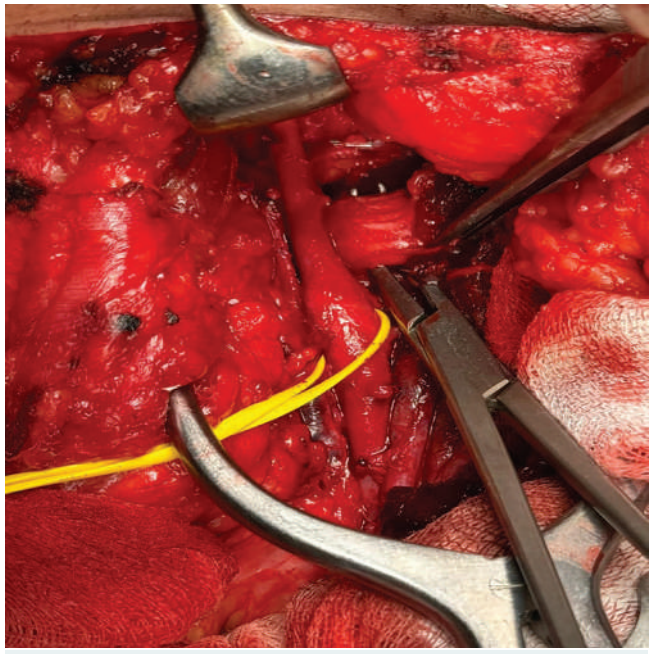

Figure 1. Compressed popliteal artery.

Poplietal artery compressed by gastrcnemius muscle tendon.

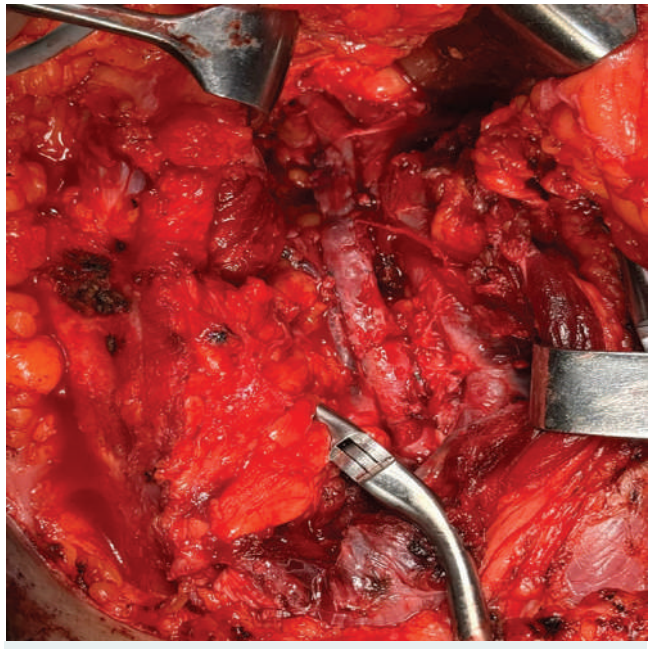

Figure 2. Decompressed popliteal artery.

[P-379]

Paraperitoneal type ureter herniation in the inguinal region: A rare case diagnosed preoperatively

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Objective: Inguinal hernia repair is one of the most commonly performed surgical procedures worldwide, performed on millions of patients each year. In contrast, uretero-inguinal hernia, characterized by herniation of the ureter into the inguinal canal, is quite rare. Paraperitoneal form is constituting the vast majority of cases. Uretero-inguinal hernias often present with typical inguinal hernia findings, making preoperative diagnosis difficult and leading to diagnosis frequently being made during the intraoperative period. Cross-sectional imaging methods are critically important for diagnosis, especially in patients with unexplained hydronephrosis, renal dysfunction, or atypical hernia contents. This report presents a rare case of paraperitoneal ureteroinguinal hernia diagnosed with preoperative imaging.

Material and Methods: Laboratory results, renal scintigraphy, and computed tomography data on the urinary system from the Gaziantep University Hospital database were retrospectively reviewed.

Results: A 27-year-old male patient was referred to our clinic for further evaluation due to elevated serum creatinine levels detected during his military medical examination. The urological evaluation revealed no dysuria, hematuria, flank pain, or lower urinary tract symptoms. The abdominal physical examination was unremarkable except for a hernia, and the patient had no history of surgery. The creatinine level was 1.04 mg/dL, which was within the normal range. Renal scintigraphy showed that the right kidney contributed 57.1% to total renal function and the left kidney contributed 42.9%. Contrast-enhanced computed tomography revealed grade II ectasia in the collecting system of the left kidney. Additionally, cross-sectional imaging showed that the left ureter was herniated into the inguinal canal. Based on these findings, surgery was planned. After completing the preoperative preparations, the patient underwent surgery. Exploration during surgery confirmed that the left ureter was herniated into the inguinal canal. The ureter was carefully dissected from the surrounding tissues and reduced into the retroperitoneal space. After controlling the hernia sac accompanying the ureter, inguinal hernia repair was performed using the Lichtenstein technique. No complications were observed in the early postoperative period, and the patient was discharged on the third postoperative day when serum creatinine returned to normal levels.

Conclusion: Although ureteroinguinal hernia is rare, its recognition in the preoperative period can facilitate surgical planning and reduce the risk of intraoperative ureteral injury. The use of cross-sectional imaging methods in patients with unexplained renal dysfunction or atypical inguinal hernia findings may increase diagnostic accuracy and contribute to the prevention of possible complications.

Keywords: Inguinal canal, lichtenstein technique, uretero-inguinal hernia

Figure 1. Paraperitoneal type ureter herniation.

[P-383]

A rare Strasberg type C injury successfully managed without surgery: A case report

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Objective: Approximately 180,000-200,000 cholecystectomies are performed annually in our country, with laparoscopic cholecystectomy being the most commonly preferred surgical treatment for cholelithiasis. However, its widespread use has been associated with an increased incidence of biliary injuries. Anatomical variations, limited operative exposure, and inflammation-related distortion of tissue planes may lead to misidentification during dissection, increasing the risk of injury. The reported incidence of biliary injury in laparoscopic cholecystectomy is 0.3-0.7%, approximately three times higher than in open surgery, and many injuries present postoperatively with bile leakage or biloma. Among the available classification systems, the Strasberg-Bismuth classification is the most widely used. Type A refers to leaks from small ducts, type B to occlusion of an aberrant right hepatic duct, and type VC to bile leakage caused by transection of this duct, which may be mistaken for the cystic duct. This case report describes the successful minimally invasive management of a rare Strasberg type C injury following laparoscopic cholecystectomy using percutaneous drainage and endoscopic interventions.

Material and Methods: This study is a retrospective case report of a patient who developed a Strasberg type C biliary injury following laparoscopic cholecystectomy performed at our clinic in September 2025. Diagnostic evaluation included ultrasonography, magnetic resonance cholangiopancreatography (MRCP), and endoscopic retrograde cholangiopancreatography (ERCP), with laboratory, clinical, and imaging findings assessed together. Management consisted of percutaneous drainage and endoscopic sphincterotomy, and the patient was followed in a multidisciplinary setting by surgical and gastroenterology teams. The study was conducted in accordance with the Declaration of Helsinki, and written informed consent was obtained.

Results: Bile duct injuries may result in significant morbidity, primarily due to bile leakage and related complications. In this case, a Strasberg type C injury was successfully managed with percutaneous drainage and endoscopic stent placement, avoiding surgical repair. Regression of the biloma and normalization of laboratory findings support the effectiveness of a conservative, minimally invasive approach in appropriately selected patients.

Conclusion: In bile duct injuries following laparoscopic cholecystectomy, early diagnosis, a multidisciplinary approach, and appropriate endoscopic and percutaneous treatment strategies can substantially reduce the need for surgical intervention. In Strasberg type C injuries, preservation of the main bile ducts enables successful management through effective drainage and pressure-decompressing endoscopic procedures. This case supports that a conservative approach is a safe and effective treatment option in carefully selected patients.

Keywords: Biliary injury, endoscopic treatment, laparoscopic cholecystectomy, percutaneous drainage, Strasberg type C

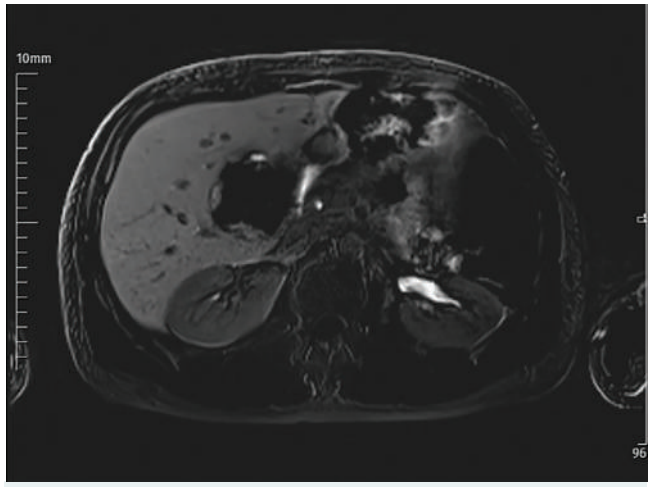

Figure 1. Biloma area.

A collection extending from the inferior hepatic hilum to the lesser curvature of the stomach (biloma?).

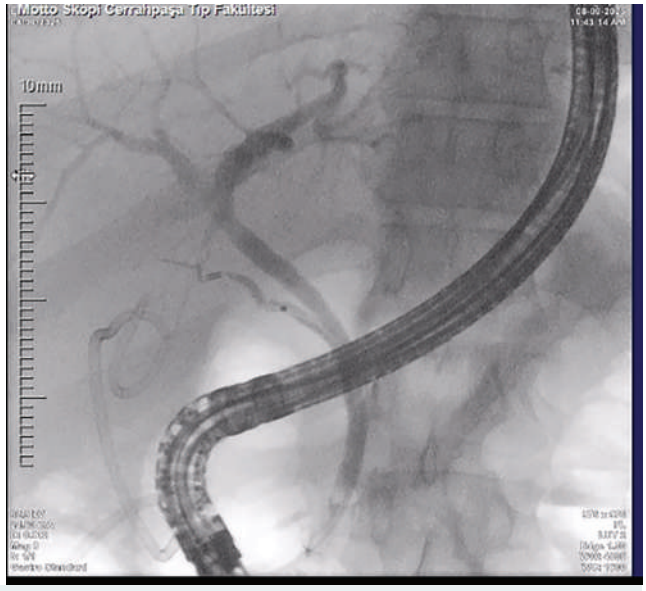

Figure 2. Placement of a plastic stent in the common bile duct.

[P-384]

Primary extranodal high-grade B-cell non-Hodgkin lymphoma extending into the abdomen, located in the rectus muscles

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Objective: Approximately 20-40% of non-Hodgkin lymphomas (NHL) present as primary extranodal disease. Primary soft tissue involvement accounts for only 0.1-1% of all NHL cases. The clinical presentation of lymphoma in soft tissue is highly variable and can mimic other soft tissue malignancies, leading to diagnostic errors. Primary extranodal cases originating from abdominal wall muscles are quite limited in the literature.

Material and Methods: Clinical presentation: A 62-year-old male patient presented with a complaint of a palpable and painless mass in his abdominal wall that had been gradually growing for approximately one year. He had no other medical conditions besides known diabetes mellitus, and no history of abdominal surgery. On physical examination, a mass lesion approximately 8x10 cm was palpated in the upper right quadrant of the abdomen. The patient did not have systemic "B symptoms" such as fever, night sweats, or weight loss. Abdominal CT scan revealed: A mass lesion approximately 13-cm in craniocaudal dimension and approximately 11x5 cm in axial plane, extending to the rectus abdominus muscle, with a unclear boundary between the bowel loops and the mass containing cystic necrotic areas, located inferiorly adjacent to the transverse colon on the right side. Tissue diagnosis is recommended. Inferior to this lesion, two nodular lesions measuring 3-cm and 2-cm are observed in the right rectus muscle.

Results: Abdominal wall lymphomas are rare and can often be confused with sarcomas, undifferentiated carcinomas, or other soft tissue tumors. Fascial plane crossing and the presence of lymphadenopathy surrounding large vascular structures on CT are critical radiological clues that differentiate lymphoma from sarcomas. Definitive differentiation is possible with tissue biopsy and immunohistochemical panels including pan-leukocyte markers. In the treatment approach, systemic chemotherapy is vital in cases of DLBCL, an aggressive subtype. Excellent clinical outcomes have been reported with chemotherapy after surgical debulking in early-stage cases.

Conclusion: This case demonstrates that NHL should always be considered in the differential diagnosis of masses detected in the abdominal wall muscles. We believe that the diagnostic procedure should be performed by planning direct en bloc resection. Non-surgical biopsy methods may not contain sufficient tissue, leading to a delay in diagnosis and the need for re-biopsy. They also delay en bloc excision of the primary lesion by leaving residual tissue. Long-term disease-free survival can be achieved in primary soft tissue lymphomas with accurate staging and modern chemo-immunotherapy protocols.

Keywords: Abdominal wall, non-Hodgkin lenfoma, resection

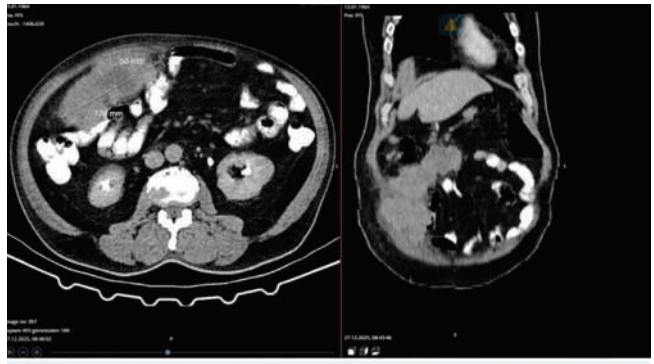

Figure 1. CT image of axial and coronal sections.

Figure 2. Specimen after resection.

[P-390]

Unexpected diagnosis of neuroendocrine tumor in a case of ileus secondary to small bowel diverticulum

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Material and Methods: A 26-year-old female patient who presented with acute abdominal symptoms and was diagnosed with ileus was evaluated. Clinical findings, radiological imaging results, surgical approach, histopathological findings, and postoperative management were retrospectively reviewed. Abdominopelvic computed tomography (CT) was used for preoperative assessment. Surgical intervention was performed laparoscopically. Histopathological evaluation included tumor grading and proliferation index (Ki-67). Postoperative staging and follow-up were conducted using Ga-68 DOTATATE PET/CT, and the patient was discussed in a multidisciplinary oncology board.

Results: Preoperative imaging revealed dilated distal ileal loops with air-fluid levels, consistent with ileus. Laparoscopic exploration demonstrated a small bowel diverticulum approximately 10-cm distal to the ligament of Treitz, forming a loop that caused strangulation of the ileal segment. The diverticulum was resected at its base. Histopathological examination revealed a well-differentiated neuroendocrine tumor (Grade 1) with a Ki-67 index of 2% and a mitotic rate of 0-1. The tumor extended from the submucosa to the subserosa, and subserosal tumor foci were identified at the surgical margin. Ga-68 DOTATATE PET/CT performed during follow-up showed no pathological uptake. Due to positive surgical margins, the patient underwent laparoscopic partial small bowel resection with side-to-side anastomosis. The postoperative course was uneventful, and no early complications were observed. The patient was placed under close clinical and oncological follow-up.

Conclusion: Small bowel neuroendocrine tumors should be considered in the differential diagnosis of young patients presenting with acute ileus, although rare. Detailed histopathological evaluation and a multidisciplinary approach are crucial for optimal management, particularly in cases involving diverticular resection.

Keywords: Small bowel diverticulum, neuroendocrine tumor, ileus, laparoscopic surgery, case report

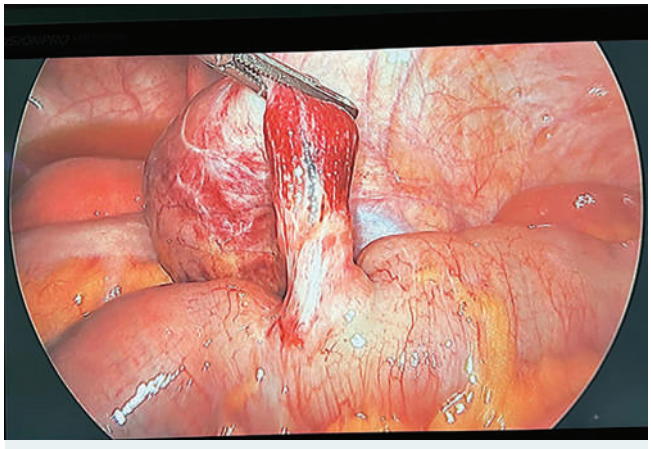

Figure 1. Peroperative images.

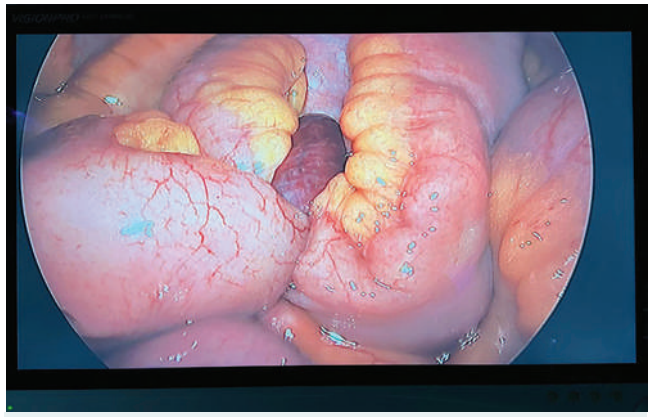

Figure 2. Peroperative images.

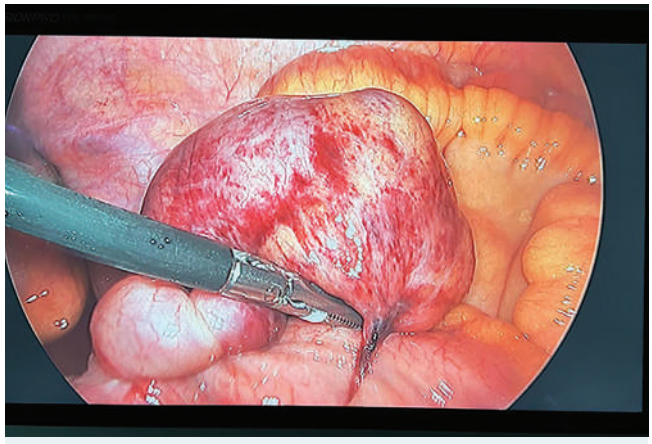

Figure 3. Peroperative images.

[P-391]

Incidental umbilical endometriosis detected during umbilical hernia repair: A case report

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Objective: Umbilical endometriosis is a rare condition characterized by the presence of endometrial tissue in the umbilical region and accounts for less than 1% of all endometriosis cases. Primary umbilical endometriosis occurs spontaneously, whereas the secondary form is usually associated with previous abdominal or gynecological surgery. Incidental detection during umbilical hernia repair is extremely uncommon.

Material and Methods: A 40-year-old female patient presented with swelling in the umbilical region. Physical examination and imaging findings were consistent with an umbilical hernia. The patient reported no cyclic umbilical pain, tenderness, or skin changes related to the menstrual cycle. Elective umbilical hernia repair was performed using mesh. The excised tissue from the umbilical region was routinely sent for histopathological examination.

Results: No remarkable macroscopic pathological findings were observed intraoperatively. Histopathological evaluation revealed endometrial glands and stroma consistent with umbilical endometriosis. The patient had no history of previous abdominal or gynecological surgery. The postoperative course was uneventful, and the patient was referred for multidisciplinary follow-up.

Conclusion: Histopathological evaluation of tissues excised during umbilical hernia repair may reveal rare but clinically significant diagnoses. Umbilical endometriosis should be considered in the differential diagnosis of umbilical lesions even in the absence of cyclic symptoms, particularly in female patients. This case highlights an atypical and incidental presentation of umbilical endometriosis and aims to raise awareness among general surgeons.

Keywords: Case report, endometriosis, hernia repair, umbilical endometriosis, umbilical hernia

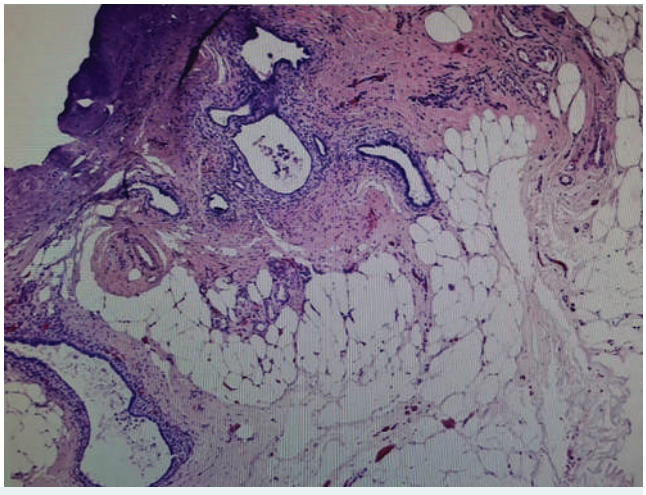

Figure 1. Glandular and stromal endometrial tissue surrounded by fibroadipose tissue (×40).

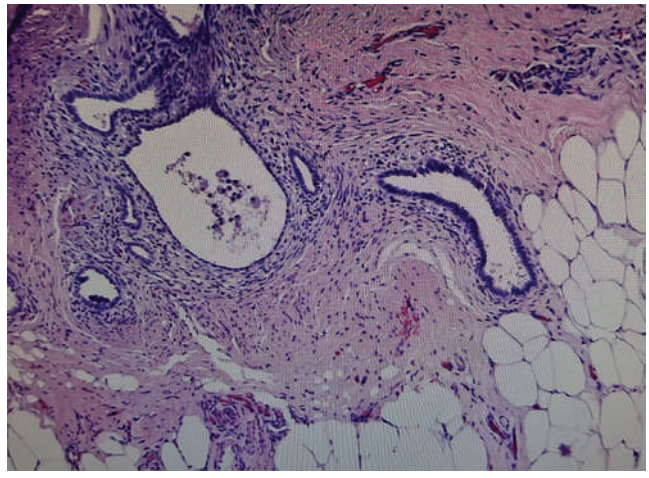

Figure 2. Endometriosis involving endometrial glandular structures in the endometrial stroma (x100).

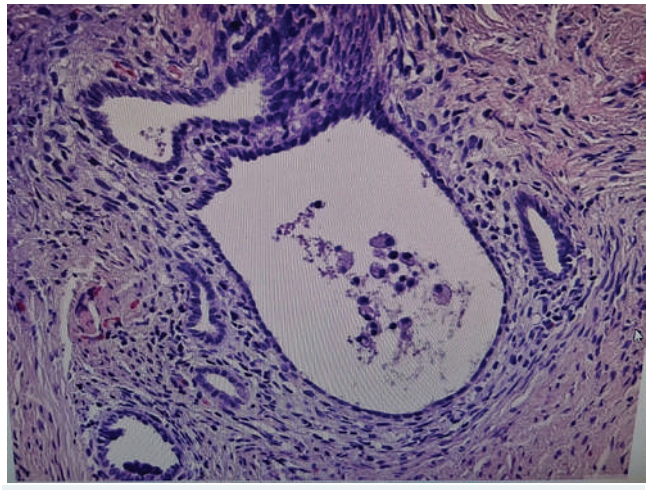

Figure 3. Endometrial glandular structure lined by columnar epithelium, surrounded by endometrial-type stroma (x200).

[P-392]

Ventriculoperitoneal shunt hernia

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Objective: Ventriculoperitoneal shunting is one of the most commonly used surgical methods in the treatment of hydrocephalus. Complications related to the shunt system can manifest as infection, mechanical dysfunction, and abdominal complications. Abdominal complications include pseudocyst, bowel perforation, catheter migration, and herniation. The presence of the shunt catheter within a hernia sac is a very rare occurrence. Reporting such cases is important for understanding the diagnosis and surgical approach.

Material and Methods: A 46-year-old patient presented with pain and swelling in the left upper quadrant. The patient's history revealed a ventriculoperitoneal shunt placement due to hydrocephalus. Physical examination revealed a reducible abdominal hernia in the left upper quadrant. Laboratory findings were within normal limits. Imaging showed a tubular structure consistent with a ventriculoperitoneal shunt catheter within the hernia sac. The patient underwent elective surgery. During the operation, the distal catheter of the ventriculoperitoneal shunt was visualized within the hernia sac. The hernia was reduced while preserving the catheter, and abdominal wall repair was performed. No postoperative complications occurred, and the patient was discharged without complications.

Results: A significant portion of VP shunt complications occur in the abdominal region. The most commonly reported complications are pseudocyst formation and catheter migration. Catheter placement within the hernia sac is a rare occurrence. The presence of an intraabdominal catheter and chronic pressure changes may contribute to abdominal wall weakness. Similar cases have been reported in both pediatric and adult patients in the literature. The basic approach to treatment is hernia repair and preservation of the shunt. Shunt revision is generally not necessary if there is no evidence of shunt dysfunction or infection.

Conclusion: In patients with VP shunts, the possibility of herniation should be kept in mind in the presence of abdominal distension and pain. Successful results can be achieved with surgical repair.

Keywords: Ventriculoperitoneal shunt, abdominal hernia, hydrocephalus, surgical complication

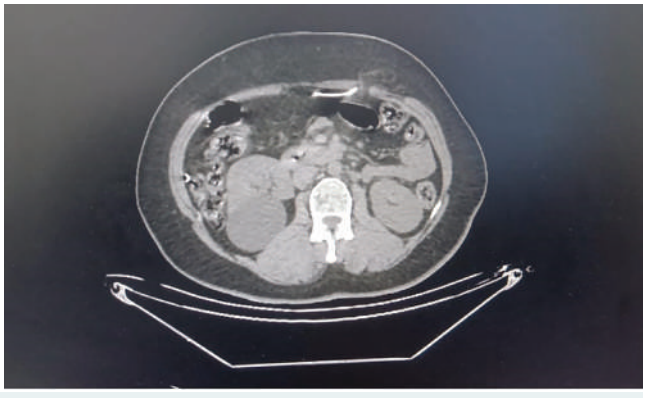

Figure 1. CT scan of a shunt hernia.

CT: Computed tomography.

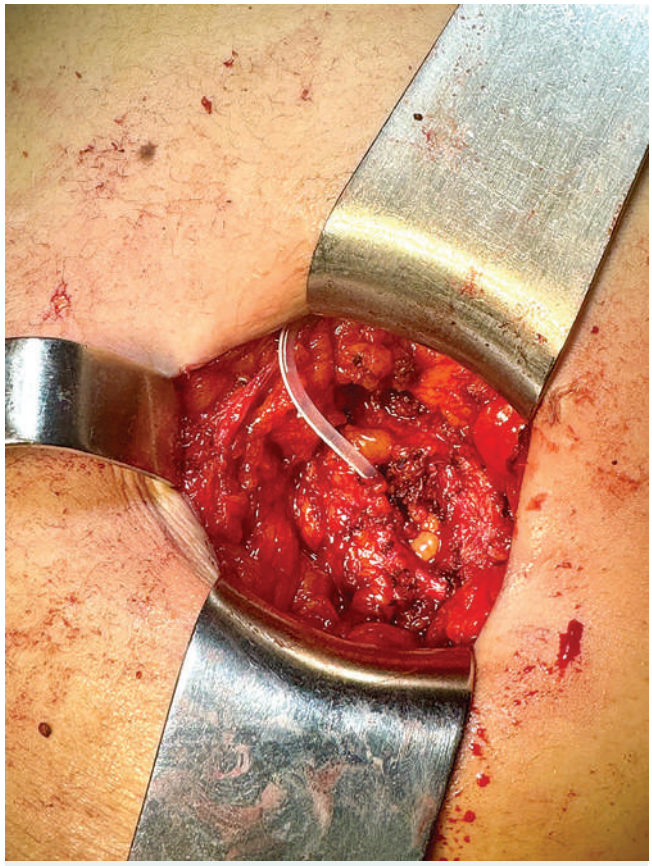

Figure 2. Intraoperative image.

[P-393]

A rare cause of elevated creatinine levels in the posttransplant period: A case of graft ureter herniation

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Objective: Kidney transplantation is the most effective treatment method for improving survival and quality of life in end-stage renal disease. However, in transplant recipients, the risk of developing incisional hernia increases due to factors such as immunosuppressive therapy, compromised tissue integrity, and delayed wound healing. The presence of the graft ureter within the hernia sac is extremely rare; if not anticipated during surgical repair, it can lead to serious complications such as iatrogenic ureteral injury, urinary leakage, obstructive uropathy, and graft dysfunction. This report presents a rare case of posttransplant incisional hernia in which a graft ureter was detected within the hernia defect, emphasizing the decisive role of preoperative diagnosis in surgical safety.

Material and Methods: Patient records from Gaziantep University Hospital were retrospectively reviewed. The patient's demographic characteristics, transplant history, laboratory parameters, and radiological findings were evaluated.

Results: A 62-year-old patient who underwent kidney transplantation from a living donor due to renal failure for 3 years was admitted to the nephrology outpatient clinic for further investigation and treatment due to a new decrease in urine output and serum creatinine of 2.77 mg/dL after transplantation. No pathological findings were found on physical examination. An abdominal computed tomography scan revealed that the lower part of the graft ureter was herniated into the incisional hernia defect and dilation was detected proximal to the graft ureter. Surgery was planned for the patient. A percutaneous nephrostomy was placed in the graft kidney during the preoperative period. The surgical intervention was performed with careful planning to prevent possible ureteral injury. Intraoperative exploration confirmed that the graft ureter was located within the defect. The ureter was carefully dissected from the surrounding tissues using sharp and blunt dissection techniques and safely reduced into the retroperitoneal space. The hernia repair defect was repaired. No intraoperative complications developed. The postoperative course was uneventful; the patient was discharged with stable renal function.

Conclusion: It should be kept in mind that in incisional hernias developing in posttransplant patients, the graft ureter may very rarely be located within the hernia sac. Preoperative cross-sectional imaging contributes to the safe establishment of the surgical strategy by enabling the recognition of atypical hernia contents and reduces the risk of iatrogenic injury that could threaten graft function. This case demonstrates that detailed radiological evaluation is critical for optimal surgical outcomes in patients with a history of transplantation.

Keywords: Kidney transplantation, graft ureter, incisional hernia

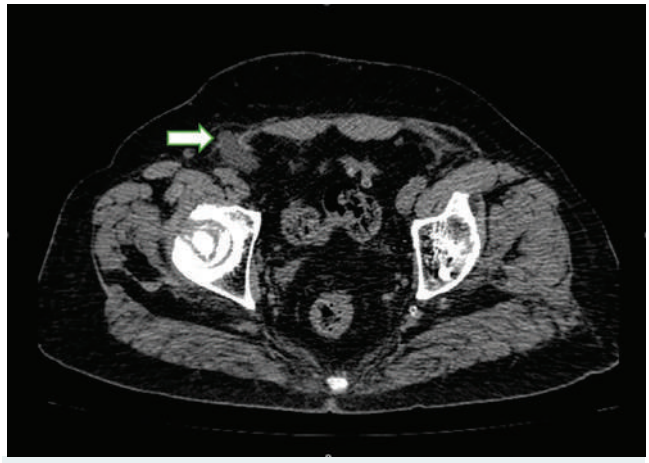

Figure 1. CT scan image of the ureteral graft.

CT: Computed tomography

[P-394]

Nipple adenoma mimicking malignancy clinically and radiologically: Diagnostic challenges and surgical management of a rare benign lesion

Cenk Yazkan, Narmin Hajizada, Leyla Tekin, Önder Özcan

Muğla Sıtkı Koçman University Faculty of Medicine, Muğla

Objective: Nipple adenoma is a rare, benign epithelial proliferation originating from the lactiferous ducts. Due to its clinical, radiological, and even macroscopic features, it can mimic malignant breast diseases, leading to diagnostic challenges.

Material and Methods: A six-year-old female patient presented to our clinic with a complaint of a palpable mass in her left breast. Physical examination revealed a palpable mass, approximately 4-cm in size, completely involving the left nipple and areola complex. The initial breast ultrasonography (USG) performed during the diagnostic imaging process revealed a mass lesion in the retroareolar area of the left breast with lobulated contours, heterogeneous hypoechoic structure, anarchic vascularity, and posterior acoustic shadowing. Subsequent dynamic contrast-enhanced breast magnetic resonance imaging (MRI) revealed a mass lesion approximately 27x22 mm in size, extending from the skin to the retroareolar area at the level of the left nipple, exhibiting intense contrast enhancement in the early stages and showing diffusion restriction. Additionally, segmental linear ductal and nodular non-mass contrast enhancement areas extending approximately 18-mm were present posterior to this mass. The MRI findings suggested an accompanying ductal carcinoma *in situ* (DCIS) or tumor spread. Due to these radiological findings, the lesion was evaluated as BI-RADS category 5 (highly malignant), and histopathological confirmation was recommended.

Results: A tru-cut (core) biopsy was performed on the patient from the retroareolar lesion of the left breast under ultrasound guidance. Histopathological and immunohistochemical examination of the biopsy material revealed papillary-like structures and ducts containing focal apocrine and columnar metaplasia. Immunohistochemically, SMMS and p63 were observed, the myoepithelial cell layer was preserved, and the ER receptor was heterogeneously positive. The biopsy report concluded that "no overt invasive malignancy was observed," but due to the high clinical and radiological suspicion, evaluation with excisional biopsy was recommended. Final histopathological examination of the excised material revealed a 2.5-cm diameter lesion consisting of partly papillary and partly solid areas. Microscopically, the lesion showed ductal hyperplasia, papilloma, adenosis, and fibrocystic changes. Immunohistochemical analysis confirmed the preservation of the myoepithelial cell layer with p63 and CD10, and the Ki-67 proliferation index was found to be 2-3%. The lesion did not extend beyond the surgical margins. All these findings were considered consistent with a diagnosis of nipple adenoma.

Conclusion: Nipple adenoma, although rare, is an important benign pathology that can mimic malignant breast diseases. Accurate diagnosis is critical to preventing unnecessary radical surgeries. Surgical excision is an effective and safe approach, both diagnostically and therapeutically.

Keywords: Nipple adenoma, benign breast tumor, differential diagnosis, nipple lesions, surgical excision

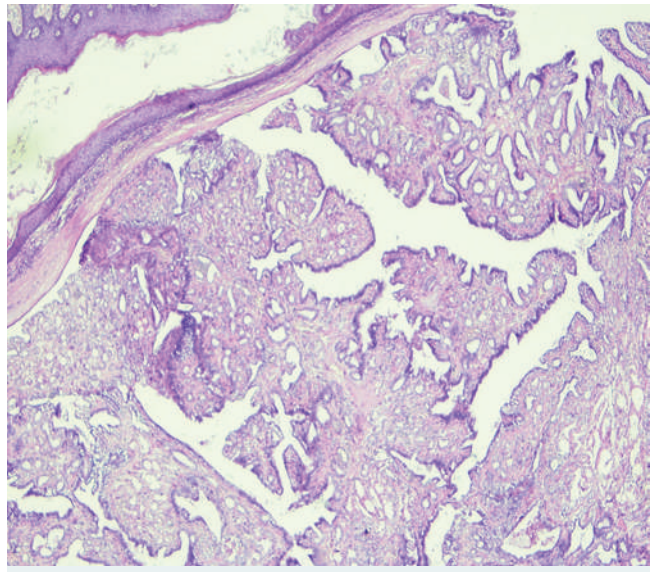

Figure 1. Nipple adenoma, papillary-adenomatous structure (H&E, x10).

H&E: Hematoxylin and eosin.

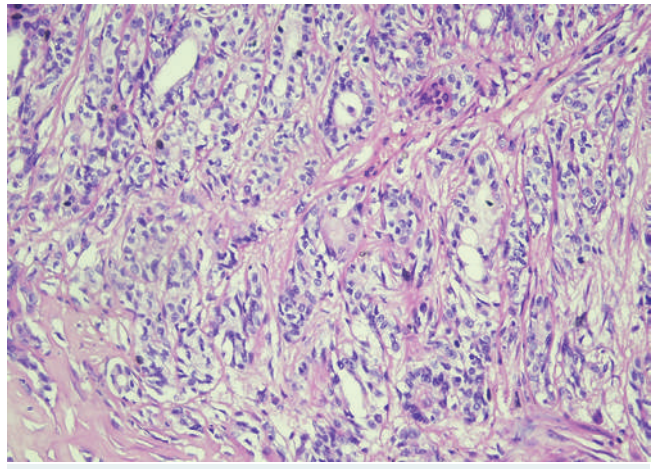

Figure 2. Nipple adenoma, H&E, x200.

H&E: Hematoxylin and eosin.

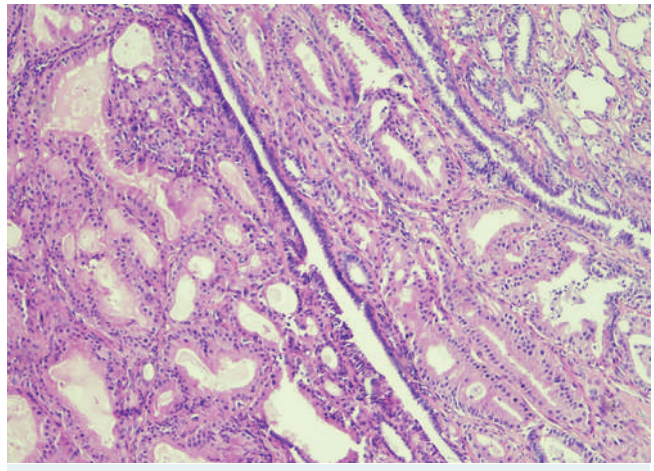

Figure 3. Nipple adenoma, H&E, x100.

H&E: Hematoxylin and eosin.

[P-395]

A rare vascular suprarenal mass mimicking malignancy: A case of cavernous hemangioma

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Objective: A rare vascular tumor of the adrenal gland, adrenal cavernous hemangioma is one of the extremely rare benign lesions, most commonly detected incidentally in the literature and described as non-functional lesions. However, when it reaches large sizes, it can present with symptoms, and due to its heterogeneous imaging characteristics, it can be challenging to differentiate from malignant adrenal neoplasms. It is reported in the literature that preoperative diagnosis is often not possible, surgical resection plays both a diagnostic and therapeutic role. In this study, the clinical, radiological, surgical, histopathological features of a symptomatic, non-functional, and large adrenal cavernous hemangioma case are presented with a review of the literature.

Material and Methods: A patient who underwent surgery for adrenal cavernous hemangioma was retrospectively reviewed. Demographic data, mode of presentation, preoperative clinical and laboratory findings, surgical method applied, pathological examination were evaluated. Postoperative follow-up was recorded.

Results: A woman in her seventies presented with abdominal pain and early satiety. Physical examination was unremarkable. Preoperative hormonal evaluation Showed no evidence of adrenal hyperfunction, and the mass was considered non-functional. Imaging studies revealed a heterogeneous, approximately 10-cm left adrenal mass with cystic, hemorrhagic, and possible vascular components, raising suspicion for malignancy. Due to the mass size and symptomatic course, surgical treatment was performed. Laparoscopic approach was initiated and converted to open surgery, resulting in left adrenalectomy. Postoperative course was uneventful. Histopathological and immunohistochemical examination confirmed cavernous hemangioma, with normal adrenal tissue and no early recurrence.

Conclusion: In the literature, it is reported that the majority of adrenal cavernous hemangiomas are non-functional, however, in particularly large cases, they can become symptomatic, and due to their heterogeneous radiological appearances, they are frequently misdiagnosed as malignant adrenal tumors. Therefore, in cases with symptomatic course and where malignancy cannot be safely excluded preoperatively, surgical resection is accepted as an appropriate approach both for diagnostic and therapeutic purposes. The presented case is instructive in highlighting the challenges in the differential diagnosis of adrenal cavernous hemangiomas and the importance of surgical treatment, with a course and successful surgical management consistent with the characteristics described in the literature.

Keywords: Adrenal cavernous hemangioma, adrenal mass, differential diagnosis of malignancy, non-functional adrenal tumor, vascular tumor

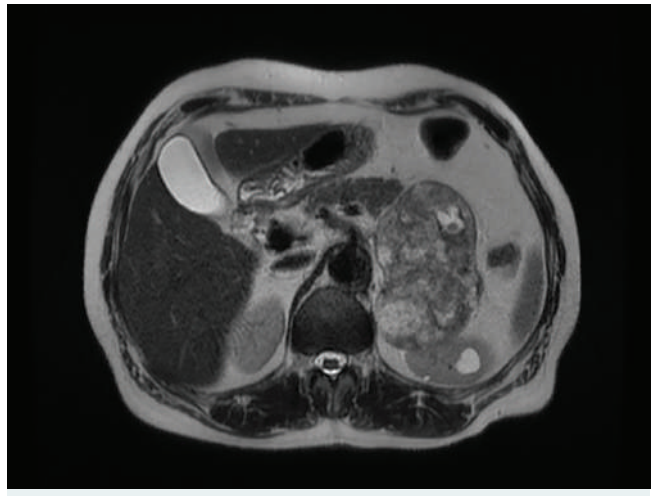

Figure 1. Preoperative MRI image.

MRI: Magnetic resonance imaging.

Table 1. Comparison with the literature

Çalışma / Yıl	Hasta (Yaş/Cinsiyet)	Taraf	Boyut	Klinik (Semptom)	Hormon değerlendirme	Görüntüleme bulguları (özet)	Preop ayırıcı tanı / malignite şüphesi	Cerrahi	Patoloji (ana bulgu)	Takip/sonuç
Bizim olgumuz	**71 / Kadın**	**Sol**	**~10.1 cm** (101 mm)	**Karın ağrısı + erken doyma** (kitlenin bası etkisi ile uyumlu)	**Non-fonksiyonel** (*kortizol, metanefrin vb. ile hipersekresyon dışlandı—klinik not*)	**USG + BT + MR mevcut.** MR'da **vasküler/heterojen görünüm** (Excel: "var"). Büyük kitle olması nedeniyle benign-malign ayırımı zor.	**Malignite şüphesi var** (Excel: 1). Ayırıcı tanıda "adenom" işaretli (Excel: 4) (*klinikte ACC/feo/metastazda pratikte gündeme gelir*)	**Lap başlandı → eksplorasyon → açık cerrahiye konversiyon.** Dren konuldu, **POD2 çekildi**, komplikasyon yok.	**Kavernöz hemanjiom.** Adrenal bez dokusu normal sınırlarda. İHK paneli çalışılmış (RCC, PAX8, CD10, kalretinin, inhibin, Ki-67).	**Nüks yok** (3 ay). R0 (Excel: 1). Yatış 11 gün.
Almajed ve ark., 2024 (Am J Case Rep)	Erkek, **41** (metinde 39 da geçiyor)	Sağ	**4.56×4.24×3.9 cm** (rezeksiyon 5×4×4 cm)	İnsidental (renal kolik araştırılırken)	**DST ile kortizol baskılı → non-fonksiyonel**	CT'de heterojen/enhansman + yağ/kalsifikasyon komponentleri; preop myelolipomaya benzetilmiş	Tanısal belirsizlik + büyüme nedeniyle cerrahi	**Laparoskopik adrenalektomi**	Hemanjiyom; dilate vasküler kanallar, düz endotel ile uyumlu	Sorunsuz iyileşme, komplikasyon yok (PMC)
Huang ve ark., 2021 (BMC Surgery)	Erkek, **67**	Sağ	**9.5×6.3 cm** (ayrıca 63×95 mm vurgusu)	Dull flank/back pain	Endokrin testler normal (renin/aldosteron, katekolaminler)	**Arteriyel fazda periferik belirgin kontrastlanma + venöz/geç fazda progresif dolum** (hemangiom lehine klasik patern)	Preop **feo** düşünülmüş (yanlış tanı)	**Retroperitoneal lap adrenalektomi**	"Adrenal hemangioma" + **iç kanama/nekroz** alanları	1 yıl takipte nüks yok (Springer)
Tokluu ve ark., 2022 (Int J Clin Exp Pathol)	Erkek, **67**	Sol	**5.4 cm** (gross 4.9 cm)	Kilo kaybı araştırılırken; HT, anemi vb. komorbid	Metanefriner ve aldosteron/renin normal; prednizon nedeniyle Cushing değerlendirmesi sınırlı	CT'de 5.4 cm adrenal kitle; büyük lezyonlarda malignite ayırımı güç vurgulanıyor	**Malignite şüphesi** nedeniyle cerrahi	**Sol adrenalektomi**	Hemanjiyom: kalın-ince duvarlı damar yapıları, hemorajik zemin, periferde adrenokortikal demanlarla uyumlu	Cerrahi ana yaklaşım olarak vurgulanıyor
Chua ve ark., 2022 (Cureus – olgu + derleme)	Erkek, **79**	Sol	**20.8 cm** (dev kitle)	Abdominal rahatsızlık + anemi; palpabl kitle	Metabolik work-up çoğunlukla normal (derleme: %70)	CT'de yağ/nekroz/kalsifikasyon; indeterminee görünüm nedeniyle malignite dışlanamamış	Malignite dışlanamadığı için rezeksiyon	**Açık sol adrenalektomi**	Kavernöz hemanjiom; tanının çoğunlukla postop histoloji ile konduğu vurgusu	Derleme: olguların çoğu açık (%71), lap %24.6; radyolojik bulgular patognomonik değil

[P-396]

A rare germ cell tumor of the adrenal gland: A case of mature cystic teratoma

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Objective: Adrenal gland-derived masses are most often detected incidentally in clinical practice; however, rare pathologies may pose significant challenges in the differential diagnosis. Mature cystic teratoma located in the adrenal gland is an extremely rare entity among germ cell tumors and has been reported in only a limited number of cases in the literature. Due to non-specific clinical manifestations and the anatomical characteristics of the adrenal region, these lesions are frequently confused with other adrenal pathologies. In this study, we present a case of an adrenal mature cystic teratoma that was surgically treated following a detailed clinical, hormonal, and radiological evaluation in a patient who presented with a complaint of abdominal distension.

Material and Methods: The patient who was operated on with the diagnosis of an adrenal-origin mass was retrospectively evaluated. Demographic data, mode of presentation, preoperative clinical and laboratory findings, the surgical approach applied, and the results of pathological examination were analyzed. Postoperative follow-up was performed.

Results: A 22-year-old female presented with abdominal distension. Physical examination and routine laboratory tests were unremarkable. Hormonal evaluation revealed normal serum cortisol and dhea-s levels, and pheochromocytoma was excluded based on hormonal and clinical findings. Abdominal computed tomography demonstrated a well-defined, heterogeneous mass approximately 120-mm in diameter in the left adrenal lodge, containing cystic areas, macroscopic fat, and calcified/tooth-like components, without contrast enhancement, invasion, or vascular involvement. These findings favored the diagnosis of a mature cystic teratoma. A laparoscopic approach was initially attempted; however, due to the size and location of the mass, conversion to open surgery was required, and left adrenalectomy was performed. No postoperative complications occurred. Histopathological examination confirmed a mature cystic teratoma with negative surgical margins. No recurrence or mortality was observed during six months of follow-up.

Conclusion: Although adrenal mature cystic teratomas are extremely rare, they may become symptomatic when they reach large sizes. As demonstrated in this case, characteristic imaging findings—namely the coexistence of fat, cystic components, and calcifications—play a crucial role in diagnosis, while functional evaluation and exclusion of pheochromocytoma are essential for safe surgical planning. The literature indicates that preoperative diagnosis is often challenging and that this rare entity may be overlooked in the differential diagnosis of adrenal incidentalomas (Table 1). Nevertheless, in large adrenal masses containing fat and calcifications, the possibility of a mature cystic teratoma should be considered to determine the appropriate surgical strategy. Surgical resection remains the cornerstone for both definitive diagnosis and treatment, with favorable and complication-free outcomes reported when appropriate patient management is applied, consistent with the literature.

Keywords: Adrenal mass, adrenal teratoma, differential diagnosis of pheochromocytoma, mature cystic teratoma, rare case

Figure 1. CT imaging of the mass.

CT: Computed tomography

Table 1. Comparison with the literature

Çalışma (Yıl)	Olgu (n)	Yaş / Cinsiyet	Lokalizasyon	Boyut	Başvuru Şikâyeti	Fonksiyonel Değerlendirme (Feo vb.)	Görüntüleme (vurgulu ipuçları)	Cerrahi Yaklaşım	Postop Seyir / Takip
Bizim olgumuz (2026, Türkiye)	1	22 / K	Sol adrenal loj	~120 mm	**Karında şişlik**	**Feokromositoma ekarte;** fonksiyonel kitle lehine bulgu yok	**Kistik + yağ komponenti + kalsifik/diş-benzeri odaklar,** invazyon yok → **matür teratom lehine**	**Laparoskopiyle başlandı → eksplorasyon kısıtlılığı nedeniyle açık cerrahiye konversiyon,** adrenalektomi	Komplikasyon yok; **dren 3. gün çekildi;** 6 ayda nüks yok
Li ve ark. (2015)	1	49 / E	Sağ adrenal	~6×7×11 cm	İnsidental	Adrenal hormonlar + AFP/hCG normal (fonksiyonel değil)	BT: **yağ densitesi + kalsifikasyon,** myelolipom/adenoma karışabilmiş	**Retroperitoneoskopik lap adrenalektomi**	Sorunsuz; **8 ayda nüks yok**
Assarrar ve ark. (2022)	1	56 / K	Sağ adrenal	76×72×80 mm	Dispepsi/epigastrik ağrı	**Hormonal değerlendirme normal**	Kontrastlı BT: **büyük kitle; yağ ağırlıklı + yumuşak doku + kalsifikasyon**	**Açık transperitoneal adrenalektomi**	Patoloji matür teratom; büyük/dejeneratif olguda açık cerrahiyi vurgular
Ma ve ark. (2022)	1	59 / K	Sağ adrenal	(metinde heterojen kitle; ölçü verisi kısıtlı)	İnsidental	**Adrenal fonksiyon normal**	BT: **heterojen adrenal kitle,** ayırıcı tanıda karışabilir	Cerrahi rezeksiyon (olgu sunumu)	Klinik olarak iyi seyir; matür teratom vurgusu
Li ve ark. (JSCR, 2024)	1	52 / E	**Sol adrenal**	7.2×7.5 cm	İnsidental	Renin/aldosteron/ACTH/kortizol normal	BT: **yağ dominant + "sac within a sac" + kalsifikasyon,** minimal/önemsiz enhancement	**Laparoskopik sol adrenalektomi**	Komplikasyon yok; **6 ayda nüks yok**
Wang ve ark. (Medicine, 2019) ***(adrenal bölge/retroperitoneal, bilateral)***	1	22 / K	**Bilateral adrenal bölge**	Sol 10.4×10.1×13.2 cm; Sağ 12.3×10.5×12.5 cm	İnsidental	24s idrar kortizol + fraksiyone metanefrinler + ARR normal	BT/MR: **solid-kistik + kemik/yağ komponentleri,** dev kitleler	**Laparoskopik simultane rezeksiyon (en-blok)**	Komplikasyon yok; taburcu **11. gün, 10 ay nüks yok**

[P-397]

Oxidized regenerated cellulose mimicking recurrent mass after total thyroidectomy: A diagnostic pitfall

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Objective: Oxidized regenerated cellulose (ORC) is a biological material widely used for hemostasis during thyroid surgery. Although it is generally expected to be resorbed within a few weeks, in rare cases it may persist and lead to pseudotumoral lesions, which can be confused with locoregional recurrence, granuloma, or residual tumor. This situation creates a diagnostic challenge, particularly in postoperative patients presenting with cervical masses. In this case report, we aimed to present a case of persistent ORC following total thyroidectomy that demonstrated clinical progression.

Material and Methods: A 54-year-old female patient underwent total thyroidectomy on March 5, 2025, with the diagnosis of multinodular goiter. No complications were observed in the early postoperative period. However, during follow-up, progressive cervical swelling developed, prompting further evaluation. Neck ultrasonography revealed a hypoechoic, avascular, solid-appearing lesion located in the thyroidectomy bed. Although the imaging findings were initially considered compatible with benign postoperative changes, the lesion demonstrated progressive enlargement over time, caused dysphagia, and became externally visible; therefore, the patient was considered symptomatic. Due to the progression of clinical findings and significant mass effect, surgical exploration was planned. During surgery, a mass consistent with persistent oxidized regenerated cellulose material was identified in the previous surgical field and was completely excised. Histopathological examination revealed fibro-adipose tissue demonstrating focal fat necrosis and foreign body-type chronic inflammatory reaction associated with oxidized cellulose material. No evidence of neoplasia was detected.

Results: Previous reports in the literature have documented that ORC and similar surgical cellulose-based materials may mimic recurrent masses following thyroid and parathyroid surgery. On ultrasonography, these lesions typically appear hypoechoic and avascular, which may serve as an important clue in the differential diagnosis. However, diagnostic uncertainty may persist in the presence of clinical progression and symptoms. In such cases, surgical excision represents an effective approach for both definitive diagnosis and treatment.

Conclusion: In patients presenting with cervical masses after thyroidectomy, particularly in the presence of lesion progression and clinical symptoms, persistent oxidized regenerated cellulose should be considered in the differential diagnosis. Minimal and well-documented use of ORC is crucial to prevent misdiagnosis of recurrence and avoid unnecessary reoperations.

Keywords: Oxidized regenerated cellulose, total thyroidectomy, postoperative cervical mass, ultrasonography

Figure 1. Clinical appearance of persistent oxidized regenerated cellulose after total thyroidectomy. (A) Anterior cervical view demonstrating a swelling in the thyroidectomy bed mimicking a recurrent mass. (B) Lateral cervical view showing a visible mass effect causing contour deformity of the neck.

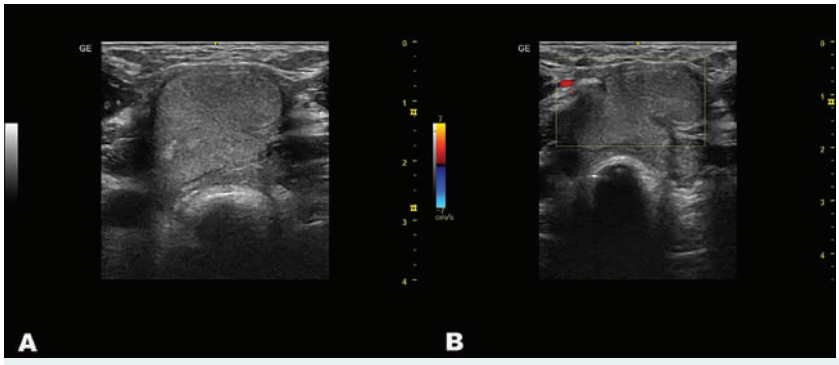

Figure 2. Ultrasonographic appearance of persistent oxidized regenerated cellulose in the thyroidectomy bed after total thyroidectomy. (A) Gray-scale neck ultrasonography demonstrating a hypoechoic, solid-appearing lesion located in the thyroidectomy bed. (B) Color Doppler ultrasonography showing that the same lesion is avascular.

[P-398]

Occult thyroid carcinoma: A rare case report

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Objective: Thyroid cancer incidence has been steadily increasing worldwide in recent years. With the more widespread use of ultrasonography and other imaging modalities, the incidence of occult thyroid carcinoma (OTC) and papillary thyroid microcarcinoma (PTMC) has also increased. The term OTC has been defined variably in the literature. In most clinical settings, OTC and PTMC are considered synonymous or closely related; however, certain discordant situations exist. Boucek et al. proposed a four-group classification for OTC, and Liu et al. additionally suggested a fifth group within this classification (Figure 1). In this case, we report an OTC presenting with isolated cervical lymph node metastasis despite normal thyroid imaging (Boucek et al., Group 3). Although lymph node metastasis in PTMC is rare and predominantly confined to the central compartment, the detection of level V lateral neck metastasis without central involvement in our patient suggests an unusual skip-metastasis pattern.

Material and Methods: The patient who presented with a complaint of neck swelling underwent thyroid ultrasonography, neck ultrasonography, and cervical MRI. An excisional biopsy was performed on a level V lymph node. To investigate the primary focus, thyroid scintigraphy was obtained, and PET/CT was performed due to a history of breast cancer. Definitive diagnosis was established by histopathological examination following total thyroidectomy with bilateral central neck dissection and left lateral neck dissection.

