SSNCON2026
Society of Surgeons of Nepal ·
Biratnagar, Nepal

BIRAT MEDICAL COLLEGE TEACHING HOSPITAL



SOCIETY OF SURGEONS OF NEPAL PRESENTS

# SSNCON2026

# XV$^{th}$ National Conference of the Society of Surgeons of Nepal



*"Advancing Surgical Excellence: Innovation, Technology & Collabortion"*

**26 – 28 November 2026, Biratnagar, Nepal**

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# In Loving Remembrance



LATE PROF. DR.

**Dinesh Nath Gongal**



LATE DR.

**Sudip Kumar Bhattacharya**



LATE DR.

**Prakash Raj Neupane**

# Message from the Chief Guest



**Hon'ble Mr. Hikmat Kumar Karki**
Chief Minister
Koshi Province

## शुभकामना

नेपाल शल्य चिकित्सक समाज (Society of Surgeons of Nepal-SSN) को पन्ध्रौँ राष्ट्रिय सम्मेलन (SSNCON 2026) को अवसरमा कोशी प्रदेशको राजधानी विराटनगरमा आउनुभएका सम्पूर्ण अतिथि, शल्य चिकित्सक, स्वास्थ्यकर्मी तथा सहभागीहरूमा हार्दिक स्वागत गर्दै सम्मेलनको भव्य सफलताको शुभकामना व्यक्त गर्दछु।

नेपाल शल्य चिकित्सक समाज, कोशी प्रदेश तथा विराट मेडिकल कलेज टिचिङ हस्पिटलको आयोजनामा यस्तो महत्त्वपूर्ण राष्ट्रिय सम्मेलन आयोजना हुनु कोशी प्रदेशका लागि गौरवको विषय हो। यसले विराटनगरलाई स्वास्थ्य शिक्षा, चिकित्सा सेवा, अनुसन्धान तथा प्राज्ञिक विमर्शको महत्त्वपूर्ण केन्द्रका रूपमा स्थापित गर्नसमेत योगदान पुऱ्याउने विश्वास लिएको छु।

स्वास्थ्य सेवा नागरिकको मौलिक हक तथा समुन्नत समाज निर्माणको आधार हो। यस क्षेत्रमा शल्य चिकित्साको विशिष्ट महत्त्व रहेको छ। बदलिँदो चिकित्सा विज्ञान, नवीनतम प्रविधि, अनुसन्धान र विशेषज्ञताको विकाससँगै शल्य चिकित्सा सेवामा पनि निरन्तर नवीनता र सुधार आवश्यक छ। यस सम्मेलनले राष्ट्रिय तथा अन्तर्राष्ट्रियस्तरका विज्ञहरूबीच ज्ञान, सिप, अनुभव र नवीनतम प्रविधिको आदानप्रदान गर्दै शल्य चिकित्सा क्षेत्रको व्यावसायिक क्षमता अभिवृद्धि, उपचार पद्धतिको आधुनिकीकरण तथा गुणस्तरीय स्वास्थ्य सेवाको विस्तारमा महत्त्वपूर्ण योगदान पुऱ्याउने अपेक्षा गरेको छु।

कोशी प्रदेश सरकारले गुणस्तरीय, सर्वसुलभ र नागरिकमैत्री स्वास्थ्य सेवा प्रवाहलाई उच्च प्राथमिकतामा राखेको छ। स्वास्थ्य पूर्वाधारको विकास, विशेषज्ञ स्वास्थ्य सेवाको विस्तार, दक्ष जनशक्तिको उत्पादन तथा स्वास्थ्य सेवामा सबै नागरिकको पहुँच सुनिश्चित गर्ने दिशामा प्रदेश सरकार निरन्तर क्रियाशील छ। यस्ता राष्ट्रिय तथा अन्तर्राष्ट्रिय सम्मेलनले स्वास्थ्य क्षेत्रका नीति, योजना र सेवा प्रवाहलाई थप प्रभावकारी बनाउन आवश्यक ज्ञान, अनुभव र दृष्टिकोण प्रदान गर्ने विश्वास लिएको छु।

अन्त्यमा, यस महत्त्वपूर्ण सम्मेलनको आयोजना गर्ने नेपाल शल्य चिकित्सक समाज, कोशी प्रदेश तथा विराट मेडिकल कलेज टिचिङ हस्पिटलसहित सम्पूर्ण आयोजकलाई हार्दिक बधाई तथा धन्यवाद व्यक्त गर्दछु। सम्मेलनमा सहभागी सम्पूर्ण महानुभावहरूको विराटनगर बसाइ सुखद, उपलब्धिमूलक र स्मरणीय रहोस्। सम्मेलनको पूर्ण सफलताको हार्दिक शुभकामना व्यक्त गर्दछु।

**हिम्मत कुमार कार्की**
मुख्यमन्त्री
कोशी प्रदेश

४ मंसिर २०८३

# 01 Message from the Organizing President



**Prof. Dr. Robin Joshi**

“

Dear Friends and Colleagues,

It is my great pleasure and privilege to welcome you to the XVth National Conference of the Society of Surgeons of Nepal, to be held at Birat Medical College Teaching Hospital (BMCTH), Biratnagar. The pre-conference workshops will take place on 26 November 2026, followed by the main scientific conference on 27–28 November 2026.

This conference is much more than an academic gathering. It is an opportunity for us to come together as a surgical fraternity: to share our experiences, learn from one another, discuss the challenges that shape our profession, and explore the advances that are transforming surgical care. Above all, it is a celebration of our shared commitment to excellence, innovation, academic growth, and compassionate care for our patients.

Under the theme “Advancing Surgical Excellence: Innovation, Technology and Collaboration”, we have put together an engaging scientific programme covering contemporary issues and emerging developments in surgery, with stimulating presentations, focused pre-conference workshops, and opportunities for interaction. We are particularly pleased to welcome distinguished national and international faculty whose expertise and experience will add tremendous value to the meeting and inspire us in our own professional journeys.

Biratnagar, with its rich history, vibrant spirit, and warm hospitality, provides a wonderful setting for this important occasion. I hope that, alongside the academic exchange, you will have the opportunity to reconnect with old friends, make new ones, and strengthen the professional relationships that make our surgical community stronger.

On behalf of the Society of Surgeons of Nepal, I warmly invite all surgeons, surgical trainees, academicians, and healthcare professionals from Nepal and abroad to join us in Biratnagar. Your presence and participation will make this conference truly special.

I look forward to welcoming you all and to sharing memorable days of learning, collaboration, friendship, and fellowship. Together, let us make the XVth National Conference of the Society of Surgeons of Nepal a milestone in our continuing journey toward advancing surgical care in Nepal.

*With warm regards and best wishes,*

**Prof. Dr. Robin Joshi**

Organizing President, SSNCON2026
Society of Surgeons of Nepal

# 02 Message from the Organizing Chairman



**Prof. Dr. Rohit Prasad Yadav**

“

It is my great honour to welcome you to **SSNCON2026**, the XVth National Conference of the Society of Surgeons of Nepal, hosted by Birat Medical College Teaching Hospital (BMCTH), Biratnagar, Nepal. With preconference workshops on **26 November** and the main conference on **27–28 November 2026**, we look forward to an enriching academic experience that inspires learning, strengthens collaboration, and promotes excellence in surgical practice.

Guided by the theme, **“Advancing Surgical Excellence: Innovation, Technology and Collaboration,”** this conference aims to bring together surgeons, academicians, researchers, and surgical trainees from across the world to share knowledge, exchange ideas, explore emerging technologies, and discuss advances shaping the future of surgical practice.

SSNCON2026 will provide an enriching academic platform featuring scientific deliberations, expert lectures, interactive discussions, and hands-on preconference workshops. We aspire to foster collaboration across surgical specialties, encourage innovation, strengthen professional relationships, and promote excellence in surgical education, research, and patient care.

As we gather in the vibrant city of Biratnagar, we look forward to welcoming distinguished national and international faculty, colleagues, and young surgeons. Your participation will be invaluable in making this conference a meaningful and memorable academic experience.

