POST-CHOLECYSTECTOMY SYNDROME: CAUSES, DIAGNOSIS AND MANAGEMENT SOLUTIONS

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Background. Cholecystectomy is used in the treatment of cholelithiasis and cholecystitis, with a global incidence of over one million cases annually. Although effective, 10–30% of patients develop post-cholecystectomy syndrome (PCS), manifested by upper abdominal pain, bloating, diarrhea, dyspepsia, or jaundice.

Objective(s). To identify the causes and effective therapeutic strategies in PCS, with emphasis on risk factors and treatment outcomes in symptomatic patients with post-cholecystectomy syndrome.

Materials and methods. Extensive literature research was carried out by looking through the databases Pub Med, Web of science and Medscape. Included were studies on PCS's clinical presentation, diagnostic techniques, and therapy

Results. To provide an overview of PCS's prevalence, common causes, diagnostic methods, through data extraction and analysis.

Results. PCS affects 5% to 40% of patients with cholecystectomy. Sphincter Oddi dysfunction, biliary strictures, and retained common bile duct stones are as biliary factors. Peptic ulcer and pancreatic diseases are non-biliary factors. Endoscopic retrograde cholangiopancreatography, magnetic resonance cholangiopancreatography and ultrasound is recommended. Treatment options include sphincterotomy, endoscopic stone removal, and medication management of gastrointestinal symptoms, depending on the etiology. Most individuals have a considerable improvement in their symptoms with early diagnosis and individualized treatment.

Conclusion(s). Post Cholecystectomy Syndrome is a rare but important complication. Personalized treatment improves symptoms and quality of life. Multidisciplinary evaluation is essential to distinguish biliary from non-biliary causes and to ensure appropriate management and better patient outcomes.

Keywords: post cholecystectomy syndrome, dyspepsia, endoscopy

HEMODYNAMIC PROFILE ASSOCIATED WITH THE INDUCTION OF GENERAL ANESTHESIA

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Background. General anesthetics have significant effects on the hemodynamic profile of the patient, depending on comorbidities and the associated anesthetic risk. Continuous intraoperative monitoring of hemodynamic parameters allows for early identification of these effects and prompt subsequent intervention.

Objective(s). To evaluate the hemodynamic profile of patients undergoing general anesthesia based on ASA score, age and comorbidities (arterial hypertension, obesity degree, diabetes mellitus).

Materials and methods. A prospective study was conducted on 60 patients undergoing general anesthesia during laparoscopic cholecystectomy, in the IMU, between January and June 2025. The analyzed hemodynamic parameters were: BP, HR, perfusion index, during

preinduction, induction and the following 20 min, using the Mann-Whitney U and Kruskal-Wallis tests.

Results. Statistically significant differences were found in the ASA I, II, III groups in induction sBP- 123.82 vs 138.69 vs 169.21 (p<0.001), induction dBP- 74.73 vs 82.89 vs 93.64 (p=0.011), induction MAP- 90.36 vs 102.34 vs 119.36 (p=0.004), induction PI- 5.51 vs 2.69 vs 2.17 (p=0.011). In the age groups > 55 and > 65 years, differences were noted in sBP, dBP, MAP at induction (p<0.05). In class I obesity, there were differences in sBP (p<0.044), dBP (p<0.016), MAP (p=0.05) at 5th min, and in class III - in sBP (p=0.032), MAP (p=0.025) at 3rd min. In hypertension, variations were noted in sBP, dBP, MAP at induction, in 1st and 2nd min (p<0.05).

Conclusion(s). The ASA score, the age and the comorbidities (obesity, hypertension) cause variations in hemodynamic indices during induction of general anesthesia, which allows early stratification of patients for appropriate pre-anesthetic preparation and according to the protocol-intraoperative management.

Keywords: hemodynamic parameters, general anesthesia, induction

FOOD POISONING OR ADRENAL INSUFFICIENCY? THE ROLE OF HYPERKALEMIA IN GUIDING THE DIAGNOSIS

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Background. Hyperkalemia (>5.9 mmol/L) has multifactorial causes. Although it is frequently associated with renal insufficiency, hyperkalemia is also a manifestation of adrenal insufficiency, especially during acute decompensation. Identifying the underlying cause of hyperkalemia is essential for appropriate management.

Objective(s). To highlight the importance of hyperkalemia as a diagnostic marker in identifying severe conditions, such as hypocortisolism, in seemingly benign contexts like suspected food poisoning.

Materials and methods. We present the case of a 29-year-old patient who presented to Medpark Hospital in the summer of 2018 with recurrent episodes of vomiting and diarrhea, salt craving, epigastric pain, asthenia, and somnolence, which began suddenly after consuming citrus fruits, initially raising suspicion of food poisoning. The final diagnosis was Addison's disease.

Results. Objective examination revealed skin hyperpigmentation and low-grade fever. Laboratory findings showed hyponatremia 126.0 mmol/L (135–145 mmol/L) and hyperkalemia 6.73 mmol/L (3.5–5.1 mmol/L), with normal renal function. Notably, potassium levels rose to 7.11 mmol/L six hours after initial treatment. The abrupt symptom onset, skin hyperpigmentation, treatment-resistant hyperkalemia, and absence of renal pathology prompted adrenal evaluation. Hormonal tests confirmed low cortisol 1.8 µg/dL (5–25 µg/dL), low aldosterone 2.7 ng/dL (5–30 ng/dL), and elevated ACTH 81 pg/mL (10–60 pg/mL), establishing the diagnosis of Addison's disease.

Conclusion(s). Hyperkalemia may serve as an early warning sign for acute adrenal insufficiency. Therefore, hyperkalemia should always be interpreted in conjunction with the