Results: A 52-year-old woman presented with a complaint of neck swelling. No abnormality was detected on thyroid ultrasonography. Cervical ultrasonography and MRI revealed pathological lymphadenopathy at level V. Excisional biopsy demonstrated metastasis of papillary thyroid carcinoma. Thyroid scintigraphy and PET/CT showed no pathology or primary lesion in the thyroid gland. Postoperative pathology revealed PTMC measuring 3 mm and 1 mm. Among 26 lymph nodes removed during lateral neck dissection, metastasis of papillary carcinoma was identified in one.

Conclusion: OTC is a thyroid carcinoma in which no thyroid tumor is detected or suspected clinically or radiologically, and the diagnosis is established either incidentally in the thyroidectomy specimen or through a metastatic focus. Incidentally detected PTMC is one of the most common subcategories of OTC, and its detection rate has increased with the routine use of imaging and FNAB. The present case demonstrates OTC presenting with isolated lateral cervical (level V) metastasis in a patient in whom no primary lesion could be identified preoperatively, emphasizing that even millimetric PTMC foci may carry metastatic potential. Better characterization of metastatic patterns and clarification of diagnostic and therapeutic strategies are warranted.

Keywords: Occult thyroid carcinoma, papillary thyroid microcarcinoma, skip metastasis

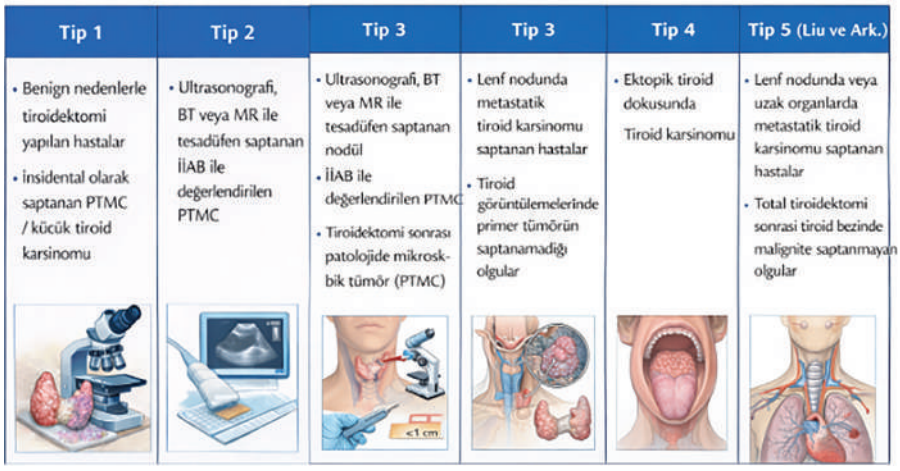

Figure 1. OTC classification.

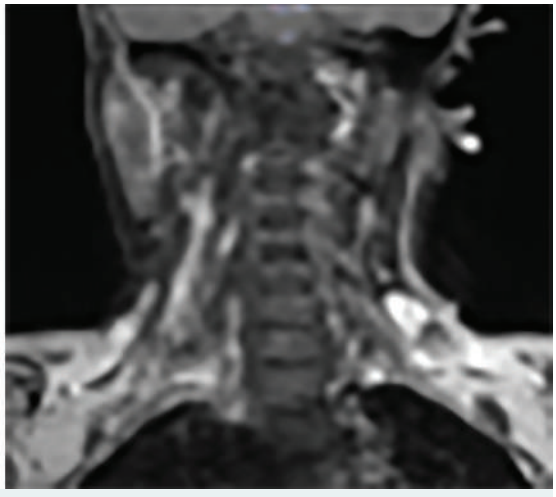

Figure 2. Level 5 lap image on neck MRI.

[P-399]

When gallstones do not remain confined to the gallbladder: Port-site abscess caused by a retained gallstone after laparoscopic cholecystectomy

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Objective: Laparoscopic cholecystectomy is the gold standard treatment for symptomatic gallstone disease. However, gallbladder perforation and spillage of gallstones may occur, particularly in cases with acute cholecystitis or difficult dissection. Although most spilled gallstones remain clinically silent, they may rarely lead to late complications such as abscess formation, fistulas, or inflammatory masses. Port-site abscesses related to retained gallstones are extremely rare and may cause diagnostic delay. We present a case of a port-site abscess caused by a retained gallstone one year after laparoscopic cholecystectomy.

Material and Methods: A 68-year-old female patient presenting with pain, swelling, and erythema at the epigastric region and a history of laparoscopic cholecystectomy one year earlier was retrospectively evaluated. Physical examination findings, laboratory results, ultrasonography, and contrast-enhanced abdominal computed tomography were reviewed. Surgical management, intraoperative findings, and postoperative outcome were analyzed.

Results: Physical examination revealed localized erythema, tenderness, and increased temperature at the previous epigastric port-site. Laboratory tests showed elevated C-reactive protein levels. Ultrasonography demonstrated a thick-walled loculated collection containing a calcified focus with acoustic shadowing. Computed tomography revealed a subcutaneous abscess in the anterior abdominal wall with a hyperdense calcified lesion within the collection. Surgical drainage and debridement were performed without entering the peritoneal cavity. A gallstone was macroscopically identified and removed from the abscess cavity. Wound culture grew *Escherichia coli*. The patient recovered uneventfully after antibiotic therapy and was discharged in good condition.

Conclusion: Retained gallstones spilled during laparoscopic cholecystectomy may rarely cause late-onset port-site abscesses. In patients with a history of laparoscopic cholecystectomy presenting with late abdominal wall infections, retained gallstones should be considered in the differential diagnosis.

Keywords: Delayed complication, laparoscopic cholecystectomy, port-site abscess, retained gallstone

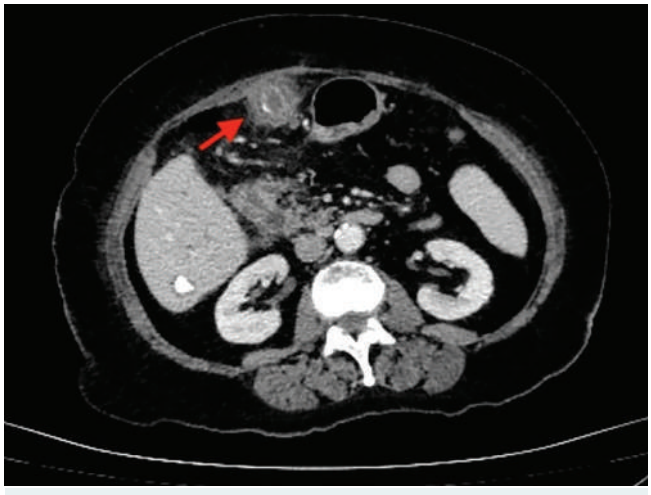

Figure 1. Axial contrast-enhanced abdominal computed tomography demonstrating a subcutaneous abscess in the anterior abdominal wall with peripheral contrast enhancement and a centrally located hyperdense calcified focus (red arrow), consistent with a retained gallstone.

Figure 2. Sagittal CT image showing a subcutaneous abscess located at the epigastric port site containing a calcified gallstone (red arrow).

Figure 3. Gallstone retrieved from the abscess cavity during surgical debridement.

[P-400]

Fungal splenic abscess in a diabetic patient requiring splenectomy

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Objective: Splenic abscess is an uncommon but potentially fatal condition, with fungal etiologies representing a small proportion of cases (0.07-0.14%). Early diagnosis is challenging due to nonspecific clinical features. Current management strategies include targeted antimicrobial therapy, image-guided percutaneous drainage, and splenectomy. Selection of therapy is guided by abscess size, number, causative organism, clinical stability, and response to initial medical management. Fungal splenic abscesses, particularly in immunocompromised patients such as those with diabetes mellitus, are associated with poor response to conservative treatment and frequently require definitive surgical intervention.

Material and Methods: A 55-year-old woman with diabetes mellitus presented with diabetic ketoacidosis. Contrast-enhanced computed tomography of the abdomen demonstrated a solitary 5-cm cystic lesion in the spleen. Comprehensive evaluation, including blood cultures, transthoracic echocardiography, and funduscopic examination, failed to identify a primary infectious source, although imaging findings were consistent with splenic abscess

Results: Empirical intravenous antimicrobial therapy was initiated in accordance with standard management protocols. Despite adequate medical treatment, the lesion persisted, and the etiology remained indeterminate. Given the abscess size (>4 cm), lack of clinical and radiologic resolution, and the high likelihood of treatment failure with medical therapy alone in suspected fungal infection, splenectomy was pursued. Surgical management provided definitive source control and allowed for histopathological diagnosis, which confirmed a fungal splenic abscess.

Conclusion: This case illustrates the importance of a structured, guideline-based approach to the management of splenic abscesses. While antimicrobial therapy and percutaneous drainage may be considered in selected patients, splenectomy is recommended in cases of large or persistent lesions, failure of conservative management, or suspected fungal infection. In such settings, early surgical intervention offers both diagnostic certainty and definitive treatment, potentially reducing morbidity and mortality.

Keywords: Fungal splenic abscess, splenectomy, immunocompromised

[P-401]

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

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Objective: Congenital internal hernias are rare in adults. However, delayed diagnosis can lead to life-threatening complications such as strangulation and intestinal necrosis. Diagnosis is particularly difficult in acute abdomen and ileus presentations in adults with no history of prior abdominal surgery. This case report presents a successful management of small bowel obstruction due to congenital transmesocolic internal herniation without resection using second-look surgery.

Material and Methods: The clinical, radiological, and surgical findings of a 27-year-old female patient with no history of surgery who presented with acute onset abdominal pain and nausea were retrospectively evaluated.

Results: Laboratory tests revealed leukocytosis and elevated C-reactive protein levels. Contrast-enhanced abdominal computed tomography showed clustering, acute dilation, wall thickening, decreased contrast enhancement, and intraperitoneal fluid in the mid-distal ileal loops. During emergency exploratory laparotomy, a segment of small bowel approximately 160 cm in length was found herniated through a congenital defect in the transverse colon mesentery. The herniated loops were reduced, and the mesenteric defect was primarily repaired. Resection was not performed due to the borderline assessment of bowel viability. A second-look surgery was planned 48 hours later. At the second look, intestinal perfusion and peristalsis were found to have improved significantly, and resection was not required. Findings of ischemia-reperfusion injury that developed in the postoperative period resolved with a conservative approach. The patient was discharged on the ninth postoperative day.

Conclusion: Although congenital transmesocolic internal hernias are rare in adults, they should always be considered in cases of unexplained acute abdomen and ileus. Computed tomography plays a critical role in early diagnosis. Second-look surgery in cases with borderline ischemia offers a bowel-preserving, safe, and effective surgical strategy by preventing unnecessary bowel resection.

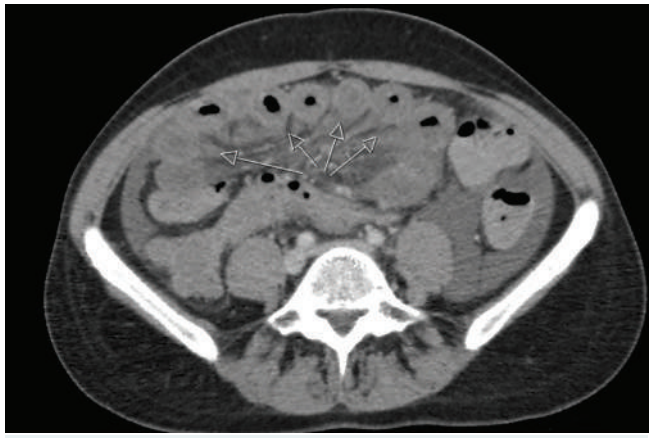

Figure 1A. Preoperative contrast-enhanced abdominal CT scan 1A.

Ileal loop wall thickening and ischemic processes.

Figure 1B. Preoperative contrast-enhanced abdominal CT scan 1B.

Acute angulation and internal herniation level.

Keywords: Congenital internal hernia, transmesocolic hernia, small bowel obstruction, second-look surgery, acute abdomen

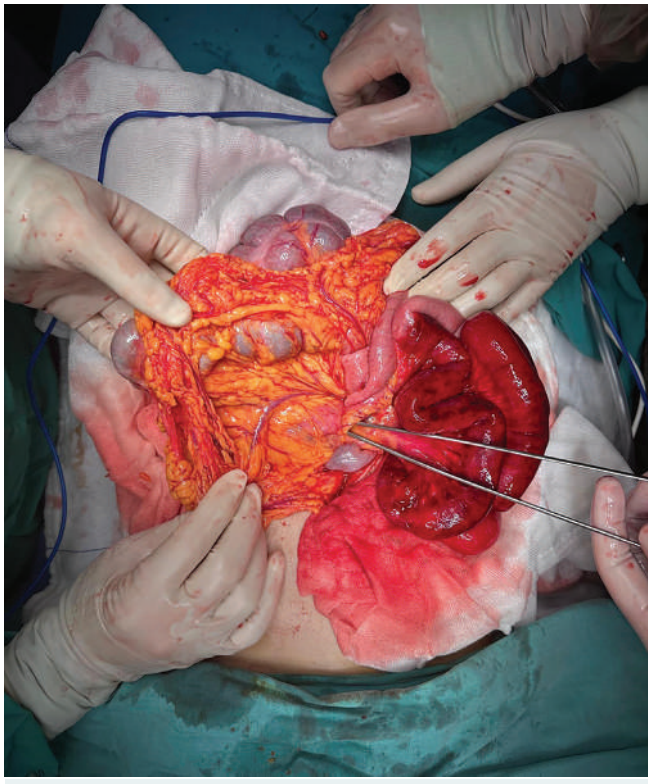

Figure 2A. Internal herniation findings 2A.
Intraoperative defect visible in the transverse colon mesentery.

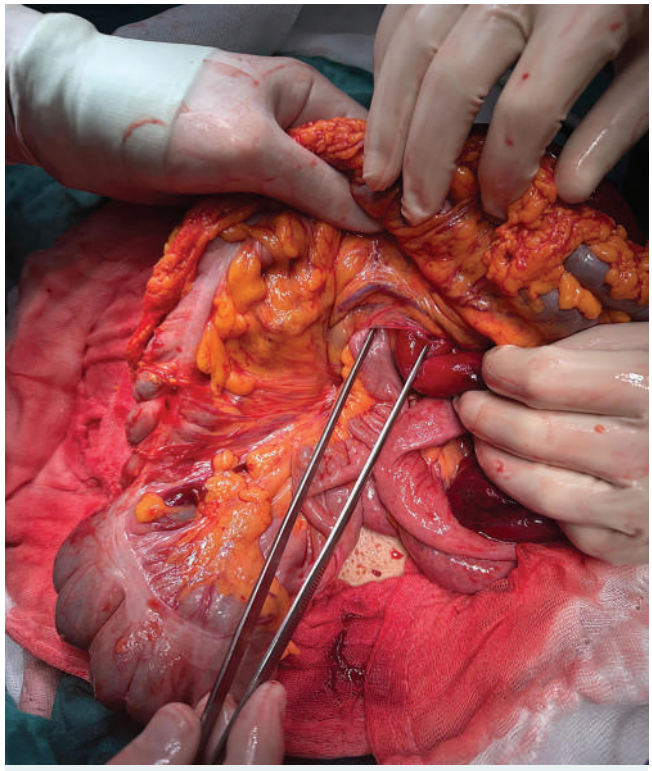

Figure 2C. Internal herniation findings 2C. Intraoperative defect visible in the transverse colon mesentery.

Figure 2B. Internal herniation findings 2B.
Intraoperative defect visible in the transverse colon mesentery.

[P-402]

Laparoscopic management of atypical appendicitis: A case of a 22 cm appendix

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Objective: Acute appendicitis is one of the most common surgical emergencies and a leading cause of acute abdomen. Although the clinical presentation is usually typical, rare anatomical variations in appendiceal length, position, and orientation may result in atypical symptoms and diagnostic challenges. The average length of the appendix is reported to be 8-10 cm; however, extremely long appendices exceeding 15-20 cm have rarely been described. An excessively long appendix may coil, follow an atypical course, or have its distal tip embedded within the mesoappendix, leading to misleading radiological findings and suspicion of perforation. We present a case of acute appendicitis with an exceptionally long appendix that caused preoperative diagnostic difficulty.

Material and Methods: A 23-year-old male patient presented to the emergency department with a three-day history of abdominal pain. The pain initially involved the epigastric and periumbilical regions and later localized to the right lower quadrant. Clinical, laboratory, and radiological evaluations were performed, and contrast-enhanced abdominal computed tomography was obtained.

Results: On physical examination, the patient was febrile (38 °C) with marked tenderness, guarding, and rebound tenderness in the right lower quadrant. Laboratory analysis revealed marked leukocytosis (WBC: 27.000/µL). Contrast-enhanced CT demonstrated findings consistent with acute appendicitis; however, the distal tip of the appendix could not be clearly identified, and radiological suspicion of perforation was reported. Laparoscopic exploration using a standard three-trocar technique revealed a markedly elongated, inflamed appendix with an anterior (preileal) course and a circularly coiled configuration. The distal portion of the appendix was embedded within the mesoappendix, explaining the inability to visualize the tip on preoperative imaging. No macroscopic perforation was observed. Inflammatory pelvic fluid was present and aspirated. Laparoscopic appendectomy was completed successfully. After complete separation of the mesoappendix, the appendix was straightened and measured along a single longitudinal axis, revealing a total length of 22 cm. The postoperative course was uneventful, and the patient was discharged on postoperative day one. Histopathological examination confirmed acute appendicitis.

Conclusion: Extreme appendiceal length is a rare anatomical variation that may lead to atypical clinical and radiological findings in acute appendicitis. Failure to visualize the distal appendiceal tip on imaging does not necessarily indicate perforation. Laparoscopy provides definitive diagnostic clarification and safe, effective treatment in cases with atypical appendiceal anatomy and should be considered the preferred surgical approach.

Keywords: Acute appendicitis, laparoscopic appendectomy, long appendix

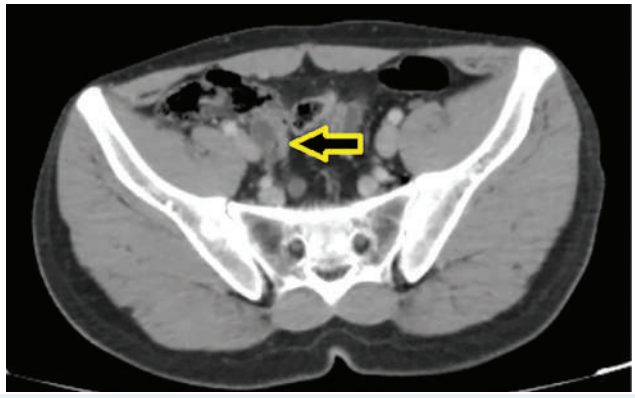

Figure 1. Contrast-enhanced abdominal computed tomography findings.

Axial contrast-enhanced abdominal computed tomography demonstrating inflammatory changes consistent with acute appendicitis. The appendiceal lumen follows a curved and circular course; however, the distal tip cannot be clearly identified as a separate structure, leading to preoperative suspicion of perforation.

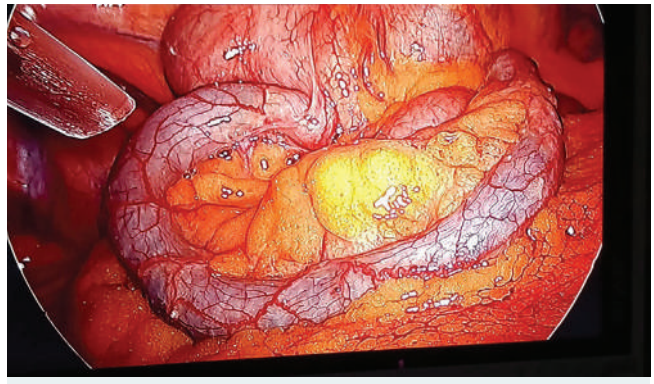

Figure 2. Intraoperative laparoscopic view.

Intraoperative laparoscopic view showing a markedly elongated and inflamed appendix with an anterior (preileal) course and a circularly coiled configuration. The atypical orientation and coiling account for the difficulty in identifying the distal appendiceal tip on preoperative imaging.

Figure 3. Gross appearance of the resected appendix.

Gross appearance of the resected appendix demonstrating marked elongation and a coiled configuration. The specimen is shown adjacent to a surgical ruler for reference. After complete separation of the mesoappendix, the appendix was straightened along a single longitudinal axis and measured to be 22 cm in length.

[P-403]

A rare clinical presentation in acute mesenteric ischemia: Gallbladder ischemia

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Objective: Acute mesenteric ischemia (AMI) is rarely encountered in the general population; however, it is a cause of acute abdominal pain that is difficult to diagnose and requires early detection due to its high mortality rate. Etiologies of AMI include arterial occlusion, non-occlusive mesenteric ischemia, and venous occlusion. We aim to present this case because the coexistence of AMI and gallbladder ischemia has not been previously reported in the literature.

Material and Methods: Patient with a history of hypertension and no known hematological disorders presented to the emergency department with nausea, vomiting and generalized abdominal pain that had started 7-8 hours prior. Laboratory analysis revealed a WBC count of $30.6\times 10^{3}\mu L$, creatinine 1.6 mg/dL, lipase 245 U/L, CRP 62.1 mg/dL, and procalcitonin 2.22 µg. Sequential lactate levels were 4.6, 4.7, and 4.5 mmol/L despite aggressive hydration. An IV contrast-enhanced abdominal CT was performed. Considering the laboratory findings and the patient's clinical status, a CT Angiography of the abdomen was subsequently ordered. Although the CT Angiography report did not explicitly state findings favoring AMI, an emergency laparotomy was planned after a detailed review of the imaging by the surgical team and obtaining informed consent from the patient and relatives.

Results: Upon exploration, ischemia and necrosis were observed in all small bowel segments, sparing only 120 cm distal to the Treitz ligament and 140 cm proximal to the ileocecal valve. Consequently, a segmental small bowel resection and double-barrel enterostomy were performed. Due to observed necrosis at the stoma ends, the patient was re-explored on postoperative day 1. Necrosis was found in the remaining small bowel, sparing only 40 cm distal to the Treitz ligament and 20 cm proximal to the ileocecal valve. Furthermore, the gallbladder was also found to be ischemic during this exploration. The abdominal aorta, right hepatic artery, superior mesenteric artery, and renal arteries were observed to be full, rhythmic, and patent. Segmental small bowel resection, double-barrel enterostomy, and cholecystectomy were performed. The patient was followed up with a diagnosis of short bowel syndrome. On postoperative day 45, the patient developed respiratory distress, was intubated in the intensive care unit, and subsequently suffered cardiopulmonary arrest. The patient did not respond to CPR and passed away.

Conclusion: In this case, while the vital role of surgical exploration is re-emphasized, the importance of clinical suspicion, the review of imaging by the general surgeon—even when not detailed in the radiology report—and the decisive action for diagnostic laparotomy are highlighted.

Keywords: Gallblader, mesenteric ischemia

Figure 1. Gallblader.

Figure 2. Gallblader.

[P-404]

Recurrent intestinal perforation and ischemic necrosis in a patient with systemic lupus erythematosus: A case report

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Objective: This case report describes the management of acute abdominal complications and subsequent surgical interventions in a 39-year-old female with systemic lupus erythematosus (SLE), highlighting the challenges of intestinal involvement.

Material and Methods: A 39-year-old female with SLE presented with abdominal pain and diarrhea. Colonoscopy revealed terminal ileitis, suggesting SLE-related intestinal involvement. Following clinical deterioration with obstructive symptoms, contrast-enhanced CT showed wall thickening in the ascending colon and terminal ileum with mesenteric fat stranding. Emergency diagnostic laparotomy revealed closed perforations in the ileal loops, gato formation, and patchy necrosis.

Results: A wide resection was performed from 130 cm distal to the ligament of Treitz to the proximal third of the transverse colon, followed by end jejunostomy and transversostomy. Despite multiple cytokine filter applications for persistent sepsis, worsening abdominal findings necessitated a second laparotomy on postoperative day 6. A new necrotic and perforated area was identified 20 cm proximal to the jejunostomy. Consequently, further resection was performed from 100 cm distal to Treitz, and a jejunocolic anastomosis was created. On postoperative day 5, fecal discharge from the wound indicated an anastomotic leak, leading to a third operation where the anastomosis was converted to a permanent end jejunostomy. The patient initially responded to IVIG and steroid therapy, with regressing sepsis. However, while being followed for short bowel syndrome, she developed pulmonary thromboembolism despite prophylactic low molecular weight heparin. She progressed to shock and cardiac arrest under heparin infusion and was declared exitus. Pathological examination revealed full-thickness ischemic necrosis, though findings were not specifically diagnostic of SLE-specific vasculitis.

Conclusion: This case underscores the devastating potential of acute abdominal conditions in SLE. While initial findings suggested lupus enteritis, recurrent perforations and full-thickness necrosis indicate a progression based on severe intestinal ischemia rather than simple inflammation. The development of thromboembolism despite prophylaxis suggests an underlying prothrombotic state.The aggressive nature of SLE-related gastrointestinal complications, characterized by recurrence despite surgical intervention, carries high mortality.The failure of multiple laparotomies and the temporary response to immunomodulators reflect significant treatment resistance. This case emphasizes the necessity of a high index of clinical suspicion, rapid evaluation of ischemic causes (vasculitis or thrombosis), and an integrated multidisciplinary approach. Even without specific pathological confirmation of SLE vasculitis, ischemic processes must be prioritized in the management of acute abdominal complaints in SLE patients to improve prognosis.

Keywords: Systemic lupus erythematosus, lupus enteritis, intestinal ischemia

Figure 1. First laparotomy.

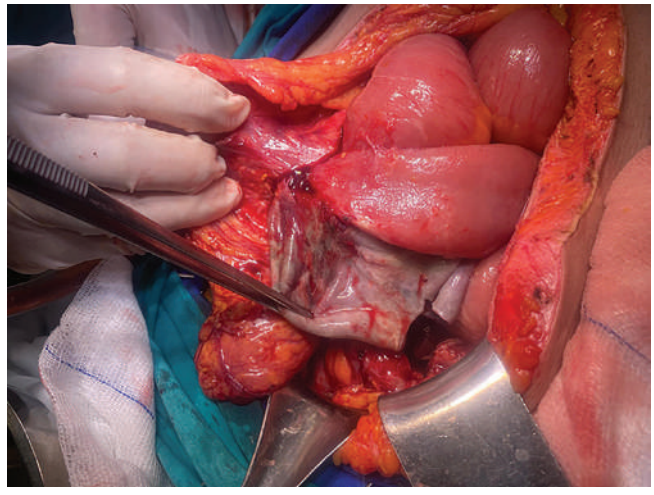

Figure 2. Ischemic necrotic segment.

[P-405]

Small bowel obstruction following gastric balloon placement: A rare complication

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Objective: Endoscopic gastric balloon placement is a commonly used minimally invasive method in the treatment of obesity. It is generally considered safe. In the literature, the reported rate of balloon migration ranges from 0.5% to 1.5%. The incidence of obstruction requiring surgical intervention is below 1%. In this study, a case of mechanical ileus secondary to balloon migration is presented.

Material and Methods: A 24-year-old female patient with no known comorbidities and no history of prior abdominal surgery presented to the emergency department with persistent epigastric and periumbilical pain that had started 2 days earlier, inability to pass gas or stool for 2 days, and three episodes of yellow-colored vomiting. According to the medical history obtained, she had undergone endoscopic gastric balloon placement 3 months prior.

Results: On physical examination, abdominal distension and epigastric and periumbilical tenderness were noted. A preliminary diagnosis of mechanical ileus/internal herniation was considered, and an emergency laparotomy was planned. During laparotomy, free intraperitoneal fluid was observed. A foreign body was identified 150 cm distal to the ligament of Treitz. A 3 cm enterotomy was performed, and the foreign body was removed. Primary repair was carried out, and the repair site was reinforced with Lambert sutures. A Jackson-Pratt drain was placed in the pelvis.

Conclusion: Oral intake was initiated on postoperative day 1, and the patient was advanced to diet 1 on the same day. On postoperative day 2, the diet was progressed to diet 3. During follow-up, no nausea or vomiting developed, and the patient had passage of flatus and stool. The patient was discharged on postoperative day 3 with prescriptions and follow-up recommendations. Balloon migration is a rare (<1%) but serious complication. It should always be considered in patients presenting with ileus who have a history of gastric balloon placement. Early surgical intervention significantly improves the prognosis.

Keywords: Emergency laparotomy, foreign body-related obstruction, ileus

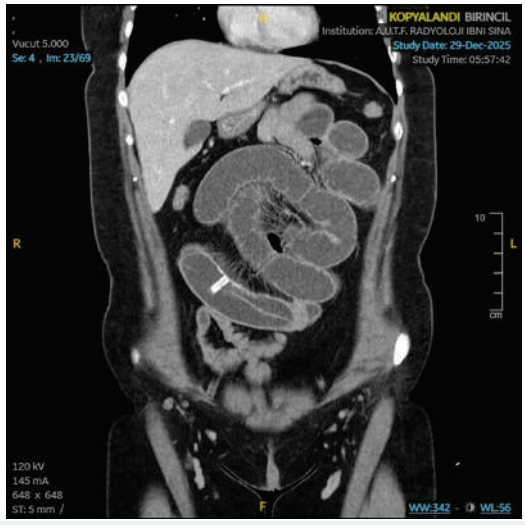

Figure 1. CT Imaging findings consistent with mechanical obstruction at the level of the small intestine.

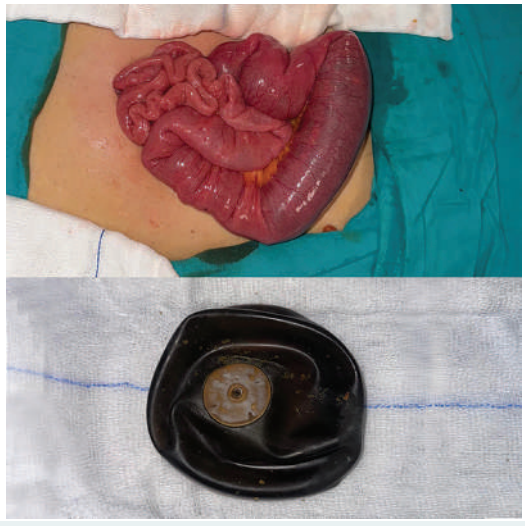

Figure 2. Intraoperative view showing a foreign body within the small bowel lumen and a transition zone located 150 cm distal to the ligament of Treitz.

[P-406]

Intestinal tuberculosis: A case undergoing ileocecal resection due to ileus

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[2]*Clinic of General Surgery, Bayburt State Hospital, Bayburt*

Objective: Intestinal tuberculosis is a rare infectious disease which may clinically and radiologically mimic inflammatory bowel disease and malignancies. The ileocecal region is the most commonly involved site, and surgical intervention may be required due to complications such as obstruction, perforation, or bleeding. In this study, we aimed to present a case of intestinal tuberculosis presenting with ileus and diagnosed after surgical treatment.

Material and Methods: A 42-year-old male patient presented to the emergency department with complaints of nausea and vomiting. In his medical history, chronic hepatitis B infection and newly diagnosed pulmonary tuberculosis were present. Abdominal computed tomography revealed wall thickening up to approximately 11 mm in the ileocecal region, which was interpreted as inflammatory bowel disease or a mass lesion. Dilatation of small bowel loops compatible with ileus was observed. The patient was hospitalized in the general surgery department and followed under anti-tuberculosis treatment with medical management for ileus.

Results: During follow-up, due to the absence of clinical improvement despite medical treatment and progression of ileus findings, surgical treatment was decided. Intraoperatively, mass-like lesions causing luminal obstruction were detected at three different segments approximately 50-60 cm proximal to the terminal ileum and at the level of the cecum (Figure 1 and Figure 2). Ileocecal resection was performed. The postoperative course was uneventful, and the patient was discharged on postoperative day six. Histopathological examination was reported as intestinal tuberculosis.

Conclusion: Intestinal tuberculosis may mimic malignancy and inflammatory bowel disease with findings such as wall thickening and obstruction in the ileocecal region. In patients who do not respond to medical treatment and develop obstruction, surgical treatment may be required both for diagnosis and treatment. Intestinal tuberculosis should be considered in the differential diagnosis in patients presenting with ileocecal mass and ileus findings.

Keywords: Intestinal tuberculosis, ileus

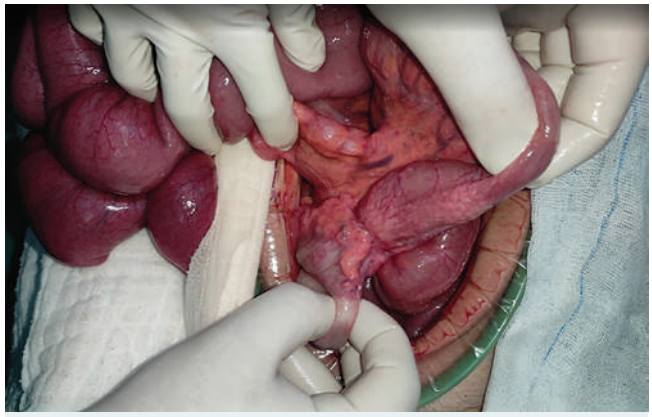

Figure 1. Intraoperative view of mass-like lesions causing ileus in the ileocecal region.

Figure 2. Intraoperative view of a mass-like lesion causing ileus in another ileal segment.

[P-408]

A reliable reconstruction option in hidradenitis suppurativa: Superior gluteal artery perforator flap

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Objective: Hidradenitis suppurativa (HS) is a recurrent, chronic, inflammatory skin disease that occurs in areas with a high concentration of apocrine glands, such as the axilla, inguinal region, perineum, and gluteal region. Its pathophysiology is explained by hyperkeratosis of the follicular epithelium and the resulting obstruction of the follicle, leading to an inflammatory condition. It presents with painful nodules, abscesses, fistulized sinuses, and prominent scarring. Conservative approaches are generally insufficient in these patients. Surgical treatment becomes inevitable to halt the progression of the disease and prevent recurrence. Incisions and drainage provide symptomatic relief during the acute abscess phase but do not eliminate the underlying cause. The gold standard in surgical treatment is extensive local excision based on the principle of radical removal of all inflammatory, hair-containing, and apocrine gland-containing skin and subcutaneous fatty tissue until healthy tissue borders are reached. The inevitable result of this excision is extensive tissue defects that cannot be closed primarily. In such cases, advanced reconstructive surgical techniques are employed.

Material and Methods: In this case, the diagnosis, treatment, and follow-up process of a patient with gluteal HS who underwent SGAP flap surgery at our clinic was evaluated.

Results: A 51-year-old male patient presented to the outpatient clinic with HS in the gluteal region, measuring approximately 12x11 cm, with a history of abscess drainage, fistulized sinuses, and deep scarring. A wide local excision was performed to include all foci of the disease. The wound was closed with a wet dressing. On the 4th postoperative day, a SGAP flap was applied to the right gluteal region by the plastic surgery team. The patient was discharged on the 7th postoperative day. No complications were observed in the flap tissue during postoperative follow-ups.

Conclusion: Pedicle perforator flap techniques represent a modern revolution in reconstruction. Secondary healing, split-thickness skin grafts, and musculocutaneous flaps-traditional reconstruction techniques-have prompted surgeons to seek new approaches due to high contracture risk, prolonged healing times, functional losses, and poor aesthetic outcomes. The fundamental principle of the pedicled perforator flap technique is the elevation of an island of tissue through a single perforator vessel that nourishes the skin and subcutaneous fatty tissue while preserving the underlying major muscle tissue. No recurrence has been reported in perforator flap repairs performed after wide local excision. In HS management, a multidisciplinary approach and correctly applied advanced reconstructive techniques have shown high success rates. However, larger case series and longer follow-up periods are needed for the future.

Keywords: Glutea, hidradenitis suppurativa, superior gluteal artery perforator flap

Figure 1. Preoperative, intraoperative, and postoperative follow-ups.

[P-411]

Managing Chilaiditi syndrome in laparoscopic surgery

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Objective: Chilaiditi syndrome is a rare anatomical condition characterized by interposition of the colon, most commonly the hepatic flexure, between the liver and the diaphragm. On imaging, it may mimic serious conditions such as pneumoperitoneum and can present with abdominal pain, nausea, or respiratory symptoms due to diaphragmatic compression. Although most cases are asymptomatic and detected incidentally, Chilaiditi syndrome becomes clinically significant when it complicates surgical procedures, particularly laparoscopic operations in the upper abdomen. Altered anatomy may obscure normal landmarks, increase the risk of bowel injury, and necessitate modifications in trocar placement. Therefore, preoperative recognition and surgical planning are essential for safe operative management.

Material and Methods: We present a case of laparoscopic cholecystectomy performed in a patient with preoperatively diagnosed Chilaiditi syndrome. Preoperative imaging findings, intraoperative technical adaptations, and postoperative outcomes were retrospectively evaluated to highlight key surgical considerations.

Results: Preoperative computed tomography revealed interposition of the colon between the liver and diaphragm, consistent with Chilaiditi syndrome. Intraoperatively, reduction of the interposed colon was achieved easily. However, the liver was found to be displaced inferiorly, altering the usual anatomical relationships. Consequently, trocar placement was modified, with ports inserted at lower-than-standard positions to avoid bowel injury. Particular caution was exercised during instrument insertion due to the atypical presence of intestinal loops in the right upper quadrant.The procedure was completed without intraoperative complications. Given the patient's underlying chronic obstructive pulmonary disease and the potential impact of diaphragmatic compression, close postoperative respiratory monitoring was performed. The patient had an uneventful recovery and was discharged on postoperative day three.

Conclusion: Chilaiditi syndrome presents unique technical challenges during laparoscopic cholecystectomy despite the relative ease of colonic reduction. Inferior displacement of the liver and altered anatomical landmarks increase the risk of injury during trocar insertion and instrument manipulation. Careful preoperative imaging review, modification of trocar positioning, and heightened intraoperative vigilance are essential to ensure procedural safety. Additionally, potential respiratory implications related to diaphragmatic compression should be considered, particularly in patients with preexisting pulmonary disease. With appropriate planning and technique adjustments, laparoscopic cholecystectomy can be safely performed in patients with Chilaiditi syndrome.

Keywords: Chilaiditi syndrome, laparoscopic surgery, cholecystectomy, anatomical variation

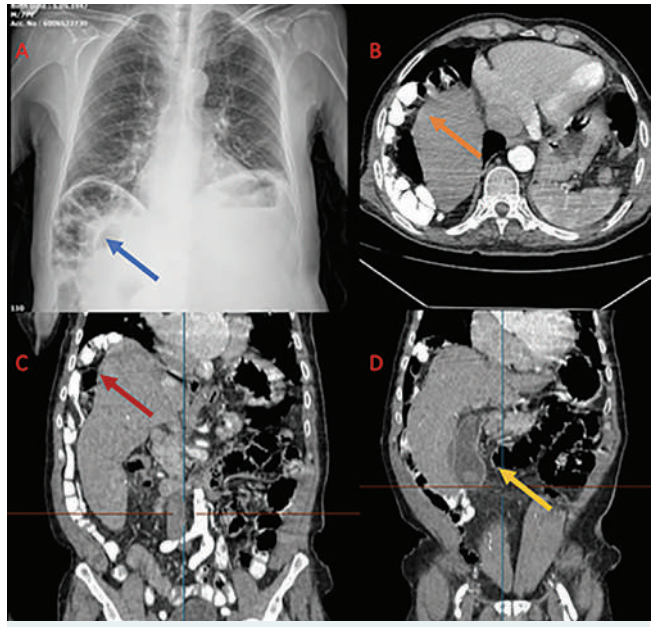

Figure 1.

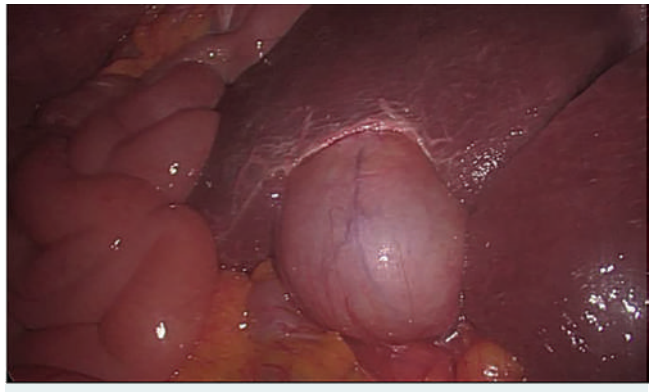

Figure 2.

[P-418]

Non-recurrent laryngeal nerve in thyroid surgery: Impact of intraoperative neuromonitoring and primary nerve repair on surgical outcomes

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Muğla Sıtkı Koçman University Faculty of Medicine, Muğla

Objective: The non-recurrent laryngeal nerve (NRLN) is a rare anatomical variation of the RLN and represents one of the highest-risk situations for nerve injury in thyroid surgery. The reported incidence of NRLN is 0.3-1% on the right side and <0.1% on the left. In this variation, the nerve branches from the vagus nerve at a high cervical level and directly enters the larynx without following the tracheoesophageal groove. Failure to recognize the NRLN intraoperatively may result in permanent vocal cord paralysis. In this study, we aimed to evaluate intraoperative neuromonitoring findings, the experience of primary repair in a case with nerve injury, and surgical outcomes in patients with NRLN identified during thyroid surgery, and to compare these findings with the literature.

Material and Methods: Patients who underwent thyroidectomy in our clinic were retrospectively reviewed. Patients in whom a NRLN was identified intraoperatively were included in the study. The evaluated parameters included demographic data, surgical indication, intraoperative neuromonitoring findings, nerve injury and repair status, postoperative vocal cord function, and pathological results.

Results: A total of four NRLN cases were identified. The mean age was 64.3 years (range: 54-70). Surgical indications were hyperthyroidism (n=2), thyrotoxicosis (n=1), and compressive symptoms (n=1). Pathology revealed papillary thyroid carcinoma in one case and benign disease in three cases. During intraoperative neuromonitoring, no signal was obtained from vagus nerve stimulation in one patient; however, a strong response was recorded from a high-located NRLN in the same patient, confirming the presence of NRLN. NRLN injury occurred in one case and was repaired intraoperatively using primary epineural suturing. Postoperative vocal cord assessment showed permanent paralysis in 1 (25%), transient minimal limitation in 1 (25%), and normal function in 2 (50%) patients.

Conclusion: In the presence of a NRLN, failure to identify the nerve in its usual anatomical location complicates dissection and increases injury risk. The 25% permanent paralysis rate in our series supports the elevated surgical risk associated with NRLN. Intraoperative neuromonitoring is a valuable adjunct; absence of response to vagus stimulation with a positive signal at the laryngeal entry level represents a typical neurophysiological pattern for NRLN, also observed in our series. NRLN injury is rare but serious, and primary epineural repair may provide functional recovery. When vagus stimulation is negative, NRLN should be suspected and sought at the laryngeal entry level.

Keywords: Non-recurrent laryngeal nerve, thyroid surgery, intraoperative neuromonitoring

Table 1. Clinical characteristics of non-recurrent laryngeal nerve cases (n=4)

Number of cases	4
Age, mean (range)	64.3 (54-70)
Gender	-
Surgical indication	Hyperthyroidism 2 (50%) Thyrotoxicosis 1 (25%) Compressive symptoms 1 (25%)
Pathology	Papillary carcinoma 1 (25%) Benign 3 (75%)
Absent vagus signal	1 (25%)
High-located NRLN response	1 (25%)
NRLN injury	1 (25%)
Primary nerve repair	1 (25%)
Vocal cord function	Normal 2 (50%) Transient limitation 1 (25%) Permanent paralysis 1 (25%)

[P-421]

Revisional sleeve gastrectomy in a patient who developed weight gain after plication surgery: A single case report

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Objective: Various bariatric surgical techniques are used in the treatment of obesity. As a primary surgical procedure, gastric plication aims to achieve weight loss by reducing gastric volume. However, in some patients, insufficient weight loss or weight regain may be observed after plication. In such cases, revisional surgical options are considered to achieve more effective weight loss. Sleeve gastrectomy is one of the commonly preferred methods in revisional surgery. The aim of this study is to evaluate the effectiveness and safety of revisional sleeve gastrectomy in patients who developed weight gain after primary plication surgery.

Material and Methods: A 38-year-old female patient who underwent gastric plication as primary obesity surgery was found to have significant weight gain within one year. Clinical and metabolic evaluations of the patient were performed, and revisional surgery was decided due to insufficient weight loss. Revisional surgery was carried out using the laparoscopic sleeve gastrectomy technique. The patient's weight, metabolic parameters, and quality of life were monitored before and after the operation.

Results: After revisional sleeve gastrectomy, a significant reduction in the patient's weight was observed. During the 6-month follow-up period, approximately 25% of the initial body weight was lost. Improvements were noted in blood glucose levels, lipid profile, and blood pressure values. No postoperative complications developed, and the patient successfully adhered to lifestyle changes after surgery.

Conclusion: Revisional sleeve gastrectomy is an appropriate and safe option for achieving effective weight loss and metabolic improvement in patients who develop weight gain after gastric plication surgery. Patient selection, a multidisciplinary approach, and long-term follow-up are key factors for success. Revisional surgery is an important component of personalized strategies in the treatment of obesity.

Keywords: Bariatric surgery, bariatric surgery, plication, revisional sleeve gastrectomy, weight gain

[P-422]

A rare benign breast lesion: Hamartoma of the right breast

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Objective: Breast hamartomas are rare tumors formed by irregular but benign proliferation of normal breast tissue components. Histopathologically, they consist of varying proportions of glandular, fibrous, and fatty tissue. Clinically, they usually present as painless, slow-growing, well-circumscribed, most commonly in middle-aged women. They can be confused with fibroadenoma, lipoma, or fibrocystic changes. Imaging provides important diagnostic clues, but definitive diagnosis is often made by histopathology. Although malignant transformation is rarely reported, correct diagnosis and appropriate surgical management are necessary.

Material and Methods: A 47-year-old woman presented our general surgery clinic with a palpable mass in the right breast. She reported noticing the mass in the for about four months. There was no family history of breast cancer. Physical examination revealed a painless, well-circumscribed mass in the lower quadrant of the right breast. No pathological axillary lymph nodes were detected. Ultrasound showed a 21×11 mm solid lesion at 7-8 o'clock in the right breast, with a hypoechoic periphery, hyperechoic center, defined margins, and macrolobulated; hamartoma was the preliminary diagnosis. MRI also demonstrated a solid mass of 2×1 cm compatible with hamartoma. Tru-cut biopsy was performed and histopathology reported findings consistent with a hamartoma containing fibrous tissue. The lesion was excised through an incision in the lower outer quadrant of the right breast. No complications occurred postoperatively, and the patient was discharged without issues on the second postoperative day. Histopathological specimen confirmed the diagnosis of hamartoma.

Results: Breast hamartomas are rare lesions that require careful diagnosis because they resemble other benign breast lesions clinically. Reported cases in the literature show that these lesions most commonly occur in middle-aged women and present as slow-growing, usually asymptomatic masses. Their well-circumscribed and mobile nature on physical examination often leads to confusion with many benign pathologies, especially fibroadenoma. Therefore, clinical evaluation must be supported by imaging methods. Mammography, ultrasonography, and magnetic resonance imaging are helpful in diagnosis by revealing the heterogeneous content and capsule-like appearance of hamartomas. However, imaging findings are not always specific, so definitive diagnosis is made by histopathological examination. Preoperative tru-cut biopsy assists in the diagnosis. Malignant transformation has been rarely reported in hamartomas. This increases the importance of surgical excision, especially in lesions with rapid growth or atypical radiologic features.

Conclusion: Although breast hamartomas are rare, they must be considered in the differential diagnosis of benign breast lesions. A multidisciplinary approach including clinical examination, imaging, and histopathological evaluation is essential for accurate diagnosis and appropriate treatment.

Keywords: Benign breast lesion, hamartomas, trucut biopsy

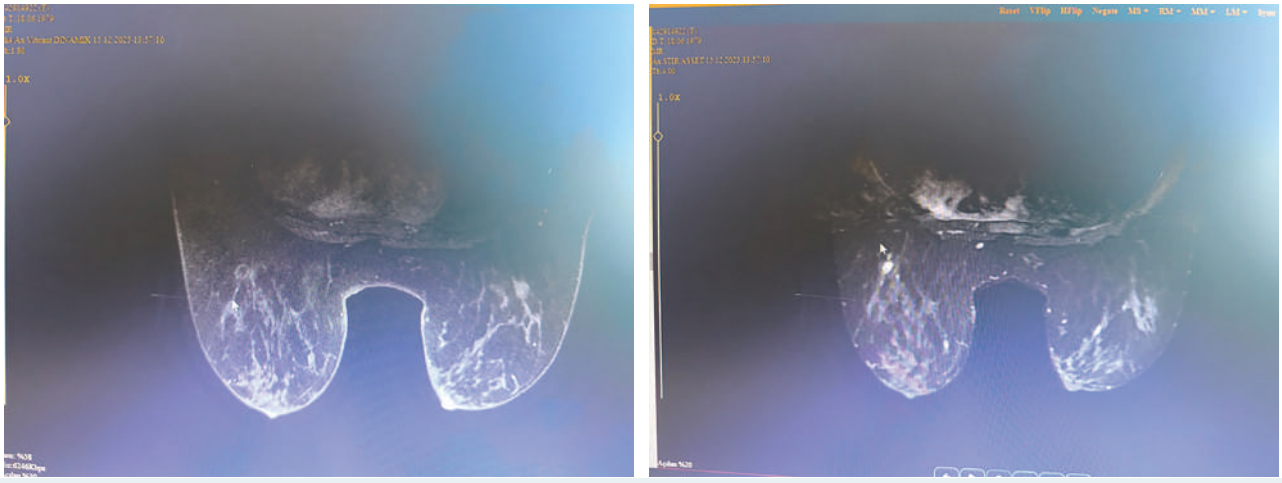

Figure 1. Breast MRI image. Image of a mass visible in the right breast. Breast MRI image dynamic phase.

[P-452]

Laparoscopic cholecystectomy in a case of hepatized gallbladder: Surgical process and outcomes

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Objective: Gallbladders have been reported in various ectopic locations. An intrahepatic gallbladder is defined as a gallbladder located within the liver parenchyma or in a subcapsular position along the anteroinferior surface of the right hepatic lobe.

Material and Methods: In this report, we present the case of a 62-year-old man in whom an intrahepatic gallbladder was not identified preoperatively but who underwent laparoscopic cholecystectomy without intraoperative or postoperative complications.

Results: A 62-year-old male presented to the outpatient clinic with a six-month history of intermittent colicky abdominal pain, predominantly localized to the right hypochondrium and radiating to the right shoulder. His past medical and family histories were unremarkable. General examination was unremarkableand all observations were stable. Abdominal examination revealed no palpable masses ororganomegaly. There was mild tenderness in the right upper quadrant and epigastric region with no rebound tenderness and Murphy's sign was negative. Initial laboratory investigations including full blood count, liver function tests, and serum amylase as well as kidney functiontests were all normal. Based on the history and clinical findings, a provisional diagnosis of gallbladder stones was suspected. Abdominal ultrasonography and computed tomography were planned for further evaluation. Following appropriate preoperative preparation, the patient underwent elective laparoscopic cholecystectomy successfully. No intraoperative complications occurred, and the patient was discharged on postoperative day one without any complications.

Conclusion: Although intrahepatic gallbladder is a rare congenital anomaly, it frequently requires surgical intervention due to an increased incidence of cholelithiasis associated with biliary stasis. Awareness of ectopic gallbladder locations and accurate recognition of this condition are crucial for appropriate intraoperative planning and for minimizing potential surgical complications.

Keywords: Gallbladder, intrahepatic gallbladder, laparoscopic cholecystectomy

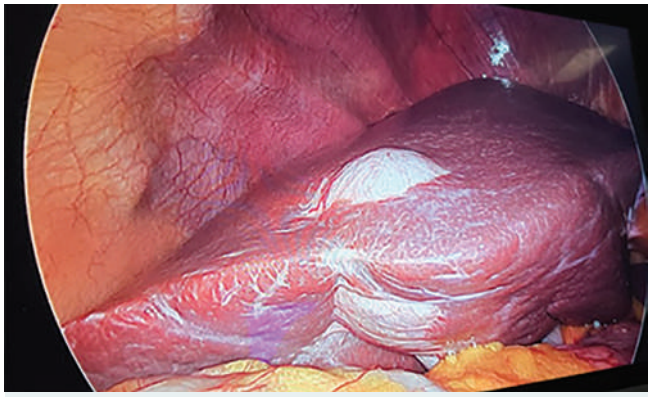

Figure 1. Intraoperative photograph of an intrahepatic gallbladder.

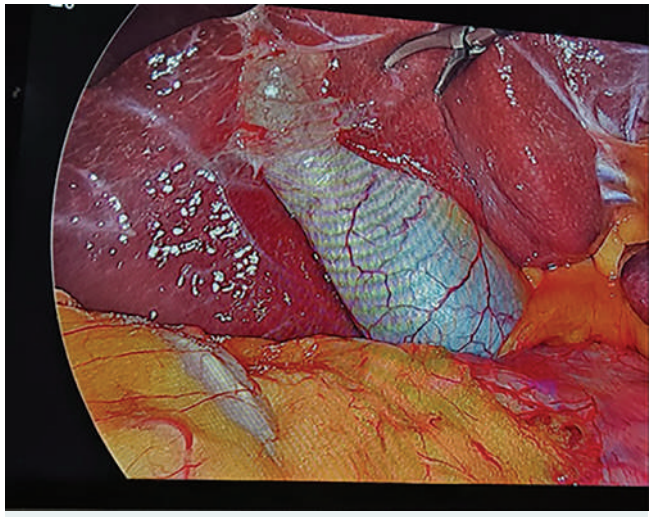

Figure 2. Intraoperative photograph of an intrahepatic gallbladder.

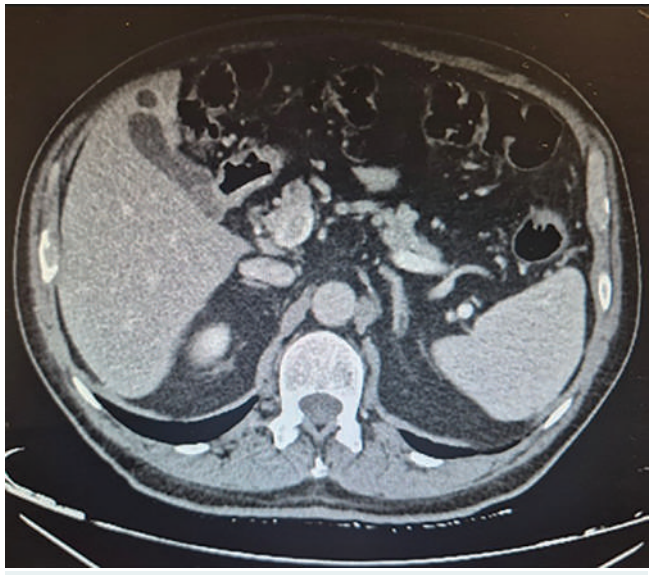

Figure 3. Intrahepatic gallbladder computed tomography imaging.

[P-453]

Gastric fistula developing after gynecological oncology surgery: Case report

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Objective: Gastrointestinal complications following gynecological oncology surgery occur in 5-10% of cases. Gastric fistula is a rare but serious condition among these complications. This study presents a case of gastric fistula that developed in a patient operated on for mucinous ovarian cancer and aims to emphasize the importance of a multimodal treatment approach.

Material and Methods: A 28-year-old female patient was operated on by gynecology for mucinous cell ovarian cancer. The patient underwent oophorectomy, total omentectomy due to omental cake, and peritonectomy. On the 45th postoperative day, the patient presented to our emergency department with epigastric abdominal pain. Computed tomography revealed an abscess between the stomach and spleen. The fistula was drained under computed tomography guidance after consultation with interventional radiology, and fistulization to the stomach was detected during drainage. The patient was monitored conservatively with discontinuation of oral intake. During follow-up, the fistula closed spontaneously. A pouch radiograph taken before catheter removal showed that the pouch had opened into the gastric vein. The patient underwent surgery, and wedge resection of the fistula area was performed with a stapler. The postoperative period was uncomplicated, and the patient was discharged in good health.