**I warmly invite all surgeons, faculty members, residents, and young surgical professionals to register for SSNCON2026 and be part of this exciting academic gathering. Join us to exchange ideas, build professional networks, explore new frontiers in surgery, and contribute to advancing surgical excellence in Nepal and beyond.**

**Register now, mark your calendar, and join us in Biratnagar for three days of learning, innovation, and collaboration!**

On behalf of the organizing committee, I look forward to welcoming you all to SSNCON2026.

*With warm regards,*

**Prof. Dr. Rohit Prasad Yadav**

Organizing Chairman, SSNCON2026
Professor & Head, Department of General Surgery
Hospital Director, Birat Medical College Teaching Hospital
Biratnagar, Nepal

# 03 Message from the Organizing Secretary, Dr. Sumita Pradhan



**Dr. Sumita Pradhan**

Dear Friends and Colleagues,

On behalf of the Organizing Committee, it is my great pleasure and privilege to warmly invite you to the XVth National Conference of the Society of Surgeons of Nepal, to be held at Birat Medical College Teaching Hospital (BMCTH), Biratnagar. The pre-conference workshops will take place on 26 November 2026, followed by the main scientific conference on 27–28 November 2026.

Under the theme “Advancing Surgical Excellence: Innovation, Technology and Collaboration”, we have prepared a scientific programme on contemporary and relevant topics in surgery. It includes inspiring lectures, interactive discussions, focused pre-conference workshops, and sessions for presenting clinical experience, research and innovative approaches to patient care. We also look forward to the award sessions and the **Annual General Meeting of the Society**.

We are particularly pleased to welcome an exceptional group of national and international faculty whose expertise and diverse experiences will add great value to the programme. We hope their presence will be especially enriching for our young surgeons, residents and trainees, giving them opportunities to learn, interact and build lasting professional connections with colleagues from Nepal and beyond.

We warmly encourage you to register early and to submit your abstracts and e-posters before the deadlines. Details of registration, abstract submission, accommodation and travel are provided in this brochure and on the conference website. Our secretariat will be happy to help with any query.

Organizing a national conference is a collective effort. I sincerely thank the Organizing Committee, the SSN Central Committee, Koshi Province, our host institution BMCTH, our sponsors and exhibitors, and all the faculty and volunteers whose dedication and support have made this conference possible.

Beyond the academic sessions, we hope you will enjoy the warmth and hospitality of Biratnagar, reconnect with old friends and meet new colleagues. We sincerely look forward to welcoming you to the XVth National Conference of the Society of Surgeons of Nepal.

*With warm regards,*

**Dr. Sumita Pradhan**

Organizing Secretary, SSNCON2026
Society of Surgeons of Nepal

# 04 Message from the Organizing Secretary, Prof. Dr. Rakesh Kumar Gupta



**Prof. Dr. Rakesh Kumar Gupta**

“

Dear Esteemed Colleagues,

On behalf of the Organizing Committee, it is my privilege to welcome you all to the 15th National Conference of the Society of Surgeons of Nepal (SSNCON2026) in Biratnagar, Nepal.

Our organizing team has worked diligently to develop a comprehensive scientific program featuring emerging scientific evidence, distinguished lectures, and interactive sessions to advance our profession.

We hope SSNCON2026 inspires new collaborations and offers a memorable experience for everyone.

Thank you for your participation. We look forward to seeing you in Biratnagar.

*Warm regards,*

**Prof. Dr. Rakesh Kumar Gupta**

Organizing Secretary
SSNCON2026

# 05 Message from the Scientific Chair



**Dr. Romeo Kansakar**

Dear Friends and Colleagues,

It is my great pleasure to welcome you to the XVth National Conference of the Society of Surgeons of Nepal (SSNCON2026), to be held at Birat Medical College Teaching Hospital (BMCTH), Biratnagar, from 26–28 November 2026.

Under the theme “Advancing Surgical Excellence: Innovation, Technology and Collaboration,” we have curated a comprehensive scientific programme designed to inspire learning, encourage innovation and strengthen surgical practice in Nepal.

The programme will feature masterclasses by world-renowned surgeons and distinguished international and national faculty, keynote lectures, expert talks, interactive panel discussions and free-paper presentations spanning contemporary surgical practice. Special highlights include multidisciplinary team (MDT) discussions on cancer, providing insights into complex clinical decision-making and the importance of collaborative, patient-centred care.

Our pre-conference workshops on 26 November will offer focused opportunities for practical learning and skills development, encompassing endoscopy and ERCP, hernia surgery, and proctology. The collaborative programme with ELSA will further promote hands-on training, didactic teaching and meaningful academic exchange. From young surgeons and residents to experienced specialists and senior mentors, the programme aims to bring every generation together through learning, mentorship and collaboration.

We are equally committed to recognising excellence through the Young Surgeons’ Awards, Resident Best Paper Award, Best Poster Award and MIS Championship. These initiatives celebrate research, innovation, academic achievement and technical proficiency while inspiring the next generation of surgical leaders.

I sincerely thank the Organizing Committee, the Scientific Committee, the SSN Central Committee, our national and international faculty, reviewers and all contributors for their invaluable efforts in shaping this scientific gathering.

I warmly invite surgeons, residents, trainees and researchers from Nepal and beyond to join us in Biratnagar. Learn from global surgical leaders, exchange ideas with peers, present your research, sharpen your skills and celebrate surgical excellence. Let us use this opportunity to build lasting collaborations, bridge generations of surgical expertise and advance the quality of surgical care for our patients.

I look forward to welcoming you all to SSNCON2026 for an enriching and memorable scientific experience.

*With warm regards,*

**Dr. Romeo Kansakar**

Scientific Chair, SSNCON2026
Society of Surgeons of Nepal

# 06 Organizing Committee

ORGANIZING CHAIRMEN

**Prof. Dr. Robin Joshi**
**Prof. Dr. Rohit Prasad Yadav**

ORGANIZING SECRETARIES

**Dr. Sumita Pradhan**
**Prof. Dr. Rakesh Kumar Gupta**

## Scientific Committee

CHAIRMAN

**Dr. Romeo Kansakar**

MEMBERS

Dr. Uttam Laudari, Prof. Dr. Bikal Ghimire, Dr. Manish Pokhrel, Dr. Nishnata Koirala, Dr. Kunal Bikram Deo, Dr. Parbatraj Regmi, Prof. Dr. Deepak Thakur, Prof. Dr. Sunil Munakomi

## Registration Committee

CHAIRMAN

**Prof. Dr. Roshan Ghimire**

MEMBERS

Dr. Akanand Singh, Dr. Nitish Koirala, Dr. Tilak Dangi, Dr. Sujan Shrestha, Dr. Romi Dahal, Dr. Sarada Khadka

## Finance Committee

CHAIRMAN

**Dr. Utsab Man Shrestha**

MEMBERS

Dr. Pranil Rai, Dr. Shail Rupakheti, Dr. Manish Roy, Dr. Dipendra Thakur, Dr. Amit Sah

## Reception Committee

CHAIRMAN

**Prof. Dr. Rupesh Mukhia**

MEMBERS

Dr. Suzita Hirachan, Dr. Rakesh Shah, Dr. Manish Chaudhary

## Souvenir Committee

CHAIRMAN

**Dr. Arbin Joshi**

MEMBERS

Dr. Bidur Prasad Acharya, Dr. B. C. Shrestha

## Inauguration Committee

CHAIRMAN

**Dr. Suzita Hirachan**

MEMBERS

Dr. Yoshika Bhattarai, Dr. Binni Shrestha, Dr. Pooja Yadav

# 07 SSN Central Committee

| Position | Name |
|---|---|
| President | Prof. Dr. Robin Joshi |
| Immediate Past President | Dr. Romeo Kansakar |
| Senior Vice President | Prof. Dr. Rupesh Mukhia |
| Vice President | Dr. Pranil Rai |
| General Secretary | Dr. Sumita Pradhan |
| Treasurer | Dr. Anip Joshi |
| Joint Secretary | Prof. Dr. Roshan Ghimire |
| Joint Treasurer | Dr. Utsab Man Shrestha |
| Members | Dr. Suzita Hirachan, Dr. Uttam Laudari, Dr. Bidur Prasad Acharya, Dr. Akanand Singh, Dr. Rakesh Shah |
| Chief Editor, JSSN | Dr. Arbin Joshi |

