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

clinical and paraclinical picture, as it may represent the first indicator of a life-threatening systemic disorder.
Keywords: hyperkaliemia, Addison disease, food poisoning, cortisol

IMAGING DIAGNOSIS OF EMPHYSEMATOUS NECROTIZING PANCREATITIS

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Background. Emphysematous necrotizing pancreatitis (ENP) is a severe form of acute pancreatitis, characterized by infected necrosis and accumulation of intra- and peripancreatic gas. Early diagnosis via computed tomography (CT) is essential for evaluating inflammation extent and guiding therapy.
Objective(s). To evaluate the performance of computed tomography in diagnosing emphysematous necrotizing pancreatitis and to compare its effectiveness with other imaging methods used in clinical practice.
Materials and methods. A retrospective observational study was conducted, based on CT image analysis and clinical data of patients diagnosed with emphysematous necrotizing pancreatitis. Methods included contrast-enhanced CT, abdominal ultrasound, and magnetic resonance imaging. Necrosis, gas, fluid collections, and inflammation extent were analyzed.
Results. CT is the gold standard in imaging evaluation of emphysematous necrotizing pancreatitis because it rapidly and accurately detects inhomogeneous parenchymal necrosis, intrapancreatic and peripancreatic fluid collections, and air in infectious foci. Abdominal ultrasound is limited by intestinal gas and reverberation artifacts, while magnetic resonance imaging, though offering excellent tissue resolution, is less accessible. Contrast-enhanced CT provides essential data for assessing inflammation severity, staging necrosis, and identifying complications. Recent studies confirm contrast-enhanced CT as the reference standard in ENP management.
Conclusion(s). Early and accurate diagnosis of emphysematous necrotizing pancreatitis by contrast-enhanced CT is an essential element in assessing the extent of necrosis and associated complications. Recent studies reinforce the role of CT as the imaging method of reference, superior to other techniques.
Keywords: emphysematous necrotizing pancreatitis, CT, medical imaging

IMAGING DIAGNOSIS OF INTRAHEPATIC VOLUME FORMATIONS

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Background. Liver nodules can occur both on the background of non-cirrhotic and cirrhotic liver. Early diagnosis through CT and MRI imaging examinations of benign and malignant liver lesions is essential for evaluating imaging criteria, assessing the extent of the tumor process, and establishing therapeutic management.
Objective(s). Evaluation of imaging performance by CT and MRI in the diagnosis of benign and malignant liver tumors and comparison of the efficiency of each imaging method in current clinical practice.
Materials and methods. In a retrospective, observational study, 200 patients with benign and malignant liver formations were selected from January 2021 to January 2025. The imaging criteria included: dimensions, structure, extension of the tumor process and vascular invasion in malignant tumors. Sensitivity, specificity, PPV and NPV were evaluated.