Results: Common cytoreductive procedures in gynecological oncology surgery, especially omentectomy and peritonectomy, are risk factors for intra-abdominal abscess development. Percutaneous drainage is the first-line treatment in patients with gastric fistulas and has a success rate of 70-90%. 15-25% of fistulas can close spontaneously with conservative treatment. Fistulography is essential for pre-surgical anatomical evaluation. In definitive surgical treatment, wedge resection with a stapler is a safe and effective method.

Conclusion: Gastric fistula developing after gynecological oncology surgery is a rare but serious complication. Early diagnosis, appropriate drainage guided by computed tomography, conservative treatment, and timely surgical intervention can lead to successful outcomes. A multimodal and multidisciplinary approach is the most important factor in patient management and provides results consistent with the literature.

Keywords: Gastric fistula, multimodal treatment, ovarian cancer, percutaneous drainage, postoperative complications

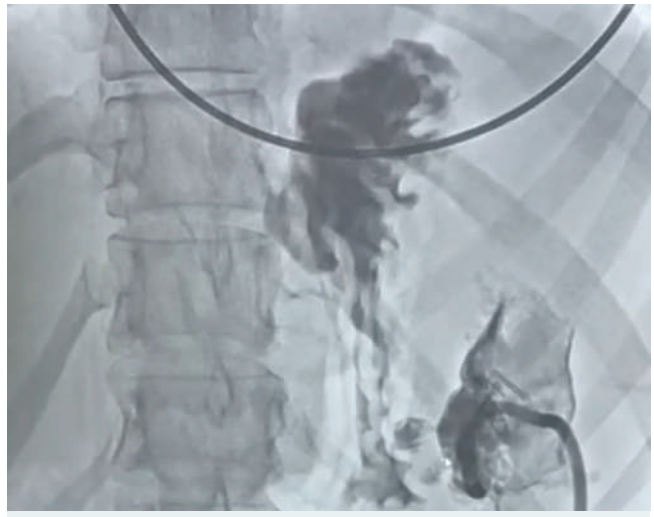

Figure 1. Catheter drainage, fistula to the porta vena. The contrast agent injected through the catheter placed in the abscess sac passes into the portal vein.

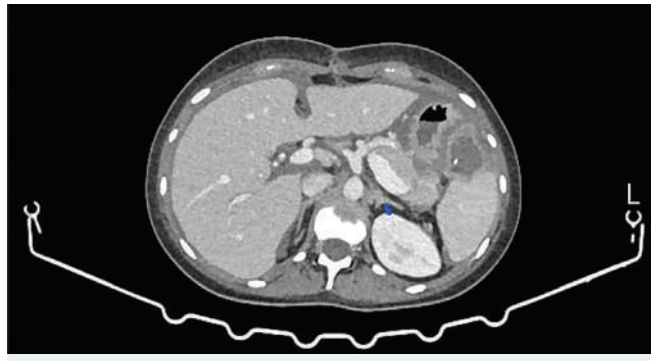

Figure 2. Abscess sac between the stomach and spleen.

[P-454]

Giant retroperitoneal dedifferentiated liposarcoma: A rare case presentation requiring multivisceral en-bloc resection

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Objective: Retroperitoneal soft tissue sarcomas are rare malignancies, accounting for approximately 10-15% of all sarcomas. Among these, dedifferentiated liposarcomas are characterized by aggressive biological behaviour and a high risk of local recurrence. Due to the expansive nature of the retroperitoneal space, these tumours often remain asymptomatic for prolonged periods, leading to delayed diagnosis and presentation at advanced stages with large tumour volumes. Radiologically, dedifferentiated liposarcomas may mimic peritoneal carcinomatosis or gynaecological malignancies, posing significant diagnostic challenges. This case report describes a patient who was initially suspected of having a gynaecological malignancy but was ultimately diagnosed with a giant retroperitoneal dedifferentiated liposarcoma following surgical and histopathological evaluation.

Material and Methods: A 76-year-old female with a medical history of hypertension and asthma presented with progressive constipation and abdominal distension over several months. Contrast-enhanced abdominal computed tomography demonstrated heterogeneously enhancing mass lesions within the mesenteric fatty tissue, consistent with an omental cake appearance. Serum tumour markers were within normal limits. Tru-cut biopsy findings were suggestive of liposarcoma, and surgical intervention was planned. Intraoperative exploration revealed a giant retroperitoneal mass measuring approximately 50×40×15 cm. With the aim of achieving R0 resection, the tumour was excised en bloc with the left kidney and left adrenal gland. Due to concerns regarding surgical margin safety, splenectomy and total abdominal hysterectomy with bilateral salpingo-oophorectomy were additionally performed. The postoperative course was uneventful, and the patient was discharged on postoperative day seven. Histopathological examination confirmed FNCLCC grade 2 dedifferentiated liposarcoma with negative surgical margins, and immunohistochemical analysis demonstrated strong positivity for MDM2 and CDK4.

Results: Retroperitoneal dedifferentiated liposarcomas typically present with nonspecific symptoms, contributing to delayed diagnosis and advanced disease at presentation. While tumour sizes reported in the literature commonly range between 15 and 30 cm, the approximately 50 cm mass observed in this case represents an exceptional finding. Moreover, the radiological mimicry of gynaecological malignancy and the requirement for extensive multivisceral en bloc resection involving the kidney, adrenal gland, spleen, and gynaecological organs render this case particularly rare. As complete surgical excision with negative margins remains the most critical prognostic factor, aggressive multivisceral resection is justified when clear anatomical planes are absent.

Conclusion: This case highlights the importance of accurate diagnosis and radical surgical management in achieving optimal oncological outcomes.

Keywords: Differential diagnosis (gynaecological malignancy), multivisceral en bloc resection, retroperitoneal dedifferentiated liposarcoma

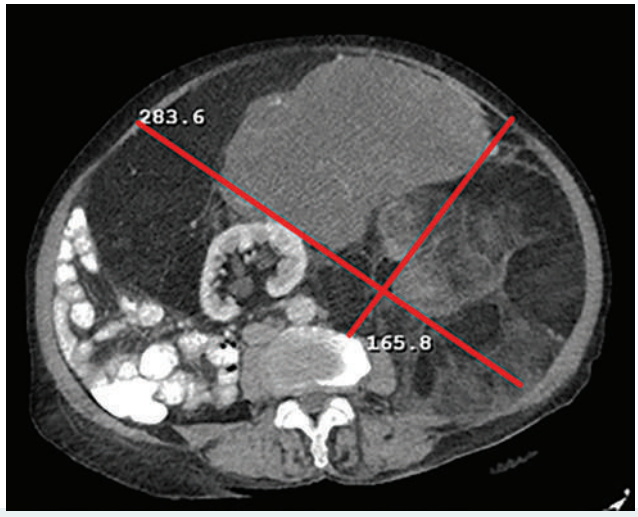

Figure 1. Contrast-enhanced abdominal CT coronal reformat image; a large mass lesion with fatty components originating from the left retroperitoneal area, displacing the left kidney medially and the intestinal loops.

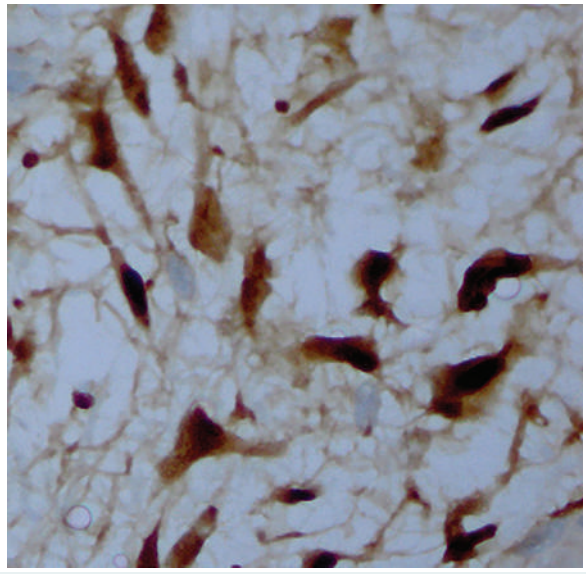

Figure 2. CDK4 x100 diffuse positivity.

[P-455]

The impact of histological subtype on clinical course in retroperitoneal adipose tumors: A comparison of dedifferentiated liposarcoma and benign adipose tumor

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Objective: Retroperitoneal adipose tumors are rare, and preoperative differentiation between benign and malignant lesions is often challenging. Because these tumors can remain asymptomatic for a long time within the wide retroperitoneal space, they are usually diagnosed after reaching a large size. Histological subtype, particularly the presence of dedifferentiated liposarcoma, has a significant impact on clinical course, local recurrence risk, and prognosis. In this study, two retroperitoneal adipose tumors with different biological behaviors were compared to highlight the impact of histological subtype on clinical outcomes.

Material and Methods: This study is a retrospective evaluation of two patients who presented with abdominal pain and were found to have retroperitoneal adipose tumors. The patients were assessed using contrast-enhanced computed tomography (CT), and open surgical resection was performed following a multidisciplinary board decision. Resected specimens were examined histopathologically and immunohistochemically. Postoperatively, the patients were followed up with clinical and radiological evaluations.

Results: In both cases, preoperative contrast-enhanced CT revealed retroperitoneal adipose tumors. In the first case, the mass measured 36×24×13 cm and showed a heterogeneous appearance with thick septations and solid nodular components. En-bloc surgical resection was performed, and histopathology revealed FNCLCC grade 3 dedifferentiated liposarcoma with positive margins. At six months, follow-up CT demonstrated local recurrence involving the left kidney, and the patient underwent reoperation with concomitant nephrectomy. In the second case, a 22×11 cm retroperitoneal mass with homogeneous fat density and thin septations was observed, and complete resection was achieved. Histopathology showed no cellular atypia or mitotic activity, consistent with a benign adipose neoplasm (lipoma), and surgical margins were negative. During one-year follow-up, no local recurrence or complications were detected. When the cases were compared, early local recurrence occurred in the dedifferentiated liposarcoma case, whereas no recurrence occurred in the benign case. Positive margins and aggressive histology adversely affected the clinical course. No perioperative mortality or major complications were observed.

Conclusion: Histological subtype is one of the most important factors determining the clinical course and risk of local recurrence in retroperitoneal adipose tumors. Dedifferentiated liposarcoma exhibits aggressive biological behavior with early local recurrence, whereas benign adipose tumors generally have a favorable postoperative prognosis. In malignant cases, achieving negative surgical margins and close long-term follow-up are critical for disease-free survival. Therefore, a histology-based surgical approach and regular surveillance are recommended in the management of retroperitoneal adipose tumors.

Keywords: Retroperitoneal tumor, liposarcoma, adipose neoplasia

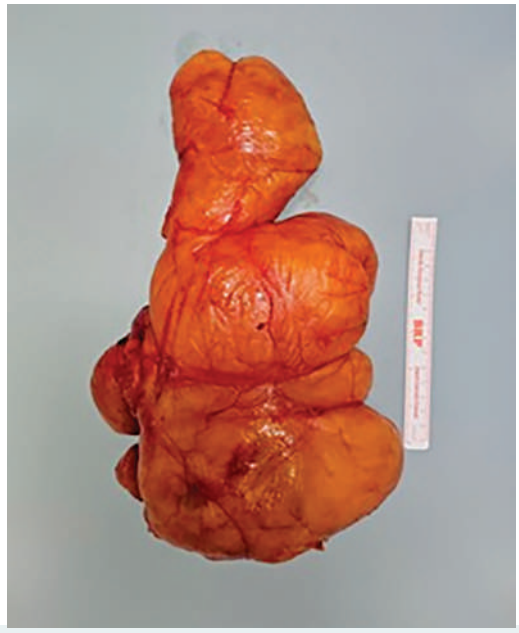

Figure 1. Adipose neoplasm.

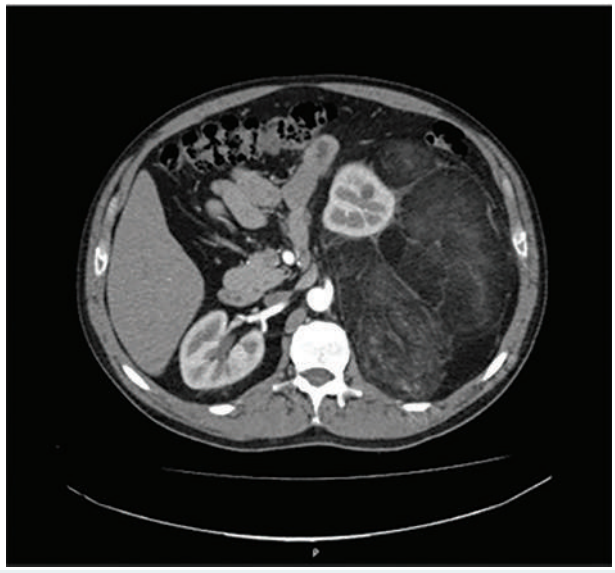

Figure 1. Dedifferentiated liposarcoma.

[P-456]

Early gastric cancer originating from a giant pedunculated gastric polyp

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Objective: Polypoid lesions are defined as mucosal or submucosal projections extending into the gastrointestinal lumen. Although initial diagnosis of a gastric polyp can be made by endoscopic visualization, histopathological examination is essential for accurate classification. In clinical practice, such polypoid lesions are commonly referred to as "polyps." Gastric polyps are encountered in approximately 2-3% of upper gastrointestinal endoscopic examinations.Early gastric cancer is defined as adenocarcinoma confined to the mucosa or submucosa (T1Nx), regardless of regional lymph node involvement. Early gastric cancer has an excellent prognosis, with five-year survival rates exceeding 90%. A 56-year-old female patient presented to our outpatient clinic with complaints of epigastric pain, nausea, and loss of appetite. Her vital signs were as follows: blood pressure 110/70 mmHg, pulse rate 80 beats per minute, and body temperature 36.7 °C. Physical examination revealed epigastric tenderness, with no other pathological findings. Laboratory investigations showed hemoglobin level of 9.8 g/dL, while other parameters were within normal limits.

Material and Methods: Upper gastrointestinal endoscopy was planned for diagnostic and screening purposes and was performed under anesthesia.

Results: Endoscopic examination revealed a giant pedunculated gastric polyp originating from the corpus and extending toward the antrum. Multiple biopsies were obtained from the polyp and sent to the pathology laboratory for histopathological evaluation. Histopathological examination revealed adenocarcinoma. The patient was subsequently referred to the oncology department for further evaluation, including contrast-enhanced thoracic and whole-abdominal computed tomography (CT) and positron emission tomography (PET). Based on imaging findings and multidisciplinary discussion at the general surgery–oncology board, the case was considered consistent with early-stage gastric adenocarcinoma. Endoscopic excision of the polyp was planned, with further treatment to be reassessed according to the histopathological findings. During the procedure, the pedunculated polyp was observed to extend from the gastric corpus through the pylorus into the duodenal bulb. The polyp was retracted from the bulb back into the stomach and resected at its stalk using a snare, completing the polypectomy. Histopathological examination of the resected specimen demonstrated that the adenocarcinoma was confined to the surface of the polyp, with no evidence of malignancy in the stalk or at the mucosal junction.

Conclusion: With the widespread use of endoscopy for the screening and diagnosis of upper gastrointestinal diseases, the detection rate of gastric polyps has increased, leading to a parallel rise in the diagnosis of early-stage gastric cancer. In polyps with a risk of malignant transformation, complete excision by polypectomy—including the stalk and adjacent mucosa—plays a critical role in both diagnosis and treatment.

Keyword: Gastric polyp

[P-457]

Deep aggressive angiomyxoma of the vulva: A rare case with an infiltrative growth pattern

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Objective: Aggressive angiomyxoma is a rare mesenchymal neoplasm of the pelvic and perineal regions with locally aggressive behavior. Although slow-growing, its infiltrative nature makes complete surgical excision difficult and is associated with a high risk of recurrence. This report presents the clinical, radiological, surgical, and pathological features of a deep aggressive angiomyxoma located in the labium majus.

Material and Methods: Clinical, radiological, surgical, and pathological data of a patient who underwent surgical treatment for a vulvar mass were retrospectively evaluated.

Results: A 25-year-old woman presented with a two-year history of progressively increasing swelling in the left genital region and recently increased pain. Physical examination revealed a soft, mobile, subcutaneous mass measuring approximately 10×5 cm along the left labium majus (Figure 1). No ulceration, discoloration, active bleeding, or bilateral inguinal lymphadenopathy was observed. The patient had no chronic diseases. Her medical history included appendectomy and genital condyloma excision in 2023. Ultrasonography demonstrated a semisolid, heterogeneous subcutaneous mass. Pelvic magnetic resonance imaging revealed a lesion extending from the left labium majus to the left inguinal canal, showing hyperintense signal intensity on T2-weighted images and peripheral-septal contrast enhancement. Imaging findings were interpreted as an infiltrative, low-grade locally aggressive soft tissue tumor (Figure 2). Surgical exploration in the lithotomy position revealed a lesion closely related to surrounding soft tissues, without a distinct capsule and with ill-defined margins. The lesion was excised. Due to the size of the defect and tissue tension, plastic surgery consultation was obtained, and reconstruction was performed using a fasciocutaneous flap (Figure 3). No postoperative complications occurred. Macroscopic examination revealed a bright, homogeneous lesion with myxoid features. Microscopic evaluation showed hypocellular areas with loose myxoid stroma and thin-walled vascular structures. Tumor infiltration into adipose tissue and peripheral nerve structures was observed, adjacent to the surgical margins. Immunohistochemistry demonstrated estrogen and progesterone receptor positivity, focal desmin positivity, and weak smooth muscle actin expression. CD31, S100, SOX10, STAT6, and MUC4 were negative. The Ki-67 proliferation index was 2%. These findings confirmed the diagnosis of deep aggressive angiomyxoma. Due to margin proximity, positron emission tomography revealed a millimetric residual lesion consistent with the surgical field. The patient was enrolled in close clinical and radiological follow-up.

Conclusion: Deep aggressive angiomyxoma has a high recurrence potential due to its infiltrative growth pattern despite benign histology. Vulvar anatomical limitations hinder clear surgical margins and increase residual disease risk, necessitating a multidisciplinary surgical approach and long-term clinical-radiological follow-up.

Keywords: Aggressive angiomyxoma, vulva, labium majus, soft tissue tumors

Figure 1. Preoperative clinical appearance of the mass located in the left labium majus.

Figure 2. Preoperative MRI image.

[P-458]

A rare cause of intra-abdominal mass in an adult patient: Omental cavernous lymphangioma

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Objective: Lymphangiomas are benign malformations of the lymphatic system, predominantly diagnosed in children; adult cases are rare. Intra-abdominal involvement represents a small fraction of all lymphangiomas and is even less frequent in adults. These lesions most commonly arise from the mesentery or omentum, while primary omental localization in adults has been only rarely reported. Although the exact pathogenesis remains unclear, progressive cystic dilatation due to congenital lymphatic drainage abnormalities during embryologic development is the most accepted mechanism. Histologically, lymphangiomas are classified as simple, cavernous, or cystic types. The cavernous subtype consists of dilated endothelial-lined lymphatic channels within a fibrous stroma. Clinical presentation is usually non-specific and may include abdominal pain, distension, nausea, or constipation. Imaging typically reveals multiloculated cystic lesions with thin septations; however, proximity to adjacent organs may complicate differentiation from malignancy. Definitive diagnosis is generally established after surgical resection and histopathological evaluation.

Material and Methods: This study represents a retrospective single-center case report. Clinical findings, radiologic imaging, intraoperative observations, and histopathological results were reviewed from medical records.

Results: A 43-year-old woman presented with longstanding abdominal pain and constipation. Physical examination suggested a mass in the left lower quadrant. Laboratory findings were normal. Contrast-enhanced abdominal computed tomography demonstrated a cystic lesion surrounding the left colon and extending toward the left adnexa, with loculated fluid in the pararectal area. Malignancy could not be excluded radiologically. Colonoscopy revealed no significant intraluminal pathology except for a small rectal polyp. Following multidisciplinary assessment, surgical exploration was performed. Intraoperatively, the omentum encased the left segment of the transverse colon, producing a marked mass effect. Given the close relationship with the colon and the inability to exclude malignancy preoperatively, a left hemicolectomy was undertaken according to oncologic principles. Histopathology confirmed cavernous lymphangioma of the omentum without evidence of colonic malignancy. The postoperative course was uneventful, and no recurrence was observed during three years of follow-up.

Conclusion: Cavernous omental lymphangioma in adults is an exceptionally rare benign condition. Its non-specific clinical and radiologic features may mimic malignant disease, making preoperative diagnosis difficult. Complete surgical excision is curative, with low recurrence rates after total resection. Lymphangioma should be considered in the differential diagnosis of intra-abdominal cystic masses in adults to guide appropriate management and potentially avoid unnecessary extensive resections.

Keywords: Cavernous lymphangioma, intra-abdominal mass

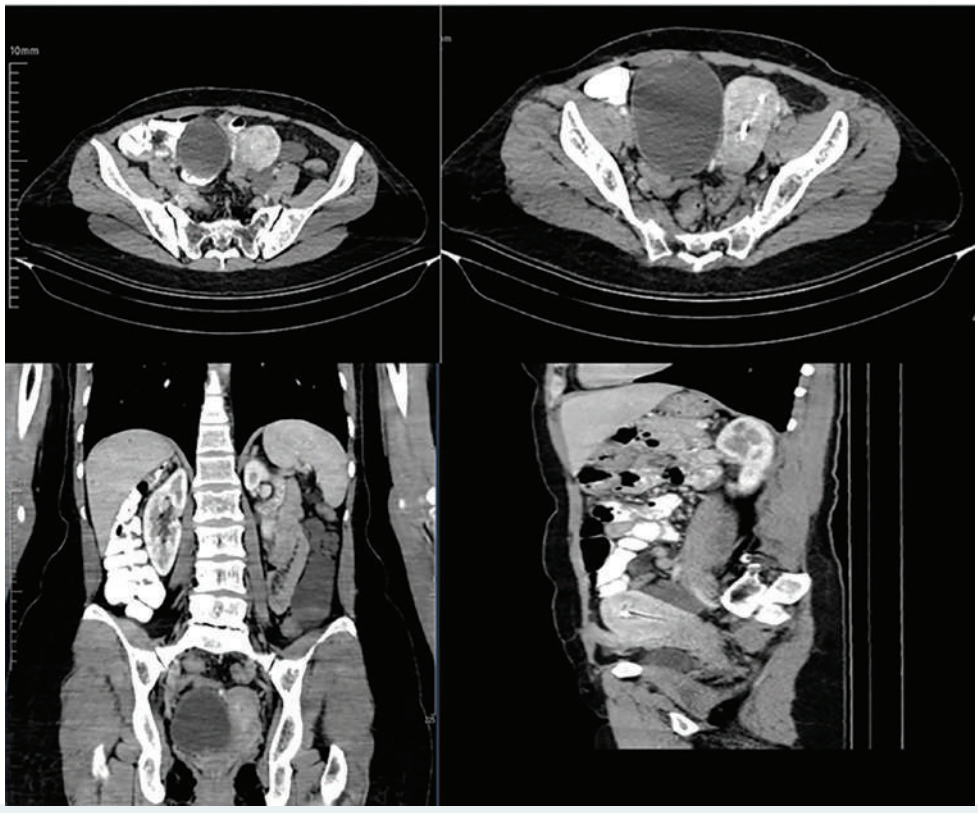

Figure 1. Imaging findings.

[P-459]

Primary squamous cell carcinoma presenting with an obstructive mass in the cecum: A rare colon tumor

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Objective: The vast majority of colorectal cancers are adenocarcinomas, whereas primary squamous cell carcinoma of the colon is extremely rare. Definitive diagnosis is established by histopathological and immunohistochemical evaluation of resection material. This report presents a case of primary squamous cell carcinoma detected in a patient after surgery for an obstructing cecal mass.

Material and Methods: Clinical, radiological, endoscopic, surgical, and pathological data of a patient who underwent surgical treatment for an obstructive cecal mass were retrospectively reviewed. Histopathological and immunohistochemical analyses of the resection specimen were performed.

Results: A 62-year-old woman presented to the emergency department with a four-day history of abdominal pain, constipation, and nausea. She was hemodynamically stable. Her medical history included cholecystectomy, appendectomy, bilateral total thyroidectomy, and incisional hernia repair, with no chronic diseases. Abdominal computed tomography demonstrated irregular wall thickening in the proximal colon with distal dilated bowel loops and air-fluid levels consistent with ileus. The patient was hospitalized, and after decompression, colonoscopy on the second day revealed a near-complete obstructing cecal mass preventing luminal passage. Biopsies were obtained; however, emergency surgery was performed on the same day due to obstruction without awaiting biopsy results. Surgical exploration revealed an approximately 6 cm obstructing cecal mass and dense adhesions between small bowel loops. No macroscopic metastasis or peritoneal carcinomatosis was observed; ascites was present. Right hemicolectomy with ileocolic anastomosis and adhesiolysis were performed. The postoperative course was uneventful, and the patient was discharged on day 8. No additional findings were noted during follow-up. Colonoscopic biopsy was reported as poorly differentiated carcinoma. Pathological examination of the resection specimen revealed an ulcerative tumor measuring 5.5×4×4 cm. Histopathology demonstrated moderately differentiated squamous cell carcinoma with subserosal invasion. Angiolymphatic invasion was present, while venous and perineural invasion were absent. All 31 lymph nodes were reactive, and surgical margins were negative. Immunohistochemical examination showed cytokeratin 5/6 positivity with widespread cytoplasmic staining and nuclear p63 positivity. Chromogranin and synaptophysin were negative. The Ki-67 proliferation index was 40%. Tumor-infiltrating lymphocytes were prominent. Mismatch repair analysis revealed loss of MLH1 and PMS2 and preserved MSH2 and MSH6 expression. Anal canal involvement, an adenocarcinoma component, and another primary squamous cell carcinoma focus were excluded, establishing the diagnosis of primary colonic squamous cell carcinoma.

Conclusion: Primary squamous cell carcinoma of the cecum is a rare histological subtype. Accurate diagnosis requires detailed histopathological and immunohistochemical evaluation of resection material and is essential for appropriate clinical management and follow-up.

Keywords: Squamous cell carcinoma, colorectal tumors, immunohistochemistry

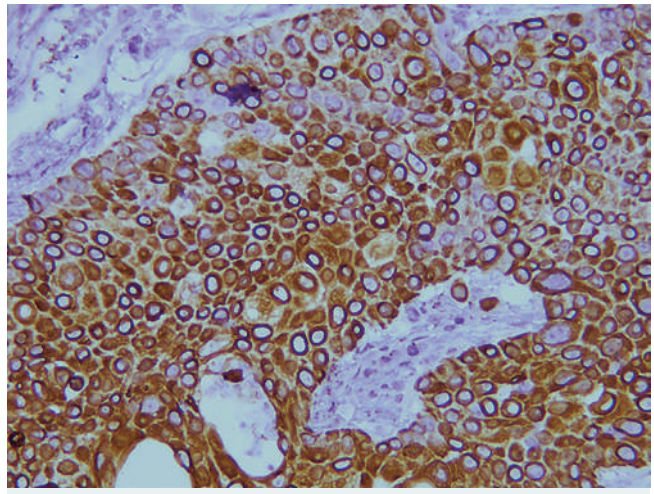

Figure 1. Widespread cytoplasmic positive staining with cytokeratin 5/6 in tumor cells (×400).

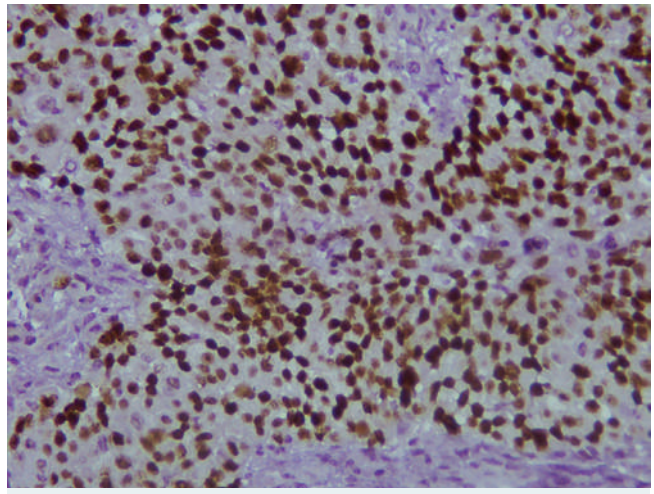

Figure 2. Prominent nuclear positivity in tumor cells with p63 (×400).

[P-460]

Incidental giant ileal GIST: A case report

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[2]*Clinic of Gastroenterology Surgery, University of Health Sciences Türkiye, University of Health Sciences Türkiye, University of Health Sciences Türkiye, University of Health Sciences Türkiye, Ankara Bilkent City Hospital, Ankara*

Objective: Gastrointestinal stromal tumors (GISTs) are the most common mesenchymal tumors of the gastrointestinal system and are usually located in the stomach and small intestine. These tumors, which often present with non-specific symptoms, can be detected incidentally, especially when they are small in size.

Material and Methods: Our hospital has accessed the preoperative and postoperative information of the patient operated on in gastroenterology surgery through the system.

Results: A 53-year-old male patient presented with a hard mass in the right lower quadrant of his abdomen. Imaging findings revealed a 16 cm mass originating in the ileum, showing no invasion into surrounding tissues. The patient underwent segmental small bowel resection. The pathology result was consistent with high-risk GIST, and R0 resection was achieved. The patient recovered without complications in the postoperative period, and adjuvant imatinib therapy was initiated. No recurrence or metastasis was observed during the twelve-month follow-up.

Conclusion: This case demonstrates that large-sized ileal GISTs with an asymptomatic course can be detected incidentally. Early surgical resection and appropriate adjuvant therapy are fundamental approaches that increase long-term survival.

Keywords: GIST, ileum, imatinib

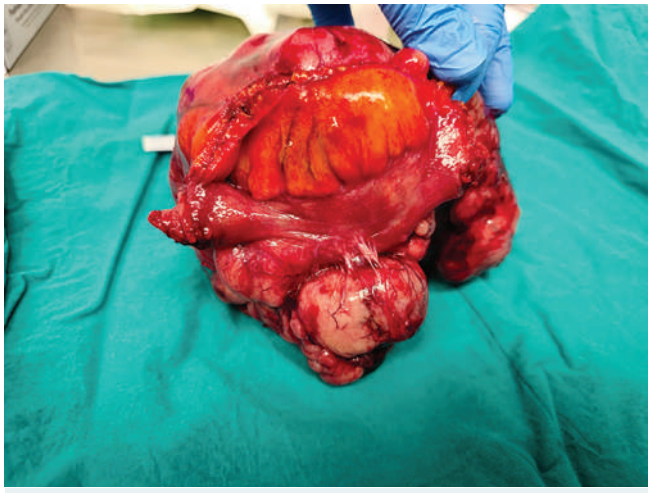

Figure 1. Small intestine GIST specimen. Specimen material from GIST originating from the ileum wall.

Figure 2. Specimen material from GIST originating from the ileum wall.

[P-462]

A rare retroperitoneal tumor detected synchronously with colorectal adenocarcinoma: PEComa

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Objective: Perivascular epithelioid cell tumors (PEComa) are rare mesenchymal neoplasms composed of distinctive perivascular epithelioid cells that co-express melanocytic (HMB-45, Melan-A) and muscle (SMA, Desmin) markers. While commonly found in the uterus and gastrointestinal system, retroperitoneal localization is exceptionally rare, and synchronous presentation with another malignancy is infrequently reported in the literature. This study aims to present a case of retroperitoneal PEComa incidentally detected during surgery for colorectal adenocarcinoma.

Material and Methods: A 73-year-old female patient presented with abdominal pain and constipation. Abdominal CT revealed wall thickening and lymphadenopathy at the sigmoid-descending colon level, but no retroperitoneal mass was reported. Following a colonoscopy that showed an ulcerovegetative mass at 30 cm, an anterior resection was planned. During surgical exploration, a yellow, 1.5 cm retroperitoneal mass, independent of the rectal tumor, was noticed in the superomedial aspect of the left kidney and was totally excised in addition to the rectal surgery.

Results: Pathological examination of the rectal specimen revealed "Moderately differentiated Adenocarcinoma (pT3N0Mx)". The retroperitoneal mass showed a mesenchymal tumor composed of epithelioid cells with clear and eosinophilic cytoplasm. Immunohistochemical analysis demonstrated that the tumor cells were positive for HMB-45, Melan-A, and SMA, while negative for S-100, CD117 (c-kit), and DOG-1. With a Ki-67 index of 2% and no necrosis, the lesion was diagnosed as "PEComa" based on its immune profile and morphology. The patient was discharged on the 10th postoperative day, and adjuvant therapy was planned for the rectal cancer.

Conclusion: Cases of retroperitoneal PEComa concurrent with colorectal malignancies are extremely limited in the literature. These tumors, which lack specific radiological findings, can be confused with Gastrointestinal Stromal Tumors (GIST) or metastases. Definitive diagnosis is established via immunohistochemical examination showing HMB-45 and SMA positivity with CD117 negativity. Surgical excision and close follow-up remain the primary treatment approach for these tumors, which may have uncertain malignant potential.

Keywords: PEComa, rectal cancer, retroperitoneal tumor

Figure 1. Radiographic appearance of a colorectal lesion on computed tomography.

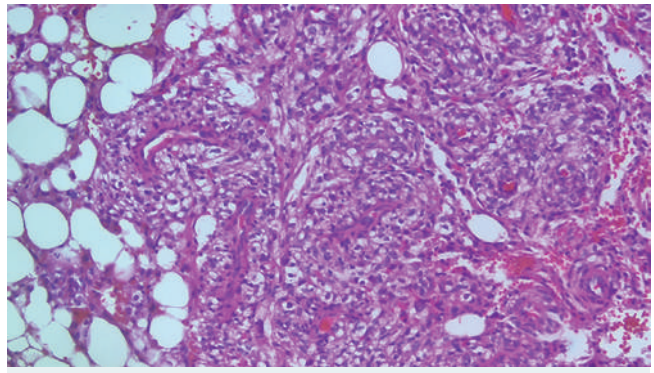

Figure 2. Microscopic appearance of the retroperitoneal mass.

[P-463]

Neostigmine use in the treatment of postoperative gastroparesis developing in a patient with Parkinson's disease: A case report

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Objective: Postoperative gastroparesis is a gastrointestinal motility disorder that can develop after abdominal surgery and is more common in patients who are elderly, have diabetes mellitus, or have neurological disease. Clinically, it presents with nausea, vomiting, gastric dilatation, and oral intake intolerance, which may prolong the hospital stay. Standard treatment includes nasogastric decompression, fluid-electrolyte balance, and prokinetic agents; however, resistance to treatment may develop in some cases. Although neostigmine, an acetylcholinesterase inhibitor, is known to increase intestinal motility, its role in the treatment of postoperative gastroparesis is limited. This study presents the successful treatment of refractory gastroparesis with neostigmine following extended right hemicolectomy.

Material and Methods: A 78-year-old male patient with a history of Parkinson's disease, hypertension, diabetes mellitus, and hypothyroidism underwent an extended laparoscopic right hemicolectomy due to a mucinous adenocarcinoma located in the hepatic flexure. During the operation, the stomach was skeletonized along the greater curvature, including the pylorus. Due to postoperative nausea, vomiting, and abdominal distension, nasogastric drainage was applied. Since metoclopramide was contraindicated due to Parkinson's disease, domperidone 3×10 mg intravenous and neostigmine 2.5 mg intravenous infusion therapy were initiated after a neurology consultation.

Results: On postoperative day 5, nausea-vomiting and abdominal distension developed after oral intake. Imaging revealed marked gastric dilatation. Daily drainage of 1300-1500 mL of bile-containing fluid was observed via nasogastric tube, and bowel sounds were hypoactive. Despite intravenous domperidone treatment, no clinical improvement was observed within three days. After neostigmine treatment: A decrease in nasogastric drainage volume, an increase in bowel sounds, gas and stool passage were observed, and an improvement in oral intake tolerance was noted. No extrapyramidal symptoms were observed during the treatment. The nasogastric tube was removed on the third day of treatment. Following the discontinuation of treatment, mild symptoms developed, and neostigmine was restarted, resulting in complete clinical improvement. Nine days after the start of treatment, the patient was able to tolerate a diet 3 regimen. No recurrence was observed during clinical follow-up.

Conclusion: Postoperative gastroparesis is a challenging clinical condition to manage, particularly in patients at high risk for autonomic dysfunction. This case demonstrates that the use of neostigmine in postoperative gastroparesis resistant to standard prokinetic therapy may improve clinical outcomes by increasing gastrointestinal motility. With appropriate patient selection and close monitoring, neostigmine may be an alternative treatment option in selected cases. However, larger clinical studies are needed to determine the optimal dose and duration of treatment.

Keywords: Postoperative gastroparesis, neostigmine, gastrointestinal motility

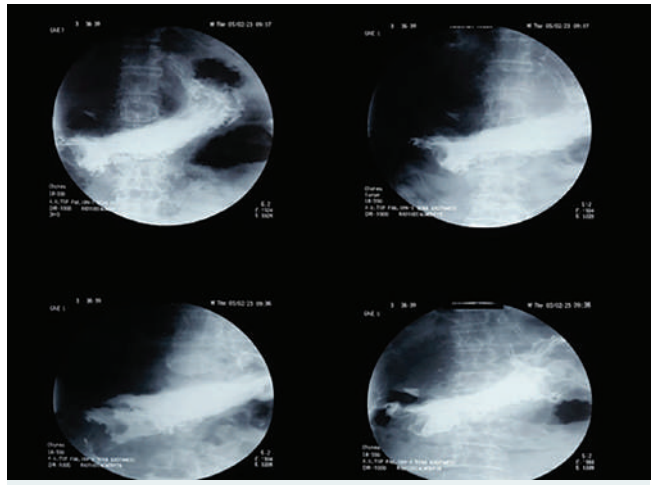

Figure 1. Findings of gastroparesis on upper gastrointestinal system imaging (top images from initial scan, bottom images from scan at 20 minutes).

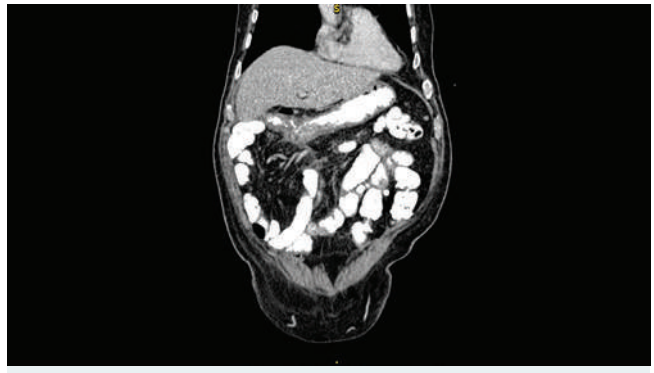

Figure 2. Control CT scan taken at the end of treatment and passage of the contrast medium into the small bowel loops.

Table 1. Nasogastric drainage volume following neostigmine therapy (mL)

Day 1	600
Day 2	200
Day 3	200
Day 4	100

[P-464]

A rare colon tumor causing intussusception in an adult

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Objective: Intussusception is defined as the telescoping of a proximal segment of the intestine into the lumen of an adjacent distal segment. It most commonly occurs in the ileocecal region, followed by ileocolic and colocolic types. In childhood, intussusception is usually caused by benign conditions and often resolves with medical treatment. In adults, however, it is rare and most often associated with an underlying malignant pathology, requiring surgical intervention. In this case report, we present a rare adult case of a tumor in the transverse colon causing intussusception

Material and Methods: A 42-year-old male patient presented with abdominal pain, nausea, constipation, vomiting, and abdominal distension. His medical history revealed no prior abdominal surgery, and there was no family history of malignancy. Physical examination showed abdominal distension without additional pathological findings. Contrast-enhanced abdominal computed tomography revealed an intussusception at the midline level of the transverse colon, measuring approximately 15×6 cm, containing areas of fat density. A lesion protruding into the lumen, inflammatory changes in the adjacent mesentery, and millimetric lymph nodes were also observed. Subsequent colonoscopy demonstrated a pedunculated tumoral mass corresponding to this region, which obstructed passage of the colonoscope. Histopathological evaluation of the biopsy specimen revealed ulceration, hemorrhage, and congestion. Total excision of the mass was recommended for definitive diagnosis. The patient subsequently unde

Results: Intussusception in adults is a rare but clinically significant condition. Benign causes include leiomyomas and lipomas of the ileocecal wall, while malignant causes include tumors such as adenocarcinoma and lymphoma

Conclusion: In adult patients with clinical and physical examination findings suggestive of intussusception, the possibility of underlying malignancy should always be considered, even though it is rare

Keywords: Intussusception, colon, malignancy

Figure 1. CT scan of intussusception.

[P-465]

Primary squamous cell carcinoma of the breast: A rare and aggressive malignancy

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Objective: Primary squamous cell carcinoma (SCC) of the breast is an exceptionally rare and aggressive malignancy, accounting for less than 0.1% of all invasive breast cancers. Diagnostic criteria strictly require that the tumor consists of >90% squamous cells and does not originate from the overlying skin, nipple, or distant sites. These tumors typically present with a triple-negative phenotype and high proliferative indices, associating them with a prognosis comparable to or worse than poorly differentiated ductal carcinomas.

Material and Methods: A 42-year-old postmenopausal woman presented with a painful mass in the left breast axillary tail. Imaging revealed a diagnostic discrepancy: mammography showed a well-circumscribed mass (BI-RADS 0), whereas ultrasonography demonstrated an irregular, hypoechoic lesion (BI-RADS 3). Following an inconclusive core needle biopsy showing only inflammatory changes, an excisional biopsy was performed. Metastatic disease from extramammary sites was rigorously excluded via PET-CT and clinical work-up.

Results: Immunohistochemical analysis confirmed a poorly differentiated, triple-negative (ER-, PR-, HER2-) SCC with positive p63 and CK5/6 expression and a Ki-67 index of 30%. The patient underwent left subcutaneous mastectomy with axillary lymph node dissection. Remarkably, while four sentinel lymph nodes were negative, one non-sentinel node exhibited carcinoma macrometastasis, illustrating the phenomenon of "skip metastasis". Adjuvant therapy included six cycles of paclitaxel, cyclophosphamide, and adriamycin followed by radiotherapy.

Conclusion: Primary breast SCC often exhibits a "pseudocystic" appearance, mimicking abscesses, which poses significant diagnostic challenges. Unlike invasive ductal carcinoma, these tumors show a lower rate of nodal involvement (10-30%), yet the phenomenon of "skip metastasis" necessitates careful surgical consideration. Therapeutically, due to potential resistance to standard anthracyclines, platinum-based regimens (cisplatin/carboplatin) and targeted therapies addressing frequent EGFR overexpression (approx. 40%) should be strongly considered to improve outcomes in these aggressive tumors.

Keywords: Breast cancer, primary squamous cell carcinoma, rare tumor, triple-negative

Figure 1. A solid mass is indicated on the breast MRI scans.

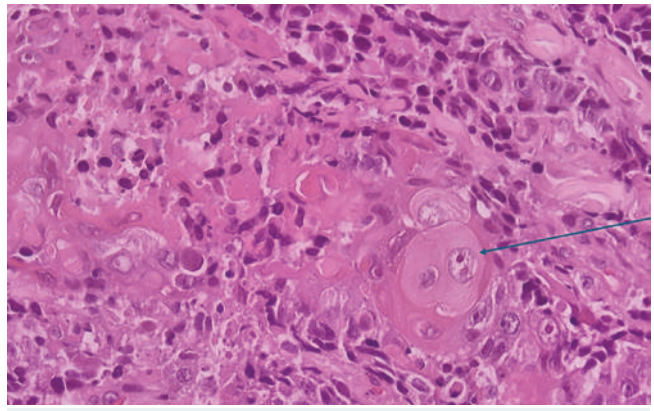

Figure 2. The image a marked pathological tumor cell.

[P-466]

Palpation thyroiditis and massive multinodular goiter: A case of mechanically-induced hyperthyroidism necessitating total thyroidectomy

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Objective: This case report presents the unusual co-occurrence of severe hyperthyroidism developing on the basis of palpation thyroiditis, combined with a massive multinodular goiter (MNG).

Material and Methods: The physical examination, biochemical investigations (thyroid function tests), and radiological imaging of the patient, who presented with weight loss and dysphagia, were evaluated. Following unresponsiveness to medical treatment and a diagnostic palpation test, a definitive diagnosis was established. The case was analyzed through the total thyroidectomy procedure, specimen weight, and histopathological results.

Results: A 65-year-old female patient presented with complaints of weight loss, hand tremor, and dysphagia. Her history included diagnosis of juvenile goiter at the age of 16 and history of radioactive iodine therapy. Physical examination revealed a bilateral, firm, fixed, massive MNG. Laboratory investigations confirmed hyperthyroidism. Imaging revealed a significant increase in gland size, numerous nodules, and reduced parenchymal activity. Medical therapy initiated under the presumptive diagnosis of Graves' disease failed to achieve a response. An increase in hormone levels following thyroid palpation, and a subsequent drop upon restriction, supported the diagnosis of palpation thyroiditis. Due to the massive MNG and uncontrolled symptoms, the patient underwent total thyroidectomy. The resected specimen weighed 737 grams. Pathological examination confirmed MNG, with no evidence of malignancy. No surgical complications occurred in the postoperative period, and the patient was discharged.

Conclusion: The increase in hormone levels subsequent to palpation serves as a critical diagnostic clue for palpation thyroiditis. While surgical intervention is rarely required, it became necessary in this case due to the co-occurrence of massive MNG and the inability to control the patient's symptoms.

Keywords: Palpation thyroiditis, giant multinodular goiter, hyperthyroidism, thyroidectomy

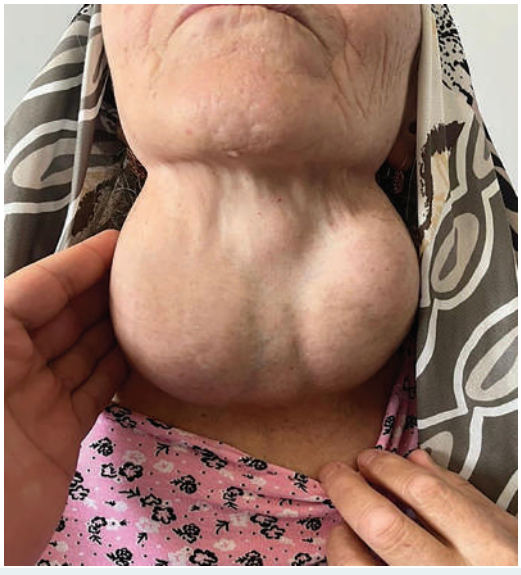

Figure 1. Preoperative image.

Figure 2. Preoperative image.

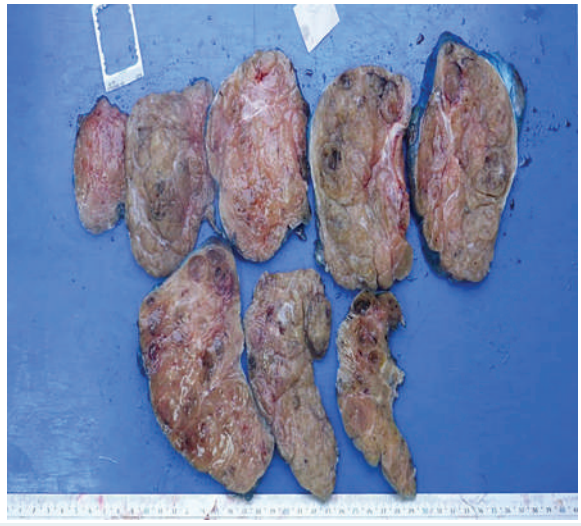

Figure 3. Pathology specimen.

Figure 4. Postoperative control.

[P-467]

A rare anatomical variation in thyroid surgery: A case of right non-recurrent laryngeal nerve confirmed by intraoperative nerve monitoring

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Objective: Non-recurrent laryngeal nerve (NRLN) is a rare but clinically critical anatomical variation in thyroid surgery. In normal anatomy, the recurrent laryngeal nerve (RLN) loops around the subclavian artery on the right and the aortic arch on the left before reaching the tracheoesophageal groove. However, due to embryological developmental differences, the nerve may directly enter the larynx without looping around these structures. The incidence of NRLN is reported between 0.5-1% in literature, predominantly on the right side; left-sided occurrence is extremely rare. When NRLN is present, failure to locate the nerve in its expected position may lead surgeons toward more aggressive dissection, increasing iatrogenic injury risk. This case presents a right NRLN confirmed by intraoperative nerve monitoring (IONM) and discusses its contribution in managing this anatomical variation.

Material and Methods: A 75-year-old female patient was evaluated for a 17x12 mm nodule in the lower pole of the left thyroid lobe. Fine needle aspiration biopsy revealed suspicious cytology for malignancy, and bilateral total thyroidectomy with IONM was planned. Surgery was initiated with left lobectomy; the left vagus nerve, left superior laryngeal nerve, and left RLN were identified through dissection and confirmed with IONM.

Results: During right lobectomy, the right vagus nerve was identified. When typical RLN course was not observed in the tracheoesophageal groove, dissection strategy was redirected in a controlled manner. The nerve was found entering the larynx with a transverse course, confirming right NRLN. The nerve was verified and preserved using IONM. According to Toniato classification, the transverse course above the inferior thyroid artery trunk was compatible with type IIa pattern. Thoracic computed tomography demonstrated findings consistent with aberrant right subclavian artery; systematic reviews report this vascular anomaly in 97% of right NRLN cases. No postoperative dysphonia or dysphagia was observed; serum calcium and parathyroid hormone levels were normal. The patient was discharged uneventfully on postoperative day two. Pathological examination revealed benign hyperplastic nodule in the left lobe and unifocal 1 mm papillary thyroid carcinoma in the right lobe.

Conclusion: NRLN, although rare, is an important anatomical variation that may predispose to major complications. Recent meta-analyses have demonstrated that IONM reduces temporary unilateral RLN injury by 38% and permanent injury by 51%. NRLN possibility should be considered in patients with aberrant right subclavian artery on preoperative imaging. IONM provides valuable contribution for evaluating nerve response via vagus stimulation and functional confirmation when the nerve is not observed in its typical anatomical course.

Keywords: Arteria lusoria, intraoperative nerve monitoring, non-recurrent laryngeal nerve, recurrent laryngeal nerve, thyroidectomy

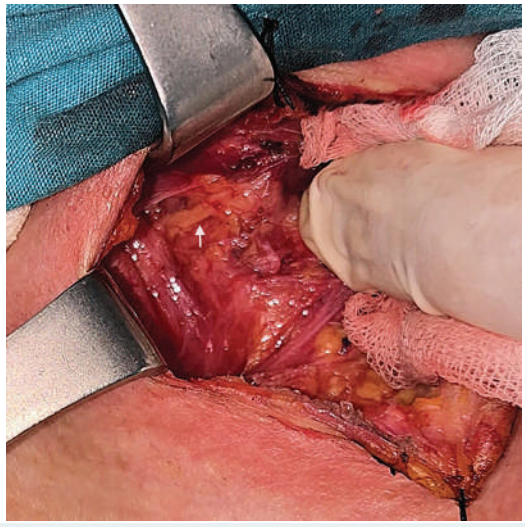

Figure 1. Non-recurrent laryngeal nerve. Transverse course of the right non-recurrent laryngeal nerve (NRLN) (white arrow) entering directly into the larynx.

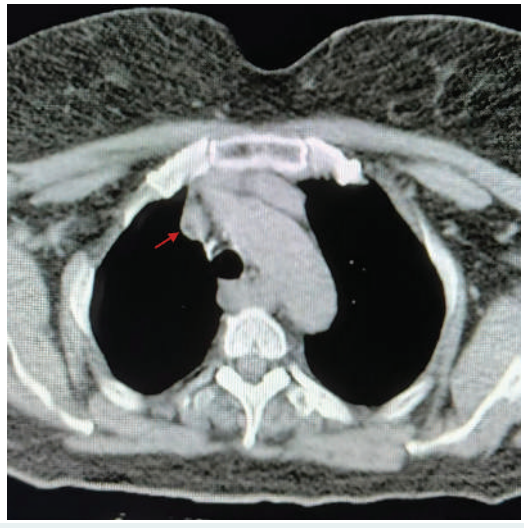

Figure 2. Aberrant right subclavian artery. Appearance of the aberrant right subclavian artery (red arrow) on preoperative CT scan.

[P-468]

Late-onset thyroid metastasis with tracheal invasion of clear cell renal cell carcinoma: A case report

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Objective: Renal cell carcinoma (RCC) is the most common malignant tumor of the kidney and is characterized by a high metastatic potential. The most frequent metastatic sites include the lungs, liver, bones, and brain; however, thyroid gland metastasis is rare. RCC accounts for approximately 12% of all tumors metastasizing to the thyroid gland. Thyroid metastases may develop many years after nephrectomy and may occasionally present as the first sign of recurrence. Therefore, metastatic RCC should be considered in euthyroid patients presenting with rapidly enlarging thyroid nodules.

Material and Methods: A 75-year-old female patient presented in August 2024 with progressive neck swelling and dyspnea. Physical examination revealed a prominent cervical mass with tracheal deviation to the left. Her medical history was notable for right nephrectomy performed in 2012 due to clear cell renal cell carcinoma. Neck ultrasonography demonstrated a heterogeneous cystic-solid nodule measuring 61×31 mm occupying nearly the entire right thyroid lobe, along with additional nodules of varying sizes. The patient was biochemically euthyroid. Due to the nodule reaching 6 cm in diameter and causing significant tracheal compression, total thyroidectomy was performed. Histopathological examination revealed a capsulated tumor with extensive hemorrhagic and cystic areas. Immunohistochemical staining showed positivity for RCC, PAX8, CD10, and Vimentin, while TTF-1 and thyroglobulin were negative, confirming the diagnosis of metastatic clear cell renal cell carcinoma.In the postoperative period, the patient developed persistent cough and reported expectoration of mass-like material. Imaging studies and bronchoscopic evaluation revealed a tracheal mass. Consequently, tracheal resection and cervical dissection were performed in October 2024. Pathological examination again confirmed RCC metastasis. The patient is currently being followed by the medical oncology department, and systemic therapy planning is ongoing.

Results: Despite its rich vascular supply, the thyroid gland is an uncommon site for metastatic disease. RCC is among the most frequent primary tumors metastasizing to the thyroid. Previous studies have reported a mean interval of 9-10 years between nephrectomy and thyroid metastasis; in the present case, metastasis occurred 12 years later, consistent with the literature. Tracheal invasion by metastatic RCC is exceedingly rare and has been infrequently reported.

Conclusion: Metastatic RCC should be considered in patients with a history of nephrectomy who present years later with rapidly enlarging thyroid nodules and compressive symptoms. Surgical resection remains an important diagnostic and therapeutic option in selected cases, and a multidisciplinary approach is essential for optimal patient management.

Keywords: Case report, clear cell carcinoma, renal cell carcinoma, thyroid metastasis, tracheal invasion

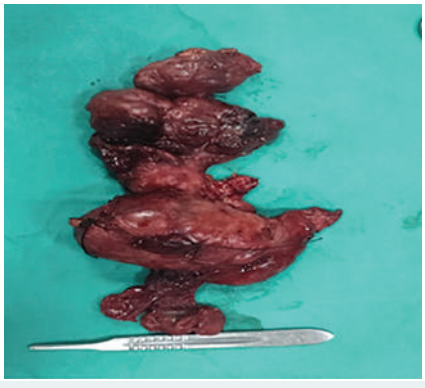

Figure 1. Total thyroidectomy specimen

[P-469]

Axillary lymph node metastasis in papillary thyroid carcinoma at early perioperative period: Report of a case and review of the literature

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Objective: Papillary thyroid carcinoma is a common thyroid cancer that usually grows slowly and has a good prognosis. Despite frequent lymph node metastases, mortality rates are low. However, metastasis to unusual regions such as the axilla can rarely occur.

Material and Methods: A 36-years-old woman with a history of neck swelling was diagnosed with papillary thyroid carcinoma. Cervical lymph node metastasis was detected in the patient.