# 08 Advisers

- Prof. Dr. L. B. Thapa
- Prof. Dr. Keshav Das Joshi
- Dr. K. N. Rayamajhi
- Prof. Dr. Bhola Raj Joshi
- Prof. Dr. Pradeep Vaidya
- Prof. Dr. Chitra Lal Bhattachan
- Prof. Dr. Mahesh Khakurel
- Prof. Dr. Manohar Lal Shrestha
- Prof. Dr. Rakesh Verma
- Prof. Dr. Jay Narayan Shah
- Prof. Dr. Vijay Kumar Sharma
- Prof. Dr. Sunil Kumar Sharma Dhakal

# 08A SSN Central Committee



**Prof. Dr. Robin Joshi**
PRESIDENT



**Dr. Romeo Kansakar**
IMMEDIATE PAST PRESIDENT



**Prof. Dr. Rupesh Mukhia**
SENIOR VICE PRESIDENT



**Dr. Pranil Rai**
VICE PRESIDENT



**Dr. Sumita Pradhan**
GENERAL SECRETARY



**Dr. Anip Joshi**
TREASURER



**Prof. Dr. Roshan Ghimire**
JOINT SECRETARY



**Dr. Utsab Man Shrestha**
JOINT TREASURER



**Dr. Suzita Hirachan**
MEMBER



**Dr. Uttam Laudari**
MEMBER



**Dr. Bidur Prasad Acharya**
MEMBER



**Dr. Akanand Singh**
MEMBER



**Dr. Rakesh Shah**
MEMBER



**Dr. Arbin Joshi**
CHIEF EDITOR, JSSN

# 08B Past Presidents & Advisers

## Advisers



PROF. DR.
**L. B. Thapa**



PROF. DR.
**Mahesh Khakurel**



PROF. DR.
**Keshav Das Joshi**



DR.
**K. N. Rayamajhi**



PROF. DR.
**Manohar Lal Shrestha**



PROF. DR.
**Bhola Raj Joshi**



PROF. DR.
**Rakesh Verma**



PROF. DR.
**Pradeep Vaidya**



PROF. DR.
**Jay Narayan Shah**



PROF. DR.
**Chitra Lal Bhattachan**



PROF. DR.
**Vijay Kumar Sharma**



PROF. DR.
**Sunil Kumar Sharma Dhakal**

## Past Presidents

| | |
|---|---|
| Prof. L. B. Thapa | 1992–94 |
| Dr. Mahesh Khakurel | 1996–98 |
| Dr. K. D. Joshi | 1998–2000 |
| Dr. K. N. Rayamajhi | 2004–06 |
| Prof. M. L. Shrestha | 2006–08 |
| Prof. Bhola Raj Joshi | 2008–10 |
| Prof. Rakesh Verma | 2010–12 |
| Prof. Pradeep Vaidya | 2012–14 |
| Dr. Jay Narayan Shah | 2014–16 |
| Prof. Dr. C. L. Bhattachan | 2016–18 |
| Prof. Dr. Vijay Kumar Sharma | 2018–20 |
| Prof. Dr. Sunil Kumar Sharma | 2022–23 |
| Dr. Romeo Kansakar | 2024–25 |

# 09 Conference Theme, Objectives & Highlights

## CONFERENCE THEME

**ADVANCING SURGICAL EXCELLENCE: INNOVATION, TECHNOLOGY AND COLLABORATION**

The XVth National Conference of the Society of Surgeons of Nepal brings together surgeons, surgical trainees, academicians, researchers and healthcare professionals to share knowledge, experience and innovation in contemporary surgical practice.

## CONFERENCE OBJECTIVES

The conference aims to:

1. Provide a platform for exchange of contemporary surgical knowledge and experience.
2. Highlight advances in surgical technology, innovation and minimally invasive techniques.
3. Promote research, academic excellence and collaboration.
4. Provide opportunities for practical learning and hands-on training.
5. Encourage interaction between senior surgeons, young surgeons, residents and trainees.
6. Discuss challenges and opportunities in advancing surgical care in Nepal.
7. Strengthen professional networking and national and international collaboration.

## CONFERENCE HIGHLIGHTS

- ✔ Distinguished national and international lectures
- ✔ Plenary and special lectures
- ✔ Oral paper presentations and e-poster presentations
- ✔ Best Resident Paper Award
- ✔ Best Poster Presentation Award
- ✔ Industry exhibition
- ✔ Social and cultural programmes
- ✔ Interactive scientific sessions
- ✔ Pre-conference workshops and hands-on training opportunities
- ✔ Young Surgeon Award
- ✔ MIS Championship Award
- ✔ Annual General Meeting (AGM)
- ✔ Networking and professional fellowship
- ✔ Opportunities to explore Biratnagar and surrounding destinations

# 10 Important Dates

| | |
|---|---|
| **30 October 2026** | Last date for abstract submission. Late abstracts will not be entertained. |
| **30 October 2026** | E-poster file deadline |
| **31 October 2026** | Early bird registration ends |
| **15 November 2026** | Notification of abstract acceptance will be sent by this date. |
| **1–25 November 2026** | Standard registration. On-site registration is available at the conference. |
| **25 November 2026** | Faculty arrival and hotel check-in |
| **26 November 2026** | Pre-conference day |
| **27-28 November 2026** | Main scientific conference |

# 11 Registration & Fees

Choose the category that applies to you. Fees are in NPR, except SAARC Region and MoU-Partner Society (INR). Early bird rates apply until 31 October 2026, standard rates from 1 to 25 November 2026, and on-site rates at the conference.

| Category | Early Bird (until 31 October) | Standard (1–25 November) | On-Site Registration |
|---|---|---|---|
| **Resident** | NPR 7,000 | NPR 7,000 | NPR 8,000 |
| **Nursing Professional** | NPR 7,000 | — | — |
| **SSN Member** | NPR 11,000 | NPR 13,000 | NPR 15,000 |
| **Non-Member Delegate** | NPR 13,000 | NPR 15,000 | NPR 17,000 |
| **SAARC Region Delegate** | INR 11,000 | — | — |
| **Delegate from MoU-Partner Society (SSN Member Rate)** | INR 11,000 | — | — |
| **Accompanying Guest (International Delegate)** | NPR 7,000 | — | — |
| **Gala Dinner Guest (Additional)** | NPR 3,000 | — | — |

*— Rate not applicable / not offered for this category and period.*

**How to register.** Registration for SSNCON2026 is completed in two steps.

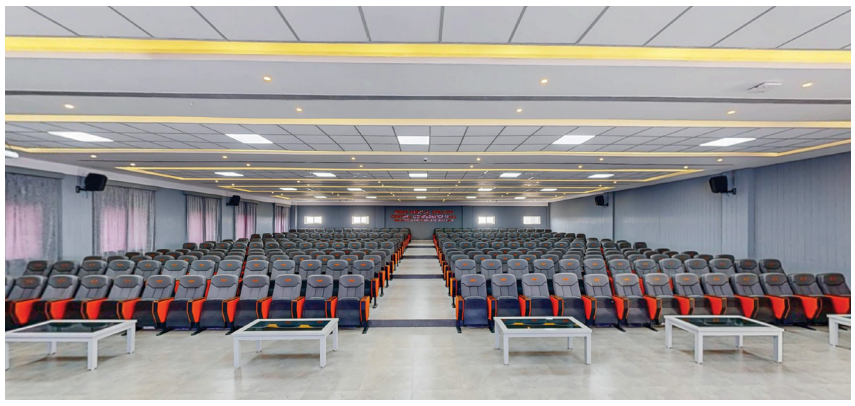
1. Visit the SSNCON2026 website by scanning the QR code, or at ssn2026.bmcteachinghospital.com.
2. On the website, select **Register** to open the official Eventio360 event portal. Choose your category and complete payment in one place.