Results: Total thyroidectomy and lateral-central neck dissection were performed. During postoperative radioactive iodine treatment and whole-body scanning, axillary lymph node metastasis was detected, and the diagnosis of metastasis was confirmed by biopsy.

Conclusion: Risk factors for poor prognosis in papillary thyroid carcinoma include large tumors, extracapsular spread, older age, specific variants, and distant metastasis. Surgical resection is the primary treatment method, aiming to eliminate local and regional spread. However, metastasis to atypical regions such as the axilla is rare and not well understood due to limited data. Such metastases are thought to develop through retrograde spread from the neck or abnormal lymphatic flow caused by surgery. Axillary metastasis is usually detected during or after surgery and may indicate systemic disease. Imaging techniques are important for diagnosis. Although it is generally a sign of poor prognosis, isolated cases without distant metastasis have also been reported. Therefore, the possibility of distant metastasis should be considered in aggressive thyroid cancer treatment.

Keywords: Axillary metastasis, thyroid cancer

[P-471]

Schwannoma of ansa-cervicalis: A rare location for schwannoma

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Objective: Schwannomas are rare neoplasms that originate from the nervous system. We describe a case of schwannoma of the ansa-cervicalis in a patient where preoperative imaging is suggestive of glomus caroticum tumor.

Material and Methods: A 44-year-old man presented to the surgical oncology department with a recurrent anterior triangle neck swelling. Magnatic resonance ımaging (MRI) demonstrated right enhancing soft tissue mass at the carotid bifurcation consistent with glomus tumor. Intraoperatively, the lesion was found abuting the bifurcatuion and arising from the right ansa-cervicalis. Histopathology evaluation revealed schwannoma.

Results: Schwannoma of the ansa-cervicalis is extremely rare. Very few cases have been reported in the literature. Making the preoperative diagnosis is difficult. Preoperative imaging is necessary to rule out other causes of neck masses such as thyroid lesions, lymphadenopathy, and carotid body tumor. Verocay bodies were noted on histology.

Conclusion: Schwannoma of cervical region can have origin from any nerve. Any Neurologic post-operative deficit depends on the nerve of origin and the precision of the surgery performed.

Keywords: Ansa-cervicalis, schwannoma, verocay body

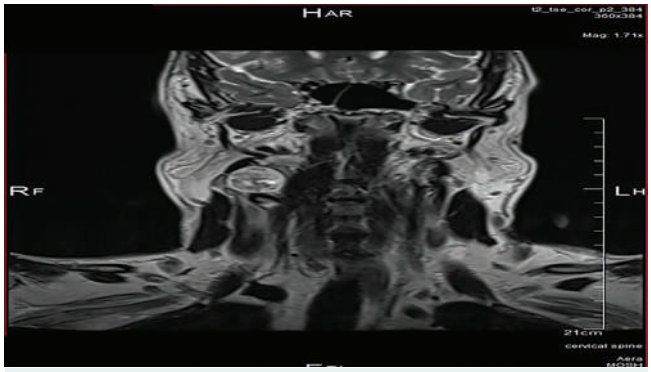

Figure 1. Sagital view of the mass in magnetic resonance investigation.

[P-472]

A rare variation in the gallbladder wall: Ectopic liver tissue and case presentation

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Objective: Ectopic liver tissue (ELT) is a rare developmental anomaly that is not connected to liver tissue but has normal liver histology. It results from the abnormal migration of the hepatic diverticulum during embryological development. It was first reported by Corsy and colleagues in 1922. Types that are located in the gallbladder serosa are usually asymptomatic and are incidentally detected in 0.24-0.47% of cholecystectomy specimens. In this case presentation, accessory liver tissue detected in a patient operated on for symptomatic cholelithiasis is discussed in the context of the literature.

Material and Methods: This study presents the surgical management and histopathological findings of a case in which ectopic liver tissue was incidentally detected in the gallbladder serosa during laparoscopic cholecystectomy planned for symptomatic cholelithiasis.

Results: A 42-year-old female patient with no known comorbidities presented with recurrent right upper quadrant pain. Preoperative ultrasonography revealed multiple stones within the gallbladder, the largest measuring 16 mm. Biochemical analysis, including liver function tests and complete blood count, was within normal limits (AST: 9 U/L, ALT: 11 U/L, ALP: 131 U/L, GGT: 31 U/L, T. Bil: 0,27 mg/dL, WBC: 8800/mm³, Htc: 44%, Plt: 368,000/mm³). During laparoscopic cholecystectomy, an accessory tissue approximately 1.5 cm in size, macroscopically identical to liver parenchyma, was identified on the serosa near the fundus-body junction of the gallbladder. The gallbladder was resected en-bloc with this tissue (Figures 1 and 2). Histopathological examination confirmed chronic cholecystitis, focal gastric metaplasia, and histologically normal liver tissue located on the gallbladder serosa. The patient was discharged with no postoperative complications.

Conclusion: Ectopic liver tissue (ELT) is a rare anatomical anomaly that arises as a result of the abnormal migration or accessory budding of the hepatic diverticulum during the embryonic development stage. Although most frequently reported in the gallbladder serosa (45-47%), it can also be detected in the pancreas, spleen, omentum, and retroperitoneal area. ELT is usually an incidental finding during surgery. Although often asymptomatic, it has the potential to cause pathologies such as hepatitis, cirrhosis, bleeding, and torsion. Due to inadequate ductal drainage, they carry a risk of malignant transformation, and the risk of hepatocellular carcinoma is higher than in normal liver tissue. Therefore, en bloc resection and definitive histopathological evaluation of suspicious tissue nodules detected on the gallbladder is recommended.

Keywords: Ectopic liver tissue, gallbladder, laparoscopic cholecystectomy

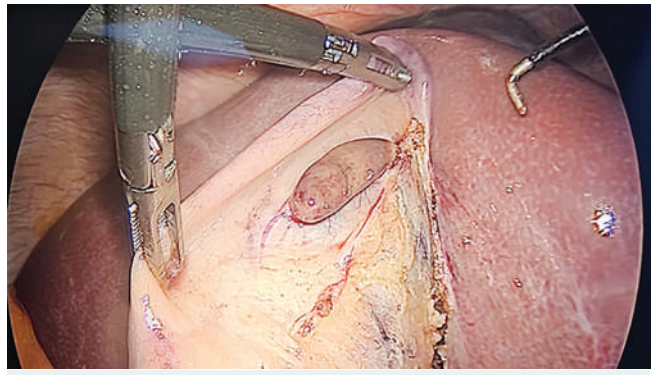

Figure 1. Intraoperative appearance of ectopic liver tissue on the gallbladder serosa.

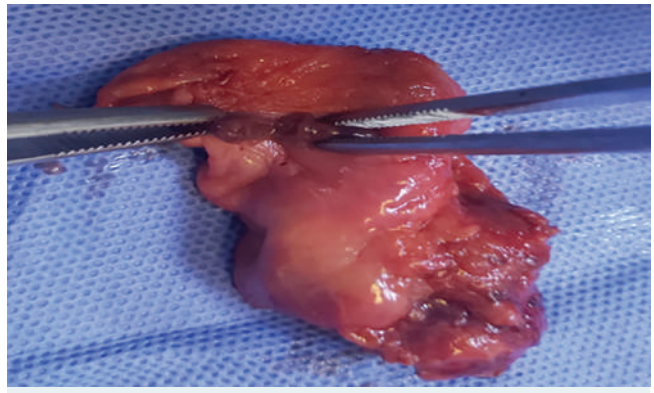

Figure 2. Macroscopic appearance of the gallbladder and ectopic liver tissue after resection.

[P-473]

Case report: Unexpected lymph node metastasis and surgical management in early-stage ampullary adenocarcinoma

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Objective: Investigating the etiology of chronic pancreatitis in patients undergoing evaluation for pancreatitis attacks following cholecystectomy can be challenging, as the inflammatory state may mask underlying malignancies. In this report, we present the management of a 52-year-old female patient who presented with a "double-duct" sign and was diagnosed with pT1a adenocarcinoma following a papillectomy.

Material and Methods: Ampullary carcinomas are rare neoplasms originating from the ampulla of Vater. Although they often present early due to biliary obstruction, their biological behavior can be aggressive. The radiologically detected "double-duct" sign is a classic finding for periampullary malignancies. Surgical resection remains the only curative option, with lymph node involvement being the most critical prognostic factor. In our case, the pathology of the papillectomy performed via ERCP (endoscopic retrograde cholangiopancreatography) was reported as "invasive adenocarcinoma (pT1a) arising from a high-grade intraampullary papillary-tubular neoplasm". Due to the proximity of the *in situ* carcinoma to the basal margin, a pylorus-preserving Whipple procedure was performed.

Results: Preoperative computed tomography (CT) revealed a common bile duct width of 12 mm and a Wirsung duct width of 5.5 mm. Preoperative tumor markers were within normal limits (CEA: 0.77 µg/L, CA 15-3: 27.4 U/mL, CA 19-9: 14.9 U/mL). During the Pylorus-Preserving Whipple procedure, the pancreas was noted to be of medium consistency with a 4 mm Wirsung duct. Reconstruction was completed via duct-to-mucosa pancreaticojejunostomy, hepaticojejunostomy, and duodenojejunostomy. Although no residual primary tumor was found in the final pathology specimen, metastasis was detected in 3 out of 26 lymph nodes (3/26). Immunohistochemical analysis showed: CK20(+), CDX-2(+), CK19(+), and CK7(-). The tumor was classified as microsatellite stable (MSS/pMMR).

Conclusion: The most striking aspect of this case is the discrepancy between the T and N stages. While the literature suggests a low risk of lymph node metastasis for pT1a lesions (the earliest stage of invasion), this case demonstrated an 11.5% nodal involvement rate. This highlights the necessity of radical surgery and the significance of nodal spread potential even in early-stage ampullary lesions. Furthermore, the immunohistochemical profile (CK20+, CDX-2+) indicating intestinal-type differentiation is crucial for understanding the biological character of the tumor. Stable tumor markers during the 15-month follow-up support the success of adjuvant therapy and achieving negative surgical margins

Keywords: Adenocarcinoma, ampulla of vater

[P-474]

Case report: Mechanical ileus presenting with segmental ileal ischemia in an elderly patient with no history of previous abdominal surgery

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Objective: In elderly patients, mechanical ileus, especially if accompanied by signs of systemic inflammatory response, should be carefully evaluated for bowel ischemia. Although segmental small bowel ischemia is rare in cases without a history of adhesions, it has high morbidity and mortality. This study presents a case of a patient who presented with ileus and was found to have intraoperative segmental ileal ischemia.

Material an Methods: An 80-year-old male patient with two days of absent stool and gas was evaluated with a preliminary diagnosis of ileus. His medical history included benign prostatic hyperplasia, coronary artery disease, and a history of coronary bypass surgery. Due to clinical deterioration and altered consciousness, laboratory tests and contrast-enhanced abdominal computed tomography (CT) scans were performed. The presence of systemic inflammation and a radiological transition zone led to the patient undergoing emergency surgery.

Results: Laboratory tests revealed a leukocyte count of 33,920/mm³ (neutrophils 92%), CRP of 167 mg/L, and procalcitonin of 2.3 ng/mL. Lactate was 2.7 mmol/L. CT scan showed extensive dilation of the small bowel loops, ileal passage zone at the umbilicus level, wall thickening, and mesenteric fatty plane contamination. No purulent fluid was detected on exploration. A segmental ischemic area approximately 15 cm long with lost peristalsis was observed 20-35 cm proximal to the cecum. The ischemic segment was resected with a 2 cm safe margin from the demarcation line and a side-to-side anastomosis was performed with a stapler.

Conclusion: Segmental bowel ischemia should be considered in patients with advanced age and cardiovascular comorbidities, as well as in the presence of significant inflammatory parameters and mesenteric contamination on CT scans. Early surgical intervention is crucial for prognosis in cases of ileus that develop clinically worsening.

Keywords: Ischemia, ileus

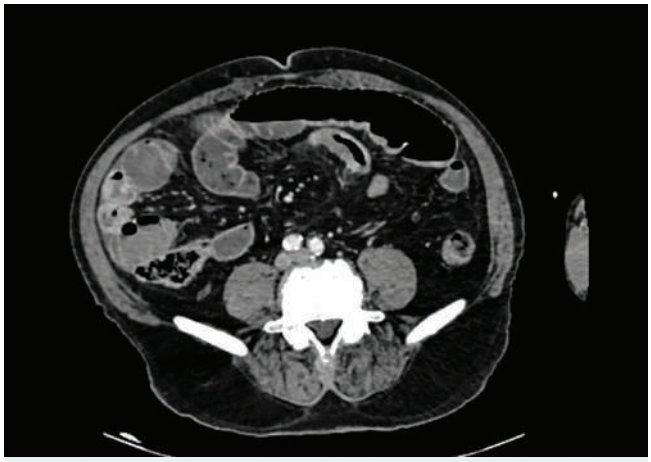

Figure 1. Oral + IV opaque abdomen CT scan. Transition zone.

Figure 2. Intraoperative view. Ischemic segment.

[P-475]

A silent emergency after vaginal birth: Obstetric anal sphincter injury

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Objective: Obstetric anal sphincter injury (OASIS) is the most severe form of perineal trauma, involving perineal damage extending to the anal sphincter complex after vaginal delivery. Its incidence varies due to differences in diagnosis and reporting methods. OASIS affects 5-7% of women having their first vaginal delivery. However, this rate rises to 26% in evaluations performed with ultrasonography. The most important risk factors include forceps delivery, shoulder dystocia, advanced gestational age, induction of labor, and episiotomy. These injuries occurring after vaginal delivery lead to long-term morbidities in women that seriously reduce their quality of life. In this case, we present the management of a successful obstetric anal sphincter injury following early intervention.

Material and Methods: In this case, the diagnosis, treatment and follow-up process of a patient who experienced anal sphincter injury after vaginal delivery at our clinic was evaluated.

Results: A 23-year-old gravida 1, parite 0 female patient was admitted to our clinic for vaginal delivery due to term pregnancy. Labor progressed spontaneously. A mediolateral episiotomy was performed at 7 o'clock during the second stage of labor. The fetal presentation was cephalic and the newborn's birth weight was measured as 3000 gr.During the postpartum perineal and rectovaginal examination, a tear was observed at the 3-9 o'clock position, with a full-thickness tear in the external anal sphincter and a tear of >50% in the internal anal sphincter. No injury was observed in the anorectal mucosa. A general surgeon was consulted for the case. The anal sphincter complex was repaired using the overlapping sphincteroplasty technique with 3.0 PDS.The patient was discharged on the 4th postoperative day. No significant anal sphincter loss was observed on endoanal ultrasound performed at 8 weeks postoperatively. No anal incontinence or other complications were observed during postoperative follow-up.

Conclusion: Early and accurate diagnosis is critical for better functional outcomes.Early diagnosis can be made through systematic perineal examination and rectal examination after vaginal delivery. However, diagnosis is missed in 80% of cases. Endoanal ultrasonography is the gold standard for assessing the location and extent of sphincter damage, while anal manometry is the gold standard for assessing sphincter function. Primary surgical repair performed immediately after diagnosis is the primary treatment method. End-to-end or overlap techniques are the main techniques frequently used in repairs. OASIS can lead to morbidities such as perineal pain, sexual dysfunction, wound dehiscence, abscess, rectovaginal fistula, and anal incontinence; therefore, early and accurate diagnosis is of vital importance. Repair of these injuries by experienced clinicians is important for successful outcomes.

Keywords: Anal sphincter, delivery, obstetrics

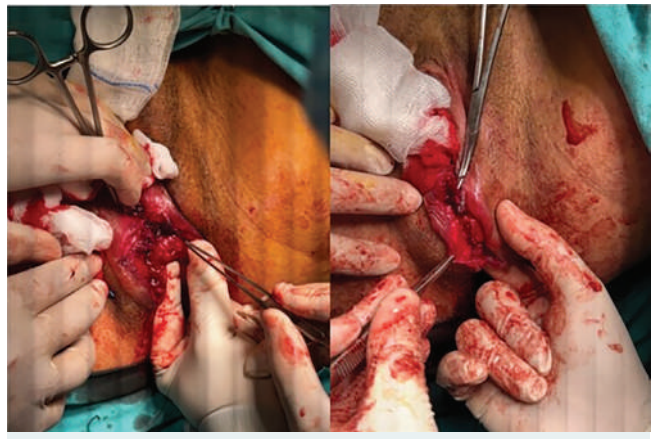

Figure 1. Before and after sphincter injury.

[P-476]

Ileocecal mesenteric duplication cyst in an adult patient: A rare case presenting with mimicry of acute appendicitis

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Objective: Gastrointestinal duplication cysts are rare congenital lesions associated with embryological developmental anomalies and are mostly diagnosed in childhood. Symptomatic cases in adults are rarer and may mimic acute abdominal conditions, particularly acute appendicitis. This case presentation describes the clinical, imaging, surgical, and histopathological findings of a mesenteric duplication cyst in the ileocecal region in an adult patient presenting with right lower quadrant pain and vomiting.

Material and Methods: Clinical data were extracted from institutional records. Contrast-enhanced abdominal CT was reviewed, followed by laparoscopic exploration and ileocecal segmental resection with primary anastomosis. The specimen underwent gross and histopathological evaluation, and postoperative course with short-term follow-up was recorded.

Results: A 37-year-old woman presented with a 2-day history of right lower quadrant pain with nausea and vomiting. Exam showed minimal tenderness without guarding or rebound. Laboratory tests were not suggestive of infection/inflammation (normal leukocytes and lactate, low CRP). Abdominal CT showed a ~25×25 mm cystic lesion on the mesenteric surface of the ileocecal region, suggestive of a duplication cyst; the appendix was normal with no radiological evidence of acute appendicitis. Gynaecological assessment found no acute pathology. Laparoscopy identified a cyst adjacent to the ileum; ileocecal segmental resection with primary anastomosis was performed. No perioperative complications occurred. Oral intake was resumed on postoperative day 3 and the patient was discharged on day 5. No recurrence or re-admission occurred on short-term follow-up. Gross pathology showed a 2.5×2×1.5 cm ileal cyst with a smooth inner surface and serous content. Histopathology confirmed an ileocecal duplication cyst with mucosal ischaemia; seven lymph nodes were reactive, the vermiform appendix was normal, and no malignancy or ectopic (gastric/pancreatic) mucosa was detected.

Conclusion: Adult duplication cysts are rare yet may mimic acute appendicitis with right lower quadrant pain. Here, low inflammatory markers and a normal-appearing appendix on imaging supported alternative aetiologies. Symptoms may arise from compression, torsion/stretching, raised intraluminal pressure and resulting mucosal ischaemia, presenting as pain and vomiting in adults. Given their close relationship to the bowel wall and vascular supply, segmental resection is a safe, curative option. Accordingly, ileocecal duplication cyst should remain a rare but clinically relevant differential diagnosis in adults with right lower quadrant pain, especially when typical appendicitis laboratory and imaging findings are absent. This case highlights mucosal ischaemia as a likely mechanism and suggests that early diagnosis and timely resection minimise morbidity and support favourable outcomes.

Keywords: Ileocecal duplication cyst, mesenteric duplication, acute abdomen in adults

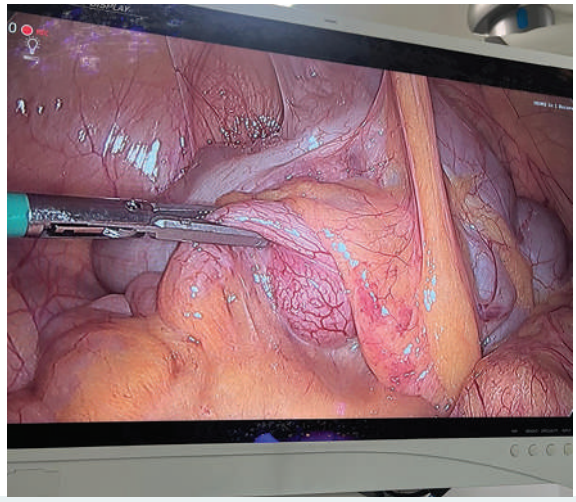

Figure 1. Duplication cyst.

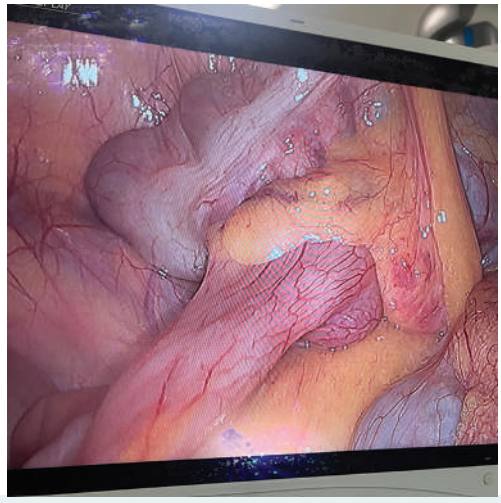

Figure 2. Duplication cyst.

Table 1. Summary of the clinical, imaging, surgical, and pathological characteristics of the case

Parameter	Findings
Age/gender	37 years old/female
Presentation	Emergency department
Duration of symptoms	2 days
Complaint	Right lower quadrant pain, nausea-vomiting
Physical examination	Minimal tenderness in the right lower quadrant, no guarding/rebound
ASA score	II
Laboratory	Leukocytes: normal (6.8), CRP low (~1.5), lactate normal (1.42), Hb normal
Radiological findings (CT)	Approximately 25×25 mm mesenteric cystic lesion in the ileocecal region; appendix normal; minimal free fluid
Preliminary diagnosis	Mesenteric duplication cyst

Table 1. Continued

Parameter	Findings
Surgical approach and procedure performed	Laparoscopic exploration followed by ileocecal segmental resection + primary anastomosis
Operation duration	150 minutes
Intraoperative Complication	None
Postoperative Complications	None
Oral intake	Postoperative day 3
Length of hospital stay	5 days
Macroscopic pathology	2.5×2×1.5 cm cystic lesion; serous content; smooth inner surface; wall thickness 0.2 cm
Histopathological diagnosis	Ileocecal duplication cyst
Additional histological findings	Mucosal ischaemia
Lymph nodes	7 reactive
Appendix	Normal
Ectopic mucosa	None
Malignancy	None
Follow-up period	1 month
Recurrence/mortality	None

[P-477]

Management of a case of gallstone ileus mimicking intussusception and literature review

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Objective: Gallstone ileus is a pathology that occurs when gallstones create an obstruction in the intestines via a bilioenteric fistula. It is especially common in elderly patients and is difficult to diagnose. Gallstone ileus has high mortality and morbidity rates due to its common occurrence in the elderly and the difficulty in diagnosing it. Treatment requires surgical removal of the stone. Fistula repair can be performed in the same session, but in high-risk patients, passage surgery should be performed and fistula repair should be postponed to a second session. The literature indicates that a two-stage treatment approach is more appropriate and that early intervention reduces mortality.

Material and Methods: We present a patient who was hospitalized in the intensive care unit, was consulted to our department due to ileus, and was operated on with a suspicion of intussusception, in whom gallstone ileus was identified intraoperatively.

Results: A 70-year-old female patient with a known diagnosis of Alzheimer's disease, immobilized due to stroke, and being monitored in the intensive care unit for pneumonia with a PEG catheter, underwent abdominal CT scanning due to bile-stained fluid coming from the PEG tube and the cessation of gas and stool passage for the past 5 days. Due to a suspicious appearance of intussusception in approximately 3.5 cm of the small intestine on the CT scan, we decided to perform surgery on the patient (Figure 1). During expulsion, obstruction and edema due to gallstones were observed in the small intestine approximately 140 cm from the ileocecal valve. There was dilation in the proximal bowel loops. The approximately 3.5 cm stone was removed via enterotomy, and the operation was completed (Figure 2). The patient experienced no complications during intensive care monitoring and was started on PEG feeding on the 3rd day after surgery.

Conclusion: In our case, where there was no known diagnosis of cholelithiasis, the presence of Alzheimer's disease and immobility in the patient led to the cholecystitis attacks being overlooked. The presence of intestinal edema due to stone and a target sign on the CT scan raised suspicion of involution in the 3.5 cm segment. It is important to remember that in the rare condition of gallstone ileus, early intervention is life-saving and that in emergency situations, enterolithotomy alone is sufficient. In intensive care, gallstone ileus should be considered in elderly patients diagnosed with ileus, even without a history of independent cholelithiasis.

Keywords: Ileus, intussusception, gallstones

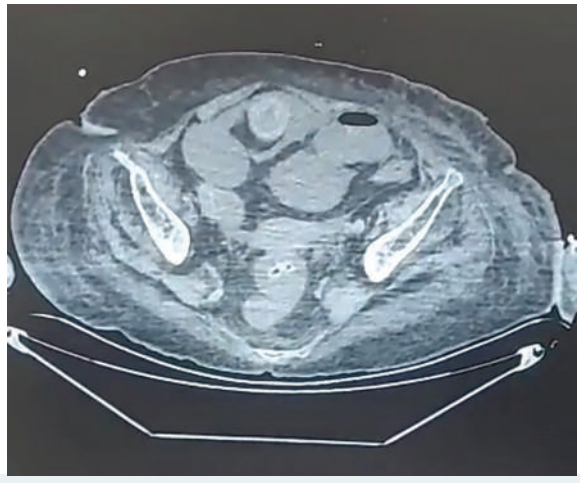

Figure 1.

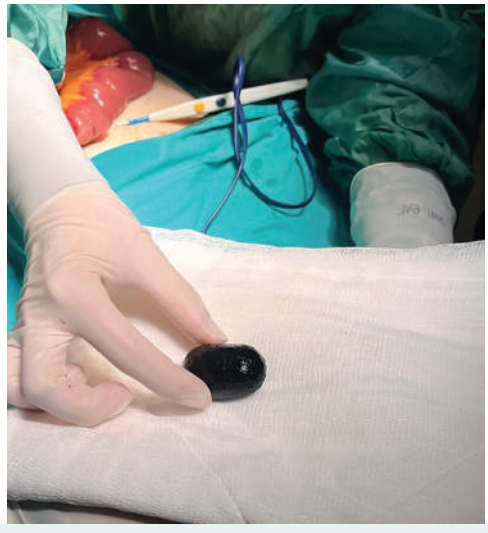

Figure 2.

[P-478]

Transverse colon volvulus: A rare cause of colonic mechanical obstruction

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Objective: Volvulus is a critical clinical condition requiring emergency surgical intervention, characterized by lumen obstruction and vascular occlusion leading to ischemia or necrosis of the colonic wall as a result of a hollow organ twisting around its own axis. Among colon volvuluses, the sigmoid colon (75-80%) and cecum (15-20%) are the most frequently affected regions. Transverse colon volvulus (TCV) accounts for only 1-4% of all cases. Etiological factors include an abnormally long transverse colon, a narrow or hypermobile mesentery, chronic constipation, distal obstructions, and adhesions resulting from previous abdominal surgeries.

Material and Methods: In this case, a 34-year-old patient who underwent surgery due to TCV is presented.

Results: Thirty-four-year-old male patient presented to our emergency department with complaints of abdominal pain, nausea, and vomiting persisting for approximately one day. The patient's history included intermittent abdominal pain for the past two years and a mesenteric detorsion operation one year ago for intermittent midgut volvulus due to intestinal malrotation. Laboratory tests at the time of admission showed no significant pathology. On physical examination, abdominal distension was present, but there was no defense or rebound tenderness. A contrast-enhanced abdominal CT scan revealed a sudden change in calibration at the level of the descending colon, the pathognomonic "whirl sign" in mesenteric structures, and significant colonic dilatation reaching 9 cm proximally. During a therapeutic colonoscopy, a volvulus area was identified at the splenic flexure. Since no signs of ischemia were found, colonoscopic detorsion and decompression were achieved. However, on the third day of follow-up, the cessation of gas and stool passage, abdominal distension, and the detection of the typical "coffee bean sign" on direct abdominal X-ray led to a repeat colonoscopic decompression. Following decompression, the patient was taken to surgery. During the operation, it was confirmed that the transverse colon mesentery was considerably long, the transverse colon had twisted around its own axis at the splenic flexure,and the proximal segments were dilated. A left hemicolectomy was performed on the patient. The postoperative course was uneventful, and the patient was discharged with full recovery on the 9th day.

Conclusion: TCV is a difficult condition to diagnose due to its rarity and non-specific clinical symptoms. High rates of morbidity and mortality have been reported in delayed cases. TCV should be considered not only in the elderly population but also in young patients and individuals with chronic obstruction attacks, as seen in our case. Abdominal CT and the "whirl sign" are of critical importance in diagnosis. To minimize the risk of recurrence, resection of the affected segment and primary anastomosis is the most reliable method rather than detorsion alone. Volvulus should be considered in the differential diagnosis of every patient presenting with mechanical large bowel obstruction; it must be remembered that early intervention.

Keywords: Transvers colon volvulus, whirl sign, intestinal obstruction

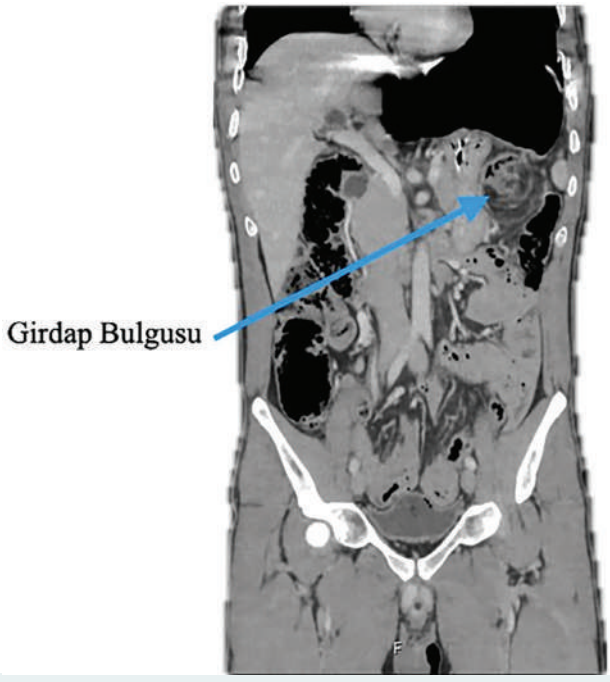

Figure 1. Whirl sign on CT imaging.

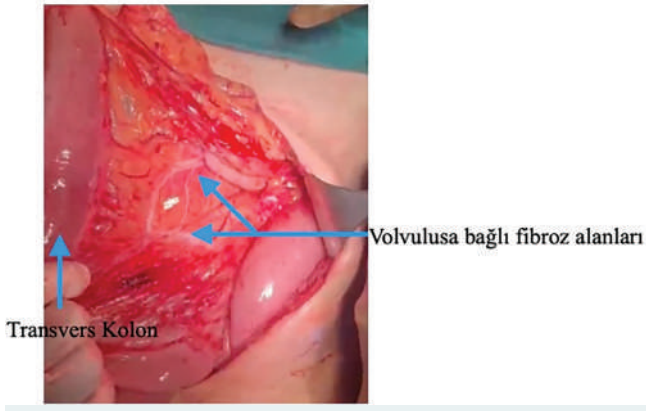

Figure 2. Perioperative findings of transverse colon volvulus.

[P-484]

Sigmoid colon duplication: A rare case report

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Necmettin Erbakan University Faculty of Medicine, Konya

Objective: Colonic duplications are rare congenital anomalies of the gastrointestinal tract and are exceptionally uncommon in adults. Clinical manifestations are often non-specific and may mimic diverticulitis, perforation, or obstruction. We present a rare case of sigmoid colon duplication identified intraoperatively in a patient operated on for suspected diverticulitis.

Material and Methods: A 38-year-old male patient was hospitalized with complaints of abdominal pain and constipation. Abdominal computed tomography demonstrated findings consistent with diverticulitis, along with suspected disruption of wall integrity at the level of the sigmoid colon. Based on clinical and radiological evaluation, the patient was scheduled for surgery.

Results: Intraoperative exploration revealed duplication of the sigmoid colon. Multiple diverticula were observed in the proximal colon segments. Due to the presence of extensive diverticular disease, total colectomy with ileorectal anastomosis was performed. The postoperative course was uneventful, and the patient was discharged in good condition on postoperative day seven.

Conclusion: Colonic duplication is an extremely rare condition in adults, and preoperative diagnosis remains challenging. Its association with diverticular disease has been rarely reported. Colonic duplication should be considered in the differential diagnosis in the presence of atypical clinical and radiological findings. Intraoperative findings play a decisive role in determining the surgical strategy.

Keywords: Colonic duplication, diverticulitis, total colectomy

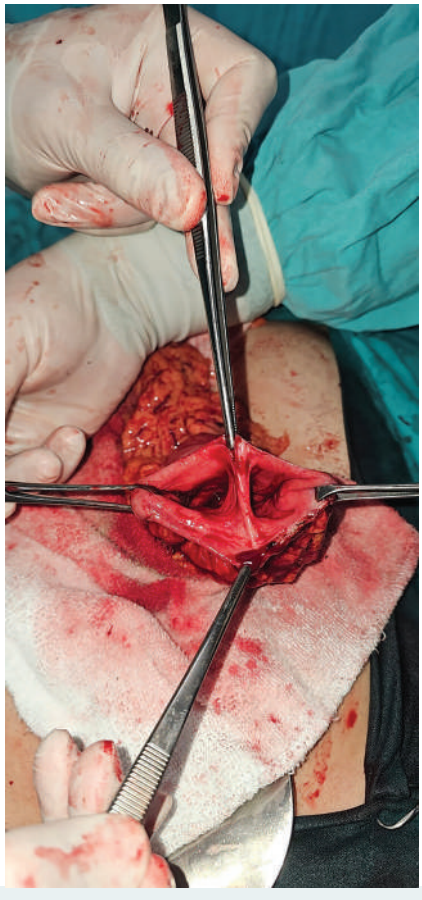

Figure 1. Duplication and double lumen image in the sigmoid colon.

[P-485]

Temporary peripheral facial nerve paralysis after facial mask hyperventilation: A case report

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Objective: Facial paralysis can be primary or secondary. Secondary peripheral facial paralysis most often results from various factors such as trauma, viral infections, post-surgical complications, and tumor compression. In this case, we aimed to present a case of peripheral facial paralysis that developed after mask ventilation, along with a review of the literature.

Material and Methods: Facial paralysis due to mechanical trauma after mask ventilation is a previously defined, rare complication. Pressure behind the mandible during face mask use, use of an inappropriately sized laryngeal mask/endotracheal tube, or difficult intubation can increase the risk of nerve injury.

Results: A 37-year-old female patient presented to our clinic with a palpable mass in her left breast. Investigations revealed a diagnosis of invasive ductal breast cancer. A racket mammoplasty + SLNB operation was planned. Following surgery, during tracheal extubation, the patient developed laryngospasm, prompting hyperventilation via mask by the anesthesiologist. With an oxygen saturation above 95%, the patient was admitted to the ward. During follow-up, the patient reported numbness on the left side of her lip and surrounding area. Neurological examination revealed findings consistent with peripheral facial paralysis. Following a neurology consultation, brain computed tomography and diffusion magnetic resonance imaging scans were performed. No pathological findings were detected, and neurology diagnosed peripheral facial paralysis secondary to mechanical compression during positional or mask ventilation. The patient was treated with 100 mg prednisolone and 40 mg pantoprazol intravenously. The patient, whose symptoms improved after the procedure, was discharged from the hospital.

Conclusion: The incidence of peripheral nerve injuries after general anesthesia is less than 1%. Perioperative nerve damage is a rare but known complication. During anesthesia, ventilation with a face mask and the jaw thrust maneuver can cause damage to the branches of the facial nerve. Cases of facial nerve and its branches (mental and buccal nerves) damage due to face mask compression exist in the literature. Treatment involves steroids and neurotropic B vitamins such as thiamine (B1), pyridoxine (B6), and cobalamin (B12).

Keywords: Facial nerve paralysis, facial mask, temporary

[P-486]

Synchronous small bowel GIST with unique exophytic hyaline degeneration in a patient with advanced gastric adenocarcinoma: Case report

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Objective: Gastrointestinal stromal tumors (GISTs) are the most common mesenchymal tumors of the digestive system. The frequency of synchronous (simultaneous) occurrence of GISTs with other primary gastrointestinal (GI) malignancies, especially gastric cancer, has been significantly reported in the literature. However, it is rare for these tumors to contain macroscopically "pearl-like" cystic and hyaline degeneration areas, and for this structure to be located on the serosal surface, which is a visually misleading presentation.

Material and Methods: A 75-year-old female patient presented with recent vomiting and excessive weight loss. An upper GI endoscopy revealed edematous and polypoid lesions constricting the gastric corpus from the fundus to the antrum. Biopsy results indicated poorly differentiated adenocarcinoma. Due to severe gastric obstruction, the patient underwent palliative surgery.

Results: During laparotomy, locally advanced gastric cancer was detected that completely involved the stomach, had penetrated the serosa, and was adherent to the colonic mesentery to a degree that made dissection impossible. The patient was assessed as inoperable and unresectable. A jejunostomy was planned for palliative feeding. During preparation for jejunostomy, a second synchronous mass was detected approximately 50 cm from the ligament of Treitz. It originated from the intestinal wall, showed exophytic growth, contained areas with a distinct creamy-white colour resembling a cap at the apex, and was partially cystic in structure. This mass was resected. Histopathological and histochemical examinations revealed a 4x3 cm cystic area filled with serous fluid on the outer surface of the 5x4x4 cm mass removed from the small intestine. Brown hemorrhagic foci were noted in the remaining solid areas. Pathological diagnosis: GIST of the small intestine. Immunohistochemistry: DOG1 (+) and CD117 (+) (diffuse and strongly positive). Intraoperative view of a well-defined, exophytic GIST located approximately 50 cm from the ligament of Treitz. At the apex of the tumor, a bright white, homogeneous, and glassy "pearl-like" appearance is noted, consistent with histopathologically significant hyaline and cystic degeneration.

Conclusion: This case is notable for its exophytic serosal hyalinization, which is the pathological counterpart of the pearl-like bright structure observed in the surgical photograph. The "marked hyalinization on free surfaces" mentioned in the pathology report refers to the tumor's stroma becoming homogeneous and glassy. This finding, combined with a low mitotic rate and low-risk of progression, supports a biologically indolent tumor profile. Furthermore, the synchronous detection of a GIST in a patient with advanced gastric cancer once again highlights the importance of surgical exploration. This case presentation demonstrates that GISTs can present with intense hyaline and cystic degeneration, deviating from their usual solid appearance. We believe that recognising such degenerative changes, especially in the presence of synchronous tumors, may be valuable in determining the surgical strategy.

Keywords: Gastrointestinal stromal tumor (GIST), hyaline degeneration, synchronous tumors

Figure 1.

[P-487]

Giant Nuck canal cyst: A case report

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Objective: Nuck's canal cyst is a congenital pathology that is rare in women and develops as a result of the peritoneal extension failing to close. While most cases are small in size, cysts reaching enormous proportions are quite rare. This article presents a case of an enormous Nuck's cyst extending from the middle section of the labium majus to the uterus.

Material and Methods: A 28-year-old female patient presented to the outpatient clinic complaining of increasing pain and swelling in the right groin area over the past few weeks. Her systemic examination was normal. Physical examination revealed a mobile, smooth-surfaced, fluctuant, painless mass palpable in the middle section of the right labium majus. No redness or fistula opening was detected on the skin. Superficial ultrasonography revealed a thin-walled, fluid-filled cystic lesion extending from the level of the labium majus along the right inguinal canal, communicating with the peritoneal cavity. The findings were considered consistent with a Nuck's canal cyst. Surgical exploration revealed that the cyst originated in the middle portion of the labium majus and extended to the uterine level of the peritoneal opening. The cyst was completely excised by dissection up to the intact portion of the peritoneum. The peritoneal defect was primarily closed, and a probing mesh support was applied to prevent possible hernia formation. No complications were observed during postoperative follow-up, and the patient was discharged one day after surgery. The excised cyst measured 12×3 cm macroscopically. Histopathological examination reported a cystic structure lined with a single layer of squamous and cuboidal epithelium and surrounded by a fibrous capsule; the findings were consistent with a Nuck canal cyst. A smooth-walled, translucent cystic structure associated with the hernia sac is observed during inguinal exploration.

Results: Embryologically, the peritoneal extension continues from the inguinal canal to the labium majus, and normally undergoes obliteration shortly after birth. If this canal fails to close, peritoneal fluid may leak into the labium majus, forming a cystic structure. Clinically, patients typically present with a painless swelling in the groin. The most common differential diagnoses are indirect inguinal hernia, lymphangioma, lipoma, Bartholin's cyst, and epidermoid cyst. Ultrasonography is usually sufficient for diagnosis. The preferred method of treatment is surgical excision.

Conclusion: Nuck's canal cyst, although rare, should be considered in the differential diagnosis of inguinal masses in women. Cases reaching enormous sizes are very rare. Excellent prognosis is achieved with surgical excision and appropriate peritoneal repair. This case is noteworthy as one of the largest Nuck's cysts in the literature due to its size.

Keywords: Inguinal canal, labium majus, Nuck channel, peritoneal cyst

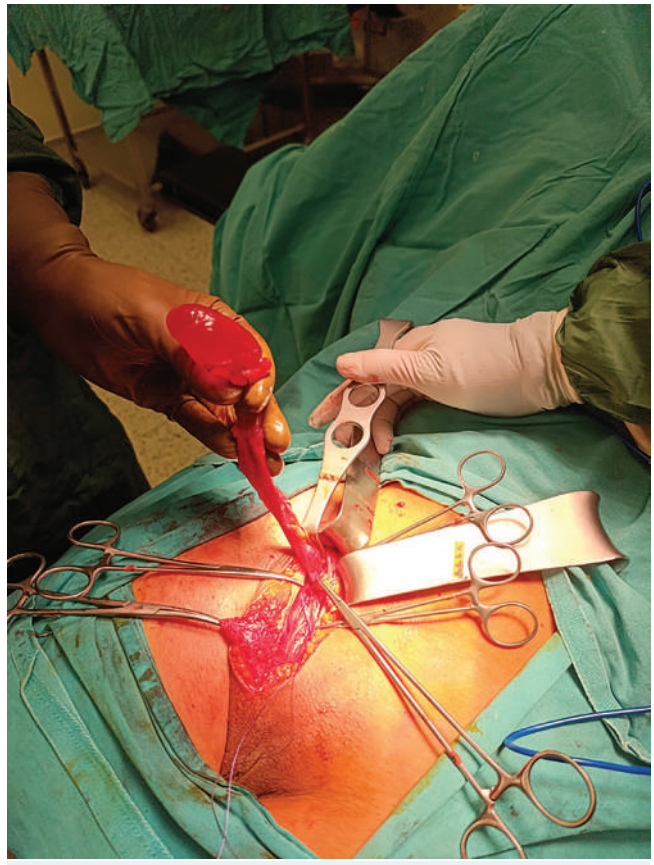

Figure 1. Intraoperative view of a canal of Nuck cyst.

[P-490]

Interparietal Spiegel hernia: Case report

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Objective: Spiegel's hernia was first described in 1645 by the Belgian anatomist Adriaan van den Spiegel, and later Klinkosch reported the first case of a Spigelian hernia in 1764. It constitutes 1-2% of all abdominal hernias. The junction of the semilunar and arcuate lines is the weakest part of the Spigelian fascia and is responsible for most Spigelian hernias. Interparietal hernias, also known as interstitial hernias, are defined by the formation of a hernia sac located between the layers of the anterior abdominal wall.

Material and Methods: In this case report, we aimed to present a case of interparietal Spiegel hernia along with a review of the literature.

Results: A 62-year-old female patient presented to our clinic with abdominal pain in the left quadrant below the umbilicus. Physical examination revealed no palpable lesions or hernia sacs. Laboratory findings showed no pathological evidence, so an abdominal ultrasound was planned. The ultrasound revealed bowel loops between the muscle planes in the left lateral quadrant of the abdomen. With a preliminary diagnosis of Spiegel hernia, a computed tomography (CT) scan of the abdomen was performed. The CT scan showed a Spiegel hernia between the muscle planes in the semilunar line. The patient was diagnosed with an interparietal Spiegel hernia, and surgery was planned. The external oblique muscle fascia was opened approximately 2 cm medially. It was observed that the internal oblique fascia had lost its integrity in an area of approximately 1 cm, and that preperitoneal fat tissue and bowel loops had herniated through this area. The hernia sac was freed from the surrounding tissues and sent back into the abdominal cavity. The internal oblique muscle fascia was repaired with prolene and a prolene mesh was placed over it.The operation was completed by closing the external oblique muscle fascia with prolene.

Conclusion: Spigelian hernia occurs through the Spigelian aponeurosis, which is the aponeurosis of the transversus abdominis muscle bounded laterally by the semilunar line and medially by the lateral border of rectus abdominis. The exact cause of Spigelian hernia is not known, but its development is related to many factors such as collagen disorders, aging, obesity, rapid weight loss, multiple pregnancies, chronic lung disease, trauma, history of surgery, and reproductive diseases. The CT is the method of choice in the differential diagnosis, which can exclude the presence of an obstructing tumor. However, it is reported that both CT and herniography are not successful in differentiating the different types of inguinal hernia.

Keywords: Hernia, interparietal, Spiegel

[P-491]

Pseudoperitoneum formation due to misplacement of dual mesh: A case evaluated with suspicion of recurrent hernia

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Objective: The use of prosthetic mesh in incisional hernia repair reduces recurrence rates; however, rare complications related to mesh malposition may cause diagnostic difficulties. Improper anatomical placement of dual mesh can lead to pseudoperitoneum and chronic seroma formation, which may mimic recurrent hernia on radiological imaging.

Material and Methods: A 70-year-old female patient with a history of multiple incisional hernia surgeries presented with abdominal pain and swelling. Computed tomography demonstrated findings suggestive of recurrent incisional hernia and ileus. As no clinical signs of ileus were present, the patient was evaluated electively and scheduled for surgical exploration.

Results: Surgical exploration revealed no true hernia defect. Instead, an epithelialized pseudoperitoneal layer with a large associated seroma sac was identified between the previously placed dual mesh and the subcutaneous tissue. Seroma drainage was performed, the epithelialized surface was mechanically disrupted, and sterile talc was applied to promote adhesion. No postoperative complications were observed.

Conclusion: Malposition of dual mesh may result in pseudoperitoneum and seroma formation, leading to radiological findings that can be misinterpreted as recurrent incisional hernia. In patients with a history of repeated hernia repairs, clinical-radiological correlation is essential to avoid misdiagnosis and unnecessary surgical intervention.

Keywords: Incisional hernia, dual mesh, seroma, pseudoperitoneum

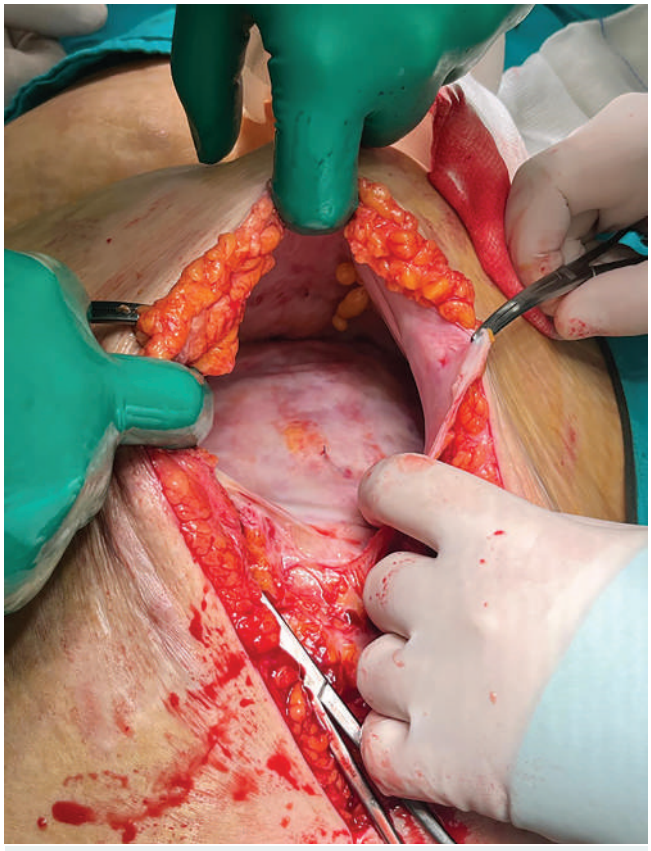

Figure 1. Pseudoperitoneum and sac formation.

Figure 2. Application of sterile talc.

[P-492]

A case of peritoneal mouse (peritoneal loose body) found incidental in a patient operated on for incisional hernia

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Objective: Peritoneal loose bodies (PLBs) are defined as benign structures, usually calcified, found freely within the abdominal cavity. They most commonly arise from torsion, infarction, and rupture of epiploic appendages. The detached fragment gradually becomes surrounded by a fibrous capsule and dystrophic calcification, acquiring a typical "egg-like" structure. PLBs are usually small (<2 cm) and are detected incidentally; however, larger ones are termed "giant PLBs" and are rarely noticed during surgery. In this article, we aim to present a case of a multifocal PLB incidentally detected in a patient who had undergone resection after ischaemia and had portal vein thrombosis.

Material and Methods: A 72-year-old male patient underwent small bowel resection and anastomosis three years ago due to mesenteric ischaemia. He was operated on in the general surgery clinic due to an incisional hernia in his current presentation. Portal vein thrombosis was detected in the patient's recent angiography-abdominal CT scan. During the abdominal exploration performed during the operation, free-floating, approximately 5 cm in diameter, white-grey, oval, smooth-surfaced masses were detected. In addition, necrotic areas in the omentum and 0.5-1 cm masses associated with the omentum were observed. The lesions were excised and sent for pathology. Macroscopically, well-defined, firm, white-grey calcified nodules were observed. Microscopic examination revealed necrotic adipose tissue in the centre, surrounded by a dense fibrotic capsule and areas of dystrophic calcification. No tumour proliferation was observed. The findings were reported as "PLB (peritoneal mouse)".

Results: PLB is a formation that is usually detected incidentally and has a clinically silent course. Most cases are detected during laparotomy, laparoscopy or imaging. Etiologically, besides epiploic appendage torsion, omental or peritoneal fat necrosis may also be a source. In our case, circulatory disorders such as previous ischaemic bowel resection and portal vein thrombosis may have predisposed the omental fat tissue to ischaemic necrosis. Therefore, the formation of PLB was likely considered a sequela of ischaemic fat necrosis. Giant PLB cases are rare in the literature; most are between 2 and 4 cm in size. The presence of multifocal lesions measuring approximately 5 cm in our case makes it interesting.

Conclusion: PLBs are generally benign and asymptomatic. However, they may be more common in patients who have previously undergone abdominal surgery or experienced ischaemic events. When detected incidentally during surgery, their characteristic macroscopic and pathological features should be known to avoid confusion with malignancy.

Keywords: Calcification, intra-abdominal mass, necrotic adipose tissue, omental body, peritoneal loose body

Figure 1. Intraoperative appearance of peritoneal loose bodies. During abdominal exploration, white-grey, smooth-surfaced PLBs found free around the omentum (view from the surgical field).

[P-493]

A rare case: Primery thyroid amyloidosis

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Objective: Amyloid goiter results from the accumulation of amyloid proteins in the thyroid gland. Amyloid deposition can cause compressive symptoms along with enlargement of the thyroid gland. Treatment is surgical, especially if there is a compressive symptom. Here, we present a rare case of primary thyroid amyloidosis diagnosed by histopathological examination after surgery.

Material and Methods: Immunohistochemical staining shows a positive result with amyloid A.

Results: A 36-year-old female patient with no underlying medical conditions was referred from the endocrinology clinic to the general surgery outpatient clinic in January 2026 with complaints of throat swelling and difficulty breathing. Examination revealed swelling in the neck. Thyroid ultrasound showed a multinodular goiter. Thoracic and abdominal computed tomography scans showed no signs of systemic amyloidosis. Surgery was planned due to compression symptoms. The patient underwent bilateral total thyroidectomy. She was discharged on the 3rd postoperative day after recovery. Pathology revealed positive staining for amyloid A, confirming thyroid amyloidosis.

Conclusion: Amyloid goiter is an extremely rare pathological condition caused by amyloid infiltration of the thyroid tissue. It occurs in association with primary or secondary amyloidosis, more frequently seen in secondary amyloidosis. Preoperatively, it simulates a multinodular goiter. Surgical intervention is necessary to diagnose the condition and alleviate the compressive symptoms.

Keywords: Bilateral total thyroidectomy, multinodular goiter, thyroid amyloidosis

[P-495]

Adult patient with an undescended testis within an inguinal hernia sac: A rare case

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Objective: Inguinal hernia is the most common abdominal wall hernia in adults and represents a frequent reason for admission to surgical clinics. Although it usually presents with groin swelling and pain, it may occasionally be associated with congenital anomalies. Cryptorchidism, defined as the absence of the testis from the scrotum, is commonly diagnosed in childhood but is rare in the adult population. While the coexistence of inguinal hernia and cryptorchidism is frequently observed in children, it has been reported only rarely in adults. Adult cases of cryptorchidism are most often detected incidentally during surgical procedures performed for inguinal hernia. Testes that remain outside the scrotum for a prolonged period are associated with an increased risk of atrophy and malignant transformation, making appropriate surgical management essential. In this case report, we present an adult patient in whom an undescended testis was identified within the inguinal hernia sac and managed surgically in the same session, along with a brief review of the relevant literature.

Material and Methods: A 25-year-old male patient presented to the hospital with complaints of pain and swelling in the right groin region. He had no known comorbidities and no history of previous surgical procedures. Physical examination revealed both direct and indirect inguinal hernias palpable in the right inguinal area.

Results: Superficial ultrasonography demonstrated herniation of intra-abdominal fatty tissue and bowel loops into the inguinal canal through a 16-mm defect in the right lower quadrant during the Valsalva maneuver, with the hernia sac being reducible. No additional pathology or mass was detected. The patient underwent elective surgery, during which an indirect inguinal hernia was identified. Opening of the hernia sac revealed an atrophic undescended testis (Figure 1). Urology was consulted intraoperatively, and orchiectomy was performed. The postoperative course was uneventful, and the patient was discharged on postoperative day 2. Histopathological examination confirmed an atrophic testis.

Conclusion: Although inguinal hernia is common in adult males, the presence of an undescended testis within the hernia sac is extremely rare and is usually diagnosed intraoperatively. Adult cases of cryptorchidism are generally detected incidentally during inguinal hernia repair, and prolonged extra-scrotal location of the testis is associated with an increased risk of atrophy and malignant transformation; therefore, orchiectomy is recommended in adult patients. This case emphasizes that, although rare, cryptorchidism should be considered during inguinal hernia surgery in adult male patients and demonstrates that a multidisciplinary approach is safe and effective.

Keywords: Inguinal hernia, undescended testis, congenital anomaly, atrophic testis

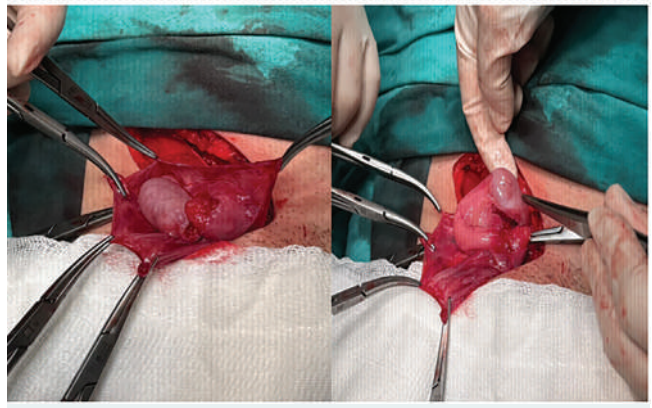

Figure 1. Intraoperative appearance of peritoneal loose bodies. During abdominal exploration, white-grey, smooth-surfaced PLBs found free around the omentum (view from the surgical field).

[P-498]

Canal of Nuck cyst detected during laparoscopic TAPP repair for presumed inguinal hernia in a female patient: A case report

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Objective: A canal of Nuck cyst is a rare condition in adult women that results from incomplete obliteration of the processus vaginalis. It may present with clinical findings similar to those of an inguinal hernia and therefore is frequently misdiagnosed or underdiagnosed. Preoperative imaging modalities are not always diagnostic, and the diagnosis is most often established based on intraoperative findings and histopathological examination.