*SSNCON2026 website: ssn2026.bmcteachinghospital.com*

**Registration includes:** access to scientific sessions; conference materials / conference kit; refreshments and meals as specified; certificate of participation; access to exhibition and networking activities.

# 12 Conference Venue, Travel & Accommodation

| | |
|---|---|
| **VENUE** | Birat Medical College Teaching Hospital (BMCTH), Biratnagar, Nepal |
| **FULL ADDRESS** | Birat Medical College Teaching Hospital, Budhiganga-2, Tankisinuwari, Morang, Nepal |
| **VENUE GEOTAG** | https://maps.app.goo.gl/Xiwx79qWF3RWNRWeA |
| **NEAREST AIRPORT** | Biratnagar Airport |



Central Conference Hall



Seminar Halls



Modular Workshop Hall



Recreation Ground



Campus entrance

## TRAVEL INFORMATION

Delegates may travel to Biratnagar by domestic air from Kathmandu, or by road from major cities. Local transportation is available within Biratnagar. Travel and airport transfers are arranged by the respective hotels.

## ACCOMMODATION

Book directly with the hotel of your choice. For reservations, please call:

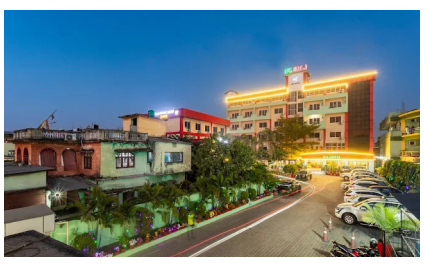
| Hotel | Reservation phone |
|---|---|
| **Hotel Harrison Palace** | +977 21 511033 / 34 / 35 |
| **Ratna Hotel** | 021-470399 / 472455 |
| **Big Hotel** | +977 980-130-3612 |
| **Lemon Tree Premier** | +977 970-000-1226 |




Hotel Harrison Palace



Ratna Hotel



Big Hotel




Lemon Tree Premier

# 13 Programme

**25 NOV 2026**
Wednesday

## Faculty Arrival

- Faculty arrival and hotel check-in

**26 NOV 2026**
Thursday

## Pre-Conference Day

- Registration
- Pre-conference workshops and interaction with experts
- Lunch and faculty soirée

**27 NOV 2026**
Friday

## Main Conference Day 1

- Scientific sessions and plenary lectures (detailed programme: page 27)
- Keynote Session, BMCTH Hall A: Dr. T. D. Yadav, “Beyond the Bile Duct Injury: Lessons from Difficult Cases and Long-term Outcomes”; Prof. Shailesh Shrikhande, “What Is Borderline vs Advanced Pancreatic Cancer? My Experience and an Update on Current Definition”
- Oral paper presentations and e-poster presentations
- Workshops and special sessions
- MIS Championship, multi-round laparoscopic skill competition, Simulation Lab, BMCTH (27 November)
- Awards and fellowship activities
- **Inaugural Ceremony of SSNCON2026, 5:00 PM onwards**
- Gala Dinner at BMC Green Park, 7:00 PM onwards

**28 NOV 2026**
Saturday

## Main Conference Day 2

- Scientific sessions and special lectures (detailed programme: page 27)
- **Annual General Meeting, 12:00 PM**
- Closing of SSNCON2026 and Awards ceremony. The programme concludes at 4:00 PM.

# 14 International Faculty

*The World of Surgery, Under One Roof*



**Prof. Dr. Abdul Majeed Chaudhry**
Pakistan



**Dr. Aditya Kumar**
AIIMS, New Delhi, India



**Dr. Aditya Kunte**
Gleneagles Hospital, Mumbai, India



**Asst. Prof. Dr. Arlyn R. Cañones**
Philippines



**Dr. Basim Alkhafaji**
Canadian Hospital, UAE



**Dr. Bishwarup Bose**
ESI Post Graduate Institute of Medical Sciences and Research, Kolkata, India



**Dr. Mandar R. Gadgil**
Gadgil's Clinic, India



**Dr. Masfique Ahmed Bhuiyan**
Dhaka Medical College and Hospital, Bangladesh



**Dr. Pinak DasGupta**
GEM Hospital, India



**Dr. Saseem Paudel**
Hokkaido University, Japan



**Prof. Dr. S. Easwaramoorthy**
IAGES, India



**Prof. Dr. Shailesh Shrikhande**
Chief Executive, Tata Cancer Care Foundation, Mumbai, India



**Dr. Tamonas Chaudhuri**
ILS Hospital, Kolkata, India



**Prof. Dr. T. D. Yadav**
PGI, Chandigarh, India



**Dr. Vimal Vasudevan**
Gleneagles Hospital, Malaysia



**Dr. Vivek Mangla**
Max Healthcare, India

# 15 Awards

Four awards recognize excellence at SSNCON2026. **For the Young Surgeon Award, Best Resident Paper Award and Best Poster Presentation Award, the abstract deadline is 30 October 2026. Registration is mandatory for acceptance of abstract.**

## 1 Young Surgeon Award




*Are you a young surgeon with original research? Present your research. Share your ideas. Compete for excellence.*

Trophy + Prize. Submit your abstract and compete for the award. For graduates who completed their MS within the past five years; the presenter must be the first author. The recipient will be offered a 2-week fellowship with AMASI in India.

## 2 Best Resident Paper Award




*Are you a surgical resident with original research? Present your research. Compete for excellence.*

Trophy + Prize. Submit your abstract and compete for the award. For residents currently pursuing MS, MCh or NBMS in Nepal or abroad. The presenter must be the first author, with a letter from the head of institute or department confirming residency status. The recipient will attend the College of Surgeons of Sri Lanka Conference in September 2027, with a 1–2 week fellowship.

# 3 MIS Championship Award




**Laparoscopic Skills Competition** for Residents & Young Surgeons:

- Laparoscopic Suturing
- Intracorporeal Knot Tying
- General Laparoscopic Skills
- Precision, Speed, Technique

**MIS Champion Award:** Trophy + Prize. *Step up. Test your skills. Become the MIS Champion!*

**Award:** free registration for the Society of Surgeons of Nepal international conference in 2027.

Registration is mandatory for participation.

## COMPETITION RULES AND STRUCTURE

**Multi-round competition.** Venue: Simulation Hall, Birat Medical College Teaching Hospital (BMCTH), Biratnagar.

### General rules

- Each medical college or teaching institute may enter only one team.
- Private hospitals and non-academic institutions are also eligible to form a team.
- Each primary team consists of two members, and up to one additional member may be registered as a backup.
- Participants must be trainees, residents, or junior surgeons within two years of graduation (MS).
- All participants must be registered for SSNCON2026.
- All participants must show a graduation certificate to confirm their year of graduation.
- Residents and trainees must show documented evidence.

### How to register for the competition

- Register for SSNCON2026.
- Register your team member details along with the required documents on the SSNCON2026 website.

### Round 1: The Preliminary Qualifier (27 November)

- **Format:** Time-trial circuit on dry-lab box trainers.
- **Task:** Individual basic laparoscopic skills (for example, peg transfer, pattern cutting, basic skills).
- **Scoring:** The cumulative time and penalty scores of all team members are combined.
- **Progression:** The top 8 teams advance to the quarterfinals (depending on the number of teams registered, teams progress to the quarterfinals or directly to the semifinals).

### Round 2: Quarterfinals and Semifinals (27 November)

- **Format:** Head-to-head knockouts or timed relay heats (decided on the same day, once the number of qualified teams is confirmed).
- **Focus:** Advanced mechanical coordination (for example, intracorporeal knotting, U-stitch).
- **Progression:** The top 2 to 4 highest-scoring teams advance to the grand finale.

### Round 3: The Grand Finale (27 or 28 November)

- **Format:** Main auditorium or Gala dinner site, to maximize audience engagement (about 10–15 minutes).
- **Focus:** Complex team-based task (running rounds, where one participant completes an event and then another participant starts).

# 4 Best Poster Presentation Award




**Call for e-posters.** *Have a case, study or research? Present. Showcase. Compete.*

Trophy + Prize. Submit your abstract and win the SSNCON2026 Best Poster Award. E-posters are assessed by judges on presentation day for scientific content, presentation, innovation and academic quality. The presenter must be present at the poster display area at the specified time. The award is announced at the end of the conference.

**Award:** free registration for the Society of Surgeons of Nepal international conference in 2027.

# 15A Senior Surgeons Award



## Dr. Sunil Chandra Adhikari

*Senior Surgeon, Department of General Surgery & Urology | Biratnagar, Nepal*

Dr. Sunil Chandra Adhikari (NMC Reg. No. 1356) is a distinguished Senior Surgeon and clinical researcher practicing in Biratnagar, Koshi Province, Nepal. He holds key surgical appointments at Koshi Hospital (formerly Koshi Zonal Hospital), Saptakoshi Hospital Pvt. Ltd., and Morang Sahakari Hospital. Renowned for his expertise in general surgery, endourology, and urethral stricture care, Dr. Adhikari specializes in advanced urolithiasis management, including ESWL, PCNL, internal urethrotomy, and flexible ureteroscopy. Alongside his clinical practice, he is a dedicated medical researcher with peer-reviewed publications in leading regional journals such as JNMA, JoNMC, and BJHS, contributing valuable clinical insights on ureteric calculi, laser infundibulotomy, and cholelithiasis.



## Dr. Niladhar Hadke, MBBS, MS (Surgery)

*Retired Director Professor of Surgery | New Delhi, India*

Dr. Niladhar Hadke is an eminent academic surgeon and medical educator from Delhi, India, bringing over 37 years of clinical, teaching, and administrative leadership across premier medical institutions in India and Nepal. After earning his MBBS and MS from Government Medical College, Nagpur, he served on the surgical faculty at JIPMER (Pondicherry) and as Professor of Surgery at Lady Hardinge Medical College (New Delhi) and B.P. Koirala Institute of Health Sciences (BPKIHS), Dharan. He culminated his illustrious academic career as Director Professor of Surgery at Maulana Azad Medical College (MAMC), New Delhi (2003–2018), where he also served as Academic Officer, Head of the Department of Medical Education, and Convener of the MCI Regional Center. His primary areas of expertise encompass general surgery, surgical oncology, medical education, and clinical research.

# 16 Abstract & E-Poster Guidelines

## I. Abstract Submission

- SSNCON2026 invites papers that are original and novel.
- Papers previously presented at a national or international meeting or conference will not be accepted.
- Papers presented locally (institutional or departmental) may be submitted with a proper declaration.
- Papers must not duplicate previously presented data, unless the new submission adds more than 50% new data, covered by a proper declaration.
- **The last date of abstract submission is 30 October 2026. Late abstracts will not be entertained.**
- All abstracts must be submitted through the SSNCON2026 website.
- All presenters must complete their conference registration.

### ABSTRACT CATEGORIES

- **Guest Lectures:** reserved for invited, eminent experts. Allocation decided by the Scientific Committee.
- **Award Papers:** Young Surgeon Award and Best Resident Paper Award (see Section 16).
- **Free Papers:** all other submissions not qualifying for guest lectures or award categories. Same submission policies apply.
- **Posters:** see E-Poster Guidelines below.

## II. Abstract Format

- 250-word limit (excludes title, author names and institutional affiliations).
- All authors must be listed in order; the presenting author must be separately identified.
- All abstracts must display institutional affiliations for every author.
- Structured format required: **Introduction, Methods, Results, Conclusion**.
- **Keywords:** 3–6, in alphabetical order, preferably using MeSH terms.

## III. E-Poster Guidelines

- Same submission policies and guidelines as oral presentations. Some oral submissions may be reassigned to poster presentation by the Scientific Committee, depending on relevance and submission volume.
- All posters will be presented in e-poster format.

| Item | Requirement |
|---|---|
| **File format** | PDF only. Please save your PowerPoint as a PDF. |
| **Layout** | One page only, landscape, 16:9 ratio at **3840 × 2160 pixels**. Viewers can zoom in and out. *Tip: use the standard 16:9 widescreen slide in PowerPoint, then save as PDF.* |
| **File size** | Less than 5 MB. |
| **Content** | Must match your accepted abstract: title, all authors with institutions, presenting author identified, and the Introduction, Methods, Results, Conclusion structure. A QR code to an optional handout is allowed. |
| **Fonts** | Arial, Calibri, Verdana, Times New Roman or Helvetica. Text must be larger than 11 pt on a standard 16:9 slide. *Recommended: titles 40 pt or larger, body text 18 pt or larger.* |
| **Images and tables** | At least 200 dpi. Insert by copy and paste, not as embedded documents. Avoid overlapping objects and layers; only the final view will show. |

| Item | Requirement |
|---|---|
| **Not permitted** | Hyperlinks, animated images, animations and embedded videos. |
| **Consent and privacy** | Patient data and photos need informed consent, compliant with applicable regulations. Please anonymise patients. Viewers may photograph or screenshot e-posters. If you do not want your content photographed, say so clearly on your poster. |
| **Template** | The template will be provided by the SSN Scientific Committee. |
| **Deadline** | 30 October 2026 |
| **How to submit** | Submit your e-poster in the same way as your abstract: through the SSNCON2026 website. |
| **Display and judging** | Posters are assessed by judges on presentation day; the presenter must be present at the poster display area at the specified date and time. The Best Poster Presentation Award is announced at the end of the conference. Display arrangements and the judging schedule will be decided closer to the conference. |

## ABSTRACT ACCEPTANCE

Accepted abstracts will be retracted if the presenter has not registered by 25 November 2026, the close of standard registration. Notification of acceptance will be sent by 15 November 2026.

# 17 Pre-Conference Workshops

**26 November 2026.** Organized by the Society of Surgeons of Nepal (SSN) and SSN Koshi Province, in collaboration with the ELSA Outreach Programme, supported by Olympus. These focused workshops provide practical knowledge, technical skills and interactive learning. **Seats are limited and allocated first-come at registration.**

132ND ELSA OP WORKSHOP · HALL A

## Endoscopy Essentials

From Basic Skills to Challenging Biliary Intervention · *"Mastering Surgery through the Lens of Endoscopy"*

WORKSHOP **Programme**

| | | |
|---|---|---|
| **8:30–9:00 AM** | Registration | |
| **9:00–9:30 AM** | Welcome | **Prof. Dr. Rohit Prasad Yadav, BMCTH, Nepal** |
| **MODULES 1–3 · 20 MINUTES EACH** | | |
| **Module 1** | Endoscopy hardware and room setup | **Dr. Ashis Pun, Bharatpur, Nepal** |
| **Module 2** | How do I perform Upper GI Endoscopy | **Dr. Arlyn Cañones, Rizal Medical Center, Philippines** |
| **Module 3** | Overview of therapeutic endoscopy | **Dr. S. Easwaramoorthy, IAGES, India** |
| *10:30 AM* | *Tea break (15 minutes)* | |
| **MODULES 4–6 · 20 MINUTES EACH** | | |
| **Module 4** | Tips and tricks for good colonoscopy | **Dr. Masfique Ahmed Bhuiyan, Dhaka Medical College and Hospital, Bangladesh** |
| **Module 5** | Complications of endoscopy and colonoscopy | **Dr. Nitish Koirala / Prof. Dr. Rohit Prasad Yadav, BMCTH, Nepal** |
| **Module 6** | ABC of ERCP | **Prof. Dr. Balaram Malla, Dhulikhel Hospital, KU, Nepal** |
| **11:45 AM–1:00 PM** | Live cases / videos | |
| *1:00–2:00 PM* | *Lunch* | |
| **2:00–4:45 PM** | Hands-on training on modules | |