Material and Methods: A 49-year-old female patient presented with right groin pain. Physical examination revealed tenderness in the right inguinal region. Based on the clinical findings, ultrasonographic evaluation was performed. On subsequent ultrasonography, findings consistent with a right indirect inguinal hernia were observed, while no cystic lesion or additional pathology was detected. Accordingly, the patient was scheduled for laparoscopic surgery with a prediagnosis of inguinal hernia, and a transabdominal preperitoneal (TAPP) repair of the right inguinal hernia was planned.

Results: During laparoscopic exploration, a cystic lesion containing serous fluid without bowel or omental involvement was identified in the right inguinal region. The lesion was considered intraoperatively to be consistent with a canal of Nuck cyst and was totally excised. Subsequently, the existing inguinal defect was repaired using the TAPP technique. Histopathological examination of the excised specimen revealed a cystic structure lined by flattened single-layer epithelium. Immunohistochemical analysis demonstrated positive staining for calretinin, while ERG, CD31, and p53 were negative. These findings were reported as consistent with a mesothelial cyst (canal of Nuck cyst). The postoperative course was uneventful, and the patient was discharged without complications.

Conclusion: Even in female patients in whom an inguinal hernia is identified on preoperative ultrasonography and no cystic lesion is detected, a canal of Nuck cyst may be encountered during surgical exploration. Therefore, the laparoscopic approach offers significant advantages in terms of both accurate diagnosis and simultaneous treatment.

Keywords: Canal of Nuck cyst, case report, inguinal hernia, laparoscopic surgery

[P-499]

A rare but aggressive appendix tumor: goblet cell carcinoma

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Objective: Goblet cell carcinoma is a rare primary tumor of the appendix, occurring in the sixth decade of life, with equal incidence in men and women, usually spreading to peritoneal surfaces without hematogenous metastasis. Like other primary appendix tumors, it may present with acute appendicitis and diagnosed incidentally, due to its aggressive spread, it may also be detected in the late stages. It contains both epithelial and neuroendocrine components and is classified into three subtypes based on histopathological features. It is reported that the subtype with signet ring cell differentiation has the worst survival rate. We aim to contribute to the literature with a case of goblet cell carcinoma that recurred with signet ring cell carcinoma differentiation one and a half years after diagnosis.

Material and Methods: A 45-year-old female patient with no comorbidities other than known hypertension presented in August 2023 with changes in bowel habits and right lower quadrant pain that had been present for three months. Contrast-enhanced CT scan revealed minimal dilation in the small bowel loops and no other pathological findings. Colonoscopy was reported as "Ileocaecal valve stenosis, ulcerovegetative appearance extending to the appendix," and biopsy revealed "Diffuse atypical cellular infiltration characterized by widespread intracellular mucin." Surgery was planned. Right hemicolectomy was performed in September 2023.

Results: The patient was referred to oncology after postoperative pathology report concluded "Appendix goblet cell carcinoma, T4bN2," and received 8 cycles of adjuvant oxaliplatin and capecitabine. No disease recurrence was observed for a year and a half of follow-up. In April 2025, the patient presented with abdominal swelling, imaging revealed widespread intra-abdominal ascites and peritoneal carcinomatosis (Figure 1). The patient was evaluated by our gastrointestinal oncology council, cytoreductive surgery and HIPEC were decided upon. In August 2025, our team performed anastomosis revision, omentectomy, peritonectomy, total abdominal hysterectomy and bilateral salpingo-oophorectomy, cholecystectomy, and administered 15 mg of mitomycin at a dose of 1.5 LT/m^2, prepared at 42 degrees Celsius, HIPEC infusion. Postoperative pathology report revealed "signet ring cell carcinoma metastasis and infiltration" in the anastomosis line serosa, both ovaries, uterus, cervix, gallbladder, peritoneal and omental specimens.

Conclusion: Biological behavior and clinical evaluation of goblet cell adenocarcinomas are controversial. There are cases treated with HIPEC and cytoreductive surgery in the literature, a high recurrence rate has been observed in follow-ups, intraperitoneal recurrence is the most common one. Due to its highly aggressive nature, it requires meticulous and multidisciplinary management, and sharing of clinical experiences is necessary.

Keywords: Appendix, HIPEC, goblet cell carcinoma

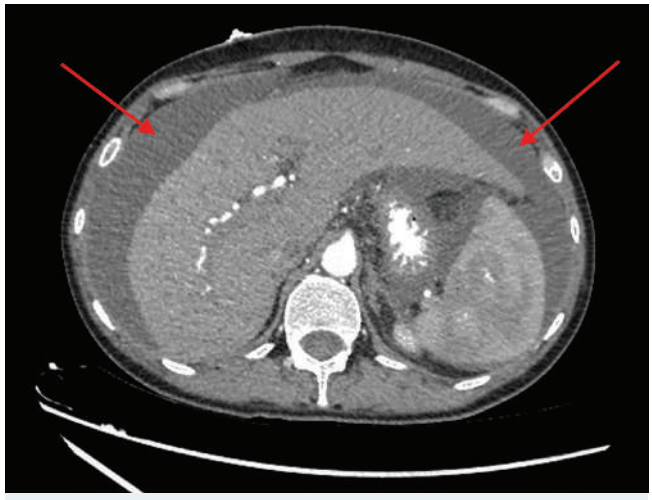

Figure 1. Intra-abdominal ascites.

[P-502]

Efficiency of nivolumab in PD-L1 positive metastatic gastric cancer: Case presentation

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Objective: Immunotherapy has recently become a new focus in the treatment of malignant tumors following surgery, chemotherapy, radiotherapy, and molecularly targeted therapy. Nivolumab, a human monoclonal antibody, is the first programmed cell death protein-1 (PD-1) inhibitor that can block the interaction of its ligand (PD-L1) restore the immune response of T-cells, and enhance the recognition of tumor cells by the immune system.

Material and Methods: PD-1 is expressed in cytotoxic T-cells and T-regulatory cells that are activated in response to inflammation or infection in peripheral tissues. Binding of programmed PD-L1 to PD-1 limits the response of T-cells to stimuli and causes immune suppression. Anti-PD-1 therapies disrupt this pathway and allow activated cytotoxic T-cells to attack cancer cells. In this case report, we aim to present a case of gastric cancer with multiple liver metastases that regressed almost completely after PD-L1 treatment, along with a review of the literature.

Results: A 68-year-old male patient with gastric cancer and multiple liver metastases was referred to our clinic from an external center. Abdominal CT scan revealed a lesion consistent with multiple metastases in the liver, the largest measuring 43×38 mm, and a mass in the gastric antrum showing local invasion of the liver. Pathology blocks showed a PD-L1 expression percentage of 70%. The patient was started on docetaxel, cisplatin, 5Fu, and nivolumab. Post-treatment follow-up showed regression of the liver lesions. The patient, who was given one course of Folfiri treatment, refused the treatment and discontinued it. Four years later, the patient presented to our clinic again with complaints of upper gastrointestinal bleeding. It was learned that the patient had received frequent blood transfusions for the past 5 months and had undergone gastric coil embolization once at an external center. A control CT scan showed that the multiple lesions in the liver responded almost completely to treatment, with only a single lesion in segment 7 showing activation. Due to the persistence of systemic disease and uncontrollable bleeding, palliative gastrectomy was performed.

Conclusion: PD-1 is expressed in activated T and B-cells in peripheral tissues in response to inflammation or infection. Binding of PD-L1 to PD-1 inactivates T-cells and limits the immune response to stimuli, leading to immunosuppression. Cancer cells enhance the immunosuppressive effect of this pathway by triggering PD-1 expression, allowing cancer to “hide” from the natural immune attack. Anti-PD-1 therapies disrupt this pathway by preventing the PD-1 ligand from binding to its receptor; thus, active cytotoxic T-cells become able to attack cancer cells.

Keywords: Immunotherapy, PD-L1, programmed cell death

[P-503]

High-risk small intestinal gastrointestinal stromal tumor with spontaneous peritoneal dissemination in the absence of tumor rupture: A rare case report

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Objective: Gastrointestinal stromal tümörler (GIST), gastrointestinal sistemin en sık görülen mezenkimal tümörleri olup biyolojik davranışları heterojendir. GIST’lerde intraabdominal yayılım çoğunlukla tümör rüptürü sonrası gelişen serbest peritoneal ekim şeklinde görülmekte ve kötü prognostik bir bulgu olarak kabul edilmektedir. Ancak rüptür bulgusu olmaksızın peritoneal ekim görülmesi nadirdir. Bu çalışmada, rüptür bulgusu olmaksızın, spontan ekim ve implantasyon gösteren yüksek riskli bir ince barsak GIST olgusunun sunulması amaçlanmıştır.

Material and Methods: Karın ağrısı şikayeti ile dış merkeze başvuran ve batın içi kitle saptanması üzerine kliniğimize refere edilen 76 yaşındaki erkek hastanın klinik, radyolojik, intraoperatif ve patolojik verileri retrospektif olarak değerlendirildi. Preoperatif kontrastlı batın bilgisayarlı tomografi görüntüleri incelendi. Cerrahi eksplorasyon sırasında elde edilen intraoperatif bulgular analiz edildi. Rezeksiyon materyallerinin histopatolojik ve immünhistokimyasal incelemeleri yapıldı.

Results: Hastanın özgeçmişinde 10 yıl önce geçirilmiş gastrointestinal sistem kanaması mevcuttu. Preoperatif görüntülemede, pelvisi ve sağ alt kadranı dolduran, yaklaşık 15 cm çapında batın içi kitle saptandı; peritoneal implant veya tümör rüptürü lehine bulgu izlenmedi. Cerrahi eksplorasyonda Treitz ligamanından 200. Cm’den köken alan, kapsülü intakt primer tümör saptandı ve kitle, köken aldığı ince barsak ansı ile birlikte en-blok rezeksiyon ile çıkarıldı. Nodüler implantların, çekum serozası, çekum mezosu ve Treitz ligamanından yaklaşık 150. cm distalinden itibaren ileoçekal bölgeye kadar uzanan ince barsak mezenterinde görüldü. Treitz ligamanının 150. cm proksimalinde implant saptanmadı. İmplantlar milimetrik boyuttan en büyüğü yaklaşık 3 cm çapa ulaşan polipoid lezyonlar şeklindeydi ve intraoperatif görüntülerle belgelendi. Primer tümörün kaynaklandığı düşünülen ince barsak ansının mezosu bölünürken mezenterik vasküler yapıda 10 yıl önce geçirilmiş GİS kanama nedenli yerleştirilen coil materyali görüldü. Postoperatif patolojide; batın içi kitle ve ince barsak mezosundan eksize edilen lezyonlar yüksek riskli GIST ile uyumlu bulundu. İmmünohistokimyasal incelemede CD117, DOG-1 ve CD34 yaygın ve güçlü pozitif, SMA, desmin, S100 ve myogenin negatif saptandı. Ki-67 proliferasyon indeksi en yoğun alanda %45-50 olarak değerlendirildi.

Conclusion: Bu olgu, GIST’lerde intraabdominal implantasyonun her zaman rüptür ve serbest peritoneal ekim ile ilişkili olmadığını göstermektedir. GİST’lerde üptür bulgusu olmaksızın intraabdominal ekim ve implantasyon görülmesi farklı yayılım mekanizmalarının varlığına işaret etmektedir. GIST olgularında, rüptür öyküsü bulunmasa dahi atipik ve lokalize intraabdominal implantasyon olasılığı göz önünde bulundurulmalıdır.

Keywords: GIST, spontaneous peritoneal implantation

Figure 1. Primary tumor.

Figure 2. Peritoneal implantation.

[P-504]

Perforated Amyand hernia in a 95-year-old male patient operated with the preoperative diagnosis of incarcerated inguinal hernia: A rare case report

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Objective: Amyand's hernia is defined as the presence of the vermiform appendix within an inguinal hernia sac and is observed in approximately 0.5-1% of all inguinal hernias. The occurrence of acute appendicitis within the hernia sac is even rarer, reported in approximately 0.07-0.13% of cases. Amyand's hernias containing perforated appendicitis are exceedingly uncommon in the literature, with an incidence of less than 0.01%. Preoperative diagnosis is often difficult, and patients are typically operated on with a preliminary diagnosis of incarcerated inguinal hernia. The surgical approach should be planned according to intraoperative findings and evaluated using the Losanoff–Basson classification.

Material and Methods: A 95-year-old male patient hospitalized in the hematology ward for myelodysplastic syndrome (MDS) was referred to our clinic with a painful swelling in the right inguinal region. He had undergone surgery for a right inguinal hernia approximately 20 years earlier. The patient reported progressive swelling in the right inguinal area for one week and severe pain during the last two days, and the previously reducible swelling had become irreducible. Laboratory investigations revealed pancytopenia (Hb: 7.7 g/dL, platelets: 23,000/mm³, leukocytes: 1,600/mm³). Physical examination demonstrated a firm, tender, irreducible mass in the right inguinal region with mild skin hyperemia. Ultrasonography showed herniated mesenteric fat and bowel loops passing through a fascial defect measuring approximately 2.5 cm. Reduction could not be achieved with probe compression, and weak vascular signals at low PRF suggested strangulation. Emergency surgery was planned, and preoperative hematologic optimization was performed with erythrocyte suspension transfusion and platelet replacement. After hemoglobin and platelet levels reached acceptable surgical ranges, the patient underwent surgery.

Results: During exploration, dense purulent fluid confined within the hernia sac and surrounded by omentum without surrounding spread was observed. The appendix was identified within the sac, and perforation was detected in its distal segment. These findings were consistent with Amyand's hernia containing perforated appendicitis (Losanoff–Basson Type 3). An appendectomy was performed, and due to contamination, mesh was avoided and primary tissue repair using the Bassini technique was preferred.

Conclusion: Although Amyand's hernia is rare, it should be considered in the differential diagnosis, particularly in patients presenting with incarcerated inguinal hernia. Preoperative imaging is often not definitive, and diagnosis is frequently established intraoperatively. In the presence of perforation, mesh repair is contraindicated because of infection risk, and primary tissue repair should be preferred. Furthermore, appropriate preoperative hematologic optimization is crucial in high-risk patients with hematologic comorbidities to reduce perioperative complications. The diagram illustrates the four types of Amyand's hernia according to the Losanoff-Basson classification. Type 1 involves a normal appendix within the hernia sac and may be managed with hernia repair with or without appendectomy. Type 2 consists of acute appendicitis within the sac and requires appendectomy with primary tissue repair. Type 3 is characterized by perforated appendicitis with peritonitis or sepsis and should be treated with appendectomy and primary repair without mesh. Type 4 describes Amyand's hernias associated with additional intra-abdominal pathology. The lower panel shows a resected perforated appendix specimen.

Keywords: Amyand's hernia, incarcerated inguinal hernia, perforated appendicitis

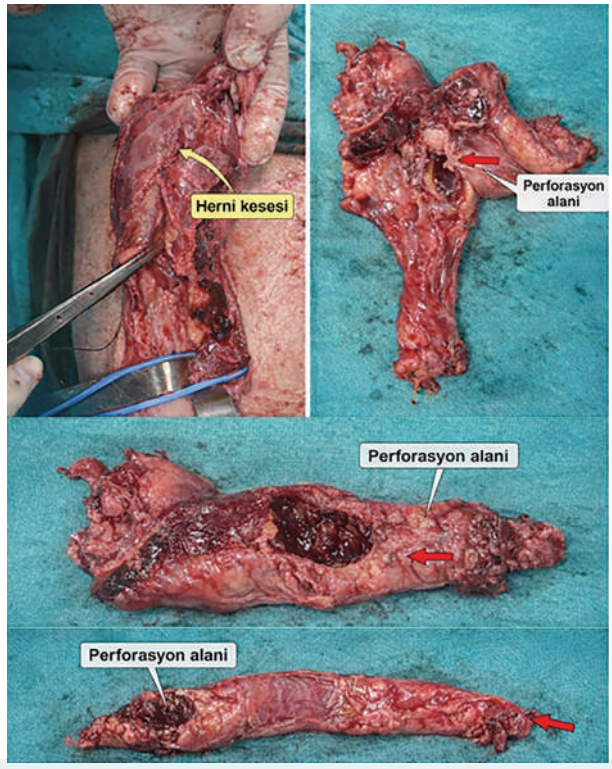

Figure 1. Intraoperative and macroscopic views of Amyand's hernia specimen. (A) Intraoperative view of the appendix located within the hernia sac; the yellow arrow indicates the hernia sac. (B) Resected specimen showing the perforation site marked with a red arrow. (C) Gross specimen demonstrating a perforation localized to the distal segment of the appendix.

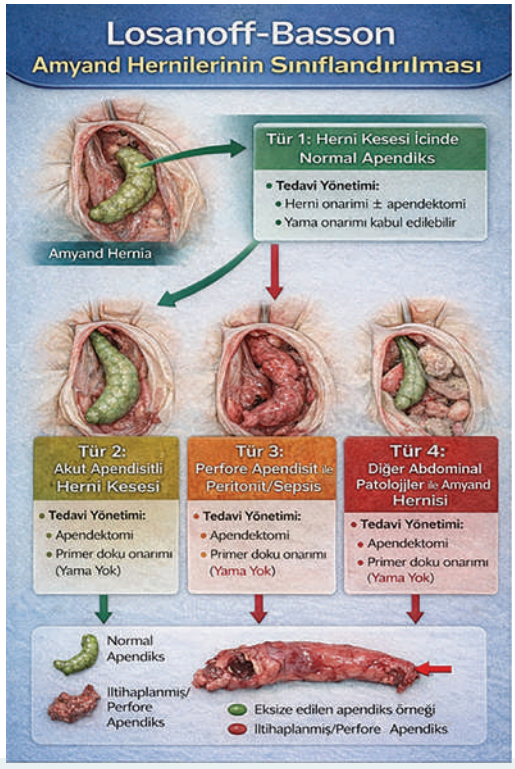

Figure 2. Losanoff–Basson classification of Amyand's hernias and recommended surgical management.

[P-511]

Unexpected diagnosis of gastric AA-type secondary amyloidosis in a patient undergoing distal gastrectomy for suspected gastric cancer: A case report

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Objective: A portion of gastric tumors occur not as primary adenocarcinomas but as secondary manifestations of systemic diseases or metastases from distant neoplasms. These cases may closely resemble primary gastric malignancies on endoscopic and radiologic evaluation, making histopathological and immunohistochemical confirmation essential. Among patients presenting with upper gastrointestinal bleeding, common causes include peptic ulcer disease, gastric cancer, and varices; rarely, gastric amyloidosis caused by amyloid deposition in the gastric wall may be responsible. Secondary (AA-type) amyloidosis develops in the context of chronic inflammatory or infectious diseases and can cause ulceration and bleeding due to amorphous protein deposits in the mucosa and submucosa. Reports of gastric amyloidosis mimicking gastric carcinoma are rare.

Material and Methods: This study presents a single case. The diagnostic workup included upper gastrointestinal endoscopy with biopsy and colonoscopy, followed by contrast-enhanced abdominal CT to assess gastric involvement. Because of uncontrolled bleeding and hemodynamic instability, emergency open distal gastrectomy with Billroth II reconstruction and D2 lymph node dissection was performed. The specimen underwent hematoxylin-eosin, crystal violet, and Congo red staining, and the amyloid type was determined immunohistochemically.

Results: A male patient in his seventies with a history of chronic kidney disease and chronic cardiac disease presented with melena. Upper gastrointestinal endoscopy revealed an ulcerovegetative mass in the gastric antrum, and biopsies were reported as gastritis. Colonoscopy showed no pathological findings. Computed tomography demonstrated irregular transmural wall thickening in the gastric antrum, which was interpreted in favor of primary gastric cancer. Histopathological examination of the gastrectomy specimen revealed dense eosinophilic amorphous deposits in the gastric mucosa and submucosa, with focal extension into the muscularis propria and vascular walls. Amyloid deposition was confirmed by crystal violet and Congo red staining. Immunohistochemical analysis demonstrated amyloid A positivity, establishing the diagnosis of AA-type secondary gastric amyloidosis. Postoperatively, further evaluation for the underlying etiology was planned; however, the patient died on postoperative day five due to cardiac causes, and comprehensive systemic evaluation could not be performed.

Conclusion: Gastric AA-type amyloidosis is a rare condition that may present with upper gastrointestinal bleeding and mimic gastric cancer clinically and radiologically. Awareness of this entity is crucial, as insufficient preoperative biopsy sampling may result in unnecessary extensive surgery. Careful histopathological evaluation and systemic assessment are essential when amyloid deposition is suspected.

Keywords: Gastric mass, amyloidosis, gastrointestinal bleeding

[P-512]

Delayed Meckel's diverticulum perforation and drug-induced toxic hepatitis following acute perforated appendicitis: A case report of a complication chain

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Objective: To present a case of delayed Meckel's diverticulum perforation and subsequent toxic hepatitis developing during follow-up after surgery for acute appendicitis, and to emphasize the importance of complication management.

Material and Methods: The demographic data, laboratory findings, imaging results, intraoperative findings, and postoperative clinical course of the patient who presented to the Emergency Department of Şanlıurfa Training and Research Hospital with abdominal pain and was operated on with a diagnosis of acute appendicitis based on clinical, laboratory, and radiological evaluations were retrospectively reviewed through the hospital information management system. Details of the surgical interventions, developed complications, and applied treatment approaches were recorded. The obtained data were evaluated in the context of the literature and organized in the format of a case report.

Results: A 21-year-old male patient presented with abdominal pain persisting for four days. Laboratory findings revealed leukocytosis (27,550/mm³) and markedly elevated CRP (>429 mg/L). The patient was operated on with a preliminary diagnosis of perforated appendicitis. Diffuse purulent content was observed intraoperatively, and an appendectomy was performed. A Meckel's diverticulum was identified approximately 100 cm proximal to the ileocecal valve; as it appeared macroscopically intact, no resection was performed. Although initial clinical improvement was observed in the postoperative period, a marked increase in acute phase reactants and right lower quadrant pain developed on postoperative day six. Computed tomography demonstrated a loculated collection with air-fluid levels suggestive of perforation. At reoperation, perforation was identified at the mid-segment of the Meckel's diverticulum with formation of a localized abscess. Segmental small bowel resection including the diverticulum with primary anastomosis and abscess drainage was performed. The patient showed clinical improvement. After discharge, the patient presented with right upper quadrant pain and marked elevation of transaminases (AST 895 U/L, ALT 612 U/L). Imaging findings were normal. Antibiotic and analgesic treatments were discontinued, and supportive therapy was initiated. Liver enzyme levels rapidly decreased, and the condition was interpreted as toxic hepatitis. Despite these complications, the patient was discharged in good health.

Conclusion: This case highlights the importance of intraoperative evaluation of concomitant Meckel's diverticulum in complicated appendicitis and the multidisciplinary management of postoperative surgical and medical complications.

Keywords: Meckel's diverticulum, toxic hepatitis, complicated appendicitis

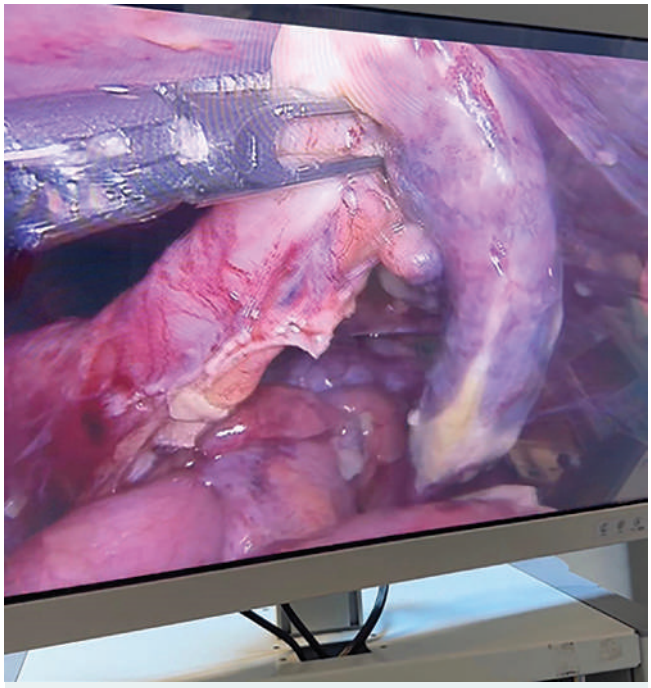

Figure 1. Appendicitis.

Figure 2. Meckel's diverticulum.

[P-513]

Application of FAST in a patient with foot ulcers due to Buerger's disease

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Objective: Buerger's disease, also known as thromboangiitis obliterans, is a segmental, non-atherosclerotic, occlusive vasculitis affecting small and medium-sized arteries and veins of the extremities, particularly prevalent in young adults. The most significant risk factor for Buerger's disease is smoking. Treatment for Buerger's disease requires a multidisciplinary approach. In cases unsuitable for revascularization and presenting with severe pain due to critical limb ischemia, neuromodulation techniques such as spinal cord stimulation have been reported to provide promising results for pain control and limb preservation.

Material and Methods: A forty-seven-year-old male patient presented with discoloration and pain in the third toe of his right foot. Approximately three years prior, he had undergone traumatic amputation of his right fourth toe, followed by the development of ulcerative lesions and persistent pain in the third toe during the post-amputation period. He reported pain with a visual analog scale (VAS) score of 9-10. Computerized tomography angiography revealed occluded bilateral tibialis anterior and posterior arteries. In accordance with these findings, medical treatment was initiated for circulatory palliation and pain control, and interventional angio procedures were performed. After failing to benefit from medical treatment and interventional angio procedures, the patient was consulted to the algology clinic. A lumbar sympathetic block was performed for pain palliation and to enhance circulation. Although a temporary reduction in pain was achieved after the procedure, the pain recurred within two days. Subsequently, it was decided to apply spinal cord stimulation (SCS) for the patient. The patient's VAS scores were assessed before permanent implantation and 15 minutes after electrode placement. The implants used were narrow-spaced (31 mm) 8-contact and wide-spaced (52 mm) 8-contact electrode systems. During electrode placement, paresthesia was achieved to cover the patient's painful areas. Following paresthesia optimization, the fast-acting sub-perception therapy (FAST) program was activated, and the perception threshold was reduced by approximately 70% (pulse width: 280–320 µs, frequency: 90 Hz).

Results: The patient, who showed a significant reduction in VAS scores during the procedure, continued to use the FAST program. At 24 hours postoperatively, the VAS score was recorded as 2. In our four-month follow-up, the VAS score remained at 0-1, and an increase in wound healing rate was observed.

Conclusion: Despite many treatment methods, the FAST program is one of the effective and current methods that can be preferred for pain palliation and wound healing support, alongside interventional and medical treatment, in Buerger's disease patients with severe pain that cannot be controlled.

Keywords: Buerger's disease, spinal cord stimulation, fast-acting sub-perception therapy (FAST)

[P-514]

Morgagni hernia in adulthood: Case report

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Objective: Morgagni hernia is a rare congenital defect located in the anterior-retrosternal portion of the diaphragm and is infrequently diagnosed in adulthood. Due to its nonspecific clinical presentation, diagnosis may be delayed. In this case report, we aimed to present the diagnostic process and laparoscopic surgical management of Morgagni hernia in an adult patient presenting with long-standing respiratory symptoms.

Material and Methods: Clinical, radiological, and surgical data of a 52-year-old male patient who presented with dyspnea and chest pain were retrospectively evaluated. Posterior-anterior chest radiography and thoracic computed tomography findings were reviewed. The surgical approach, intraoperative findings, and postoperative follow-up outcomes were analyzed.

Results: Laboratory findings were within normal limits. Posterior-anterior chest radiography revealed a suspicious mass or consolidation in the right lower lung zone. Thoracic computed tomography demonstrated herniation of a colonic segment into the thoracic cavity through a wide defect in the right diaphragm. Preoperative respiratory exercises and medical treatment were administered. The patient underwent laparoscopic surgery. Intraoperatively, a diaphragmatic defect measuring approximately 6×7 cm was identified on the right side, containing herniated omentum and colon. The herniated organs were reduced into the abdominal cavity. The defect was repaired primarily and reinforced with a dual mesh to reduce the risk of recurrence. No postoperative complications were observed. The patient was discharged on the fourth postoperative day. At the 12th-day and one-month follow-up visits, the patient's respiratory symptoms had completely resolved.

Conclusion: Although Morgagni hernia is rare in adults, it should be considered in the differential diagnosis of patients presenting with long-standing and unexplained respiratory symptoms. Computed tomography is the main diagnostic modality. Laparoscopic repair is a safe and effective treatment option with low morbidity, short hospital stay, and improved patient comfort.

Keywords: Adult, diaphragmatic hernia, Morgagni's hernia

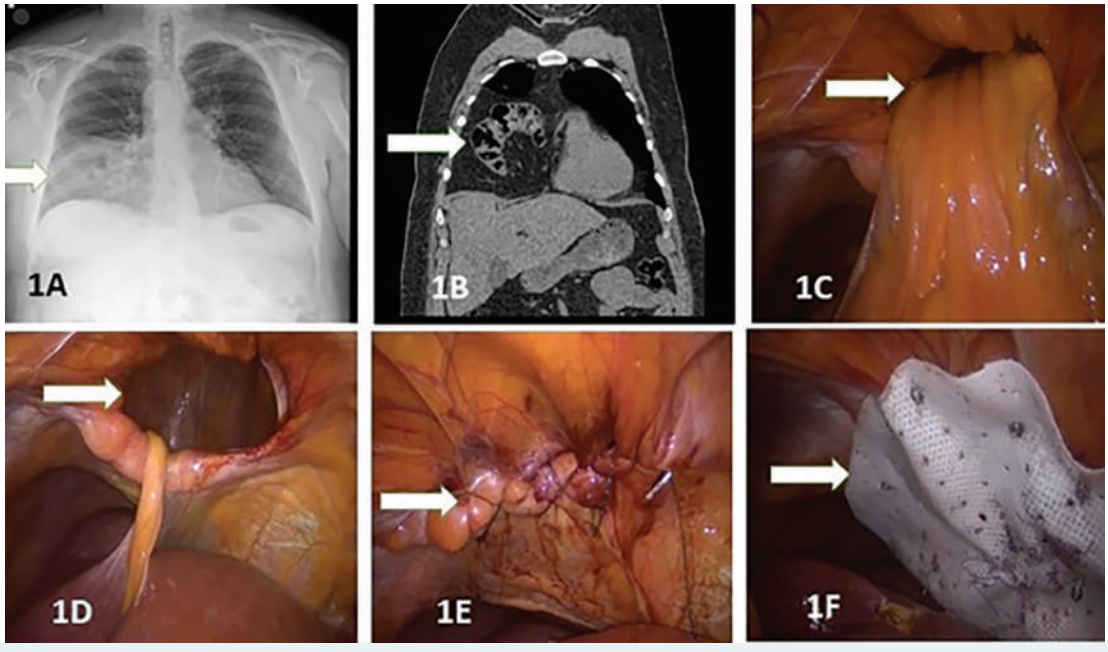

Figure 1. Radiological and intraoperative images. (A) Posterior–anterior chest radiograph showing an opacity in the right lower lung zone suspicious for a mass or consolidation; (B) thoracic computed tomography demonstrating herniation of a colonic segment into the thoracic cavity through a right diaphragmatic defect; (C) intraoperative laparoscopic view showing the diaphragmatic defect and herniated omentum; (D) reduction of the herniated omentum and colon into the abdominal cavity; (E) primary suturing of the diaphragmatic defect; (F) final view after reinforcement of the diaphragmatic repair with dual mesh.

[P-517]

Nuck canal cyst in women: A multicenter approach to the diagnostic and surgical management of a rare pathology

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Objective: Nuck canal cyst is a rare congenital anomaly resulting from incomplete obliteration of the processus vaginalis during embryologic development in women. Clinically, it presents as painful or painless inguinal swelling and is frequently misdiagnosed as indirect inguinal hernia, lymphadenopathy, lipoma, or round ligament endometriosis. This study aimed to retrospectively evaluate adult female patients diagnosed and surgically treated at three centers, focusing on diagnostic challenges, radiologic features, and surgical outcomes of Nuck's canal cysts.

Material and Methods: Five adult female patients diagnosed with Nuck's canal cyst and treated surgically in three general surgery centers between 2023 and 2025 were retrospectively analyzed. The mean age was 41.6 years (range: 36-51). Four patients had right-sided and one had left-sided involvement. All patients presented with a palpable inguinal mass. Ultrasonography was used as the initial imaging modality in all cases, while magnetic resonance imaging was performed in one patient to better define anatomical extension. All patients underwent complete cyst excision via open surgery, with simultaneous inguinal reinforcement using Lichtenstein or mesh plug repair.

Results: Radiologic evaluation revealed well-circumscribed, thin-walled, anechoic cystic lesions measuring 3-6 cm in diameter in the inguinal region. Histopathological examination confirmed the diagnosis of Nuck's canal cyst in all cases. No early or late postoperative complications, seroma formation, or recurrence were observed during a mean follow-up period of 8 months. The demographic characteristics, side predominance, radiologic findings, and surgical management were consistent with the largest adult case series reported in the literature, particularly those by Prodromidou et al. and Kohlhauser and Pirsch. All cases involved adult women, with right-sided involvement in three and left-sided involvement in one. The most common reason for presentation was painless swelling in the groin area. All patients were treated with open surgery, and no postoperative complications or recurrence were observed.

Conclusion: Although rare, Nuck's canal cyst should be considered in the differential diagnosis of inguinal masses in adult female patients. Ultrasonography is a practical and accessible first-line diagnostic tool, while MRI provides additional value in assessing lesion extent and identifying associated hernia components. Surgical excision is a safe and definitive treatment with excellent outcomes. This multicenter experience contributes to the limited literature on adult cases and highlights the importance of clinician awareness to ensure accurate diagnosis, appropriate surgical planning, and avoidance of unnecessary extensive procedures.

Keywords: Nuck's canal cyst, female, inguinal cyst, diagnostic difficulty, ultrasonography, magnetic resonance imaging, surgical excision, Lichtenstein repair, multicenter study

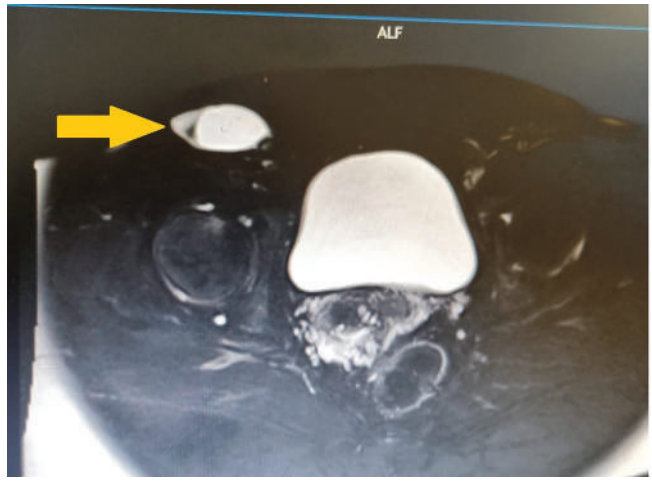

Figure 1. MRI image. Marked area femoral Nuck canal cyst.
MRI: Magnetic resonance imaging.

Figure 2. Intraoperative appearance of the cyst.

Table 1. Nuck duct cysts in women: comparative review with the literature

Source	Number of cases	Age (average or range)	Bias (right/left)	Imaging methods used	Accompanying Hernia	Surgical approach	Repair method applied	Recurrence or complication status
The current work (this series)	5	41.6 (36-51)	4/1	Resonance imaging was added in one case.	1 case of indirect inguinal hernia	Open surgery in all cases.	Lichtenstein repair in all cases.	No recurrence or complications were observed in any patient.
Prodromidou et al., 2020	16	35.1 (±3.2)	13/3	Ultrasonography (6 cases), computed tomography (3 cases), magnetic resonance imaging (6 cases)	Hernia was associated with 5 cases.	13 cases underwent open surgery, and 3 cases underwent laparoscopic surgery.	Simultaneous hernia repair in 5 cases.	No recurrence or complications were reported.
Kohlhauser and Pirsch, 2022	1 (case report) + review	38 (single case)	Right side	Ultrasonography and magnetic resonance imaging	Not reported	Open surgery	Closing the channel	No recurrence reported.
Venkateswaran et al., 2024	20	27.8±8.3	Not reported	Ultrasonography and magnetic resonance imaging	Hernia association in 11 cases (55%).	10 cases were treated with transabdominal preperitoneal (laparoscopic) surgery, and 10 cases with open surgery.	Patch repair according to the approach.	No recurrence reported.
Adhikari et al., 2023	5	Not reported	Not reported	Ultrasonography, and in some cases magnetic resonance imaging may be used in addition.	Not reported	Open surgery	Not reported	No recurrence or complications were reported.
Keeratib harat et al., 2022	Compilation	Not reported	Not reported	Ultrasonography is the primary diagnostic tool, while magnetic resonance imaging provides additional diagnostic benefits.	Not reported	Both open and laparoscopic approaches have been reported.	Not reported	Not reported

Table 2. Clinical features and surgical findings of Nuck canal cyst cases

Cases	Age (years)	Side	Application complaint	Imaging method	Cyst size (cm)	Accompanying hernia	Surgical approach/ repair	Postoperative condition
Case 1	36	Right	Painless groin swelling	USG	3.0	None	Open excision + Lichtenstein	Smooth recovery
Case 2	40	Right	Painful groin swelling	USG	4.5	Right indirect hernia	Open excision + Lichtenstein	No recurrence/complications.
Case 3	43	Left	Painless femoral swelling	USG	5.0	None	Open excision + Mesh plug	Smooth recovery
Case 4	51	Right	Painful groin swelling	USG + MRI	6.0	None	Open excision + Lichtenstein + Mesh plug	No recurrence/complications.
Case 5	38	Right	Painless femoral swelling	USG	3	None	Open excision + Mesh plug	No recurrence/complications.

[P-518]

Intraductal carcinoma arising from the epithelial component of a fibroadenoma as a rare breast tumor

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Objective: Fibroadenomas are the most common benign solid tumors of the breast and are usually observed in younger age groups. These lesions consist of epithelial and stromal components, and epithelial atypia or malignant transformation within a fibroadenoma is extremely rare. The development of ductal carcinoma *in situ* (DCIS) within a fibroadenoma has been reported in less than 1% of cases in the literature. In this case report, we present a rare case of DCIS arising from the epithelial component of a fibroadenoma.

Material and Methods: Clinical and pathological data of a patient who underwent surgery at our center were retrospectively evaluated.

Results: A 27-year-old woman with a family history of breast cancer presented with a progressively enlarging painless mass in the right breast. Following physical examination and imaging studies, the lesion was classified as BI-RADS 4A, and a tru-cut biopsy was performed (Figure 1). Ultrasonographic image of the right breast showing an isoechoic solid lesion measuring 15×7×18 mm, located 3 cm from the nipple at the 11 o'clock position, with its long axis parallel to the skin, focal contour irregularities, microlobulations, and no vascular signal on color Doppler imaging. Due to the detection of epithelial atypia on pathological examination, an excisional biopsy was performed. The surgical specimen was evaluated histopathologically and immunohistochemically. Histopathological examination revealed low-grade, solid-type DCIS arising in a background of fibroadenoma. Immunohistochemical analysis demonstrated diffuse estrogen receptorpositivity and loss of CK5/6 staining, while myoepithelial cells were preserved with calponin and p63 staining (Figure 2). Surgical margins were negative. Following discussion at the multidisciplinary oncology council, adjuvant radiotherapy and tamoxifen therapy for five years were planned. No residual or recurrent disease was detected during follow-up.

Conclusion: Since fibroadenomas are typically observed in younger patients, the possibility of malignancy should always be considered in older patients presenting with presumed fibroadenomas. Given the impracticality of examining every fibroadenoma and the potential associated morbidity, this issue raises important questions regarding breast cancer surveillance in women with multiple fibroadenomas. Tru-cut biopsies often fail to sample the entire lesion, and the increasing reliance on core needle biopsy for the diagnosis of fibroadenomas should raise awareness of the risk of overlooking epithelial atypia. Patients with microcalcifications on imaging, a positive family history, BI-RADS 4 lesions, and atypia on biopsy—as in our case—should be considered high risk, and excisional biopsy should be recommended rather than relying solely on tru-cut biopsy.

Keywords: Fibroadenoma, Ductal carcinoma *in situ*, tru-cut biopsy

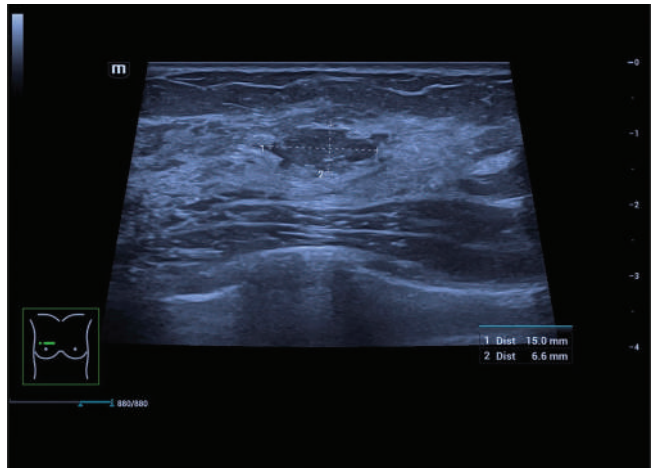

Figure 1. Ultrasonographic image of the right breast showing an isoechoic solid lesion measuring 15×7×18 mm, located 3 cm from the nipple at the 11 o'clock position, with its long axis parallel to the skin, focal contour irregularities, microlobulations, and no vascular signal on color Doppler imaging.

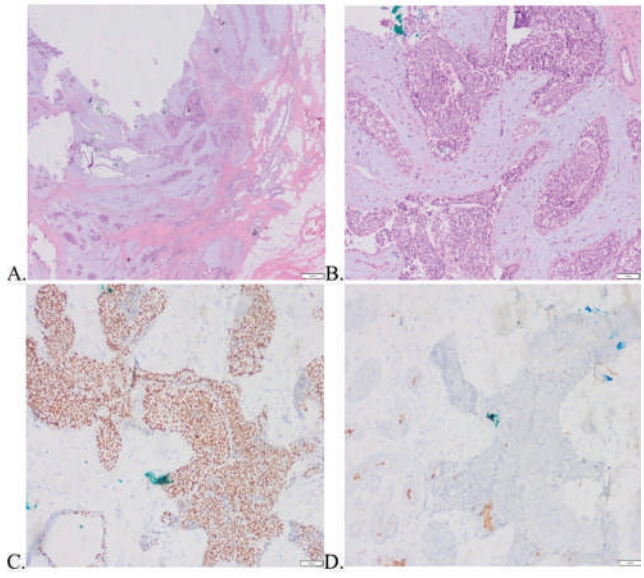

Figure 2. A: Fibroadenoma composed of stromal and glandular components. B: Intraductal carcinoma showing a monomorphic appearance with solid growth pattern, completely filling the ductal lumen in the epithelial component (H&E, ×10). C: Diffuse and strong immunohistochemical expression of estrogen receptor (ER) in the intraductal carcinoma area (×10). D: Loss of immunohistochemical CK5/6 expression in myoepithelial cells within the intraductal carcinoma area (×10).

[P-519]

Isolated colonic metastasis developing five years after primary cutaneous malignant melanoma

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Objective: Malignant melanoma is an aggressive malignancy that can metastasize to regional lymph nodes in the early period and exhibits an unpredictable metastatic pattern in advanced stages. Gastrointestinal system metastases are clinically detected rarely, and colonic involvement is reported to be extremely uncommon. In this study, a rare case of isolated colonic metastasis developing approximately five years after the diagnosis of primary cutaneous malignant melanoma is presented. Although lymph nodes, lungs, liver and brain are the most common metastatic sites, the gastrointestinal tract is an important and often overlooked target, with postmortem involvement reported in 50-60% of advanced cases, while clinically symptomatic disease is uncommon. Gastrointestinal involvement most frequently affects the small intestine, whereas colonic metastases are rare and usually present with obstruction, bleeding or anemia, leading to diagnosis at advanced stages. Rarely, isolated asymptomatic colonic metastases are detected incidentally. This case report highlights the diagnostic and clinical features of colonic metastases of melanoma.

Material and Methods: Five years after wide excision with grafting and axillary dissection for stage III malignant melanoma of the volar right wrist (Figure 1), a 56-year-old man receiving adjuvant dabrafenib + trametinib showed increased metabolic activity in the appendix, cecum and ascending colon on follow-up ^{18}F-FDG PET/CT (Figure 2). Colonoscopy revealed two polypoid masses at 130 cm in the hepatic flexure and a polyp in the transverse colon (Figure 3), and biopsies demonstrated colonic mucosa infiltrated by malignant melanoma. The patient was diagnosed with isolated colonic metastasis and underwent right hemicolectomy. Pathology showed ulcerated polypoid malignant melanoma with biphenotypic morphology, melanoma infiltration of the appendix, and 0/15 tumor-free regional lymph nodes (Figure 4). The tumor was present as three polypoid foci limited to the mucosa and submucosa, with sparing of the muscularis propria, subserosa and serosa. No postoperative complications occurred, and follow-up ^{18}F-FDG PET/CT confirmed removal of all metabolically active lesions.

Results: Gastrointestinal metastases of malignant melanoma reflect the aggressive nature of the disease, and colonic metastases are diagnostically challenging because of their rarity and often asymptomatic or nonspecific presentation. In patients with a history of melanoma, late-detected colonic lesions should raise suspicion for metastasis. Although CT, PET-CT and colonoscopy are useful, definitive diagnosis is based on histopathological and immunohistochemical evaluation. In isolated organ metastasis, surgical treatment may provide a survival benefit, while immunotherapy requires careful patient selection because of gastrointestinal adverse effects.

Conclusion: In conclusion, metastatic disease should be considered in atypical colonic lesions in melanoma patients, and a multidisciplinary approach is essential.

Keywords: Malignant melanoma, colonic metastasis

Figure 1. a) Malignant melanoma on the right forearm b) Grafted appearance after wide excision c) Conglomerated axillary lymphadenopathy package.

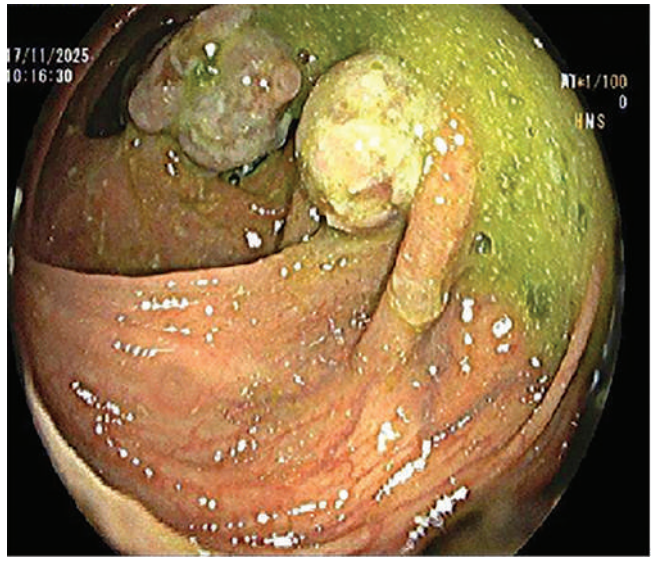

Figure 2. Polypoid-appearing malignant melanoma metastases detected at colonoscopy.

[P-522]

A breath-restricting mass: Mesenteric desmoid tumor

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Objective: Desmoid tumors (aggressive fibromatosis) are rare fibroblastic/myofibroblastic neoplasms characterized by the absence of metastatic potential but a tendency for locally invasive behavior. Their annual incidence is approximately 2-4 per million, accounting for nearly 3% of all soft tissue tumors.Intra-abdominal lesions most commonly originate from the mesentery and are more frequently observed in young women. Imaging findings are non-specific and may mimic mesenteric cysts, gastrointestinal stromal tumors, or other benign lesions

Material and Methods: A 19-year-old female presented with left-sided thoracic pain and difficulty during inspiration. Thoracic CT revealed mild pleural effusion. As symptoms persisted despite drainage, abdominal CT and ultrasonography were performed. Due to progressive pain, the patient underwent surgery. The mesenteric mass was completely excised with negative surgical margins (R0 resection). The diagnosis was confirmed by histopathological and immunohistochemical examination.

Results: Abdominal CT demonstrated a well-circumscribed cystic lesion in the left upper quadrant. Ultrasonography revealed a heterogeneous, mildly vascularized solid mesenteric mass measuring approximately 7 cm. Histopathological analysis confirmed a desmoid tumor (aggressive fibromatosis) with nuclear β-catenin positivity. Postoperatively, the patient's symptoms resolved. Following multidisciplinary evaluation, active surveillance was recommended. No recurrence was detected during follow-up.

Conclusion: Although desmoid tumors exhibit benign histology, they demonstrate locally aggressive behavior, with reported local recurrence rates ranging from 20% to 40%. Mutations in β-catenin (CTNNB1) play a significant role in their pathogenesis. Current guidelines recommend an initial active surveillance strategy for asymptomatic or stable patients. However, surgery remains an appropriate treatment option in symptomatic, progressive, or organ-compressing cases. Achieving negative surgical margins reduces recurrence risk, although the prognostic impact of microscopically positive margins remains controversial. In the present case, atypical thoracic onset symptoms and the initial cystic appearance on imaging were potential factors that could delay diagnosis. Due to symptomatic mesenteric involvement and progressive pain, surgical intervention was preferred. Following R0 resection, no adjuvant treatment was required. This approach is consistent with current literature. Desmoid tumors should be considered in the differential diagnosis of chronic abdominal pain and abdominal mass in young women. Imaging findings may be misleading; definitive diagnosis relies on histopathological examination. In symptomatic mesenteric cases, R0 resection represents an effective treatment option.

Keywords: Desmoid tumor,mesenteric mass, surgical resection

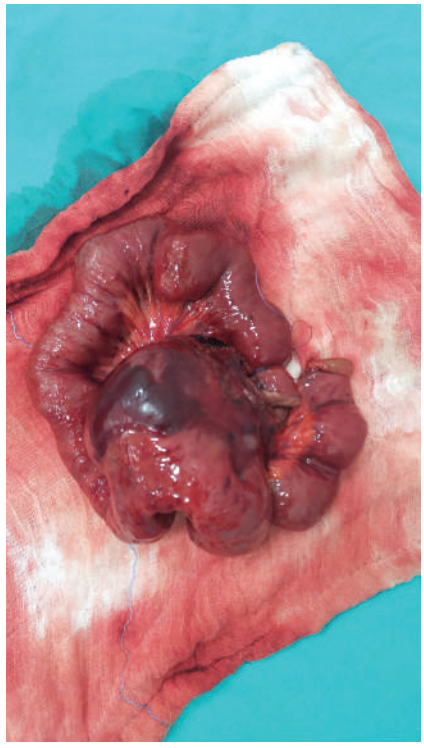

Figure 1. Desmoid tumor; A 10 cm mass was identified, filling the mesentery of an approximately 50 cm intestinal segment beginning 10 cm distal to the ligament of Treitz, with focal invasion of the small bowel serosa.

[P-523]

Surgical approach in an alkali cement burn with delayed presentation: A case report

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Objective: This study aimed to present a case of chemical burn caused by exposure to wet cement that required surgical treatment due to delayed presentation, and to discuss the clinical characteristics of cement burns. Although chemical burns are less common than thermal burns, they represent an important clinical problem because their alkaline nature can lead to deep and progressive tissue damage. Wet cement forms a highly alkaline environment as a result of the hydration of the calcium oxides it contains, causing liquefaction necrosis and allowing the injury to progress for hours or even days.

Material and Methods: The presented case was a 54-year-old male who initially received conservative treatment at an outside medical center for wounds that developed after both lower extremities remained in wet cement for approximately one hour during construction work. However, due to the lack of healing over a period of about 40 days, he was referred to our burn unit. Upon evaluation, the total burn surface area was calculated as 8% and was consistent with deep dermal burns.

Results: Following hospitalization, nutritional support was provided, and regular wound cleansing along with autolytic debridement was performed. Due to the presence of chronic inflammation in the wound bed and insufficient epithelialization, tangential excision and skin grafting were carried out on the 9th day of admission. The postoperative course was uneventful, with satisfactory graft take observed, and the patient was discharged with recommendations for appropriate wound care and moisturizing therapy. No additional complications developed during follow-up.

Conclusion: Cement burns are often recognized late because they typically present with a painless onset, and in many cases this leads to the need for surgical intervention. Early recognition of exposure, prompt irrigation with copious amounts of water, removal of contaminated clothing, and appropriate wound management are the key factors determining prognosis. This case highlights the importance of increasing awareness among individuals at occupational risk and demonstrates the critical role of timely treatment in reducing morbidity.

Keywords: Alkali burn, chemical burn, tangential excision and skin grafting

Figure 1. Burn areas at hospital presentation; the burn areas at the patient's presentation to our unit are shown in the attached image.

Figure 2. Postoperative burn areas; the burn areas on postoperative day 7 are shown in the attached image.

[P-527]

Radiation-induced partial liver injury following right breast radiotherapy: A rare case presenting as hepatic metastasis

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Objective: Breast cancer is the most common malignancy among women worldwide and requires a multidisciplinary treatment approach including surgery, systemic therapy, and radiotherapy. While radiotherapy-related toxicities most commonly affect the skin and soft tissues, adjacent organs may also be exposed to unintended radiation. Although the liver is generally considered a low-risk organ in right breast radiotherapy, especially in lower quadrant tumors and tangential field techniques, liver segments IV-VIII may receive low-to-moderate radiation doses. Partial radiation-induced liver disease (RILD) is a rare but clinically misleading condition that may mimic hepatic metastasis.

Material and Methods: Case report.

Results: A 50-year-old premenopausal woman with pT1cN0, ER (+), PR (+), HER2 (–), Ki-67 60% pleomorphic invasive lobular carcinoma underwent: •Oncoplastic breast-conserving surgery •Sentinel lymph node biopsy •4 cycles of TC chemotherapy •Adjuvant radiotherapy: 50 Gy/25 fractions to the right breast •16 Gy boost to the tumor bedTwo weeks after completion of radiotherapy, the patient presented with right upper quadrant pain. Imaging and laboratory findingsct scan: a newly developed 68×18 mm hypodense lesion adjacent to liver segments IV-VIII (suspicious for metastasis). PET-CT: SUV_{max}: 3.73 (mild-to-moderate FDG uptake). Liver biopsy: •Inflammatory cell infiltration •Young fibrous tissue •No evidence of malignancy. Notably, liver function tests (AST, ALT, ALP, bilirubin) remained within normal limits throughout the entire course.

Conclusion: Radiation-induced liver injury is primarily dose-volume dependent and may present as: •Segmental hypodense lesions •Mild FDG uptake on PET •Early onset (2 weeks to 4 months post-RT) •Clinical symptoms without significant laboratory abnormalitiesIn this case: ✔Lesion localized adjacent to the radiotherapy field ✔ Onset at the 2nd week post-RT ✔Mild SUV uptake ✔Normal liver enzymes ✔Negative biopsy for malignancy. These findings strongly support radiation-induced partial liver injury rather than metastatic disease. Importantly, the absence of elevated liver enzymes differentiates this case from classic RILD and highlights the diagnostic difficulty. Newly detected hepatic lesions after right breast radiotherapy should not be immediately considered metastatic. Radiation-induced partial liver injury must be included in the differential diagnosis, particularly when: •The lesion is adjacent to the radiation field •Symptoms develop early after RT •FDG uptake is mild •Liver enzymes are normal. Awareness of this entity may prevent unnecessary systemic treatment and invasive interventions.

Keywords: Breast cancer, radiotherapy, liver injury following radiotherapy

[P-547]

Isolated colonic metastasis developing five years after primary cutaneous malignant melanoma

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Objective: Malignant melanoma is an aggressive malignancy that can metastasize to regional lymph nodes in the early period and exhibits an unpredictable metastatic pattern in advanced stages. Gastrointestinal system metastases are clinically detected rarely, and colonic involvement is reported to be extremely uncommon. In this study, a rare case of isolated colonic metastasis developing approximately five years after the diagnosis of primary cutaneous malignant melanoma is presented. Although lymph nodes, lungs, liver and brain are the most common metastatic sites, the gastrointestinal tract is an important and often overlooked target, with postmortem involvement reported in 50-60% of advanced cases, while clinically symptomatic disease is uncommon. Gastrointestinal involvement most frequently affects the small intestine, whereas colonic metastases are rare and usually present with obstruction, bleeding or anemia, leading to diagnosis at advanced stages. Rarely, isolated asymptomatic colonic metastases are detected incidentally. This case report highlights the diagnostic and clinical features of colonic metastases of melanoma.

Material and Methods: Five years after wide excision with grafting and axillary dissection for stage III malignant melanoma of the volar right wrist, a 56-year-old man receiving adjuvant dabrafenib + trametinib showed increased metabolic activity in the appendix, cecum and ascending colon on follow-up 18F-FDG PET/CT. Colonoscopy revealed two polypoid masses at 130 cm in the hepatic flexure and a polyp in the transverse colon, and biopsies demonstrated colonic mucosa infiltrated by malignant melanoma. The patient was diagnosed with isolated colonic metastasis and underwent right hemicolectomy. Pathology showed ulcerated polypoid malignant melanoma with biphenotypic morphology, melanoma infiltration of the appendix, and 0/15 tumor-free regional lymph nodes. The tumor was present as three polypoid foci limited to the mucosa and submucosa, with sparing of the muscularis propria, subserosa and serosa. No postoperative complications occurred, and follow-up 18F-FDG PET/CT confirmed removal of all metabolically active lesions.

Results: Gastrointestinal metastases of malignant melanoma reflect the aggressive nature of the disease, and colonic metastases are diagnostically challenging because of their rarity and often asymptomatic or nonspecific presentation. In patients with a history of melanoma, late-detected colonic lesions should raise suspicion for metastasis.Although CT, PET-CT and colonoscopy are useful, definitive diagnosis is based on histopathological and immunohistochemical evaluation. In isolated organ metastasis, surgical treatment may provide a survival benefit, while immunotherapy requires careful patient selection because of gastrointestinal adverse effects.

Conclusion: In conclusion, metastatic disease should be considered in atypical colonic lesions in melanoma patients, and a multidisciplinary approach is essential.

Keywords: Malignant melanoma, colonic metastasis

Figure 1. a) Malignant melanoma on the right forearm. b) Grafted appearance after wide excision. c) Conglomerated axillary lymphadenopathy package. Polypoid-appearing malignant melanoma metastases detected at colonoscopy.

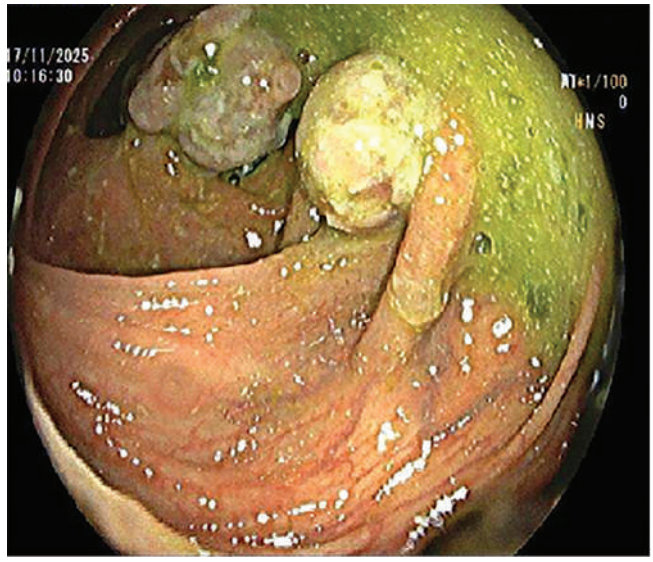

Figure 2. Polypoid-appearing malignant melanoma metastases detected at colonoscopy. Submucosal malignant melanoma of the colon.

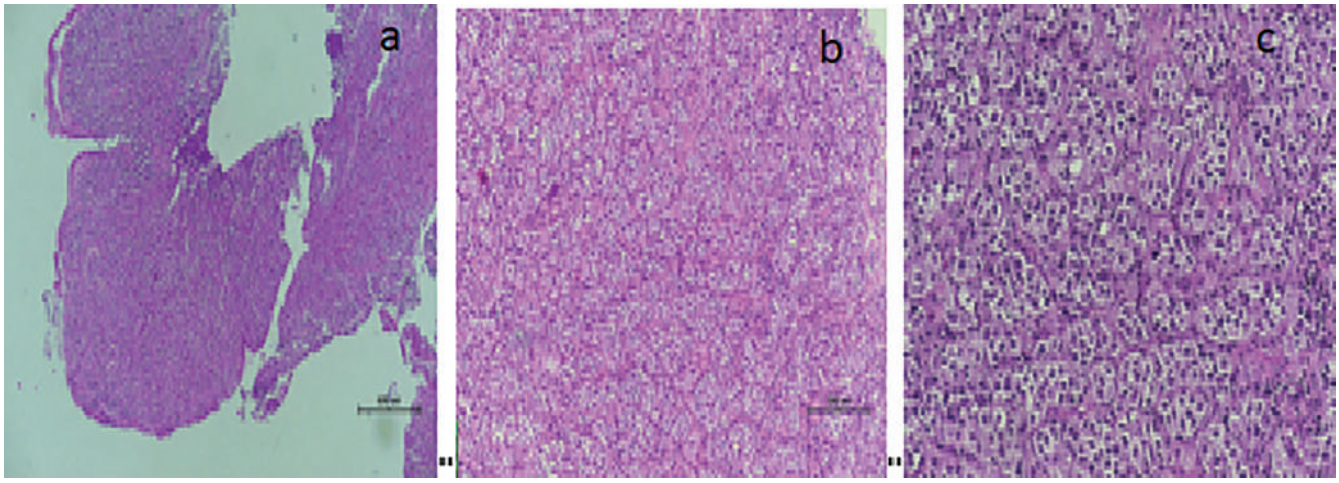

Figure 3. Submucosal malignant melanoma of the colon. a) Partial ulceration is observed in the overlying colonic mucosa, and the tumor is seen to be predominantly located in the submucosa (×4). b) Expansion of the submucosa by the tumor beneath the ulcerated mucosa is observed (×10). c) Atypical melanocytic tumor cells showing marked cytological pleomorphism (×20) (H&E).

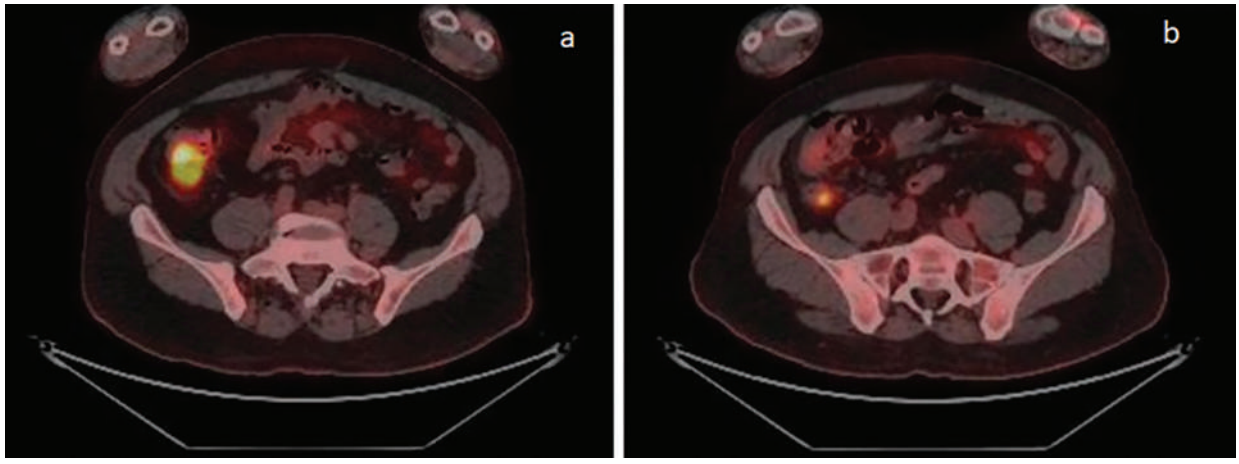

Figure 4. PET-CT. a) Involvement of the ascending colon. b) Involvement of the appendix.

[P-548]

Two cystic teratomas mimicking mesenteric cysts

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Objective: Intraabdominal and abdominopelvic masses are common in general surgical practice; however, when they reach large dimensions, they may create diagnostic uncertainty. Although cross-sectional imaging supports evaluation, the precise origin of large cystic lesions cannot always be clearly defined preoperatively. In some cases, cysts of gynecologic origin may not be recognized as ovarian and may be referred to surgical clinics with a preliminary diagnosis of mesenteric cyst. Mature cystic teratomas can similarly mimic mesenteric masses. We present two cases initially suspected to be mesenteric cysts but ultimately diagnosed as ovarian mature cystic teratomas after surgical exploration and histopathological assessment, and we outline the diagnostic and surgical management process.

Material and Methods: This retrospective single-center case series included two patients operated on for presumed intraabdominal masses and subsequently diagnosed histopathologically with mature cystic teratoma. Clinical, radiological, laboratory, and operative findings were reviewed.

Results: The first patient, a 49-year-old woman, was initially asymptomatic and presented with a large cystic mass extending to the left upper quadrant. Computed tomography showed an approximately 15 cm lesion containing fat and calcifications; CA 19-9 was elevated, whereas other tumor markers were normal. The second patient, aged 38 years, presented with abdominal pain. Imaging studies reported a 16 cm lesion interpreted as a mesenteric mass. In both cases, the exact origin of the lesion could not be definitively established preoperatively. After multidisciplinary evaluation, laparotomy was performed to obtain diagnostic clarity and exclude malignancy. Intraoperative exploration demonstrated a large cystic mass arising from the left ovary and extending from the pelvis toward the upper abdomen. Due to the potential risk of gynecologic malignancy, the gynecologic oncology team was invited intraoperatively, and the procedure continued in a multidisciplinary setting. To reduce the risk of cyst rupture and chemical peritonitis, aspiration was avoided, and the mass was removed with preservation of capsular integrity. Left salpingo-oophorectomy was performed in both patients. Frozen-section analysis indicated a benign lesion, and final histopathology confirmed mature cystic teratoma without malignant or immature components. Postoperative recovery was uneventful.

Conclusion: Giant mature cystic teratomas, despite their benign nature, may mimic mesenteric cysts when presenting as intraabdominal masses and complicate preoperative diagnosis. Multidisciplinary assessment, careful surgical planning, and intact resection are essential for safe management. Ovarian mature cystic teratoma should be considered in the differential diagnosis of large intraabdominal cystic masses in general surgical practice.

Keywords: Mesenteric cyst, mature cystic teratoma

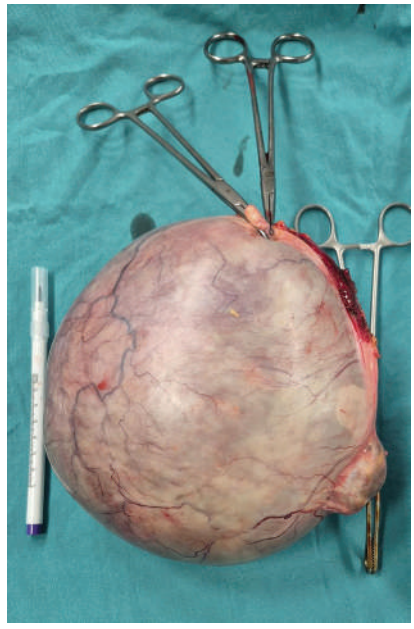

Figure 1. Intraoperative image.

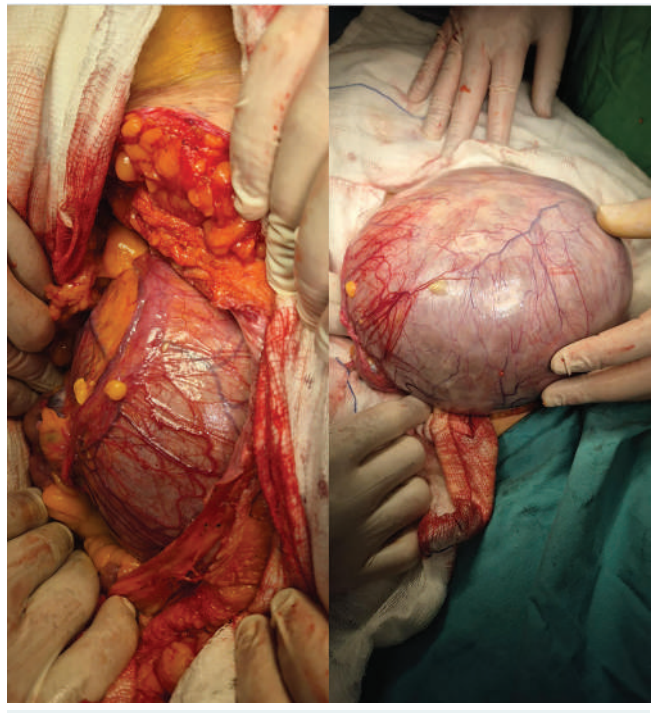

Figure 2. Intraoperative image.

[P-549]

Retroperitoneally located epidermoid cyst: A rare case report

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Objective: Primary cystic lesions arising in the retroperitoneal space independent of retroperitoneal organs are extremely rare and have been reported in limited numbers in the literature. Most of these cysts originate from congenital ectodermal remnants and are classified as epidermoid cysts. The incidence of retroperitoneal epidermoid cysts is reported to be less than 1 in 40,000, and they are most commonly located in the presacral region. Localization behind the pancreatic neck or at the root of the mesenteric vessels is considerably rarer. These lesions are usually asymptomatic; however, when symptoms occur, they are generally non-specific and related to the size, location, or complications such as hemorrhage, infection, or rupture. Radiologically, they may be confused with other retroperitoneal cystic lesions, pancreatic cystic tumors, or gynecological masses. Definitive diagnosis is established by histopathological examination.

Material and Methods: A 55-year-old female patient presented with intermittent nausea and abdominal pain for approximately 4-5 months. There were no specific aggravating or relieving factors. She had no known comorbidities, previous abdominal surgery, trauma, or history of pancreatitis. Physical examination revealed minimal tenderness in the left upper quadrant and epigastric region. Abdominal ultrasonography demonstrated a 9×5 cm multiloculated cystic mass located in the retroperitoneum. Contrast-enhanced computed tomography revealed a 57×43 mm cystic lesion extending from the pancreatic tail region toward the posterior aspect of the aorta, along with an adjacent 50×35 mm bilobulated cystic lesion. Endoscopic ultrasonography (EUS) showed a 6 cm cystic lesion adjacent to the pancreas without any solid component. The pancreatic duct was not dilated, and the pancreatic parenchyma appeared normal. Surgical excision was planned with a preliminary diagnosis of a retroperitoneal cyst.

Results: Total excision of the cyst was achieved using blunt and sharp dissection techniques. No invasive relationship with the pancreas or major vascular structures was observed intraoperatively. The postoperative course was uneventful, and the patient was discharged on postoperative day six without complications. Histopathological examination revealed a cyst wall lined by stratified squamous epithelium, with the lumen filled with keratinized material and cellular debris, accompanied by chronic inflammatory findings. These features were consistent with an epidermoid cyst.

Conclusion: Retroperitoneal epidermoid cysts are rare benign lesions that may be confused with other retroperitoneal cystic masses in the preoperative period. Imaging modalities have limited specificity. Definitive diagnosis relies on histopathological evaluation. Total surgical excision remains the most appropriate approach for both diagnosis and treatment.

Keywords: Retroperitoneal epidermoid cyst, retroperitoneal cystic mass, surgical excision

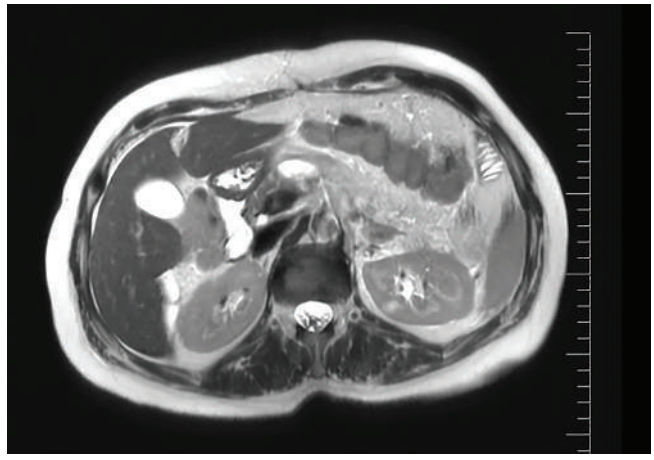

Figure 1. Magnetic resonance imaging sections. A 24×8 mm fluid-density area is present anterior to the head of the pancreas. In the tail region, a 5×3 cm fluid collection, considered secondary to prior surgery, is observed.

[P-550]

Management of a secondary perirectal abscess associated with rectal adenocarcinoma prior to neoadjuvant therapy: A transrectal internal drainage strategy

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Objective: Tumor-associated perirectal abscess formation in rectal cancer represents a rare but clinically significant complication that may delay neoadjuvant chemoradiotherapy (nCRT) and substantially increase the risk of sepsis. In such cases, opting for transrectal internal drainage rather than conventional external drainage is a crucial strategy, as it preserves oncological principles while minimizing the risk of chronic malignant fistula formation within the radiotherapy field.

Material and Methods: This case manages the clinical management of a 45-year-old female patient with rectal cancer who developed a peritumoral abscess secondary to the rectal tumor.

Results: A 45-year-old female patient presented with diarrhea and abdominal pain. Colonoscopic evaluation revealed a circumferential rectal adenocarcinoma extending from 1-1.5 cm above the anal verge to 8 cm proximally. Staging positron emission tomography-computed tomography (PET-CT) demonstrated a 47×40 mm hypermetabolic, necrotic perirectal collection adjacent to the tumor on the right lateral aspect of the rectum. As total neoadjuvant therapy (TNT) was planned, surgical intervention was undertaken to eradicate the infectious focus prior to oncological treatment. Under lithotomy position, examination using an anal retractor identified a fluctuant area at the 9 o'clock position, approximately 5 cm proximal to the anal verge, corresponding to the tumor level. A cruciate intraluminal rectal incision was performed to achieve internal drainage, resulting in evacuation of approximately 50 cc of purulent material. The abscess cavity was thoroughly irrigated with normal saline, and a drain was placed into the rectal lumen. Postoperatively, the patient was closely monitored. On postoperative day 3, a marked reduction in inflammatory markers (CRP and WBC) was observed, allowing safe drain removal and discharge. Following successful control of the infection, the patient proceeded to the planned nCRT regimen.

Conclusion: Transrectal internal drainage for tumor-associated perirectal abscesses offers high clinical efficacy by enabling rapid infection control, early normalization of inflammatory parameters, and timely initiation of TNT. By avoiding the creation of an external cutaneous opening, this approach eliminates the risks of radiation-induced dermatitis and chronic malignant fistula formation during radiotherapy, thereby serving as a safe and effective bridge to nCRT. In conclusion, transrectal internal drainage of perirectal abscesses adjacent to low rectal tumors represents a reliable surgical option with low morbidity that prevents delays in oncological management.

Keywords: Rectal cancer, perirectal abscess, transrectal drainage

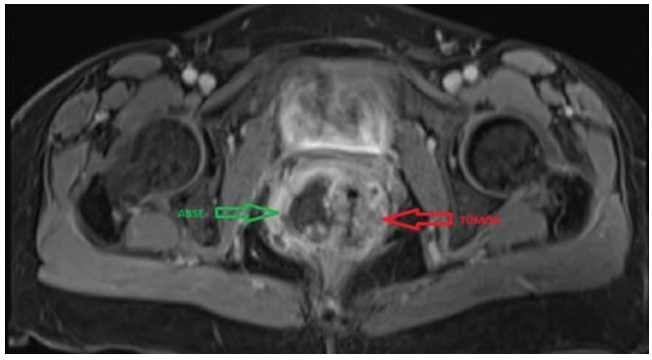

Figure 1. T1 postcontrast secans. The appearance of the abscess on the patient's MRI imaging.

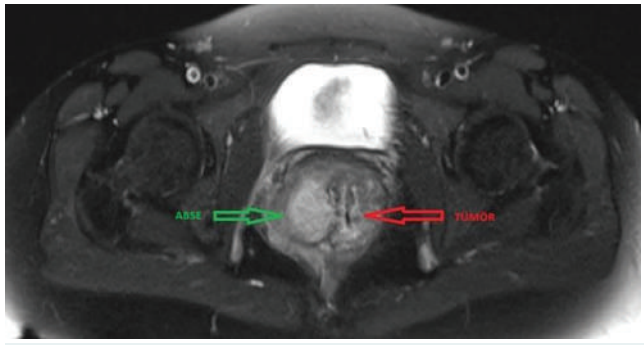

Figure 2. T2 secans. The appearance of the abscess on the patient's MRI imaging T2.

Table 1. Blood count

	Preoperative	Postoperative
WBC	12400	13300
Neutrophil (%)	83%	78%
CRP	100	40

[P-552]

Colon fistulization as a complication of ventriculo-peritoneal shunt: A rare case report and literature review

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Objective: Ventriculoperitoneal (V-P) shunting is considered one of the gold standard surgical methods in the treatment of hydrocephalus. Although complications such as infection, mechanical obstruction, and dysfunction are frequently reported in the literature, migration of the catheter into the gastrointestinal system and subsequent colon perforation are among the extremely rare but serious complications. In this report, we present a case where a V-P shunt fistulized into the rectal lumen following a sigmoid colon perforation.

Material and Methods: A 19-year-old male patient with a known history of meningomyelocele and spina bifida had previously undergone V-P shunt placement for hydrocephalus. His first shunt revision was performed in 2022 due to dysfunction. In 2024, the patient presented with the complaint of a foreign object emerging from the rectal area during defecation. Physical examination and laboratory parameters revealed no signs of acute abdomen. Computed tomography (CT) imaging identified that the shunt catheter had penetrated the sigmoid colon wall and terminated within the rectal lumen.

Results: During emergency surgical exploration, the shunt, which was found free on the anterior surface of the rectum and posterior to the bladder, was removed. In a concurrent evaluation with the neurosurgery team, the shunt identified under the fascia was tracked; it was confirmed to be fistulized to the sigmoid colon and was exteriorized via blunt dissection. The perforation site was repaired with primary sutures and covered with a small bowel mesenteric flap. The existing shunt system was converted to an external ventricular drain. Postoperatively, the patient remained clinically stable and followed a complication-free course under appropriate antibiotic therapy with cerebrospinal fluid penetration.

Conclusion: Complications of V-P shunts associated with colon perforation are exceedingly rare, accounting for 0.01-0.07% of all V-P shunt complications. The literature indicates that these complications typically manifest in the late period and may remain asymptomatic in some cases; therefore, early diagnosis is of critical importance. Successful outcomes can be achieved through surgical repair and appropriate antibiotic therapy. This case report highlights a rare but clinically significant dimension of V-P shunt complications.

Figure 1. Sagittal abdominal CT scan demonstrating the extension of the ventriculoperitoneal shunt catheter into the pelvic cavity and the localization of its distal tip within the rectosigmoid region.

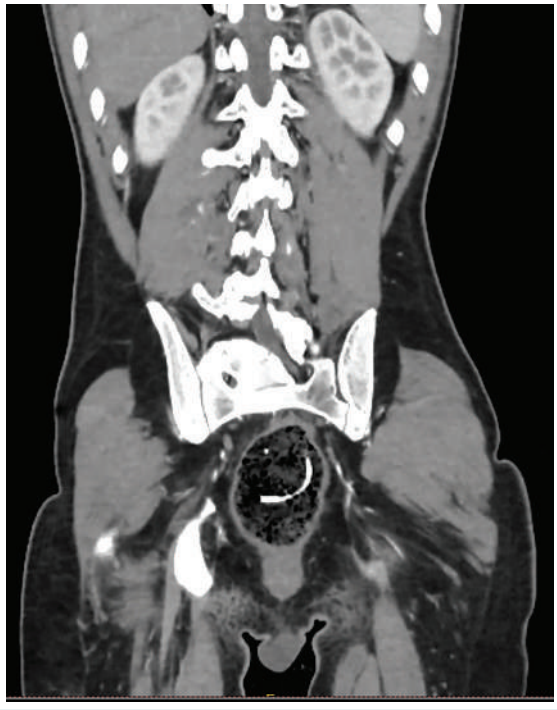

Figure 2. Coronal plane abdominal CT scan; shows the shunt catheter passing through the sigmoid colon wall and reaching the rectal area.

[P-553]

Ileocecal intussusception secondary to appendiceal mucocele: A minimally invasive surgical approach

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Objective: Intussusception is a rare clinical entity in adults, accounting for approximately 5% of all cases. Unlike pediatric cases, adult intussusception is usually secondary to an underlying organic pathology, most commonly neoplasms. Ileocecal intussusception caused by appendiceal mucocele is particularly uncommon. In this report, we present the laparoscopic management of ileocecal intussusception secondary to an appendiceal mucocele.

Material and Methods: Laparoscopic exploration revealed a mass lesion of the appendix causing ileocecal intussusception. Given the extension of the lesion to the appendiceal base and suspicion of malignancy, a laparoscopic right hemicolectomy with total mesocolic excision was performed to avoid the risk of reoperation. The ileocolic side-to-side anastomosis was constructed extracorporeally. The postoperative course was uneventful, and the patient was discharged on postoperative day five. Final histopathological examination confirmed appendiceal mucocele without evidence of malignancy. In the literature, this rare condition is most commonly managed by open surgical approaches.

Results: A 36-year-old female presented with a 2-3-day history of right lower quadrant abdominal pain, nausea, and loss of appetite. She had no vomiting and maintained active bowel movements and flatus passage. Physical examination revealed tenderness in the right lower quadrant. Laboratory findings showed no leukocytosis, while C-reactive protein was mildly elevated. Contrast-enhanced abdominal computed tomography demonstrated an approximately 6 cm invaginated segment in the ileocecal region. As there were no signs of peritonitis at admission, initial conservative observation was undertaken. However, due to the development of rebound tenderness, an increase in acute phase reactants, and persistent intussusception on follow-up imaging, surgical intervention was indicated.

Conclusion: Although rare, ileocecal intussusception in adults is frequently associated with an underlying organic lesion. Appendiceal mucocele should be considered in the differential diagnosis. In selected patients, laparoscopic management is a safe and effective alternative, providing the advantages of minimally invasive surgery.

Keywords: Intussusception, appendiceal mucocele, minimally invasive surgery

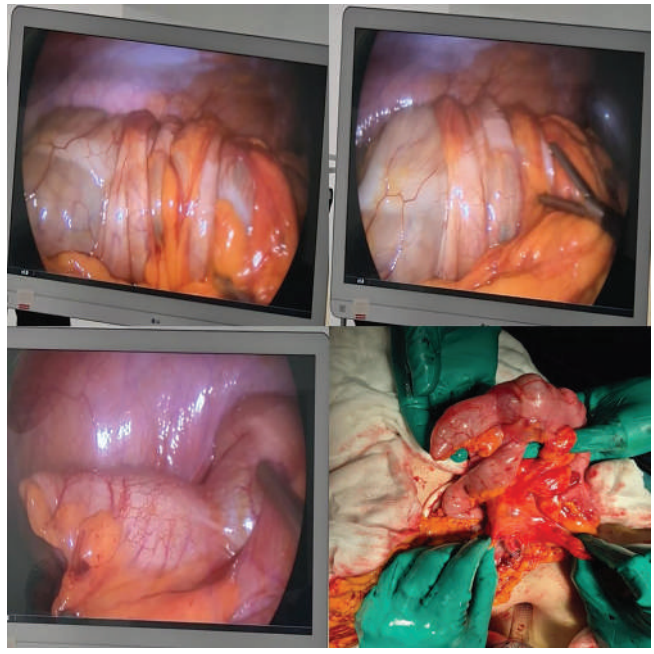

Figure 1. Intraoperative case images.

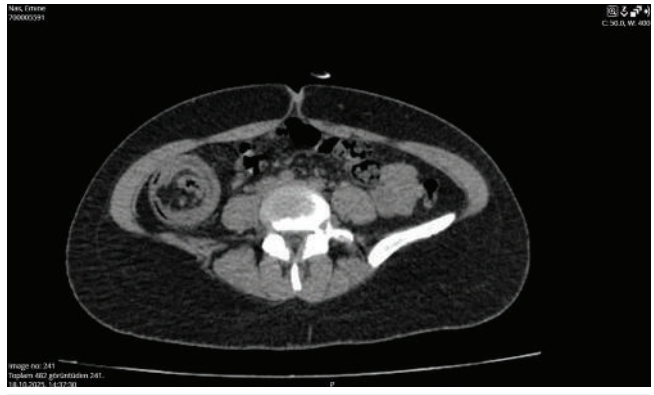

Figure 2. Preoperative CT images.

[P-554]

Rapidly growing inverted follicular keratosis in the anal region: A rare localization - case report

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Objective: Anal region lesions are most commonly benign in nature, and pathologies such as hemorrhoids, fibroepithelial polyps, and condyloma are usually considered in the differential diagnosis. However, lesions demonstrating rapid growth and atypical exophytic macroscopic features may raise suspicion for malignant or premalignant processes. Inverted follicular keratosis (IFK) is a benign epidermal proliferation showing squamous differentiation, typically observed on the face and scalp. Anal localization is extremely rare and may clinically mimic squamous cell carcinoma.

Material and Methods: A detailed medical history and physical examination were performed in a patient presenting with a rapidly growing anal lesion. There was no history of suspicious sexual contact. No family history of dermatological disease was reported. Due to the rapid growth and atypical appearance of the lesion, total excision under local anesthesia was planned. The lesion was excised with clear surgical margins and sent for histopathological examination.

Results: A 34-year-old male patient presented with an anal mass that had been present for approximately one month and had shown significant growth in recent weeks. Physical examination revealed an exophytic lesion approximately 1 cm in diameter, located adjacent to the anal verge, with a grape-like appearance. Macroscopic examination described a 2×1.5×0.5 cm polypoid excision specimen covered with mucosa. Microscopic evaluation demonstrated parakeratosis on the surface and an endophytic growth pattern of squamous cell proliferation extending from the epidermis into the dermis. The lesion was noted to extend to the surgical base margin. Immunohistochemical analysis showed focal weak p16 positivity and basal cell staining with Ki-67. The findings were reported as consistent with IFK.

Conclusion: Although malignancy is often suspected in rapidly growing exophytic anal lesions, rare benign entities should also be considered in the differential diagnosis. Anal localization of IFK is extremely uncommon and may clinically mimic malignant lesions. Therefore, excisional biopsy provides both diagnostic and therapeutic benefit. In our case, due to involvement at the surgical base margin, close clinical follow-up was recommended.

Keywords: Inverted follicular keratosis, anal lesion, excisional biopsy

[P-555]

What can we do if we cannot repair peritoneal defects? Case presentation: A patient who underwent bilateral TEP and laparoscopic cholecystectomy

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Objective: In TEP and TAPP inguinal hernia repairs, peritoneal opening is common. When using standard prolene mesh, the defect must be closed to prevent mesh-bowel contact. Various closure methods have been described depending on defect size and surgeon preference (energy sealing, suturing, clipping). In recurrent hernias, the peritoneal defect may be large and standard techniques may be insufficient. This study presents a patient undergoing elective surgery for bilateral inguinal hernia (right recurrence) and symptomatic gallstones.

Material and Methods: The patient's data was reviewed from digital records and surgical images were used.

Results: The patient had no abdominal surgery other than a previous open right inguinal hernia repair. A subumbilical incision was made, and the preperitoneal space was created for TEP. Before dissection, a large rightsided peritoneal defect caused by adhesions was identified. The direct and indirect hernia sacs were reduced. Closure of the defect was evaluated but deemed unfeasible due to its size and tissue fragility, so intraperitoneal assessment was performed. Leftsided hernia sacs were dissected, and a prolene patch was placed. The subumbilical port was advanced intraperitoneally. Because the peritoneal opening could not be closed with standard techniques, it was left open, and a composite mesh was positioned in the preperitoneal space. The patient was placed in reverse Trendelenburg, and laparoscopic cholecystectomy was completed without complications. Mesh position was confirmed, pneumoperitoneum was ended, and the 120 minutes procedure concluded uneventfully. At one year followup, the patient had no complaints or recurrence.

Conclusion: We were unable to close the uncontrolled peritoneal defect using the described techniques, forcing us to seek an alternative approach. We opted for repair using a composite patch, known not to cause problems when in contact with intra-abdominal organs. The fact that the affected side had previously undergone repair using an open surgical technique influenced our decision. On the other hand, the patient's second surgery had not yet been performed. We concluded the case in this manner due to the absence of acute cholecystitis and the lack of complicated gallbladder surgery. In the event of complicated gallbladder surgery, we might have reconsidered our decision during the operation due to the risk of infection of the patch. Such challenging situations may arise due to patient- or operator-related reasons. To determine whether this approach can be safely used when it is not possible to close the peritoneal defect, multiple case series are required.

Keywords: Inguinal hernia, minimally invasive surgery

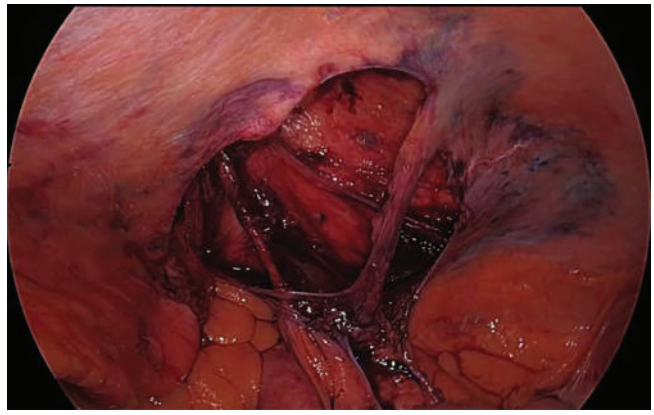

Figure 1. Image of the peritoneal defect from inside the abdomen.

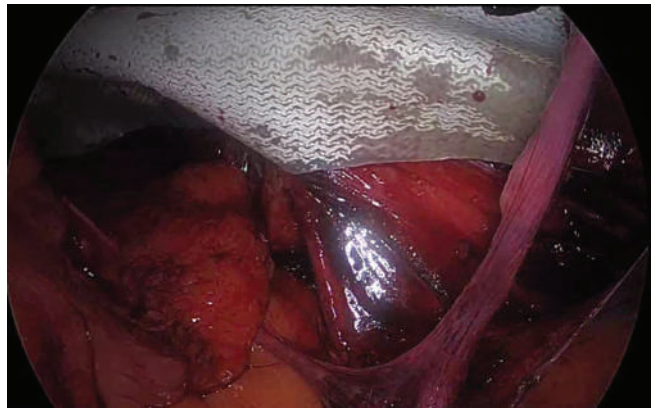

Figure 2. Position of the composite mesh within the peritoneal defect.

[P-556]

Use of a probe (PTeye) in minimally invasive parathyroidectomy: A case report

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Objective: Hyperparathyroidism is a condition characterized by excessive secretion of parathyroid hormone (PTH) by the parathyroid glands. The most common cause is primary hyperparathyroidism, and approximately 80-85% of these cases are due to a parathyroid adenoma. Surgery remains the gold standard treatment. Parathyroid detectors refer to devices and techniques used intraoperatively during thyroid and parathyroid surgery to identify and preserve parathyroid glands or to localize parathyroid adenomas when present. Rather than a single device, various systems based on different technologies are currently available for this purpose.In this study, we aimed to present a case in which PTeye autofluorescence technology was used during minimally invasive parathyroidectomy, representing a novel application method that, to our knowledge, has not yet been reported in the literature.

Material and Methods: A 50-year-old male patient with no known comorbidities presented with a three-month history of muscle pain and fatigue. Laboratory investigations revealed elevated serum calcium (10.9 mg/dL) and PTH levels (150 pg/mL). Neck ultrasonography and parathyroid scintigraphy demonstrated a lesion consistent with a parathyroid adenoma located adjacent to the inferior pole of the right thyroid lobe. The patient was informed about the procedure, and written informed consent was obtained.

Results: Preoperatively, the planned skin incision of approximately 1.5 cm was marked under ultrasonographic guidance corresponding to the adenoma localization. Reference measurements were obtained using PTeye before reaching the parathyroid tissue. With the assistance of PTeye, the parathyroid adenoma located at the right inferior pole was identified. Measurements confirmed the tissue to be parathyroid in origin, and parathyroidectomy was performed. The operative time was approximately 35 minutes. Intraoperative rapid PTH (quick PTH) measurement showed a decrease to 87.6 pg/mL, confirming successful excision of the adenoma.

Conclusion: Minimally invasive techniques are increasingly preferred in parathyroid surgery. The PTeye system, a next-generation parathyroid detector, may facilitate minimally invasive parathyroidectomy by enabling quicker and more reliable identification of parathyroid tissue while also providing superior cosmetic outcomes.

Keywords: Minimally invasive surgery, parathyroid adenoma, PTeye

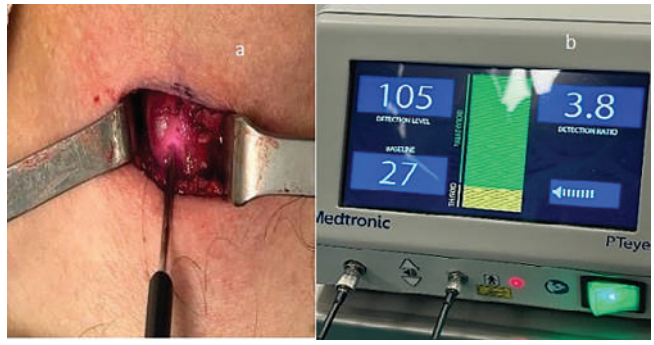

Figure 1. Intraoperative use of PTeye. Use in PTeye and real-time monitoring of adenoma detection.

[P-557]

A silent neuroendocrine tumor: A case of pancreatic somatostatinoma detected at an early stage

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Objective: Somatostatinoma is a rare pancreatic neuroendocrine tumor (NET) that often presents with non-specific clinical symptoms, frequently leading to delayed diagnosis. Although a classic triad of diabetes mellitus, steatorrhea, and cholelithiasis has been described in functional cases, these findings may not coexist in every patient. This report aims to present the clinical course, preoperative evaluation, surgical treatment, and pathological findings of a histopathologically confirmed somatostatinoma located in the pancreatic head, treated at the Department of General Surgery, University of Health Sciences Türkiye, Ankara Etlik City Hospital.

Material and Methods: The case of a patient diagnosed with somatostatinoma and operated on at University of Health Sciences Türkiye, Ankara Etlik City Hospital was evaluated retrospectively. Demographic data, presenting symptoms, functional findings, laboratory values, imaging modalities, preoperative localization success, surgical approach, operative time, postoperative complications, length of stay, and histopathological parameters (tumor diameter, localization, WHO NET grade, Ki-67 proliferation index, surgical margin status, and presence of metastasis) were examined.

Results: A 47-year-old female (BMI: 21 kg/m^2, ASA 2) presented with abdominal pain for six months. Functional evaluation revealed achlorhydria without steatorrhea, diabetes, or cholelithiasis. Fasting glucose was 121 mg/dL, and serum somatostatin was 233 pg/mL. Contrast-enhanced CT and MRI localized an 11 mm tumor in the pancreatic head without distant metastasis. The patient underwent robotic pancreaticoduodenectomy (operative time: 360 min). No postoperative complications or fistulas occurred (Clavien-Dindo 1); the hospital stay was 10 days with complete symptomatic resolution. Histopathology confirmed a WHO Grade G1 NET (Ki-67: 2%) with R0 resection. No recurrence or mortality was noted at 1 month follow-up.

Conclusion: Somatostatinoma is prone to diagnostic delay due to its rarity and non-specific presentation, with many cases reaching advanced stages and limiting curative options. This case highlights that early-stage (11 mm) pancreatic somatostatinomas carry curative potential when surgically resected. While the surgical approach depends on tumor location (e.g., pancreaticoduodenectomy for head lesions, distal pancreatectomy for distal ones), the primary goals are accurate staging to exclude metastasis and achieving R0 resection. In this case, the combination of low-grade histology (G1), low Ki-67 (2%), absence of metastasis, and R0 status provides strong pathological indicators for a favorable prognosis. In conclusion, somatostatinoma should be considered in the differential diagnosis; early diagnosis and appropriate surgical strategies can yield successful oncological outcomes in selected cases.

Keywords: Functional neuroendocrine tumor, pancreatic neuroendocrine tumor, rare pancreatic tumors, Somatostatinoma, WHO NET classification

Table 1. Somatostatinoma (pancreatic/duodenal origin)-comparison of present case with selected literature

Çalışma	Tasarım	Primer odak	Fonksiyonel bulgular (triad)	Ki-67 / Grade	Metastaz (tanı anı)	Tedavi yaklaşımı	Ana mesaj
Patel ve ark., 2022	Olgu sunumu	**Pankreas**	DM + Gİ semptomlar (sendrom değişken)	Bildirilmiş (olgu bazlı)	Olgu bazlı	Cerrahi/olgusal yönetim	Somatostatinoma klinik olarak heterojen; tanı çoğu zaman sendromu taklit ederek gelir.
Kos-Kudła ve ark., 2022	Derleme / güncelleme	PanNEN bağlamı	Fonksiyonel tümörlerde tablo değişken	Ki-67/Grade prognostik	Evre prognozu belirler	Lokalize hastalıkta cerrahi temel	Prognozda proliferasyon (Ki-67/grade) ve evre belirleyicidir.
Wahba ve ark., 2024	Derleme	Pankreas/duodenum	DM, steatore, safra taşı vb. değişken	Sınıflama vurgusu	Evreye bağlı	Lokalize hastalıkta cerrahi, metastatikte medikal/onkolojik	Somatostatinoma nadir; **lokalize hastalıkta cerrahi ana tedavidir**, semptomlar her zaman klasik değildir.
Albers ve ark., 2024	Nadir fonksiyonel pNEN serisi	**Pankreas (fonksiyonel nadir grup)**	Sendromlar heterojen	R0 + düşük evre iyi	Karaciğer tutulumu kritik	R0 rezeksiyon + seçilmiş olgular	Hastalıksız seyirde **R0 rezeksiyon** ve **başlangıçta karaciğer tutulumu olmaması** öne çıkar.
StatPearls, 2025	Kanıta dayalı özet	Pankreas/duodenum	Triad her zaman tam değil	NET sınıflaması	Sık geç yakalanabilir	Lokalize hastalıkta cerrahi	Nadirlik + non-spesifik semptomlar tanıyı geciktirir; erken yakalanırsa küratif potansiyel vardır.
Bizim olgumuz (Etlik Şehir Hast., 2026)	Tek olgu	**Pankreas başı**	Hipoklorhidri var; **DM/steatore/safra taşı yok**	**G1, Ki-67 %2**	**Yok**	Lokalizasyona uygun rezeksiyon (baş yerleşimi nedeniyle pankreatikoduodenektomi), robotik	Klasik triad olmadan da somatostatinoma olabilir; **erken evre + düşük Ki-67** ile rezeksiyon küratif potansiyel taşır.

[P-558]

Emergency spleen-preserving distal pancreatectomy for traumatic distal pancreatic transection after blunt abdominal trauma: A case report

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Objective: Pancreatic injuries, although rare in blunt abdominal trauma due to their retroperitoneal location, are high-morbidity clinical conditions presenting significant challenges in diagnosis and treatment. Surgical treatment is often unavoidable, particularly in distal pancreatic injuries affecting the main pancreatic duct. However, with appropriate patient selection, spleen-sparing surgical approaches are important for preserving immune function in young patients. This case report presents a patient who underwent emergency spleen-sparing distal pancreatectomy due to distal pancreatic detachment following a heavy fall.

Material and Methods: Case report: A 24-year-old male patient was referred to our emergency department from an external center after a heavy block fell on him at a construction site.

Results: The patient was conscious and had stable vital signs upon admission. Physical examination revealed tenderness and rebound tenderness in the right quadrant of the abdomen. Laboratory investigations showed significantly elevated amylase and lipase levels. Contrast-enhanced abdominal computed tomography scans performed at other centers and our hospital showed free fluid in the pelvis, but pancreatic injury was not initially reported. Due to continued clinical suspicion, the images were re-evaluated by a radiology specialist, revealing a near-complete laceration in the distal pancreas. The patient underwent emergency laparotomy, and exploration revealed approximately three-quarters separation of the distal pancreas. Splenic-sparing distal pancreatectomy and Wirsung duct repair were performed, preserving the splenic vessels and spleen. In the postoperative period, the patient required intensive care monitoring, developed a pancreatic collection, underwent drainage by interventional radiology, and performed endoscopic retrograde cholangiopancreatography due to ongoing pancreatitis. The patient was discharged after clinical improvement and underwent elective surgery for incisional hernia during long-term follow-up.

Conclusion: In pancreatic injuries due to blunt abdominal trauma, diagnosis may be delayed, and computed tomography may not always be sufficient. With high clinical suspicion, early surgical decision, and appropriate patient selection, spleen-sparing distal pancreatectomy can be a safe and effective treatment option for distal pancreatic injuries.

Keywords: Pancreatic trauma, distal pancreatectomy, spleen-sparing surgery, blunt abdominal trauma

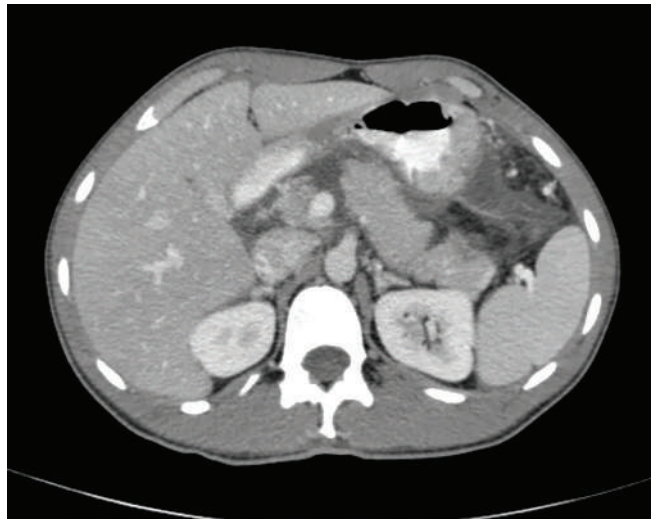

Figure 1. CT imaging shows distal pancreatic injury.
CT: Computed tomography.

Figure 2. Distal pancreatectomy specimen.

[P-559]

An unusual adhesion-related ileus at the right inferolateral border of the liver: A case report

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Objective: Adhesive small bowel obstruction (SBO) accounts for approximately 60-70% of all mechanical SBOs and is most commonly caused by pelvic or mesenteric adhesions. Perihepatic adhesions leading to mechanical ileus are extremely rare, with a reported incidence of less than 1%. Mechanical obstruction caused by fibrotic bands originating from the inferolateral surface of the liver has been described only in a limited number of cases in the literature. This case report aims to present a rare cause of SBO resulting from a fibrotic band arising from the right inferolateral border of the liver.

Material and Methods: A patient presenting with acute ileus was retrospectively evaluated in terms of clinical presentation, laboratory findings, radiological imaging, intraoperative findings, and postoperative course. Diagnostic evaluation included contrast-enhanced computed tomography (CT) and serial upright abdominal radiographs. Following failure of conservative management, surgical exploration was performed. Operative findings and clinical outcomes were analyzed.

Results: A 34-year-old female patient with no known comorbidities had previously undergone emergency laparotomy for acute abdomen following cesarean section in 2023, during which right hemicolectomy with ileocolic anastomosis was performed due to severe colonic dilatation and torsion at the hepatic flexure. Six-teen months later, she was admitted with abdominal distension and tenderness consistent with mechanical ileus. Laboratory parameters showed no evidence of bowel ischemia. Contrast-enhanced CT demonstrated marked dilatation of proximal small bowel loops with normal-caliber distal segments, supporting the diagnosis of mechanical obstruction. Serial upright abdominal radiographs revealed multiple air-fluid levels. As conservative management failed, surgical intervention was undertaken. During median laparotomy, dense intra-abdominal adhesions were dissected. Exploration revealed a thin, fibrotic band approximately 1 cm in length originating from the right inferolateral border of the liver and extending to the small bowel mesentery, causing mechanical obstruction approximately 100 cm distal to the ligament of Treitz. Proximal bowel loops were dilated, distal segments were normal, and bowel viability was preserved. The fibrotic band was divided, and bridotomy was performed without the need for bowel resection.

Conclusion: Mechanical SBO caused by fibrotic bands originating from the right inferolateral border of the liver is an exceptionally rare entity and may be difficult to diagnose preoperatively. Atypical perihepatic adhesions may not produce a clear transition zone on imaging studies. Therefore, perihepatic bands should be considered in patients with SBO who fail conservative treatment. Surgical bridotomy is a safe and effective approach that can result in rapid clinical recovery, as demonstrated in this case.

Keywords: Perihepatic adhesion, bridotomy, mechanical small bowel obstruction, explorative laparotomy, adhesion

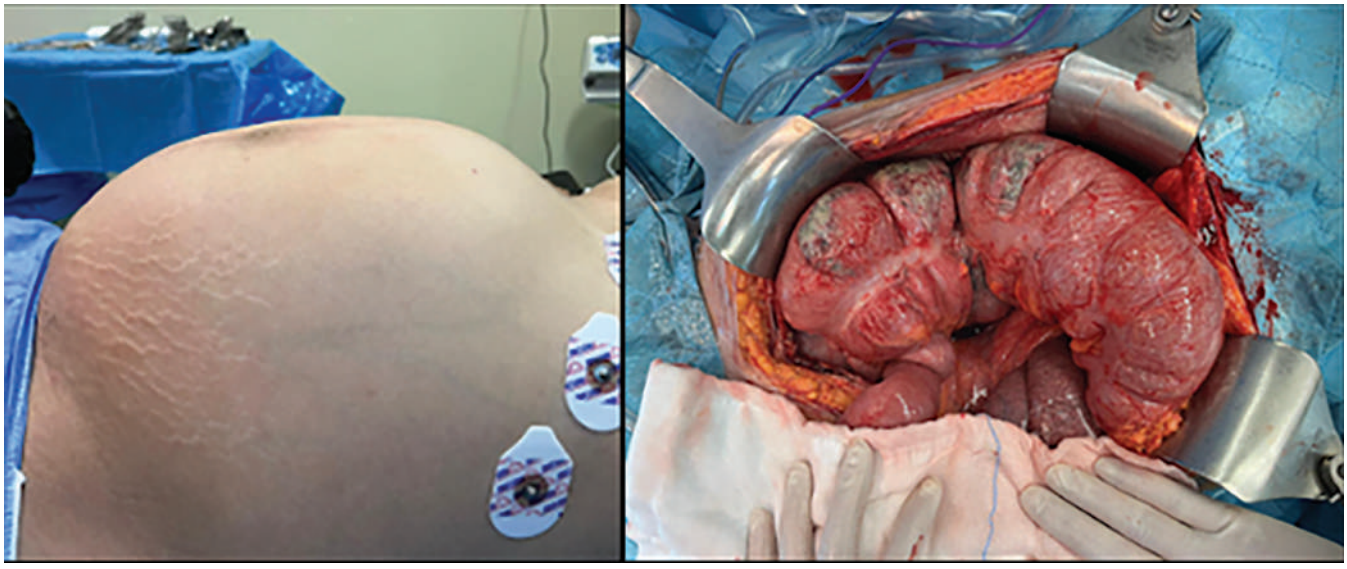

Figure 1. Abdomen before and after emergency laparotomy.

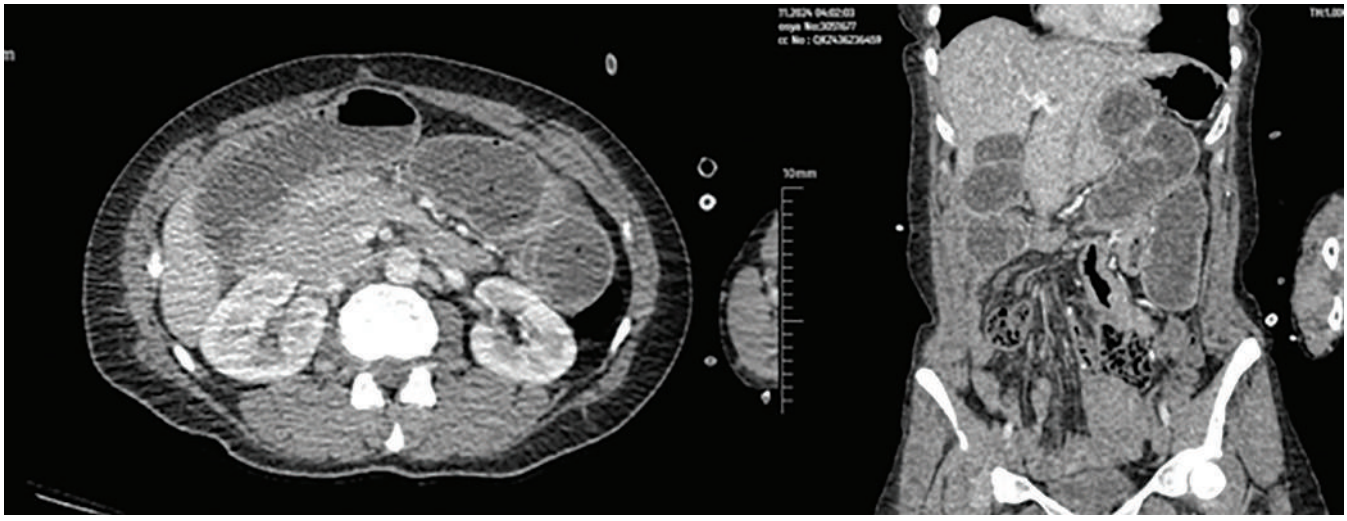

Figure 2. Preoperative contrast-enhanced CT image.

Marked dilatation of the proximal small bowel loops was observed, while the distal segments were of normal caliber, favoring a mechanical obstruction.

CT: Computed tomography.

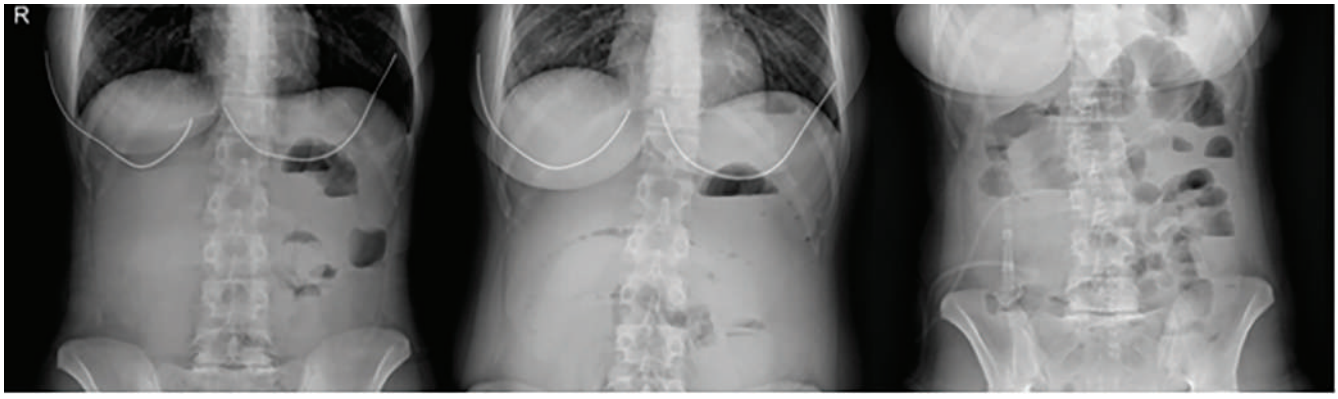

Figure 3. Upright abdominal radiograph series.

The presence of prominent air-fluid levels on serial upright abdominal radiographs supported the diagnosis of mechanical ileus.

Figure 4. Intraoperative brid images.

Approximately 100 cm distal to the ligament of Treitz, a thin fibrotic band measuring about 1 cm in length originating from the right inferolateral border of the liver was identified, extending to the small bowel mesentery and causing mechanical obstruction; proximal bowel loops were dilated, distal segments were normal, bowel viability was preserved, and the band was divided by bridotomy without additional pathology.