133RD ELSA OP WORKSHOP · HALL B

# Advances in Abdominal Wall Hernia Surgery

**8:00–8:30 AM** Registration · **8:30–8:35 AM** Welcome address

## SESSION 1 Groin Hernia

**MODERATORS** Kishor Manandhar, Abhijeet Kumar, Dinesh Adhikari

| | | |
|---|---|---|
| **8:35–8:50 AM** | Laparoscopic repair of Groin Hernia: Tips and Tricks – TAPP (Critical view of MPO) | **Vimal Vasudevan** |
| **8:50–9:05 AM** | Laparoscopic repair of Groin Hernia: Tips and Tricks – TEP (Critical view of MPO) | **Amit Bhattarai** |
| **9:05–9:20 AM** | Strategy for Recurrent Inguinal Hernias | **Rakesh Kumar Gupta** |
| **9:20–9:35 AM** | Decision making in Groin Hernia | **Pinak DasGupta** |
| **9:35–9:50 AM** | Management of Complications in Laparoscopic Groin Hernia repair | **Basim Alkhafaji** |
| **9:50–10:05 AM** | Q&A | |
| *10:05–10:20 AM* | *Tea break* | |

## SESSION 2 Ventral Hernia

**MODERATORS** Sunil Sharma Dhakal, Sahil Rupakheti, Sanjay Paudel

| | | |
|---|---|---|
| **10:20–10:35 AM** | The Hidden Anatomy of extraperitoneal Spaces | **Rajiv Mishra** |
| **10:35–10:50 AM** | Laparoscopic VHR: Tips, Tricks, Modern Modifications (IPOM: Saviour of Destruction in the era of Reconstruction) | **Vimal Vasudevan** |
| **10:50–11:05 AM** | Laparoscopic e-TEP Rives Stoppa repair of ventral/incisional hernia: steps by step | **Nirvan Rai** |
| **11:05–11:20 AM** | Q&A | |
| *11:20–11:35 AM* | *Tea break* | |
| **11:35–11:50 AM** | Widen the Abdomen: CS and TAR (open) | **Saseem Paudel** |
| **11:50 AM–12:05 PM** | Lap e-Tep TAR for ventral hernia | **Mandar R. Gadgil** |
| **12:05–12:20 PM** | Management Strategy for symptomatic rectus diastasis | **Pranil Rai** |
| **12:20–12:35 PM** | Surgical management of Parastomal hernia | **Pinak DasGupta** |
| **12:35–12:45 PM** | Q&A | |

## SESSION 3 — Morbidity & Mortality Session · Panel discussion (all faculty)

| | | |
|---|---|---|
| 12:45–1:00 PM | Decision making in Ventral / Incisional Hernia Surgery | Mandar R. Gadgil |
| 1:00–1:15 PM | Management of Complications in Ventral / Incisional Hernia Surgery | Saseem Paudel |
| 1:15–1:25 PM | Closing remarks & certificates presentation | |
| *1:30–2:00 PM* | *Lunch break* | |
| 2:00–4:30 PM | Hands-on practice on suturing & advanced hernia modules | All faculty |

PRE-CONFERENCE WORKSHOP · HALL C

# Proctology Beyond Basics

Practical Decision-Making & Operative Techniques for the Surgeon

| | | |
|---|---|---|
| 8:30–8:50 AM | Registration | |
| 8:50–9:00 AM | Welcome | Romeo Kansakar |
| **HEMORRHOIDS** | | |
| 9:00–9:15 AM | Anatomy relevant to proctology | Sujan Shrestha |
| 9:15–9:30 AM | Open and closed hemorrhoidectomy | Dipendra Thakur |
| 9:30–9:45 AM | Fundamentals of laser surgery | Romi Dahal |
| 9:45–10:00 AM | Laser hemorrhoidoplasty and hybrid procedure | Bishwodeep Timilsina |
| 10:00–10:15 AM | MIPH in hemorrhoids | Rakesh Shah |
| **ANAL FISSURE** | | |
| 10:15–10:30 AM | Conservative management including Botox | Arbin Joshi |
| 10:30–10:45 AM | Lateral sphincterotomy: open and closed techniques | Sujan Shrestha |
| *10:45–11:00 AM* | *Tea break* | |
| **SINUS AND FISTULA** | | |
| 11:00–11:15 AM | Conventional surgery for fistula-in-ano | Satyadeep Bhattacharya |
| 11:15–11:30 AM | Laser and hybrid techniques for anal fistula | Romi Dahal |
| 11:30–11:45 AM | EPSIT for pilonidal sinus | Anuj Parajuli |
| 11:45 AM–12:00 PM | Flap procedures for pilonidal sinus | Arbin Joshi |
| **CASES, COMPLICATIONS AND HANDS-ON** | | |
| 12:00–12:30 PM | Interesting cases in proctology | Bishwodeep Timilsina |
| 12:30–1:00 PM | Complications of anorectal procedures | Satyadeep Bhattacharya |
| *1:00–1:30 PM* | *Lunch* | |
| 1:30–4:00 PM | Hands-on training: laser procedures and MIPH | All faculty |

HALL A · 4:00–5:00 PM

## Masterclass

**MASTERCLASS** **Shailesh Shrikhande** 4:00–4:30 PM

### Resectable Gastric Cancer: NACT First or Knife First? Japanese Guidelines, Western Evidence — Where Should We Stand?

**MODERATOR** Nishnata Koirala

**CHAIRPERSONS** Paleswan Joshi Lakhey, Bikal Ghimire, Ashmita Rayamajhi

**MASTERCLASS** **Aditya Kunte** 4:30–5:00 PM

### Planning for Liver Resection

**MODERATOR** Sumita Pradhan

**CHAIRPERSONS** Ramesh Singh Bhandari, Roshan Ghimire, Manish Raj Pathak, Romeo Kansakar

# 18 Annual General Meeting (AGM) Notice

### Annual General Meeting of the Society of Surgeons of Nepal

**DATE AND TIME** 28 November 2026, 12:00 PM

**VENUE** Birat Medical College Teaching Hospital (BMCTH)

**AGENDA**

1. Review and approval of the General Secretary's annual progress report, the Treasurer's financial report, and the decisions made at the previous meeting.
2. Discussion of the Society's upcoming annual work plan, budget, and long-term strategic plan, and decisions on proposals submitted by members.
3. Discussion and decisions on matters relating to the Executive Committee, amendments to the Society's constitution, and other necessary institutional matters.

# 19 Tourism

Delegates will have the opportunity to explore Biratnagar and selected destinations in eastern Nepal. Distances are approximate, from Biratnagar.



### Dharan

a vibrant city at the foothills

**45 km, about 1.5 hours**



### Koshi Tappu Wildlife Reserve

a paradise for wildlife and bird lovers

**50 km, 1.5 to 2 hours**



### Bhedetar

a scenic hill retreat

**55 km, about 2 hours**



### Barahakshetra

a sacred destination by the Koshi River

**80 km, 2.5 to 3 hours**



### Mai Pokhari

a serene Himalayan lake

**165 km, 5 to 6 hours**



### Ilam & Kanyam Tea Gardens

where Nepal's tea country begins

**170 km, 5 to 6 hours**



### Shree Antu

sunrise over the eastern hills

**200 km, 6 to 7 hours**



### Pathibhara Temple

a sacred Himalayan pilgrimage

**290+ km, 10 to 12+ hours**

# 20 Certificates & Conference Help Desk

**Certificates will be provided as applicable for:**

- Conference participation
- Oral paper presentation
- E-poster presentation
- Pre-conference workshop participation
- Award recipients

**Conference Help Desk. The conference help desk will assist delegates with:**

- Registration
- Venue information
- Accommodation
- Transportation
- Workshop registration

# 21 SSN Provincial Branches

| Province | President | General Secretary |
|---|---|---|
| **Koshi** | Prof. Dr. Rohit Prasad Yadav | Prof. Dr. Rakesh Kumar Gupta |
| **Madhesh** | Dr. Rakesh Pandit | Dr. Abdhesh Kumar Sah |
| **Bagmati** | Dr. Binay Thakur | Dr. Anil Acharya |
| **Gandaki** | Dr. Amar Gurung | Dr. Binod Bade Shrestha |
| **Lumbini** | Prof. Dr. Santosh Shah | Dr. Pravin Joshi |
| **Karnali** | Dr. Ganesh Thapa | Dr. Nirmal Thapa |
| **Sudurpaschim** | Dr. Meraj Alam Ansari | Dr. Lalit B. K. |

# 22 Conference Secretariat & Contacts

**SSNCON2026 Secretariat**, Society of Surgeons of Nepal

Prof. Dr. Rohit Prasad Yadav

For information on registration, scientific submissions, workshops, accommodation, sponsorship and exhibition, contact the SSNCON2026 Secretariat or the Chairman.

| | |
|---|---|
| GENERAL ENQUIRIES | ssncon2026@gmail.com |
| ABSTRACT SUBMISSION | abstractssn@gmail.com |
| PHONE | +977 9768988406 (Mr. Kamal Sherpa) |
| WEBSITE | ssn2026.bmcteachinghospital.com |
| REGISTRATION | through the conference website, ssn2026.bmcteachinghospital.com |

# 23 Scientific Programme

Programme at a glance. All sessions take place at Birat Medical College Teaching Hospital (BMCTH), Biratnagar, Nepal.