[P-560]

Atypical presentation and emergency surgical management of spontaneous hepatic rupture in amyloidosis: A case report

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Objective: Systemic amyloidosis is a rare disease characterized by extracellular amyloid fibril deposition. While hepatic involvement is generally asymptomatic, amyloid infiltration increases liver parenchyma and vascular fragility, predisposing patients to spontaneous hepatic rupture a rare but fatal complication. This report presents a patient with amyloidosis who underwent emergency surgery for spontaneous hepatic rupture and hemorrhagic shock triggered by severe coughing fits.

Material and Methods: A 60-year-old male with systemic amyloidosis presented to the emergency department with nausea, vomiting, and dizziness. His history included intermittent liver function test elevations, non-nephrotic proteinuria, and chronic kidney disease. Notably, he reported severe coughing for the past week. Initially hypotensive, he received intravenous fluids, achieved hemodynamic stability, and was discharged. Hours later, he returned with a deteriorating condition, confusion, tachycardia, and a blood pressure of 70/40 mmHg. Laboratory tests revealed a hemoglobin level of 5.1 g/dL. Due to hemodynamic instability and acute abdomen, a non-contrast abdominal CT was performed, showing hemorrhagic free fluid in the subhepatic, perihepatic, and right paracolic regions. The patient was taken for emergency laparotomy. Approximately 1000 cc of hemorrhagic fluid was aspirated. A massive rupture with active bleeding was observed in the right liver lobe. Because the amyloid-infiltrated liver tissue was extremely fragile, making primary suturing impossible, perihepatic packing was applied for hemorrhage control. After receiving 3 units of packed red blood cells, the abdomen was closed, and the intubated patient was transferred to the ICU.

Results: Spontaneous hepatic rupture in systemic amyloidosis is rare but carries a high acute-phase mortality rate (30-70%). Amyloid fibril accumulation impairs vascular elasticity, causing extreme fragility. In our case, the sudden intra-abdominal pressure increase from a week of severe coughing fits created mechanical stress on the fragile liver and Glisson's capsule, triggering the rupture. The patient's initial presentation with non-specific symptoms and fluid-responsive transient hypotension demonstrates how amyloidosis-related bleeding can be insidious. While transarterial embolization is the first-line treatment for hemodynamically stable patients, emergency laparotomy is life-saving for those presenting with hemorrhagic shock. Because amyloid-infiltrated liver tissue cannot hold sutures, perihepatic packing—as successfully applied here—is the safest and most effective surgical maneuver to achieve hemostasis, avoiding the risks of primary suturing or resection.

Conclusion: In patients with known amyloidosis or unexplained hepatomegaly, spontaneous hepatic rupture must be considered if sudden hypotension and anemia develop following Valsalva-like maneuvers. In hemodynamically unstable patients, prompt laparotomy and perihepatic packing are life-saving.

Keywords: Spontaneous hepatic rupture, amyloidosis, packing

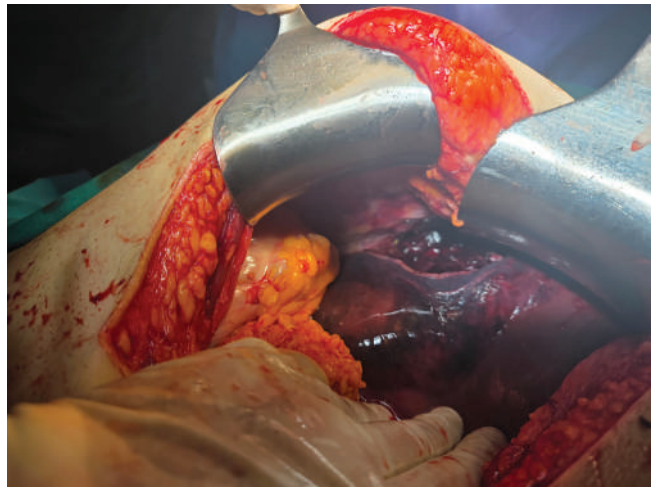

Figure 1. Spontaneous hepatic rupture intraop photo.

[P-564]

A rare cause of anal polypoid lesion: Perianal hidradenoma papilliferum

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Objective: Hidradenoma papilliferum is a rare benign tumor which is thought to originate from apocrine glands or anogenital mammary-like glands. It is most commonly seen in middle-aged women and usually located in the vulvar and perianal regions. Clinically, it generally presents as a slow-growing, well-circumscribed solitary nodule and may be confused with hemorrhoids, anal polyps, or other benign anal lesions. Malignant transformation is extremely rare; however, definitive diagnosis can only be made by histopathological examination. In this study, we aimed to present a rare case of hidradenoma papilliferum located in the perianal region.

Material and Methods: A 42-year-old female patient presented with a complaint of a swelling in the anal region for approximately 3-4 years. The patient reported intermittent bleeding and pain from time to time. On physical examination of the anal region, a polypoid lesion originating from the anal verge was observed. No additional pathology was detected. Rectosigmoidoscopy revealed no abnormal findings. Surgical excision of the anal polypoid lesion was planned. In the operating room, the lesion was totally excised under spinal anesthesia (Figures 1, 2).

Results: The patient was discharged uneventfully on the postoperative first day. No complications or recurrence were observed during follow-up. Histopathological examination of the excised specimen was reported as hidradenoma papilliferum. The macroscopic and clinical appearance of the lesion was similar to other benign anal tumors, and a specific preoperative diagnosis could not be established. Consistent with the literature, the definitive diagnosis was achieved after surgical excision and histopathological evaluation.

Conclusion: Hidradenoma papilliferum is a rare benign anogenital tumor most commonly observed in the vulvar and perianal regions. Since it may clinically mimic hemorrhoids and other benign anal lesions, it should be considered in the differential diagnosis of benign anal masses. Complete surgical excision is sufficient for both diagnosis and treatment, and the prognosis is generally favorable. Proctologists should keep hidradenoma papilliferum in mind during the evaluation of benign anal lesions.

Keywords: Hidradenoma papilliferum, perianal polyp, benign anal tumor

Figure 1. Preoperative view of the polypoid perianal lesion located at the anal verge.

Figure 2. Early postoperative appearance after total excision of the lesion.

[P-565]

Ulcerative giant breast cancer: Case report

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Objective: Large, ulcerated breast lesions are a rare and bothersome consequence of advanced breast cancer. The most significant factors in the etiology include patient denial of the illness, delayed diagnosis, psychological distress, low socioeconomic status, social isolation, and male gender. This means the condition can be seen not only in developing countries but also in developed ones.

Material and Methods: Patients typically present to healthcare facilities with complaints of uncontrolled bleeding, recurrent infections, chronic pain, aesthetic concerns, and, most importantly, foul odor. In this case report, we aim to present a breast cancer patient with a locally advanced, giant ulcerated wound, along with a review of the literature.

Results: A 42-year-old female patient presented to our clinic with complaints of discharge and bleeding from her left breast. Her medical history revealed no prior examination or imaging studies related to breast diseases. Physical examination revealed an ulcerated lesion approximately 15x20 cm in size, covered with fibrin, with occasional purulent discharge and bleeding in the left breast. A tru-cut biopsy was performed for pathological diagnosis. The pathology result was consistent with isolated Her2^{+} invasive ductal cancer, and a screening for distant organ metastases was performed. Lung and femur metastases were detected, and a multidisciplinary council decided on mastectomy due to the patient's uncontrollable bleeding and infection. The patient underwent salvage mastectomy with axillary sampling. The pathology report showed negative hormone levels, positive Her2^{+}, and a Ki67 index of 40%. The patient experienced no complications during postoperative follow-up and was discharged with oncology recommendations.

Conclusion: Patients with ulcerative tumors constitute a particularly challenging group due to the complexities in managing tumor-related symptoms such as pain, exudative discharge, foul odor, bleeding, infections, and aesthetic concerns. Individuals with ulcerative breast tumors experience a significant impairment in quality of life. This may be due to delays and disruptions in the healthcare system, but it can also be primarily attributed to psychological reluctance to accept their condition, advanced age, and male gender. Currently, there is no standard treatment approach for this patient group. Therefore, discussing optimal management within a multidisciplinary team is crucial. The primary approach in patient management is usually surgical intervention, total or modified radical mastectomy, or palliative procedures aimed at reducing tumor thickness.

Keywords: Ulcerative, breast cancer

[P-567]

Isolated heel pressure injury following peripheral arterial bypass surgery: A case report

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Objective: Pressure injuries are difficult clinical problems to heal, especially in the elderly and in the presence of diabetes mellitus (DM). Microvascular disorders associated with DM, peripheral neuropathy, and the risk of infection negatively affect wound healing. The heel region is one of the high-risk areas due to bone protrusions and constant exposure to pressure.

Material and Methods: This case report aims to evaluate the effectiveness of current wound care methods and position changes on wound healing in the treatment of a pressure ulcer that developed on the heel of a patient with DM who underwent bypass surgery.

Results: A 69-year-old male patient with a history of hypertension, DM, and right femoropopliteal bypass graft presented to the Chronic Wound Care Clinic with a 4*5 cm unstaged stage 2 pressure ulcer in the right heel area. The wound margin was dry, and calluses were present on both heels. The patient was on insulin and smoked. He stated that he had undergone bypass surgery one month prior and presented to us with a complaint of a non-healing wound on his right heel due to immobility during the postoperative period. The patient's blood glucose level was 319 mg/dL, and HbA1C level was 7%. The wound was primarily treated with an autolytic debridement product and surgical debridement procedures, and necrotic tissue was removed from the wound. A barrier cream was applied to the dry edges of the wound. After preparing the wound bed, a topical growth factor was used to promote granulation and epithelialization. During this process, regular position changes were implemented to protect the foot from pressure, and metabolic control was ensured by monitoring blood glucose levels, which positively supported the healing process. The patient's wound healed in approximately 4 months under outpatient conditions; the patient and their family were informed about protective measures and foot care to prevent the recurrence of pressure injuries.

Conclusion: The combined use of autolytic debridement and topical growth factor is an effective approach in the treatment of heel pressure injuries in elderly patients with DM. Comprehensive treatment focused on wound bed preparation accelerated the healing process and prevented the development of complications. This combined approach can be considered a viable treatment option in similar patient groups. Applications focused on pressure protection, especially in high-risk patient groups, play a key role in reducing morbidity by preventing the development of pressure ulcers.

Keywords: Pressure ulcer, chronic wound, bypass surgery, heel ulcer

Figure 1. The course of treatment for pressure ulcers developing on the heel.

[P-570]

Use of a nanocellulose-based wound dressing in second-degree facial burns: Two case reports

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Objective: Burn injuries are among the traumatic conditions that lead to significant morbidity at both individual and societal levels. The frequent involvement of the head and neck region, along with the critical functional and aesthetic importance of the face, makes the management of burns in this area particularly challenging. Due to the complex anatomical structure of the face, resulting deformities may cause not only physical impairment but also psychosocial problems.

Material and Methods: In this study, the effectiveness of a nanocellulose-based wound dressing was evaluated in two patients with second-degree facial burns.

Results: In both cases, standard wound cleansing and topical antimicrobial therapy were applied in the early period, followed by continued treatment with a nanocellulose-based wound dressing. Granulation tissue formation was observed at an average of six days, and no infection, allergic reaction, or additional complications were detected.

Conclusion: No pathological scar formation was observed during the follow-up period. Our findings suggest that the nanocellulose-based wound dressing is a safe and effective biomaterial that supports tissue healing in facial burns.

Keywords: Facial burn, nanocellulose wound dressing, second-degree burn

Figure 1. Burn areas of case 1.

Figure 2. Burn areas of case 2.

[P-571]

Isolated endometrioid adenocarcinoma developing on the abdominal wall on the basis of endometriosis: A case report and current literature review

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Objective: Endometriosis predominantly develops during obstetric and gynecological procedures due to iatrogenic transplantation of endometrial tissue. Malignant transformation in endometriosis is exceedingly rare (0.3-1%). Cases of ectopic endometriosis demonstrating malignant transformation are even rarer.

Material and Methods: In this study, we report such a case and review previous literature. All studies addressing cases of ectopic endometriosis showing malignant transformation reported in the literature to date have been reviewed, and the study has been completed.

Results: This study presents a case of isolated endometrioid adenocarcinoma developing on the anterior abdominal wall on the basis of endometriosis, unrelated to surgical scars. A well-defined, fixed, and firm mass measuring 3-4 cm deep subcutaneously to the right of the umbilicus was identified in a 29-year-old female patient. The mass with a preliminary diagnosis of desmoid tumor was removed en bloc. Pathology result showed endometrioid adenocarcinoma. As a result of further examinations, no other focus was detected in the patient. Similarly, 54 cases were identified in the literature.

Conclusion: It is essential for clinicians to keep in mind that carcinomas may develop on the basis of endometriosis.

Keywords: Endometrioid adenocarcinoma, endometriosis, malignant transformation, abdominal wall

Figure 1. Computed tomography image.

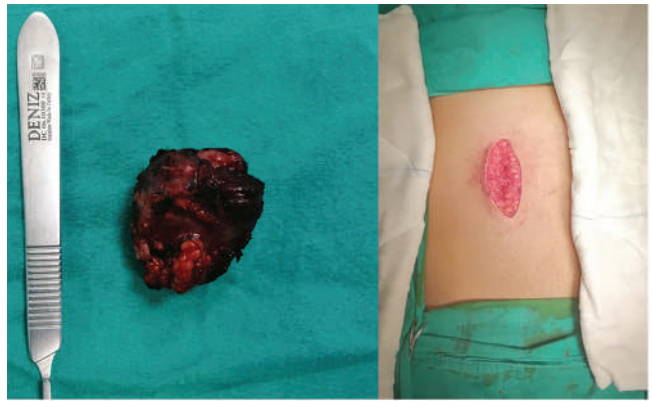

Figure 2. Macroscopic view of the mass.

[P-572]

Clinical importance of inhalation injury in burn patients: A case report

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Objective: Inhalation injury is an important clinical condition that describes damage to the respiratory tract and lung parenchyma caused by the inhalation of hot gases, smoke, and toxic chemicals, and it significantly increases morbidity and mortality in burn patients. Particularly when associated with flame burns, early recognition and appropriate management are of vital importance due to the risk of airway edema, impaired gas exchange, and a systemic inflammatory response.

Material and Methods: A 55-year-old male patient with a known history of hypertension and diabetes mellitus presented to the emergency department with flame burns involving the face, neck, anterior trunk, and left hand after being set on fire following the pouring of a flammable substance over him.

Results: The patient, whose total burn surface area was calculated as 12%, was intubated early and admitted to the intensive care unit for close monitoring due to inhalation injury and the development of laryngeal edema. Bronchodilator therapy, systemic corticosteroids, appropriate fluid resuscitation, and anticoagulant prophylaxis were administered. Fluid therapy was arranged according to the Parkland formula, and the patient was closely monitored with hourly urine output and clinical parameters. A multidisciplinary treatment plan was established with the involvement of ophthalmology, otorhinolaryngology, pulmonology, and psychiatry departments. Local wound care included antiseptic cleansing and the use of enzymatic and autolytic debridement methods; no infection developed during follow-up. The patient was successfully extubated after five days of intubation, and pulmonary complications were prevented with respiratory exercises. In the later course of hospitalization, tangential excision and grafting were performed, and the patient was discharged in stable condition.

Conclusion: In conclusion, in burn patients with inhalation injury, early establishment of airway security, controlled fluid resuscitation, effective pulmonary care, and a multidisciplinary approach improve treatment outcomes. This case demonstrates that timely intervention and coordinated clinical management play a critical role in preventing complications.

Keywords: Burn, inhalation injury, airway management

[P-575]

A rare case with pathology reported as giant distal esophageal diverticulum- leiomyoma with a diameter of 15 cm

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Objective: Esophageal diverticula are rare pathologies, most commonly measuring 2-5 cm in diameter. Lesions exceeding 10 cm are defined as giant esophageal diverticula and represent an extremely uncommon clinical entity. Giant diverticula may clinically and radiologically mimic gastric or other intra-abdominal masses, leading to diagnostic challenges. In rare instances, biopsies obtained from the diverticular wall may be interpreted as leiomyoma due to smooth muscle hypertrophy, irregular fasciculation of muscle fibers, and focal muscular thickening. Such findings may result in diagnostic confusion and necessitate careful clinicopathological correlation. In this report, we present a rare case of a 15×15 cm giant distal esophageal diverticulum with pathological findings reported as leiomyoma.

Material and Methods: A 55-year-old male patient with no known comorbidities presented to the emergency department with nausea, vomiting, epigastric discomfort, and inability to tolerate oral intake. Detailed clinical examination, laboratory investigations, radiological imaging, and endoscopic evaluations were performed. The patient's medical history, including previous surgical interventions and pathological reports, was thoroughly reviewed. Based on the overall assessment, a diagnosis of giant distal esophageal diverticulum was established, and the patient was scheduled for surgical treatment.

Results: Physical examination revealed epigastric tenderness. Laboratory tests showed a leukocyte count of 24,000/mm^3 and a CRP level of 22 mg/L. Approximately 2000 cc of dilatation fluid was aspirated via a nasogastric tube. Contrast-enhanced abdominal and pelvic computed tomography demonstrated an extra-gastric pouch-like structure.The patient's history revealed that three years earlier he had undergone emergency Graham patch repair for perforated peptic ulcer. During that operation, a giant intra-abdominal mass was observed and biopsied, and the pathology was reported as leiomyoma. Subsequent gastroscopy revealed a 40-cm-long esophagus and a distal esophageal diverticulum, after which the patient was referred for surgery. Intraoperative exploration demonstrated a giant diverticulum originating from the distal esophagus with a markedly hypertrophic muscular layer measuring approximately 15×15 cm. The diverticulum was excised, and an esophagogastric anastomosis was performed using a circular stapler, followed by pyloroplasty. Postoperatively, the patient tolerated oral intake well and was discharged in good condition.

Conclusion: Giant esophageal diverticula often present with non-specific gastrointestinal symptoms, including nausea, vomiting, early satiety, and intolerance to oral intake. In symptomatic cases, conservative management is usually inadequate. Surgical treatment serves both diagnostic and therapeutic purposes. Therefore, early surgical intervention is essential to relieve symptoms, prevent complications, and improve patient quality of life.

Keywords: Esophageal surgery, giant esophageal diverticulum, leiomyoma, upper gastrointestinal surgery

Figure 1. Surgical excision of a giant esophageal diverticulum giant esophageal diverticulum.

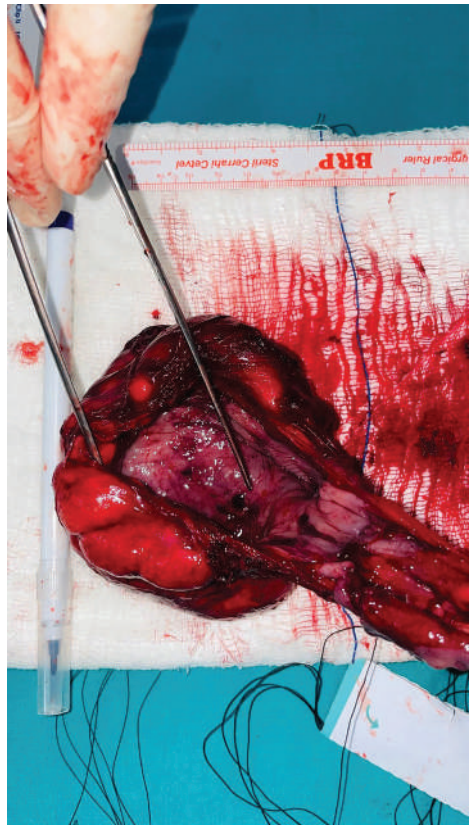

Figure 2. Surgical excision of a giant esophageal diverticulum.

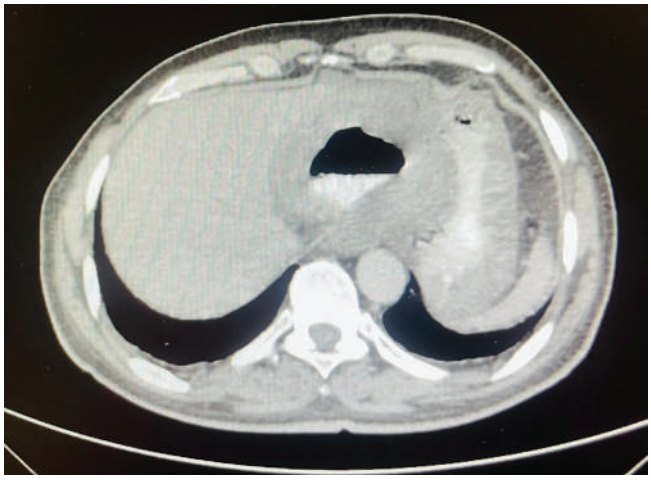

Figure 3. Giant esophageal diverticulum CT scan image.

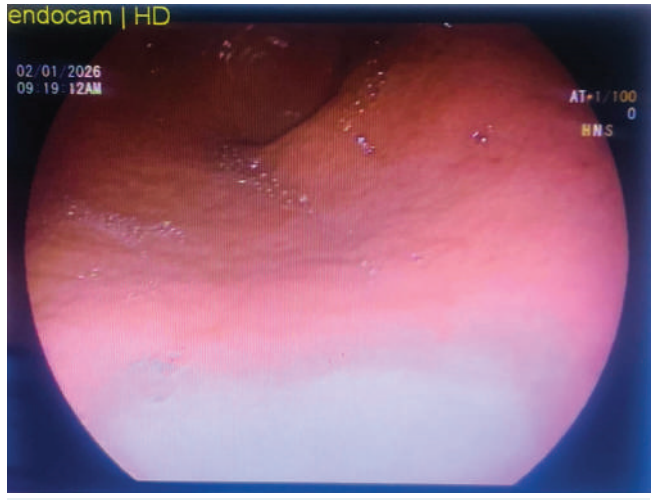

Figure 4. Giant esophageal diverticulum endoscopic image.

[P-576]

A giant sacrococcygeal chordoma: A case report

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Objective: Chordomas are rare, malignant, primary bone tumors with poor prognosis. They only account for 1-4% of all primary bone tumors which are thought to arise from ectopic embryonic notochord remnants along the neuroaxis. Although, not common, chordoma is the most frequent primary malignant neoplasm of the sacrum. It has been reported that the most common sites are the sacrum (40-50%), spheno-occipital area (35-40%), and the vertebral bodies (15%-20%). Although, histologically considered to be a benign neoplasm, chordomas have a malignant potential due to a remarkable recurrence. Anterior invasion to the rectum is uncommon due to presacral fascia.

Material and Methods: In this case report, we aim to present a case of sacral chordoma approximately 25 cm in size, along with a review of the literature.

Results: A 62-year-old male patient presented to our clinic with complaints of tenesmus and constipation. Physical examination revealed no pathological findings. Rectal examination revealed a well-defined mass 4 cm proximal to the anal verge, without disrupting mucosal integrity. Colonoscopy was planned. Colonoscopy showed an external compression image of the rectum extending approximately 10 cm proximally from the dentate line. CT scan revealed a 25x10 cm soft tissue lesion with smooth contours in the presacral area, clearly visible in relation to the rectum. Trucut biopsy was performed, and the result was reported as consistent with "well-differentiated chordoma". The patient underwent surgery in conjunction with neurosurgery. Initial extremity and anal sphincter neuromonitoring was performed. Sacrectomy was performed at the S2 level, the chondroma was excised, and a colostomy was created. Postoperatively, the patient had extremity movement, but no muscle tone was detected on rectal examination. The patient was referred to medical oncology based on the pathology results.

Conclusion: Chordoma is a rare, slow-growing but locally invasive tumor. It accounts for less than 5% of all primary bone neoplasms. Since chordoma is poorly sensitive to chemotherapy and radiotherapy, surgery is the treatment of choice. For the preoperative evaluation, CT scan is necessary to identify the local bony extension and MRI is used to determine the sacrectomy level. It is important to protect the lumbosacral trunks and sciatic nerves as much as possible.

Keywords: Sacrococcygeal chordoma, giant, sacrectomy

[P-578]

Squamous cell carcinoma secondary to pilonidal cyst: A case report

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Objective: Pilonidal sinus (PS) is a disease characterized by recurrent abscess formation and chronic inflammation, usually seen in the sacrococcygeal region.Although rare, recurrent chronic cases may carry a risk of malignant transformation. Squamous cell carcinoma (SCC) may present as a rare but serious complication of PS. This article presents a case of chronic PS with a history of recurrent abscesses, in which SCC was diagnosed.

Material and Methods: A 58-year-old male patient presented to us with painful swelling in the anal region. The medical history revealed a history of recurrent abscesses and drainage due to chronic PS. It was learned that he had had a weeping wound adjacent to the anal opening on his right gluteal region for 2 months. Physical examination revealedextensive granulation tissue and signs of infection in the wound area. Based on clinical evaluation andimaging findings, he underwent surgery with a preliminary diagnosis of Fournier's gangrene. Infected and necrotic tissues were debrided, and a biopsy was taken from the wound area. Pathology results confirmed a diagnosis of SCC. The patient was referred to a plastic surgery council for a multidisciplinary approach. Based on the council's decision, it was decided to administer chemotherapy and radiotherapy after surgical excision.

Results: Patients with chronic PS experience recurrent abscesses and pain. There is no universally accepted classification to determine the severity of pilonidal disease, but factors such as the number, size, and location of the sinuses and the presence of abscesses may influence the treatment approach. Malignant degeneration, a rare but serious complication of PS, may occur in cases that have been neglected for a long time. The average age of patients with SCC described in the literature is 52. Malignant degeneration, a rare but serious complication of PS, may occur in cases that have been neglected for a long time. The literature reports high recurrence rates (39%) and mortality rates in patients diagnosed with SCC. Early diagnosis and aggressive treatment in the presence of SCC can improve survival rates.

Conclusion: Although malignant transformation is a rare complication in patients with PS,this risk should not be overlooked in long-term and recurrent cases. Chronic inflammation andrecurrent infections may play a triggering role in SCC development. Therefore, careful clinical evaluation and histopathological examination are important in long-term follow-ups. A multidisciplinary approach is critical in determining and implementing the optimal treatment strategy for patients diagnosed with SCC. In SCC, the use of radiotherapy in addition to surgery may reduce recurrence ratesand have positive effects on long-term survival.

Keywords: Squamous cell carcinoma, pilonidal cyst, malignant transformation

Figure 1. Squamous cell carcinoma appearance formed on the basis of a pilonidal sinus.

[P-590]

Spindle cell mesenchymal tumor of the lower extremity: Case report

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Objective: Soft tissue sarcomas are a heterogeneous group of neoplasms that mostly originate from embryonic mesoderm cells, i.e., connective tissue, muscle, joints, fat, blood vessels, and peripheral nerves. Spindle cell neoplasms originate from mesenchymal cells that make up the body's connective tissue system. These cells include nerve, fibroblast, myofibroblast, epithelial, or vascular tissue.

Material and Methods: Spindle cell sarcomas are generally deep-seated lesions originating from large nerves along the extremity and predominantly exhibiting local recurrence. In this case report, we aim to present a case of a malignant spindle cell mesenchymal tumor of approximately 10 cm located at the femoral-patella junction in the lower extremity, along with a review of the literature.

Results: A 56-year-old female patient presented to our clinic with complaints of a palpable mass and limited range of motion in her left leg. Physical examination revealed a palpable lesion extending from the distal femur to the patella; it was firm, fixed, immobile, but showed movement with joint movement. A CT scan of the extremity showed a soft tissue lesion extending to the patellar tendon, including the distal rectus femoris muscle of the left foot, with a spiculated extension that was not clearly defined by the vastus lateralis muscle. A mesenchymal tumor was suspected, and thoracic and abdominal CT scans were performed to rule out distant organ metastasis. No evidence of metastasis was found, and excision was performed, including the skin and rectus femoris tendon. The pathology report stated "High-grade pleomorphic and spindle cell malignant mesenchymal tumor." The patient was discharged with a postoperative physical therapy and rehabilitation plan and oncology recommendations.

Conclusion: Spindle cell neoplasms encompass a wide spectrum of clinical presentations, ranging from benign lesions to high-grade malignant tumors. These tumors typically originate in connective tissue layers, extending between muscle layers and encircling organs, forming a mass image. In the early stages, they are localized and generally do not spread beyond the encapsulated form. However, they can also develop malignant potential. The incidence of these tumors is three per 3.5 million, with a 2:1 predisposition in women compared to men. The preferred treatment for extremity spindle cell sarcoma is wide local excision, including the biopsy site. Wide local excision involves 1-2 cm of surrounding normal tissue and a narrower margin if there are large, unaffected critical neurovascular structures near the tumor. Postoperative radiotherapy may be supportive.

Keywords: Spindle cell, mesenchymal tumor

[P-591]

Retroperitoneal giant leiomyosarcoma: Case report

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Objective: Soft tissue sarcomas constitute less than 1% of all cancers. They originate from mesenchymal stem cells found in muscle, fat, and connective tissues. Soft tissue sarcomas most commonly develop in the extremities. The incidence in intra-abdominal and retroperitoneal areas is 40%. The most common intra-abdominal and retroperitoneal soft tissue sarcomas are gastrointestinal stromal tumors, leiomyosarcomas (LMS), and liposarcomas. LMS accounts for up to 25% of all newly diagnosed soft tissue sarcomas.

Material and Methods: In this presentation, we aim to present a case of extensive retroperitoneal leiomyosarcoma, along with a review of the literature.

Results: A 69-year-old female patient presented to our clinic with a complaint of a palpable mass in the right inguinal region and lower quadrant of the abdomen. Physical examination revealed a firm, approximately 20 cm lesion extending from the umbilicus to the lower quadrant. Oral and intravenous contrast computed tomography showed a well-defined mass originating in the right retroperitoneal region, invading the right renal capsule, and extending into the iliac fosa. Lung CT scan showed no pathological findings, and laparotomy was planned. Excision of a 4.5 kg, 21x18x19 cm mass consistent with retroperitoneal sarcoma was performed. The patient was discharged with no postoperative complications and recommendations. Pathology was reported as epithelioid type, consistent with high-grade leiomyosarcoma. Mitotic rate was >30 per 10 BBA.

Conclusion: LMS constitute less than 10% of all soft tissue sarcomas. With an incidence of 20%, they are the second most common type of retroperitoneal sarcoma. They are twice as common in women and are generally more frequent in the 50-70 age group. Due to their slow growth and anatomical location, retroperitoneal tumors usually reach large sizes by the time of diagnosis. Patients with retroperitoneal sarcoma have a low life expectancy. Low-grade tumors offer a 50% survival advantage compared to high-grade tumors. The primary goal in the treatment of retroperitoneal LMS is excision with clear surgical margins.

Keywords: Leiomyosarcoma, retroperitoneal

[P-592]

Clinical evaluation of thyroid surgery in a patient with congenital breast Absence compatible with Poland syndrome: A case report

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Objective: Poland syndrome is a rare congenital anomaly first described by Alfred Poland in 1841. It is typically characterized by unilateral hypoplasia or aplasia of the pectoralis major muscle, accompanied by ipsilateral absence of breast tissue and upper extremity anomalies. The condition most commonly affects the right side. In female patients, breast absence may lead to significant cosmetic and psychosocial concerns. The most widely accepted etiological theory suggests a disruption of subclavian artery blood flow during the embryonic period.

Material and Methods: Case report: A 23-year-old female patient presented to the general surgery clinic with a thyroid nodule. Her medical history revealed congenital absence of the right breast. Physical examination demonstrated absence of right breast tissue, including underdevelopment of the areola and nipple. Marked hypoplasia of the right pectoral region was noted. No obvious skeletal or digital anomalies of the upper extremity were detected. These findings were considered consistent with Poland syndrome. Thyroid ultrasonography revealed a nodule in the right lobe suspicious for malignancy. Fine-needle aspiration biopsy suggested a follicular neoplasm, and surgical intervention was indicated. Preoperative evaluation revealed no additional cardiopulmonary pathology. The patient underwent total thyroidectomy under general anesthesia. No intraoperative or postoperative complications occurred. Serum calcium levels and vocal cord functions remained normal throughout follow-up. The patient was discharged without complications. Postoperative histopathological examination revealed follicular variant papillary thyroid carcinoma.

Results: Discussion: The incidence of Poland syndrome has been reported to range between 1 in 30.000 and 1 in 50.000 live births. The clinical spectrum is broad, varying from mild pectoral muscle hypoplasia to severe chest wall and limb deformities. In female patients, breast aplasia is often the most prominent clinical feature. Diagnosis is primarily clinical, while imaging modalities assist in evaluating associated anomalies. In this case, the syndrome was re-evaluated during assessment for thyroid pathology. Although no direct association between Poland syndrome and thyroid disease has been established, awareness of chest wall anatomy is important for surgical planning. A multidisciplinary approach is particularly valuable when reconstructive procedures are considered.

Conclusion: Although Poland syndrome is rare, it may present with congenital breast absence, especially in female patients. Careful physical examination is essential in patients presenting to different specialties for unrelated conditions. This case demonstrates that thyroid surgery can be safely performed in patients with Poland syndrome. Multidisciplinary evaluation and individualized surgical planning are key to achieving optimal outcomes.

Keywords: Congenital absence of breast, Poland syndrome, thyroid surgery

Figure 1. Patient with Poland syndrome.

[P-593]

A rare case of Graves' disease treated with therapeutic plasmapheresis as a preoperative rescue therapy for antithyroid and lithium-resistant disease

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Objective: Antithyroid drugs are used as first-line treatment in the vast majority of patients with hyperthyroidism. If antithyroid drugs used in the treatment of thyrotoxicosis cannot be used due to their side effects, or if adequate hormone suppression cannot be achieved despite high-dose use, or if there is a rapidly developing clinical condition such as thyroid storm, plasmapheresis can be used as an alternative treatment method. This article presents a case of Graves' disease in which therapeutic plasmapheresis was used as a preoperative rescue treatment.

Material and Methods: A 36-year-old female patient presented to our university's endocrinology clinic with a history of approximately 3 years of antithyroid (propylthiouracil) medication use. Agranulocytosis was detected during follow-up, and propylthiouracil was discontinued, followed by initiation of lithium carbonate 300 mg (oral 2x1) treatment. Surgery was recommended, but sufficient hormone suppression could not be achieved, so preoperative plasmapheresis was planned.

Results: The patient's TSH: 0.001 mIU/L, sT3: 9.32 pg/mL, and sT4: 4.18 ng/dL before lithium carbonate treatment, and TSH: 000.1 mIU/L, sT3: 6.7 pg/mL, sT4: 2.17 ng/dL before plasmapheresis. Following 2 units of plasmapheresis, the TSH was found to be 0.001 mIU/L, sT3: 4.0 pg/mL, and sT4: 1.67 ng/dL. With these values and anesthesia approval, the patient underwent surgery. No postoperative complications occurred in this case of bilateral total thyroidectomy, and the pathology report was consistent with Graves' disease.

Conclusion: Preoperative therapeutic plasmapheresis emerges as an alternative treatment method for patients with thyrotoxicosis. It should always be kept in mind that it can be an effective treatment method, particularly in cases of inadequate hormonal suppression response or side effects associated with antithyroid drugs, and for rapidly achieving adequate hormonal suppression prior to surgical interventions.

Keywords: Graves, antithyroid drug, plasmapheresis

[P-594]

Pylorus-preserving total pancreatectomy for a giant pancreatic cystic lesion of uncertain preoperative origin: A case report

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Objective: Giant cystic pancreatic lesions are often asymptomatic but may rarely cause obstructive jaundice due to compression of the hepatic hilum or duodenum. Although hepatocyte-specific magnetic resonance imaging (MRI) has high sensitivity for detecting biliary involvement, it may not always clearly differentiate between pancreatic and biliary origins. The management of large cystic lesions with uncertain origin poses significant diagnostic and surgical challenges. This report presents a case of a giant cystic pancreatic lesion presenting with obstructive jaundice and hyperosmolar hyperglycemic state (HHS), managed with pylorus-preserving total pancreatectomy (PP-TP).

Materiald and Methods: Clinical presentation, laboratory findings, radiological imaging, intraoperative findings, and postoperative course were retrospectively evaluated. Diagnostic workup included contrast-enhanced computed tomography (CT) and hepatocyte-specific MRI. Perioperative metabolic disturbances were managed using a multidisciplinary approach.

Results: A 58-year-old female patient presented with right upper quadrant pain, abdominal distension, dark-colored urine, and pruritus. Laboratory evaluation revealed findings consistent with obstructive jaundice and HHS. CT and MRI demonstrated a giant thin-walled cystic lesion measuring approximately 14×11×11 cm adjacent to the pancreatic head, causing latero-inferior displacement of the duodenum and marked intrahepatic bile duct dilatation. Hepatocyte-specific MRI showed no contrast uptake within the cyst, and biliary communication could not be demonstrated. A robotic surgical approach was initially attempted; however, due to significant anatomical distortion at the hepatic hilum, conversion to open surgery was required. Following portal triad dissection, PP total pancreatectomy was performed, and reconstruction was achieved with hepaticojejunostomy and gastrojejunostomy. Histopathological examination revealed a pancreatic pseudocyst with no evidence of malignancy. Postoperatively, rapid improvement in liver function tests and metabolic parameters was observed, and no major complications occurred.

Conclusion: Giant pancreatic pseudocysts may present with severe clinical manifestations such as obstructive jaundice and HHS, closely mimicking malignant or biliary pathologies. In selected patients with large cystic lesions of uncertain origin and complex anatomical relationships, PP total pancreatectomy represents a safe and effective surgical option. Successful outcomes depend on careful patient selection, multidisciplinary perioperative management, and early initiation of endocrine and exocrine replacement therapy.

Keywords: Giant pancreatic cyst, hyperosmolar hyperglycemic state, pylorus-preserving total pancreatectomy, hepatocyte-specific MRI, robotic surgery

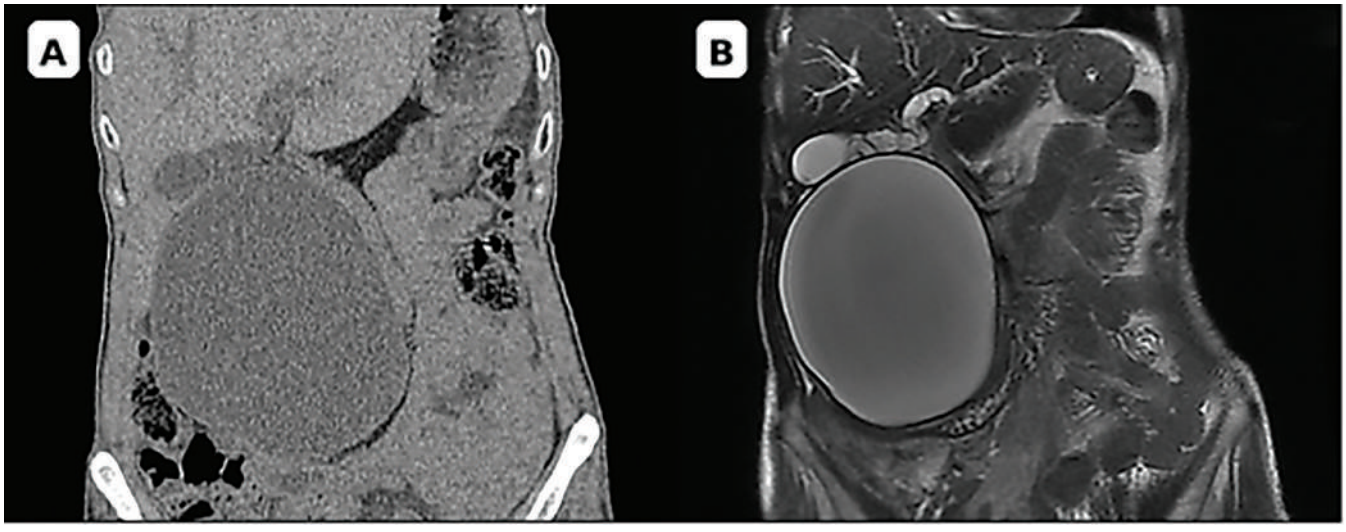

Figure 1A. Abdominal CT (coronal view) Figure 1B: MRI, T2-Weighted (coronal view).

Figure 1A. Abdominal CT (coronal section): A giant thin-walled cystic lesion measuring approximately 14×11×11 cm with clear fluid content is observed in the right upper quadrant, causing latero-inferior displacement of the duodenum and dilatation of the intrahepatic bile ducts. Figure 1B. T2-weighted MRI (coronal section): The cystic lesion demonstrates a homogeneous hyperintense appearance with marked mass effect on adjacent organs; no contrast enhancement of the cyst wall is observed.

MRI: Magnetic resonance imaging.

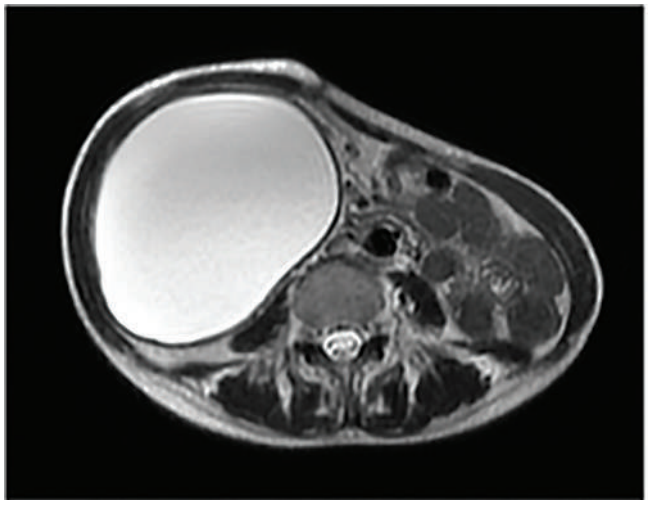

Figure 2. Hepatocyte-specific MRI (axial).

No contrast enhancement was detected within the cyst, thereby excluding the possibility of biliary communication. MRI: Magnetic resonance imaging.

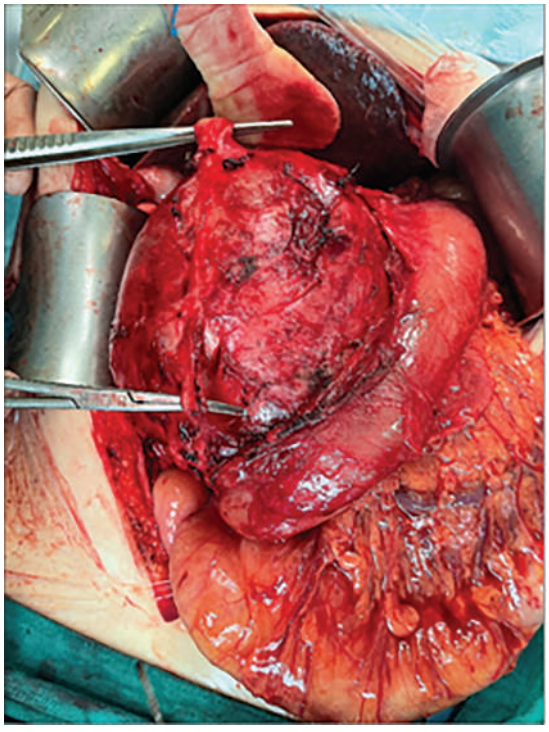

Figure 3. Intraoperative view.

Intraoperative view showing a giant cystic lesion originating from the pancreatic head causing compression of the hepatoduodenal region, prior to portal triad dissection.

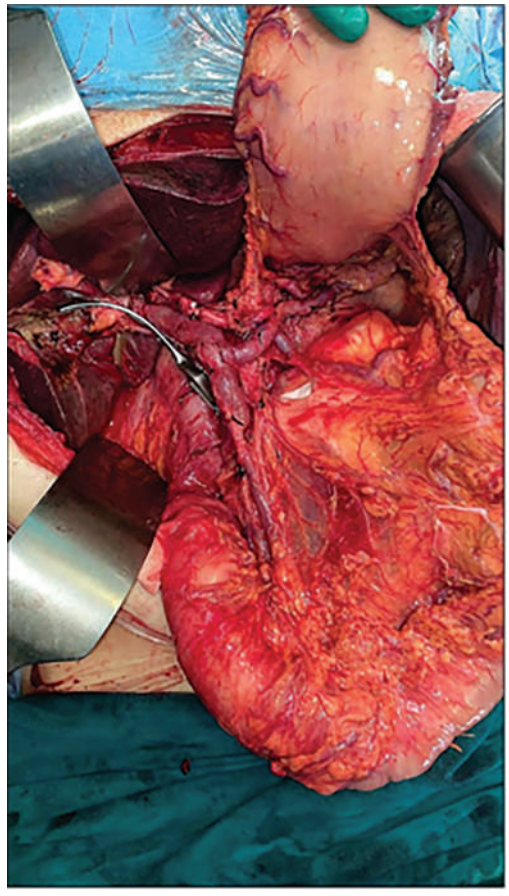

Figure 4. Intraoperative view.

Intraoperative view demonstrating elongation and thinning of the common hepatic duct (marked with clamps) due to cyst compression, during the preparatory stage prior to hepaticojejunostomy.

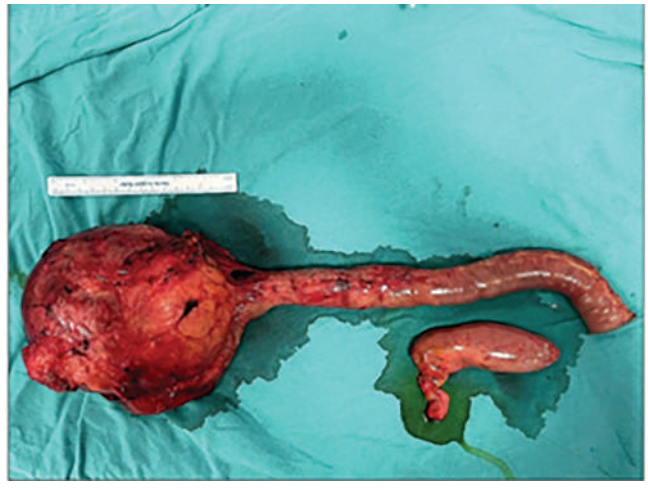

Figure 5. Resection specimen (macroscopic).

Macroscopic appearance of the giant cystic component extending along the pancreas in the pylorus-preserving total pancreatectomy specimen.

Table 1. Laboratory trend during hospitalization

Parameter	Preop	POD 1	POD 4	Discharge
AST (U/L)	177	3148	262	41
ALT (U/L)	231	2182	889	62
ALP (U/L)	855	1782	436	298
GGT (U/L)	3172	5110	441	210
Total bil (mg/dL)	13.9	9.2	3.91	1.4
Direct bil (mg/dL)	12.8	8.6	3.38	1.2
CRP (mg/L)	42	88	36	9
Glucose (mg/dL)	749	236	158	112
WBC ($\times 10^3/\mu L$)	12.4	9.8	7.3	6.4
Hemoglobin (g/dL)	12.1	10.6	11.2	12.4

POD: Postoperative day, AST: Aspartate aminotransferase, ALT: Alanine aminotransferase, ALP: Alkaline phosphatase, GGT: Gamma-glutamyl transferase, CRP: C-reactive protein, WBC: White blood cell count.

[P-595]

Surgical management of ectopic opening of the common bile duct (EOCBD): A report of two rare cases

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Objective: Ectopic opening of the common bile duct (EOCBD) is an exceedingly rare biliary anomaly arising from the early division of the hepatic diverticulum (Boyden's hypothesis). Its incidence ranges from 0.1% to 2.7%. The absence of the sphincter of Oddi in EOCBD leads to alkaline reflux, predisposing patients to chronic gastritis, refractory duodenal ulcers, apical stenosis, and recurrent cholangitis.

Material and Methods: Two rare cases treated surgically for recurrent peptic ulcer fibrosis and biliary stasis are presented with a literature review.

Results: Case 1: A 49-year-old male presented with a 4-day history of jaundice, fever, and abdominal pain. Laboratory results showed cholestatic enzyme elevation and hyperbilirubinemia. MRCP revealed intrahepatic duct dilatation and 16 mm stones in the distal common bile duct (CBD). Gastroscopy identified a "choledochobulbar fistula" at the bulbar level, where the pancreatic and CBD orifices opened separately. During ERCP, the CBD was cannulated via this atypical orifice with difficulty due to bulbar stenosis. After failed balloon dilatation, an 8.5F pigtail stent was placed. Following the resolution of cholangitis, the patient underwent cholecystectomy and Roux-en-Y hepaticojejunostomy. He was discharged on postoperative day 14. Case 2: A 60-year-old male with a history of cholecystectomy presented with abdominal pain and rigors. CT showed left portal vein thrombosis and a characteristic "hook-shaped" angulation of the distal CBD. MRCP measured the CBD at 20 mm with duodenal narrowing. Gastroscopy revealed an atypically located papilla. During ERCP, a 25 mm dilated CBD was cannulated via the atypical papilla, and a stent was placed. Surgery was performed for EOCBD and gastric outlet obstruction. Following Roux-en-Y hepaticojejunostomy and gastroenterostomy, the patient was discharged on day 16 without complications.

Conclusion: EOCBD should be suspected when the normal papilla is absent and the pylorus-papilla distance is <50 mm. The "hook-shaped" distal CBD is a key radiological criterion. The lack of a sphincter mechanism causes duodenal reflux, leading to recurrent stones and cholangitis. Endoscopic extraction often fails (40-70%) due to anatomical challenges. In cases of recurrent cholangitis or failed ERCP, Roux-en-Y hepaticojejunostomy remains a curative surgical option.

Keywords: Ectopic opening of the common bile duct, gastric outlet obstruction, biliary anomaly, peptic ulcer, hepaticojejunostomy

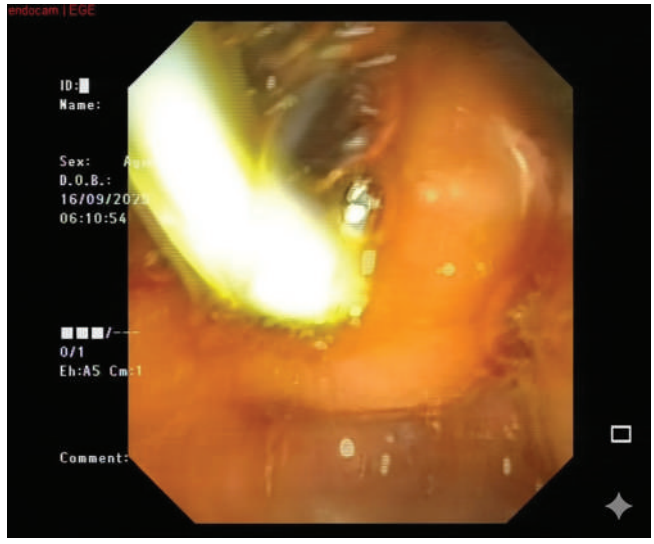

Figure 1. Preoperative ERCP image.

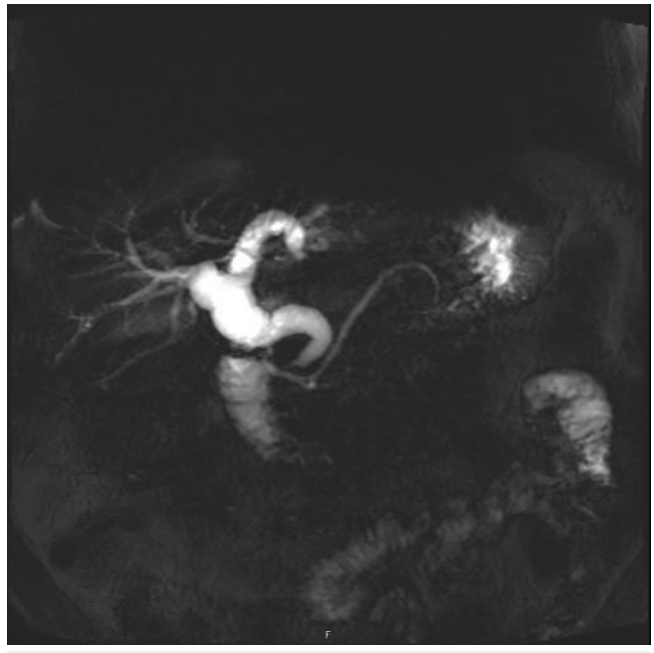

Figure 2. Preoperative MRCP image.

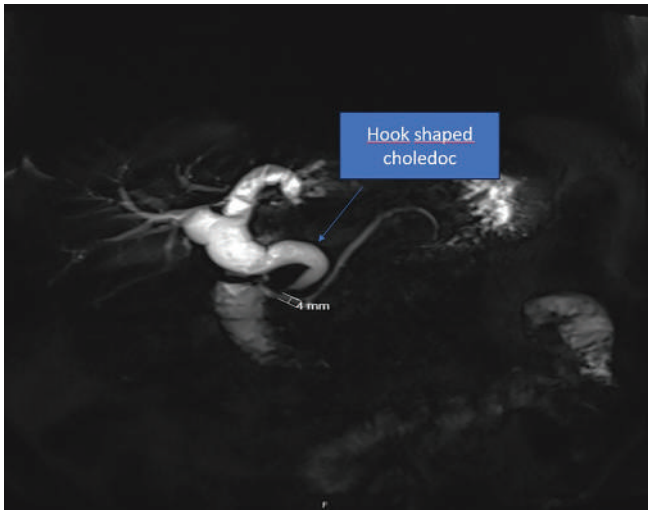

Figure 3. Preoperative MRCP image-2.

Figure 4. Preoperative ERCP image-2.

[P-596]

Abdominal epilepsy: Diagnosis and follow-up results in an adult case

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Objective: Abdominal epilepsy is a rare form of epilepsy that is difficult to diagnose because epileptic seizures are accompanied by primarily gastrointestinal symptoms. It presents with recurrent abdominal pain, nausea, vomiting, and autonomic symptoms, while the absence of motor seizure findings can lead to diagnostic delays. Although it is mostly diagnosed in childhood, an increasing number of cases are being reported in the adult age group.

Material and Methods: A 54-year-old female patient with recurrent abdominal pain attacks for approximately 20 years was evaluated for increasingly frequent and particularly severe abdominal pain, nausea, vomiting, and autonomic symptoms occurring at night in recent years. Given the stereotypical nature of the attacks, their termination with marked fatigue suggestive of a postictal period, and the absence of organic pathology on comprehensive gastrointestinal investigations, abdominal epilepsy was considered as a preliminary diagnosis. Although routine electroencephalography (EEG) was normal, lamotrigine treatment initiated based on the clinical picture resulted in a marked reduction in attacks, and the patient became completely asymptomatic during one year of follow-up.

Results: Abdominal epilepsy is a rare form of focal epilepsy characterised by recurrent abdominal pain, nausea-vomiting, and autonomic symptoms, and often results in delayed diagnosis due to its tendency to mimic gastrointestinal disorders. During the diagnostic process, the paroxysmal and stereotypical nature of the attacks, the presence of accompanying autonomic or neurosensory symptoms, the exclusion of other gastrointestinal causes, and the clinical response to antiepileptic treatment are of great importance. The diagnostic sensitivity of electroencephalography is limited, and normal EEG findings are frequently observed, particularly during the interictal period. This is explained by the fact that epileptic activity may originate from deep cortical or autonomic networks. In the presented case, the typical clinical pattern, the history of long-standing stereotypical attacks, and the complete clinical improvement that began shortly after lamotrigine treatment and became permanent in the long term strongly supported an epileptic aetiology despite normal EEG findings. Therefore, clinical evaluation should be prioritised in the diagnosis of abdominal epilepsy.

Conclusion: Abdominal epilepsy must always be considered in the differential diagnosis of unexplained and recurrent abdominal pain attacks, particularly in adult patients. Normal EEG findings should not rule out the diagnosis; clinical features, the stereotypical nature of the attacks, and the response to antiepileptic treatment should be decisive in the diagnostic process. With early diagnosis and appropriate treatment, significant and lasting clinical improvement can be achieved in patients.

Keywords: Abdominal epilepsy, recurrent abdominal pain attacks

[P-597]

Psoas abscess presenting with atypical symptoms: Case report

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Objective: Psoas abscess was first described by Mynter in 1881. It can be classified as primary or secondary depending on the presence or absence of an underlying disease. Primary psoas abscesses develop hematogenously, usually from an infection focus in another part of the body, particularly in immunocompromised patients. The most common cause of secondary psoas abscesses is Crohn's disease. Its classic presentation is characterized by fever, back pain, and pain in the thigh and groin area. In this presentation, we aim to present a case of atypical psoas abscess diagnosed with the symptom of difficulty walking, along with a review of the literature.