HALL A · HALL B · HALL C · HALL D · HALL E · POSTERS · SIMULATION LAB

## Thursday 26 November

Pre-Conference Day · workshops in Section 17, pages 21–24

| | |
|---|---|
| 8:30 AM – 4:45 PM | HALL A 132nd ELSA OP Workshop – Endoscopy Essentials |
| 8:00 AM – 4:30 PM | HALL B 133rd ELSA OP Workshop – Advances in Abdominal Wall Hernia Surgery |
| 8:30 AM – 4:00 PM | HALL C Proctology Beyond Basics |
| 4:00 – 5:00 PM | HALL A Masterclass – Shailesh Shrikhande and Aditya Kunte |

## Friday 27 November

Day 1 · Oral and poster presentations

| | |
|---|---|
| 7:45 – 8:00 AM | HALL A Inauguration of Scientific Session |
| From 8:00 AM | Oral presentations in Halls A, B, C and D |
| 9:00 – 10:00 AM | HALL A Keynote Session – T. D. Yadav, Shailesh Shrikhande |
| All day | Poster presentations in Hall E · MIS Championship in the Simulation Lab |
| 5:00 PM onwards | **Inaugural Ceremony** |
| 7:00 PM onwards | **Gala Dinner** |

## Saturday 28 November

Day 2 · Oral and poster presentations

| | |
|---|---|
| From 8:00 AM | Oral presentations in Halls A, B and C |
| 9:00 – 9:30 AM | HALL A Keynote Session – SVS Deo |
| All day | Poster presentations in Hall E |
| 12:00 – 1:00 PM | **SSN Annual General Meeting** |
| 1:00 – 1:30 PM | Lunch break |

## In this section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# Day 1 at a Glance

Friday 27 November 2026 · Oral presentations by hall

## Hall A

**7:45–8:00 AM**
Inauguration of Scientific Session

**8:00–9:00 AM**
I · General Session-I

**9:00–10:00 AM**
Keynote Session

**10:00–11:45 AM**
II · Hernia Session

**11:45 AM – 1:15 PM**
III · Surgical Endoscopy session

**1:45–3:15 PM**
IV · Pancreas Session-I

**3:15–4:30 PM**
V · General Session-II

## Hall B

**8:15–9:00 AM**
VI · SSN Talks

**10:00–11:45 AM**
VII · Esophageal Session

**11:45 AM – 12:45 PM**
VIII · Gastric Session

**1:15–2:45 PM**
IX · Urology Session

**2:45–3:45 PM**
X · Video Session

**3:45–4:30 PM**
Bile Duct Injury

## Hall C

**8:00–8:45 AM**
XI · Nursing Session-I

**10:00 AM – 12:15 PM**
XII · Neurosurgery session

**12:15–1:25 PM**
XIII · Young Surgeons Award Papers

**1:45–3:00 PM**
XIV · Breast session

**3:00–4:00 PM**
XV · Vascular Session

## Hall D

**10:00–11:30 AM**
XVI · Residents Best Paper Award -I

**11:30 AM – 12:40 PM**
XVII · Residents Best Paper Award -II

**1:30–2:20 PM**
XVIII · Residents Best Paper Award -III

**2:30–3:30 PM**
XIX · Nursing Session-II

**5:00 PM onwards** Inaugural Ceremony

**7:00 PM onwards** Gala Dinner

MIS CHAMPIONSHIP

### SSNCON 2026 – MIS Championship

**Multi-round laparoscopic skill competition**

**Venue** Simulation Lab, BMCTH

**Date** Friday, 27 November 2026

**Coordinators** Bikal Ghimire, Kunal Bikram Deo, Parbatraj Regmi, Nirvan Rai, Nitish Koirala, Saseem Paudel

**Hall E** Poster Presentations · both days

# Hall A

Friday 27 November 2026 · Oral presentations

**7:45–8:00 AM** **Inauguration of Scientific Session**

Robin Joshi, Rohit Prasad Yadav, Sumita Pradhan, Rakesh Gupta, Romeo Kansakar

## SESSION I General Session-I

8:00–9:00 AM

**CHAIRPERSONS** Robin Joshi, Rohit Prasad Yadav, Sumita Pradhan, Rakesh Gupta

| | | |
|---|---|---|
| 8:00–8:15 AM | End of life care: when and how should we stop | Lalit Rajbanshi |
| 8:15–8:30 AM | Bridging Skill, Technology and Context: Advancing Safe, Equitable Surgery in Nepal | Pradeep Ghimire |
| 8:30–8:45 AM | Complex Robotic Surgery index cases | Pratik Man Singh Gurung |
| 8:45–9:00 AM | Digital learning and AI in Medical Education | Bikal Ghimire |

## KEYNOTE Keynote Session

9:00–10:00 AM

**CHAIRPERSONS** Manohar Lal Shrestha, Sunil K Sharma Dhakal, Bishowroop Bose, Tanka Prasad Bohara

| | | |
|---|---|---|
| 9:00–9:30 AM | Beyond the Bile Duct Injury: Lessons from Difficult Cases and Long-term Outcomes | T. D. Yadav |
| 9:30–10:00 AM | What Is Borderline vs Advanced Pancreatic Cancer? My Experience and an Update on Current Definition | Shailesh Shrikhande |

## SESSION II Hernia Session

10:00–11:45 AM

**CHAIRPERSONS** Vimal K Vasudevan, Basim Alkhafaji, Bishowroop Bose, Rajiv Nakarmi, Nirvan Rai

| | | |
|---|---|---|
| 10:00–10:15 AM | Giant inguinal hernia: halfway between love and nightmare | Basudev Devkota |
| 10:15–10:30 AM | Decision making in management of complex ventral hernia repair | Kishor Manandhar |
| 10:30–10:45 AM | eTEP for UH with GH | Pinak Das Gupta |
| 10:45–11:00 AM | Purpose, Passion & Pathway in abdominal wall reconstruction | Mandar Ramchandra Gadgil |
| 11:00–11:15 AM | Peritoneal Flap Hernioplasty for Complex Ventral Hernia: An Institutional Review | Rakesh Kumar Gupta |
| 11:15–11:30 AM | Minimal Invasive Preperitoneal Repairs for Ventral Hernia | Aditya Kumar |
| 11:30–11:45 AM | Social Media, AI, Health, Finance: It's More Than Just a Hernia | Amit Bhattrai |

HALL A · CONTINUED

## SESSION III Surgical Endoscopy session — 11:45 AM – 1:15 PM

**CHAIRPERSONS** Mukund Raj Joshi, Arbin Joshi, Sudip Khaniya, Rajesh Kumar Mandal

| | | |
|---|---|---|
| 11:45–12:00 PM | EUS-guided biliary drainage for bile duct obstruction | Arlyn Canones |
| 12:00–12:15 PM | Post-ERCP perforation management | Balaram Malla |
| 12:15–12:30 PM | ERCP vs LCBDE: Rethinking the Optimal Approach to Choledocholithiasis | Ashis Pun |
| 12:30–12:45 PM | ERCP by Surgeons | Rohit Prasad Yadav |
| 12:45–1:00 PM | Endoscopy training for surgeons – why and how? | S. Easwaramoorthy |
| 1:00–1:15 PM | Painless water-assisted colonoscopy | Masfique Ahmed Bhuiyan |