Material and Methods: Different causes are implicated in the etiology of primary and secondary psoas abscesses. Patients usually describe their symptoms with abdominal pain, flank pain,weakness, high fever, sweating, weight loss, limping, and lower back and leg pain.

Results: A 50-year-old male patient presented to the emergency department with fever, weakness, weakness in the right leg, and difficulty walking. Physical examination revealed no pathological findings on the abdominal examination. However, increased temperature and edematous skin tissue (cellulitis) were detected in the right lateral quadrant. The patient had a high fever, with a WBC of 21,000 and a CRP of 212 mg/L. Plastron appendicitis was suspected, and abdominal ultrasound revealed a fluid collection consistent with a dense abscess in the right psoas region. CT scan showed a prominent 76x81 mm abscess in the right psoas region containing air densities. The patient was hospitalized, and a percutaneous drainage catheter was placed. Approximately 500 cc of abscess was drained. Broad-spectrum antibiotic therapy was initiated, and post-drainage physical examination showed improvement in the motor loss in the right leg and a decrease in WBC and CRP levels. The patient, who showed no signs of infection in urinary and gastrointestinal examinations, underwent Brucella antibody and PPD tests. The patient, whose general condition remained stable, was discharged after recovery.

Conclusion: Psoas abscess is a rare disease that develops secondary to inflammation in the psoas muscle and iliac muscle fascia. The incidence of psoas abscess is three times higher in men than in women. Patients typically present with abdominal pain, flank pain, weakness, fever, sweating, weight loss, limping, lower back pain, and leg pain. Treatment of psoas abscess involves antibiotic therapy and abscess drainage. Abscess drainage is recommended as percutaneous drainage with surgical or radiological guidance. In secondary psoas abscess, treatment should include drainage along with treatment of the primary disease causing the abscess.

Keywords: Percutaneous drainage, psoas abscess

[P-598]

A rare gastric schwannoma presenting as a suspected gastrointestinal tumor

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Objective: Gastric schwannomas are rare benign mesenchymal tumors originating from Schwann cells of the peripheral nerve sheath and account for a small proportion of gastrointestinal mesenchymal neoplasms. They are most commonly located in the stomach and are often detected incidentally. Due to significant overlap in radiological and endoscopic features, they are frequently misdiagnosed preoperatively as gastrointestinal stromal tumors (GISTs). Unlike GISTs, which carry malignant potential, gastric schwannomas typically follow a benign clinical course. Therefore, accurate diagnosis is essential for appropriate management and prognosis.

Material and Methods: A 71-year-old male patient presented with nausea and vomiting. His medical history was significant only for hypertension. Physical examination and laboratory findings were unremarkable. Contrast-enhanced computed tomography revealed a 26×18 mm well-circumscribed, homogeneous hypodense solid mass on the lesser curvature of the stomach. Upper gastrointestinal endoscopy demonstrated a 1.5 cm submucosal lesion in the gastric corpus. Based on imaging findings, GIST was suspected. The patient underwent laparoscopic wedge resection of the stomach.

Results: The postoperative course was uneventful, and the patient was discharged on postoperative day five. Macroscopic examination of the specimen revealed a 2.5 cm gray-white solid tumor. Histopathological analysis showed spindle cell proliferation. Immunohistochemical staining demonstrated strong S-100 positivity and negativity for CD34, SMA, desmin, and DOG1, confirming the diagnosis of gastric schwannoma. Surgical margins were negative.

Conclusion: Although rare, gastric schwannomas should be considered in the differential diagnosis of gastric submucosal tumors. Preoperative distinction from GIST is challenging, and definitive diagnosis relies on immunohistochemical evaluation. Complete surgical resection with negative margins is curative, and the prognosis is excellent. This case highlights the importance of accurate pathological diagnosis in guiding appropriate treatment and follow-up strategies.

Keywords: Gastric schwannoma, gastrointestinal stromal tumor (GIST), gastric submucosal tumor

[P-599]

Foreign body ingestion in adults with intellectual disability: A rare case of pacifier-induced jejunal perforation

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Objective: Foreign body ingestion in adults is common, with 80-90% passing spontaneously and less than 1% requiring surgical intervention. Pacifier ingestion causing bowel obstruction has been reported in children but never documented in adults with resulting jejunal necrosis and perforation.

Material and Methods: A 23-year-old male with intellectual disability and epilepsy presented with acute abdominal pain and vomiting. Clinical examination revealed peritonitis. Computed tomography demonstrated small bowel obstruction with a non-radiopaque foreign body and pneumoperitoneum. Emergency laparotomy revealed a pacifier lodged in the jejunum 100 cm distal to the ligament of Treitz, causing segmental necrosis and a 3-cm perforation. The patient underwent segmental jejunal resection with primary hand-sewn anastomosis. Histopathology confirmed transmural necrosis. The postoperative course was uncomplicated, with resumption of oral intake on day 2 and discharge on postoperative day 4. Antiepileptic therapy continued throughout hospitalization without seizure recurrence.

Results: This represents the first documented case of pacifier-induced jejunal perforation in an adult. The jejunum is an uncommon perforation site due to lack of anatomical narrowing. Non-radiopaque plastic objects pose diagnostic challenges requiring high clinical suspicion and computed tomography imaging. Primary anastomosis in jejunal resections demonstrates excellent outcomes with leak rates of 0.6-3%, substantially lower than colonic anastomoses. Individuals with intellectual disability and epilepsy face elevated risk for foreign body ingestion, necessitating preventive supervision strategies.

Conclusion: Pacifier ingestion in adults with intellectual disability can cause life-threatening jejunal complications. Early recognition, computed tomography diagnosis, and prompt surgical intervention with primary anastomosis achieve favorable outcomes.

Keywords: Intestinal obstruction, foreign bodies, jejunal perforation

Figure 1. Jejunum perforation. Jejunum perforation due to foreign body.

[P-600]

A rare case report of delayed colon perforation due to blunt trauma

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Objective: In abdominal trauma, perforations of hollow organs and injuries to solid organs such as the liver and spleen may be observed. Although hollow organ perforations are more commonly seen in penetrating injuries, they can also occur in hollow organs following high-energy blunt trauma. While perforation usually occurs in the early period after trauma, in some cases it may also present in a delayed phase.

Material and Methods: A 29-year-old male patient presented to the emergency department of our hospital due to a fall from an electric scooter that occurred 6 days earlier. Upon further history taking, it was learned that after falling from the scooter, he struck the left side of his abdomen against stone bollards. The patient stated that he came to the hospital because of pain in the left lower quadrant and reported that the pain was not severe. On abdominal examination, no abnormal findings were noted except for tenderness in the left lower quadrant. No acute pathology was observed on the radiographs obtained.

Results: The patient evaluated by our team was hemodynamically stable. On abdominal examination, no significant findings were detected except for tenderness in the left lower quadrant. Laboratory investigations revealed elevated infectious markers: WBC 14.2 (normal range: 4.01-9.75), CRP 79.8 (normal range: 0-5), and procalcitonin 6.06 (normal range: 0-0.5). Due to the elevationhan elevated infectious markers and left lower quadrant tenderness on abdominal examination, a computed tomography (CT) scan was performed for further evaluation. The CT findings were reported as follows: "A suspicious wall defect is present in the proximal sigmoid colon and distal descending colon. Inflammatory stranding is observed in the surrounding adipose tissue. Mesenteric fat stranding and millimetric free air are noted distal to the sigmoid colon."

Conclusion: The patient was admitted to the ward for surgical management due to a perforation secondary to trauma that had occurred 6 days earlier. A millimetric perforation was identified in the sigmoid colon, and the omentum was observed to be covering the perforated area.Due to colonic distension and intra-abdominal contamination, it was decided that a safe anastomosis could not be performed; therefore, a colostomy was created and a Hartmann procedure was performed. Oral intake was started at the 8th postoperative hour. The patient passed gas from the colostomy on postoperative day 1 and had stool output on postoperative day 2. After completion of antibiotic therapy, the patient was discharged from our ward.

Keywords: Blunt trauma, perforation

[P-603]

A rare case: Low-grade (Grade 1) dedifferentiated liposarcoma in a giant intra-abdominal mass and surgical management

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Objective: Liposarcomas are the most common subtype of retroperitoneal and intra-abdominal soft tissue sarcomas. Dedifferentiated liposarcoma (DDLPS) typically exhibits high-grade malignancy and an aggressive course. However, rarely, the dedifferentiated component may display low-grade (FNCLCC score 3) features. We present the surgical management of a giant Grade 1 DDLPS case requiring partial cystectomy, which was initially considered inoperable at an external center.

Material and Methods: A 69-year-old male patient presented with abdominal swelling lasting for 6 months. External center imaging revealed a 30x30 cm mass filling the abdomen and causing bilateral Grade 3 hydronephrosis. After placement of bilateral nephrostomy and DJ stents, the patient was referred to our surgery clinic following oncology board evaluation. After preoperative preparation, the patient underwent surgery. A midline incision revealed a giant, lobulated, septated, fixed mass containing cystic and solid areas, originating from the anterior abdominal wall and displacing the intestines laterally.

Results: The mass was separated from the peritoneum and intra-abdominal organs with careful dissection. The lower lobe was observed to be adherent to the bladder and vascular structures, invading the bladder. The upper lobe was removed with its capsule. Since the posterior capsule of the lower lobe was adherent to vascular structures, it was resected over the capsule, preserving vital structures. Due to bladder invasion, partial cystectomy was performed en-bloc with the mass, and the bladder was repaired. Bilateral ureters were preserved. Histopathological examination revealed dedifferentiated liposarcoma. According to FNCLCC scoring, the total score of tumor differentiation, mitosis, and necrosis was reported as 3 (Grade 1). The patient had an uneventful postoperative course and was discharged.

Conclusion: Giant intra-abdominal liposarcomas are surgically challenging cases due to their close proximity to vascular structures and urinary system organs. As in this case, management of urological compression signs (hydronephrosis) in the preoperative period and achieving complete clearance with organ resections (partial cystectomy) if necessary during surgery are vital. Encountering a rare score like “Grade 1” despite the pathological diagnosis of “Dedifferentiated” contributes to the literature in terms of demonstrating the biological behavioral diversity of these tumors.

Keywords: Dedifferentiated liposarcoma, intra-abdominal mass

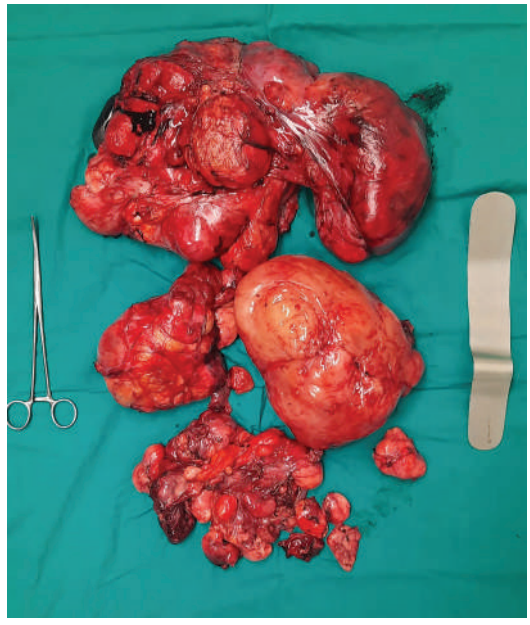

Figure 1. Macroscopic view of the resected giant mass. Heterogeneous structure with lobulated contours containing solid and cystic areas.

NUMUNE TÜRÜ:	Bağ dokusu, sütkutan doku ve diğer yumuşak dokular, BBT	**NUMUNE ALIM ŞEKLİ**	EKSİZYONEL BİOPSİ - AMELİYAT MATERYALİ
KLİNİK BİLGİ:	batın içi kitle		
MAKROSKOPİ:	Büyüğü 42x22x17 cm ölçülerde, küçüğü 5.2x4.3x4 cm ölçülerde olan çok sayıda krem pembe renkli dokulardır. Kesitlerinde büyük doku kesit yüzünün kirli krem renkli yer yer hemorajik alanlar içerdiği dikkati çekti. Dokulardan birinin iç ve dış yüzü parlak pembe-krem renkli, jelatinöz kıvamdadır. Bir kısmından 10p10k örneklendi. 29.12.25 Dr Cansu YP 15 parça 15 kaset alındı. dr.cansu 5.12.25		
MİKROSKOPİ:			
TANI:	**DEDİFERANSİYE LİPOSARKOM, DERECE 1 (FNCLCC skor:3); batın içi kitle, rezeksiyon.**		
ICD-O KODU :	8858/3 Dediferansiye liposarkom		
UYGULANAN ÖZEL YÖNTEMLER:	Eksternal kontroller eşliğinde çalışılan immunhistokimyasal testlerde tümör hücreleri S100 ile yaygın sitoplazmik ve nükleer, CDK4 ile yaygın nükleer pozitiftir. SOX10 ve MDM2 negatiftir. Ki67 proliferasyon indeksi yaklaşık %1-2 olarak değerlendirilmiştir.		

Figure 2. Pathology report. Pathology report confirming the histopathological diagnosis (dedifferentiated liposarcoma) and FNCLCC score (Grade 1).

[P-604]

Massive gastrointestinal bleeding due to a dieulafoy lesion: A rare case report

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Objective: Dieulafoy lesion is a rare but potentially life-threatening cause of gastrointestinal bleeding, resulting from erosion of an abnormally large submucosal artery through the mucosa. It accounts for approximately 1-2% of cases of acute gastrointestinal bleeding. Approximately 70-80% of Dieulafoy lesions are located in the stomach, with the most common site being the lesser curvature. Less frequently, Dieulafoy lesions may be observed in the duodenum, jejunum, colon, and rectum. Its presentation with sudden-onset, intermittent, and massive bleeding episodes may complicate the diagnostic process. Although endoscopic therapy is the first-line treatment, surgical intervention may be required in cases of massive and uncontrolled bleeding.

Material and Methods: A 77-year-old female patient presented to the emergency department with complaints of hematemesis that began overnight. Her medical history included diabetes mellitus, hypertension, congestive heart failure, and rivaroxaban (Xarelto) use. She had no prior history of gastroscopy or colonoscopy. After insertion of a nasogastric tube, dilated gastric contents with clotted hemorrhage were aspirated. Initial laboratory evaluation revealed hemoglobin/hematocrit levels of 8.5 g/dL and 26.7%, respectively, a platelet count of 264×10^3/L, and an INR of 1.4. During follow-up and erythrocyte suspension replacement, the patient developed intermittent episodes of bright red rectal bleeding. At times, abundant hemorrhage reaching 500-600 cc was observed. Despite transfusion therapy, hemoglobin and hematocrit levels decreased to 6.2 g/dL and 19.8%. In total, 7 units of erythrocyte suspension and 3 units of fresh frozen plasma were transfused. Although a transient increase in hemoglobin was achieved, recurrent massive bleeding episodes accompanied by clinical deterioration, hypotension, and tachycardia developed. Inotropic agent support was initiated, and the patient underwent emergency surgery with the diagnosis of massive gastrointestinal bleeding.

Results: Intraoperative exploration revealed an actively spurting Dieulafoy lesion located on the anterior wall of the gastric bulb. The bleeding vessel was ligated, and the lesion was excised. Postoperatively, the patient was transferred intubated to the intensive care unit. During ICU follow-up, inotropic support was discontinued, and vital signs stabilized.**Conclusion:** The patient was transferred to the surgical ward, tolerated oral intake, and showed no further decrease in hemoglobin levels, allowing discharge in stable condition. This case emphasizes that Dieulafoy lesions should be considered in the differential diagnosis of elderly patients receiving anticoagulant therapy who present with massive gastrointestinal bleeding mimicking both upper and lower sources, and that timely surgical intervention can be lifesaving when bleeding is uncontrollable.

Keywords: Dieulafoy lesion, massive upper gastrointestinal bleeding, emergency surgery

Figure 1. Dieulafoy lesion.

An atypically located Dieulafoy lesion on the anterior wall of the gastric bulb.

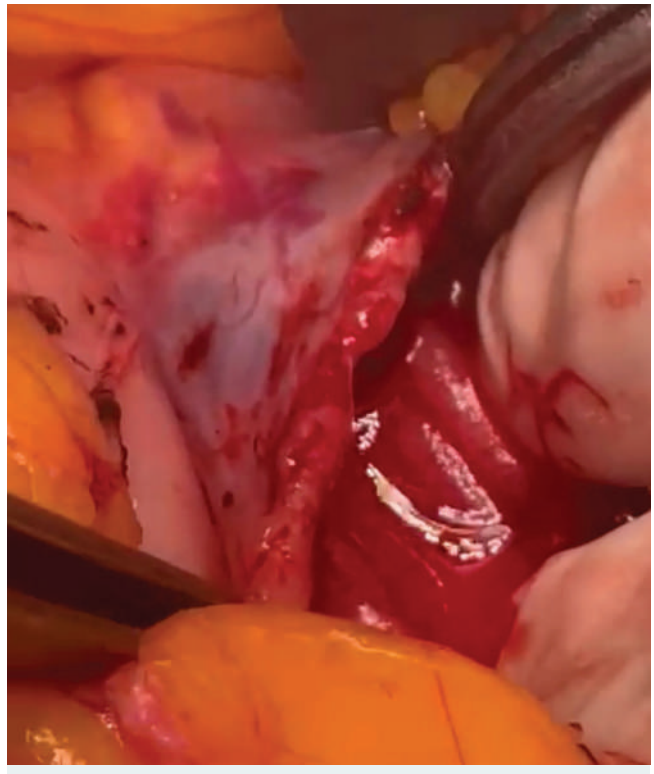

Figure 2. Dieulafoy lesion.

Abnormal submucosal vasculature.

[P-610]

Isolated sister Mary Joseph's nodule allowing curative resection in cecal adenocarcinoma: A rare case and review of the literature

Aytaç Selman, Elif Elgiz Aktarı, Emre Berat Akçay, Enver Açıkgöz, Meryem Günay Gürleyik

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Objective: Sister Mary Joseph's nodule (SMJN) is a rare clinical finding that typically indicates advanced intra-abdominal malignancy and is associated with a poor prognosis. However, in uncommon circumstances, it may present as an isolated metastasis amenable to curative resection. It is most commonly related to gastrointestinal and gynecological cancers and usually reflects disseminated disease. Here, we present a rare case of cecal adenocarcinoma in which an isolated SMJN was the initial clinical manifestation and permitted curative surgical treatment.

Material and Methods: A 76-year-old male patient presented with a painful umbilical mass that had persisted for several weeks. His medical history revealed an unintentional weight loss of approximately 8 kg over the preceding four months, without nausea, vomiting, or changes in bowel habits. Physical examination demonstrated a firm and tender umbilical mass measuring approximately 2 cm in diameter; no additional pathological findings were detected on abdominal examination.Abdominal computed tomography revealed a mass lesion in the cecum consistent with a primary tumor, along with an isolated lesion in the umbilical region. Tumor markers (AFP, CEA, and CA 19-9) were within normal limits. Biopsy of the umbilical mass demonstrated metastatic adenocarcinoma consistent with colorectal origin (CK20 positive, CK7 negative). FDG-PET/CT showed no evidence of distant organ metastasis or diffuse peritoneal involvement apart from the cecal and umbilical lesions. Colonoscopy revealed an ulcerovegetative mass in the cecum. Based on the clinical and radiological findings, curative surgical resection was planned.

Results: The patient underwent a right hemicolectomy with simultaneous umbilical metastasectomy. The operation and postoperative course were uneventful, and the patient was discharged on postoperative day 6. Histopathological examination revealed a moderately differentiated cecal adenocarcinoma invading the visceral peritoneum (pT4a), with metastases in five regional lymph nodes (pN2a). The umbilical lesion was consistent with metastatic adenocarcinoma (pM1a). Surgical margins were negative. The patient was referred to the oncology department for planned adjuvant chemotherapy.

Conclusion: Although SMJN is generally regarded as a sign of advanced and disseminated malignancy, it may rarely present as an isolated metastasis amenable to curative resection. This case underscores the importance of thorough staging and careful patient selection, as early recognition of this rare presentation may allow potentially curative surgical treatment.

Keywords: Sister Mary Joseph's nodule, umbilical metastasis, colorectal cancer

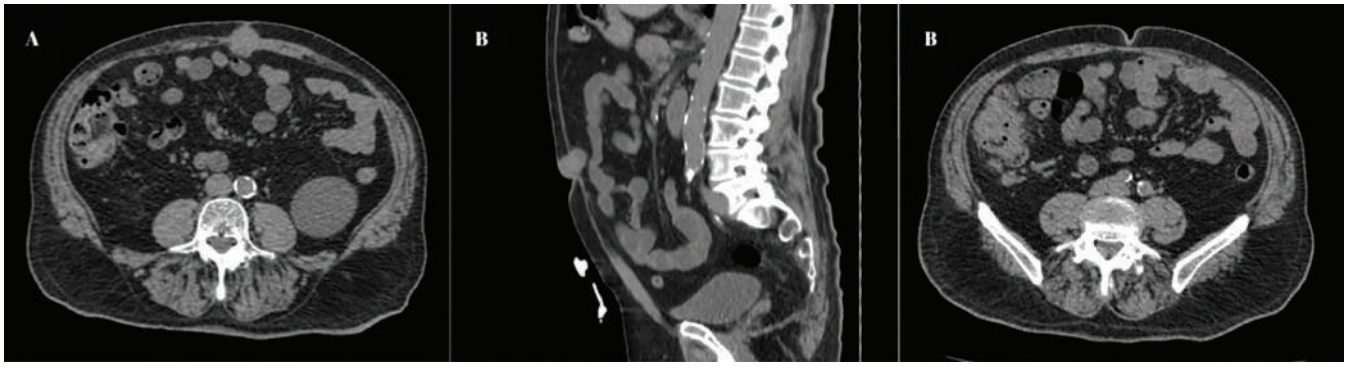

Figure 1. Contrast-enhanced abdominal computed tomography demonstrating (A) theprimary cecal adenocarcinoma and (B) the isolated umbilical metastatic lesion consistent withSister Mary Joseph's nodule.

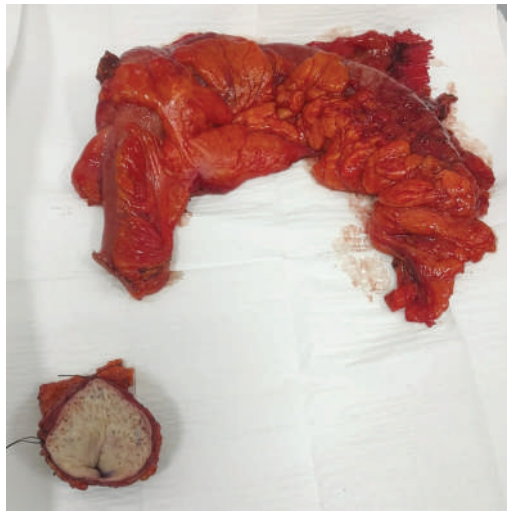

Figure 2. Gross surgical specimen following right hemicolectomy with synchronous resectionof the umbilical metastatic lesion.

[P-611]

Mechanical ileus caused by a degenerated hydatid cyst: A case report

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Objective: Hydatid disease is a zoonotic infection caused by the parasite Echinococcus granulosus. It most commonly affects the liver and lungs. Rarely, intraabdominal hydatid cysts may lead to complications and cause gastrointestinal obstruction. In this report, we present a rare case of mechanical ileus due to a degenerated hydatid cyst.

Material and Methods: Case presentation patient information -83-year-old male- Abdominal pain for 2 days -ınability to pass gas or stool physical examination -abdominal distension -diffuse tenderness -no guarding or rebound tenderness -decreased bowel sounds -empty rectal ampulla on digital rectal examination -laboratory findings -leukocytosis: 11,050 $\times 10^9$/L -CRP: 8.5 mg/L -liver function tests: within normal limits -sodium: 126 mmol/L radiological findings abdominal CT scan: -sigmoid colon displaced anteriorly -diffuse colonic dilatation with closed -loop obstruction (possible sigmoid volvulus) -multiple intraabdominal calcified lesions suggestive of degenerated hydatid cyst -obstruction likely related to a 5 cm lesion in the left lower quadrant. Treatment and surgical findings -the patient underwent emergency surgery with a preliminary diagnosis of mechanical ileus.

Results: Intraoperative findings: -sigmoid colon twisted around a degenerated hydatid cyst located in the sigmoid mesocolon -colon diameter reached 7-8 cm -Hartmann procedure was performed. Hydatid disease is usually asymptomatic but may cause complications such as rupture, infection, or compression. Degenerated mesenteric hydatid cysts are a rare cause of mechanical ileus. Abdominal CT is highly valuable for diagnosis. Treatment typically includes surgical excision and antiparasitic therapy.

Conclusion: Degenerated hydatid cysts, although rare, should be considered in the differential diagnosis of mechanical ileus. Early diagnosis and surgical intervention are critical to reduce morbidity.

Keywords: Hydatid cyst, mechanical ileus, mesenteric involvement

[P-612]

Advanced appendiceal adenocarcinoma in a patient presenting with unexplained abdominal pain and weight loss: The role of diagnostic laparoscopy in staging

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Objective: Appendiceal adenocarcinoma is a rare malignancy among gastrointestinal system cancers and usually presents with non-specific clinical findings. This often complicates the diagnostic process and may result in detection at an advanced stage. In patients with unexplained abdominal pain and systemic symptoms, diagnostic laparoscopy may provide significant contribution to both diagnosis and staging.

Material and Methods: A 62-year-old male patient presented with long-standing abdominal pain and unintentional weight loss. Due to the detection of anemia and elevated tumor markers during initial evaluation, the patient was hospitalized for further investigation. Laboratory analysis revealed a hemoglobin level of 8.2 g/dL, CA 19-9 level of 18,569 U/mL, and CEA level greater than 995 ng/mL. Abdominal computed tomography demonstrated marked thickening of the appendiceal wall, luminal dilatation up to 12 mm, contrast enhancement, and paracecal lymph nodes. Colonoscopy revealed no pathological findings. As no definitive diagnosis could be established clinically or radiologically, the patient was evaluated at a multidisciplinary tumor board and diagnostic laparoscopy was planned. Laparoscopic exploration revealed a firm and distended appendix, along with diffuse flat lesions on the peritoneal surfaces suggestive of widespread involvement. Appendectomy was performed using a linear stapler to include the entire palpable lesion, and peritoneal biopsies were obtained.

Results: Histopathological examination revealed a moderately differentiated (G2) adenocarcinoma measuring 7 cm in greatest dimension, involving the entire appendix with transmural invasion including the serosa. Lymphovascular and perineural invasion were present. The proximal and mesenteric surgical margins were reported as positive. The tumor was staged as pT4a according to the AJCC 8th edition. Peritoneal biopsies were consistent with metastatic adenocarcinoma.

Conclusion: Appendiceal adenocarcinoma may present with unexplained abdominal pain and systemic symptoms, leading to diagnostic challenges. Diagnostic laparoscopy is an important modality for determining disease extent and guiding appropriate oncological treatment planning. In this case, laparoscopic assessment revealed peritoneal metastasis, and the patient was referred for chemotherapy followed by HIPEC.

Keywords: Appendectomy, diagnostic laparoscopy, appendiceal adenocarcinoma

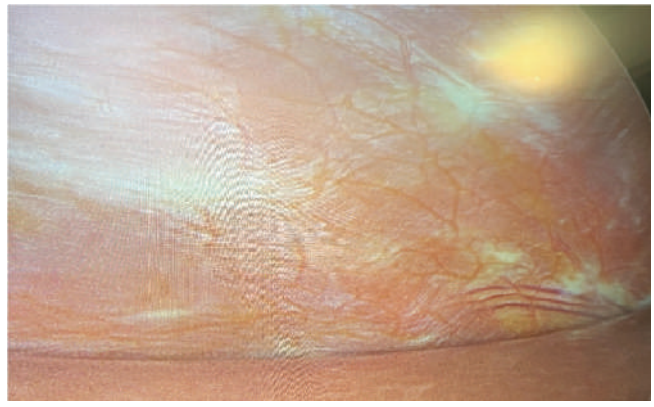

Figure 1. Peritoneal involvement.

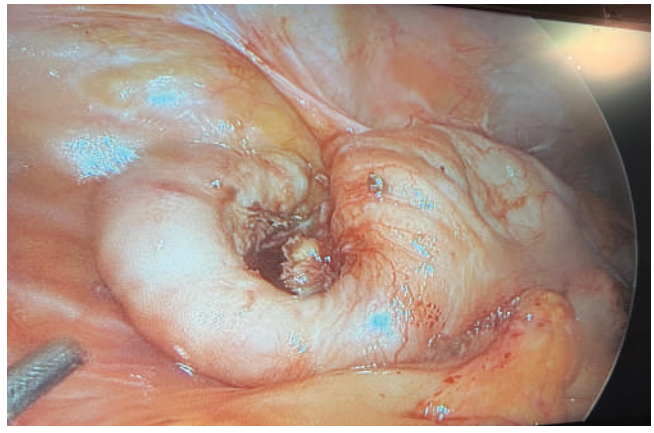

Figure 2. Appendix.

[P-613]

A rare case of upper gastrointestinal bleeding: Our clinical experience

Kubilay Sertkaya, Berat Demir, Seda Külekçi, Samet Şahin

Muğla Sıtkı Koçman University Faculty of Medicine, Muğla

Objective: Gastrointestinal stromal tumors (GISTs) are mesenchymal neoplasms originating from interstitial Cajal cells and constitute approximately 1-2% of all gastrointestinal cancers. While most commonly found in the stomach and small intestine, duodenal localization is quite rare, accounting for only about 3% of all GIST cases. Duodenal GISTs present unique challenges in surgical management due to their close anatomical relationship with the papilla of Vater and the head of the pancreas. Therefore, balancing oncological competence with organ-preserving approaches is of paramount importance in treatment planning.

Material and Methods: A 71-year-old male patient was evaluated for gastrointestinal bleeding. Abdominal computed tomography revealed a mass lesion in the descending duodenum, approximately 6 cm in diameter, with well-defined and heterogeneous features, suggestive of GIST (gastrointestinal stimulation). Upper gastrointestinal endoscopy showed a subepithelial lesion in the second portion of the duodenum, with visible vascular structures in the center.

Results: Based on the current clinical, radiological, and endoscopic findings, the patient was diagnosed with duodenal GIST and surgical treatment was planned. Considering the location of the tumor between the third and fourth segments of the duodenum and its possible anatomical relationship with the papilla of Vater, the need for pancreaticoduodenectomy was evaluated; however, due to the appropriate patient and tumor characteristics, an organ-conserving surgical approach was preferred. Accordingly, the patient underwent duodenal wedge resection. Lymph node dissection was not performed due to the low tendency of GISTs to metastasize lymphadically. In the patient's postoperative follow-up, no anastomotic leakage or surgical complications occurred, and the patient, whose clinical course was uneventful, was discharged in good health.

Conclusion: Duodenal GISTs present surgical challenges due to their rarity and close association with critical anatomical structures. Pancreaticoduodenectomy may be unavoidable, particularly in cases with close association with the papilla of Vater or the head of the pancreas. However, the literature reports that organ-preserving surgical approaches such as wedge resection or limited duodenal resection can be safely applied in appropriately selected cases. These approaches reduce surgical morbidity while maintaining adherence to oncological principles. The presented case is important because it demonstrates that organ-preserving surgery, with careful preoperative evaluation and surgical planning, can be an effective option in duodenal GISTs.

Keywords: Upper GI bleeding, duodenal GIST, gastrointestinal stromal tumor

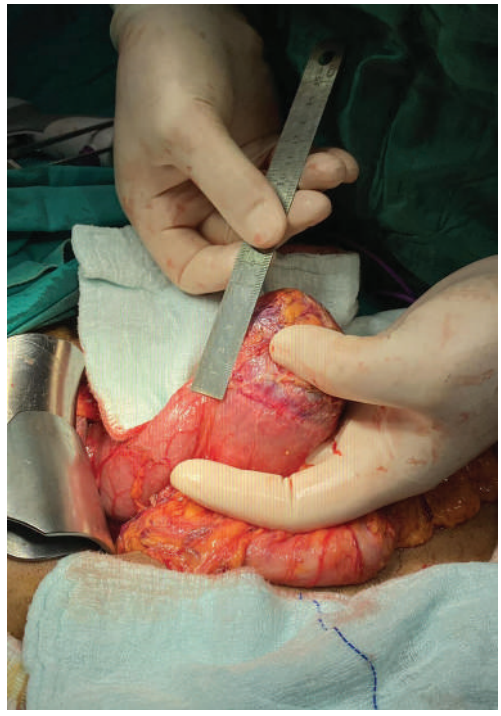

Figure 1. Duodenal GIST.

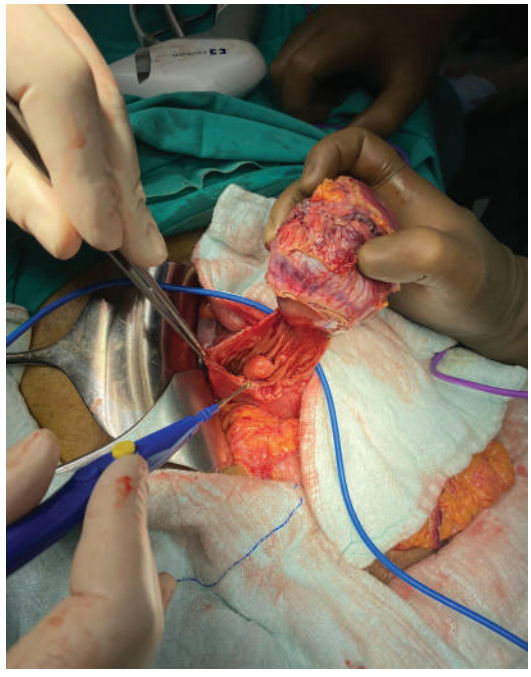

Figure 2. Duodenal gist wedge resection.

[P-614]

A rare cause of ileus: Ileus due to compression from an abdominal aortic aneurysm

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Objective: Ileus can occur as a slowing or cessation of normal intestinal motility, and it may also be caused by internal or external compression of the bowel. Mechanical causes are usually mass lesions. Although rare, ileus may also occur due to compression of the intestines by an abdominal aortic aneurysm.

Material and Methods: A 75-year-old male patient presented to our hospital's emergency department with complaints of nausea, vomiting, and abdominal pain. His medical history included hypertension, angina pectoris, and cysts in the right kidney. He had previously undergone graft surgery for the abdominal aorta and iliac arteries due to an abdominal aortic aneurysm (AAA). The patient had not passed gas for one day and had no bowel movements for two days. Because of his pain and tenderness, especially in the epigastric region, an upright abdominal radiograph was obtained, which did not show any significant pathology.

Results: He had tenderness in the epigastric region and minimal abdominal distension. WBC 10.19 (4.01-9.75), CRP 14.7 (0-5), potassium 5.11 (3.5-5.1). A CT scan was performed to investigate the cause of the ileus. The CT findings were reported as follows: "The stomach appears markedly distended. Additionally, dilation up to 5 cm with air-fluid levels was observed in the first and second parts of the duodenum. The transition zone is located in the third part of the duodenum adjacent to the AAA sac". The patient was admitted to our ward with a diagnosis of ileus due to compression of the third part of the duodenum by the AAA. An NG tube was placed, and over 24 hours it drained approximately 1.000 cc of bile- and gastric fluid-mixed content. Despite 24 hours of medical treatment, the patient's symptoms did not improve and his distension persisted. The patient underwent a laparoscopic gastrojejunostomy for duodenal obstruction caused by the AAA in the third part of the duodenum.

Conclusion: In our review of the literature and case reports, only a few studies were found describing ileus caused by compression from an AAA due to intestinal malrotation in adults. Intestinal malrotation is usually diagnosed in the neonatal period, but studies have shown that its incidence in adults is approximately 0.2%. Although malrotation was not present in this case, the patient developed ileus due to duodenal compression by an AAA. As the ileus did not resolve with medical treatment, a gastrojejunostomy was performed and the patient was discharged in complete remission.

Keywords: Abdominal aortic aneurysm, ileus

Figure 1. X-ray. Preoperative upright abdominal radiograph.

[P-617]

Double pyramidal lobe of the thyroid gland: Report of two consecutive cases with surgical and oncologic implications

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Objective: The thyroid gland typically consists of two lateral lobes connected by an isthmus. A pyramidal lobe (PL), derived from the thyroglossal duct remnant, may extend superiorly toward the hyoid bone and is reported in up to 40-65% of individuals. Because of this frequency, the PL is often regarded as a common anatomical component. We present two consecutive surgically documented cases of DPL, one associated with papillary thyroid carcinoma and the other with benign multinodular goiter, emphasizing the surgical and oncologic implications of this rare anatomical variant.

Material and Methods: Case 1: Fifty one old woman with chronic kidney diseaseand hypertension was referred for evaluation of a thyroid nodule. Her surgical history included cervical spine surgery, multiple renal stone operations, and cesarean sections. Family history revealed multiple thyroid surgeries for benign disease. Preoperative evaluation neck ultrasonography demonstrated a 19×13 mm hypoechoic nodule with lobulated margins and internal microcalcifications in the posterior mid-zone of the left thyroid lobe (TI-RADS 4-5). Fine-needle aspiration biopsy reported suspicion for malignancy; papillary carcinoma could not be excluded. No PL was identified on imaging. Surgery total thyroidectomy with central lymph node dissection was performed. During routine cervical exploration, two distinct PLs arising from the superior aspect of the isthmus and extending cranially toward the infrahyoid region were incidentally identified and completely excised. Case 2A: Fifty five-year-old man with a history of asthma underwent thyroidectomy for multinodular goiter. He had no history of thyroid malignancy. Preoperative evaluation. Neck ultrasonography revealed an enlarged thyroid gland with heterogeneous parenchyma and multiple solid nodules. Bilateral cervical lymph nodes were reactive in appearance. No PL was reported on imaging. Surgery during routine cervical exploration, two distinct PLs arising from the superior aspect of the isthmus were clearly identified.

Results: Failure to recognize and excise PLs may have significant clinical consequences. Residual thyroid tissue following total thyroidectomy can lead to recurrence of benign disease and may present years later as a midline cervical mass. In patients with differentiated thyroid carcinoma, remnant pyramidal tissue may compromise oncologic completeness and interfere with postoperative radioactive iodine therapy by acting as a competing site for iodine uptake. Furthermore, secondary surgery in the central neck carries an increased risk of complications compared to meticulous primary resection.

Conclusion: Double pyramidal lobe (PL) is an extremely rare thyroid anatomical variation. Two consecutive cases were identified within a short time interval. One case was associated with papillary thyroid carcinoma and nodal metastasis. Preoperative imaging failed to identify the PLs in both patients. Systematic prelaryngeal exploration is crucial during thyroidectomy.

Keywords: Double pyramidal lobe, thyroid gland, papillary thyroid carcinoma, anatomical variation, thyroidectomy

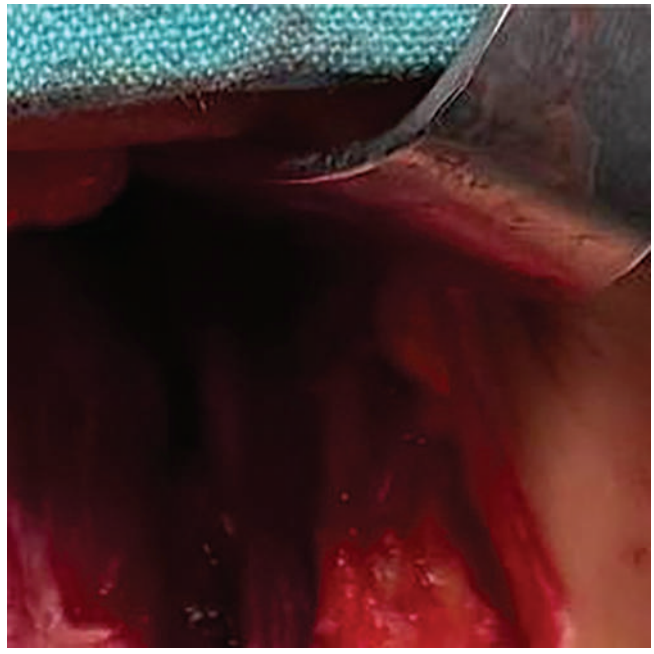

Figure 1.

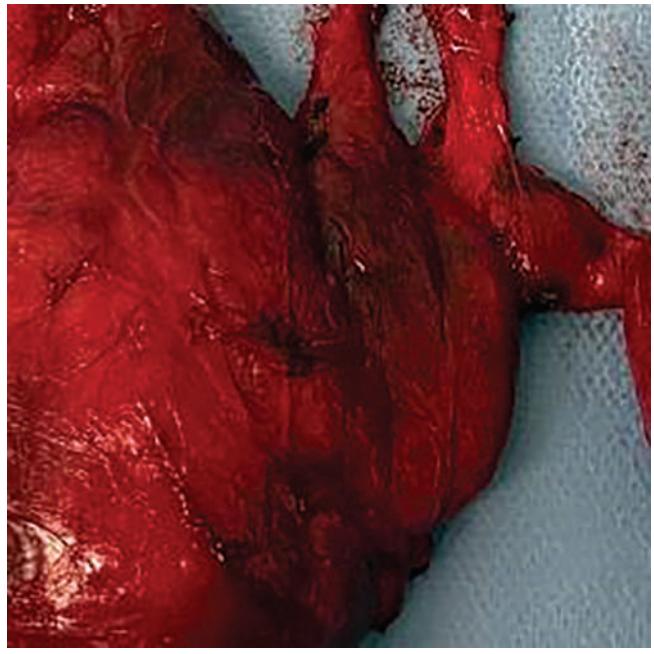

Figure 2.

Table 1. Result

Double pyramidal lobe (PL) is an extremely rare thyroid anatomical variation.
Two consecutive cases were identified within a short time interval.
One case was associated with papillary thyroid carcinoma and nodal metastasis.
Preoperative imaging failed to identify the PLs in both patients.
Systematic prelaryngeal exploration is crucial during thyroidectomy.

[P-618]

Giant retroperitoneal liposarcoma: Diagnosis and en block resection in a 59-year-old male patient

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Objective: Liposarcomas are rare malignancies originating from primitive mesenchymal cells rather than mature adipose tissue. Although they constitute less than 0.2% of all malignancies, they make up approximately 40-50% of retroperitoneal sarcomas. More than half of the masses are larger than 20 cm at the time of diagnosis. The main goal in treatment is radical surgical resection with negative surgical margins.

Material and Methods: A 59-year-old male patient presented with complaints of abdominal swelling and intermittent abdominal pain, which he had noticed for approximately three months, without any known chronic disease or history of previous abdominal surgery. Detailed physical examination revealed a palpable, well-defined mass in the right quadrant of the abdomen. The patient was scheduled for a complete blood count, extensive biochemistry and tumor markers, along with abdominal ultrasonography and contrast-enhanced abdominopelvic computed tomography. On abdominal ultrasonography, the pancreas, midline, and abdominal aorta could not be visualized due to high echogenicity. A hyperechoic solid/fatty mass lesion measuring 273x186 mm at its largest dimension was reported in this echogenic area, with no significant vascular signal.

Results: The definitive treatment of RPLSs is complete surgical resection. In giant tumors, the rate of invasion of surrounding organs can reach up to 80%. In these cases, in order to reduce the risk of recurrence and increase local control, en bloc resection of organs such as the kidney, colon, or spleen may be necessary in selected patients. Local recurrence is the most fundamental problem responsible for a large part of mortality in cases where distant metastasis does not develop. According to the World Health Organization classification, histological subtype is the most critical determinant of prognosis. While well-differentiated liposarcomas carry a low metastatic risk but a high potential for local recurrence, dedifferentiated liposarcomas may show a more aggressive clinical course. Although aggressive surgical approach has been shown to reduce recurrence, its effect on overall survival continues to be debated in the literature.

Conclusion: En bloc resection is the key step in achieving cure in giant retroperitoneal liposarcomas. Due to the rarity of the disease and the complexity of the surgery, a multidisciplinary approach and management by an experienced surgical team are crucial. Long-term and close follow-up of patients is necessary due to the high potential for local recurrence.

Keywords: Liposarcoma, retroperitoneum, giant

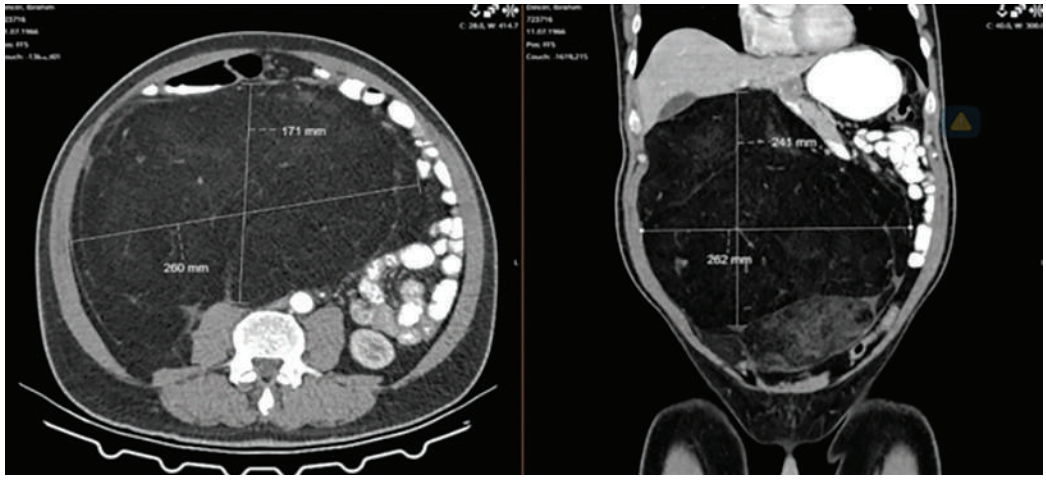

Figure 1. Axial and coronal section CT scan.

[P-620]

Peritoneal loose body in a 66-year-old male patient: A case report

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Objective: Peritoneal loose body (PLB), also known as a peritoneal mouse, is a rare intra-abdominal condition. Most cases are asymptomatic and are incidentally detected during radiological imaging. PLBs are usually smaller than 2-3 cm in diameter, although in rare cases they may grow to several centimeters. They are most commonly thought to originate from torsion of an epiploic appendage or from small intra-abdominal fat necrosis.

Material and Methods: A 66-year-old male patient was referred to our university hospital with decreased urine output, benign prostatic hyperplasia (BPH), and glob vesicale managed with catheterization. The patient had no complaints of abdominal pain, constipation, or palpable mass. Contrast-enhanced computed tomography (CT) performed for evaluation of his urinary symptoms incidentally revealed a well-defined, nodular lesion measuring approximately 40×27 mm, showing heterogeneous contrast enhancement, located between the bowel loops adjacent to the right lateral aspect of the urinary bladder (Figure 1). An open surgical procedure for BPH was planned by the urology department, and the general surgery team accompanied the operation. During surgery, a freely mobile, white, ovoid mass was identified between the urinary bladder and the bowel loops, floating freely within the mesentery. The mass was removed from the abdominal cavity without the need for dissection (Figure 2). No additional intra-abdominal pathology was detected during exploration.

Results: Peritoneal loose bodies are rare benign entities, and their true incidence worldwide remains unknown. Although their exact etiopathogenesis has not been fully elucidated, they are most commonly believed to result from torsion of epiploic appendages followed by ischemia, fat necrosis, and subsequent calcification. PLBs are more frequently observed in male patients and are generally asymptomatic. However, when the mass enlarges or exerts pressure on adjacent organs, symptoms such as urinary retention, constipation, or small bowel obstruction may occur. CT and magnetic resonance imaging (MRI) are helpful diagnostic tools, and the mobility of the lesion—demonstrated by changes in position on serial imaging—may be a distinguishing feature.In the present case, the patient was male and had no symptoms suggestive of an intra-abdominal mass. His urinary complaints were attributed to pre-existing prostatic enlargement. The PLB was incidentally detected during surgery and was easily removed without the need for dissection.

Conclusion: Peritoneal loose bodies are most often diagnosed incidentally through radiological imaging. Evaluation by an experienced radiologist can facilitate accurate diagnosis and differentiation from other intra-abdominal pathologies. Surgical removal is recommended once the diagnosis is established. Subsequent histopathological examination is important to exclude malignancy.

Keywords: Peritoneal loose body, peritoneal mouse, case report, incidental finding, intra-abdominal mass

Figure 1.

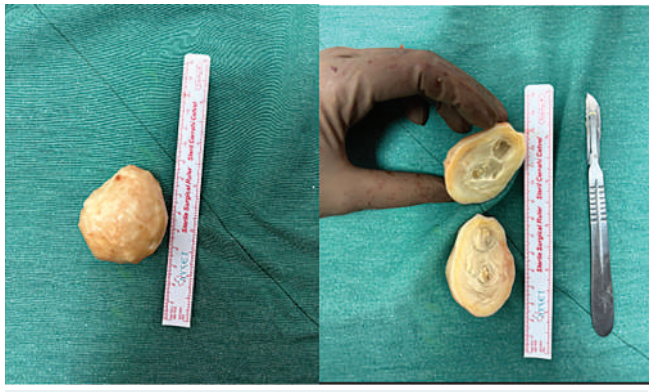

Figure 2.

[P-628]

A rare ileus in adults: Jejunal intussusception

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Objective: Intussusception is the penetration of the proximal bowel segment into the distal bowel segment. Intussusception is a pathology usually seen in children. It is also rarely encountered in adults. It constitutes 1-5% of all bowel obstructions. In this presentation, we aim to present a case of jejunal intussusception along with a review of the literature.

Material and Methods: Adult intussusception cases are seen on average in the 5th decade. Unlike in children, intussusception in adult patients almost always occurs due to a secondary pathology.

Results: A 20-year-old male patient presented to the emergency department with sudden onset of severe abdominal pain, nausea, and vomiting. Physical examination revealed tenderness in all quadrants of the abdomen, particularly prominent in the left upper quadrant. The patient described enteritis, and rectal examination revealed liquid stool contamination. Laboratory evaluation showed no pathological findings except for a WBC count of 17.3x10³ µL. An upright plain abdominal X-ray showed air-fluid levels consistent with ileus in the proximal segments. Oral and IV contrast-enhanced abdominal CT scans revealed intussusception in the proximal jejunal segments, involving approximately 10 cm, consistent with the target sign. No further pathological findings were detected, and the patient was hospitalized. He underwent NG decompression, fluid resuscitation, and antibiotic therapy. On the second day after admission, spontaneous gas and stool discharge was observed. Follow-up X-rays showed regression of ileus findings, and the patient was discharged with an appointment for MR enterography.

Conclusion: The general consensus regarding the treatment of intussusception is that non-operative reduction is the primary approach. However, the main treatment for adult intussusception is surgical resection. This is because the likelihood of an underlying predisposing factor causing intussusception is higher in adult patients compared to pediatric patients. CT scan is the radiological method with the highest diagnostic accuracy rate. The most common symptom at presentation is abdominal pain. Bloody diarrhea and signs of obstruction are other symptoms.

Keywords: Intussusception, jejunum

[P-629]

Tailgut cyst case report

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Objective: Tailgut cyst is a benign lesion that is rarely seen in the abdominal region and is often asymptomatic. Referred to as "tailgut cyst" in various sources, it is generally a congenital anomaly and is classified among "developmental cystic lesions". Tailgut cyst develops during the embryonic period, particularly as a result of an epithelial malformation originating from endodermal tissues. Clinical symptoms are usually absent; however, as the cyst enlarges, abdominal pain, a palpable mass, and, rarely, complications (e.g., infection or cyst rupture) may be observed. Tailgut cyst is often identified incidentally through radiological imaging methods. Imaging studies provide important information about the cyst's content, localization, and its relationship with surrounding tissues. Early diagnosis is critical in terms of enabling surgical intervention and preventing potential complications. Treatment generally consists of surgical excision, depending on the size of the cyst and the presence of symptoms. Management of these cysts may require a multidisciplinary approach.

Material and Methods: A 32-year-old female patient had previously presented to different medical centers with complaints of intermittent abdominal pain persisting for eight years, which did not significantly affect her daily life. During her gynecology consultation, a pelvic MRI was requested with a preliminary diagnosis of endometriosis. After imaging findings consistent with a tailgut cyst were identified on pelvic MRI, she was referred to our department.

Results: She had no known comorbidities and no history of prior surgery. On physical examination, minimal tenderness was noted in the suprapubic region. No pathological findings were detected in laboratory tests. On the follow-up MRI requested by our department, a lesion measuring approximately 66×37×52 mm was identified in the retrorectal space, surrounding the rectum, with no apparent relationship to adjacent structures. The imaging findings were primarily consistent with a tailgut cyst.

Conclusion: In this case, consistent with the general consensus in the literature, a follow-up strategy rather than surgical intervention was considered appropriate for an asymptomatic and small tailgut cyst. This approach allows for the management of potential complications before they develop and helps avoid unnecessary surgery.

Keywords: Tailgut, cyst, semptomq

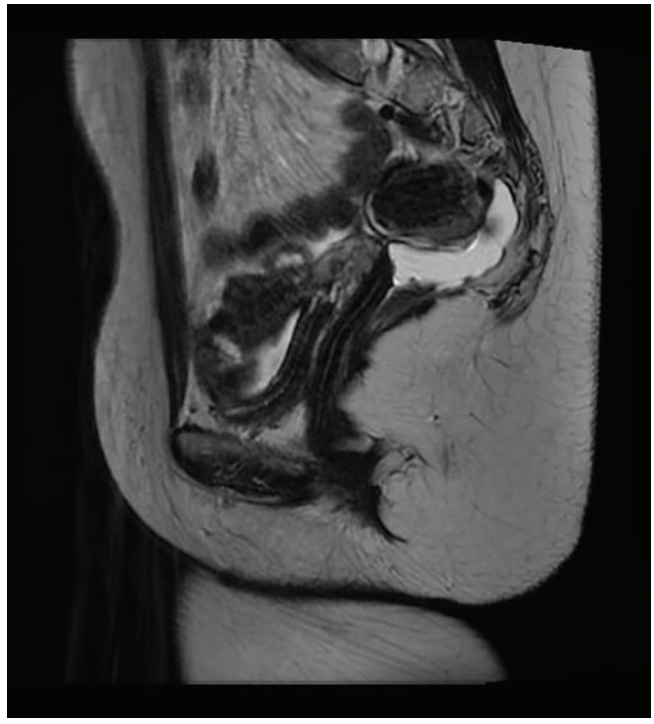

Figure 1. Radiological imaging.

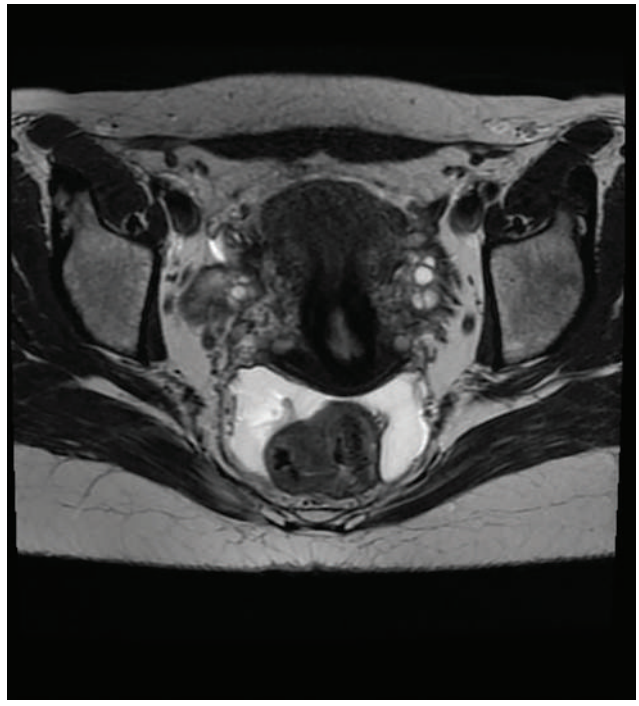

Figure 2. Radiological imaging.