**1:15–1:45 PM** Lunch Break

## SESSION IV Pancreas Session-I — 1:45–3:15 PM

**CHAIRPERSONS** Sunil K Sharma Dhakal, Binaya Thakur, Deep Lamichhane, Mukti Devkota

| | | |
|---|---|---|
| 1:45–2:00 PM | Pancreatic Cancer: What Should the MDT Decide? | Ambuj Karn |
| 2:00–2:15 PM | Pancreatic neuroendocrine tumor – surgical challenges and outcomes | Paleswan Joshi Lakhey |
| 2:15–2:30 PM | Organ-sparing duodenum-preserving approaches for pancreatic and periampullary lesions | Sushil Bahadur Rawal |
| 2:30–2:45 PM | "POPF Prediction" – The Quest for the Best | Ramesh Singh Bhandari |
| 2:45–3:00 PM | ICG in pancreatic surgery | Dhiresh Kumar Maharjan |
| 3:00–3:15 PM | Pancreatic necrosis – when and how to intervene | Tanka Prasad Bohora |

## SESSION V General Session-II — 3:15–4:30 PM

**CHAIRPERSONS** Mahesh Khakurel, Pradeep Ghimire, Shail Rupakheti, Ashok Koirala

| | | |
|---|---|---|
| 3:15–3:30 PM | Why SSN | Romeo Kansakar |
| 3:30–3:45 PM | Surgical Societies' Role and the Need for Surgical Skill Accreditation in Nepal | Sunil K. Sharma Dhakal |
| 3:45–4:00 PM | Surgical options for drug resistant epilepsy | Rajiv Jha |
| 4:00–4:15 PM | Learning through complications | Tamonas Chaudhary |
| 4:15–4:30 PM | Train Abroad, Transform at Home: A Model for Nepali Surgery | Satyadeep Bhattacharya |

# Hall B

Friday 27 November 2026 · Oral presentations

## SESSION VI — SSN Talks — 8:15–9:00 AM

**CHAIRPERSONS** RK Saboo, Ashis Pun, Robin Singh, Balaram Malla

| | | |
|---|---|---|
| 8:15–8:30 AM | Surgery without boundaries: Managing complex cases in resource-limited hospital | Shashi Shekhar Adhikari |
| 8:30–8:45 AM | Quality and safety in surgery | Rupesh Mukhiya |
| 8:45–9:00 AM | Medical education in Nepal: Transition from time based to competency based education | Gehraj Dahal |

**9:00–10:00 AM** KEYNOTE Session in Hall A

## SESSION VII — Esophageal Session — 10:00–11:45 AM

**CHAIRPERSONS** Mukti Devkota, Bikal Ghimire, Pranil Rai, Narayan Belbase, Bimarsha Adhikari

| | | |
|---|---|---|
| 10:00–10:15 AM | Surgical care for benign esophageal disease | Akriti Sharma |
| 10:15–10:30 AM | POEM (Per-Oral Endoscopic Myotomy) | Masfique Ahmed Bhuiyan |
| 10:30–10:45 AM | Fundoplication: How I Do It and How I Deal with Failure | Aditya Kumar |
| 10:45–11:00 AM | Changing Paradigms in Esophageal Cancer: Neoadjuvant Chemotherapy, Chemoradiotherapy or Immunotherapy? | Birendra Yadav |
| 11:00–11:15 AM | Mesenteric Principles in Esophageal Cancer Surgery | Sagar Khatiwoda |
| 11:15–11:30 AM | Gastroesophageal Junction Tumors: From Classification and Staging to Surgical Strategy | Shivraj Sharma |
| 11:30–11:45 AM | Innovation and Growth of Esophageal Surgery in Central Nepal: Nearly a Two-Decade Experience | Binay Thakur |

## SESSION VIII — Gastric Session — 11:45 AM – 12:45 PM

**CHAIRPERSONS** Sanjaya Poudyal, Kapendra Amatya, Birendra Yadav, Manish Roy, Rajeev Mishra

| | | |
|---|---|---|
| 11:45–12:00 PM | Gastric Cancer Beyond FLOT: How Immunotherapy and Precision Oncology Are Changing MDT Decisions | Ramila Shilpakar |
| 12:00–12:15 PM | Surgical management of Stage IV gastric cancer | Punya Kharbuja |
| 12:15–12:30 PM | H. pylori/gastritis treatment and gastric cancer in the current era in Nepal | Bikram Pradhan |
| 12:30–12:45 PM | D2 Gastrectomy after Neoadjuvant therapy | Hemanta Batajoo |

HALL B · CONTINUED

**12:45–1:15 PM** Lunch Break

## SESSION IX Urology Session — 1:15–2:45 PM

**CHAIRPERSONS** CS Agrawal, Rakesh Verma, Robin Joshi, Awaz Kafle

| | | |
|---|---|---|
| 1:15–1:30 PM | Recent Advances in Kidney Transplant – Robotic Transplant and Complex Transplants | Mrigank Shekhar Jha |
| 1:30–1:45 PM | Nephron sparing surgery | Pukar Maskey |
| 1:45–2:00 PM | Challenges and Outcomes of Retrograde Intrarenal Surgery for Large Renal Stones | Zubin Silwal |
| 2:00–2:15 PM | Comprehensive Laparoscopic Urology Beyond Metropolitan Centres: The BPKIHS Experience | Rikesh Jung Karkee |
| 2:15–2:30 PM | PCNL in patients with history of previous open renal surgery | Robin Bahadur Basnet |
| 2:30–2:45 PM | Step by Step Left Radical Laparoscopic Nephrectomy: Key operative steps and Technical pearls | Deepak Kumar Thakur |

## SESSION X Video Session — 2:45–3:45 PM

**CHAIRPERSONS** Arbin Joshi, Rupesh Mukhiya, Prasan Kansakar, Dinesh Adhikari, Ranjis Pahari

| | | |
|---|---|---|
| 2:45–3:00 PM | Laparoscopic Splenic Vessel Preserving and Spleen Preserving Distal Pancreatectomy (Kimura technique): | Sujan Shreshtha |
| 3:00–3:15 PM | Role of Robotics for the general surgery | Aditya Kumar |
| 3:15–3:30 PM | Step by Step Laparoscopic Nephrectomy : How We Do. | Ashok Yadav |
| 3:30–3:45 PM | Laparoscopic Nissens's Fundoplication | Binay Thakur |

## PANEL DISCUSSION Bile Duct Injury — 3:45–4:30 PM

**MODERATOR** Arun Gnyawali

**PANELISTS** Mukund Raj Joshi, Prasan Kansakar, Balaram Malla, Manish Raj Pathak

| | |
|---|---|
| 3:45–4:30 PM | Bile Duct Injury |

# Hall C

Friday 27 November 2026 · Oral presentations

## SESSION XI Nursing Session-I — 8:00–8:45 AM

**CHAIRPERSONS** Asha Pokharel, Lahar Maya Bhasinka, Nitish Koirala

| | | |
|---|---|---|
| 8:00–8:15 AM | Beyond the Discharge Slip: Effective Patient Education for Low-Literacy and Remote Communities | Ashna Shrestha, Nursing In-charge, Semicabin |
| 8:15–8:30 AM | Safe surgical checklist and OT nursing | Shova Rai |
| 8:30–8:45 AM | Surgical Site Infection Prevention: Bundles, Dressing Care and Patient Teaching | Sujeeta Rajbanshi |

**9:00–10:00 AM** KEYNOTE Session in Hall A

## SESSION XII Neurosurgery session — 10:00 AM – 12:15 PM

**CHAIRPERSONS** Gopal Raman Sharma, Rajiv Jha, Pramod Chaudhary

| | | |
|---|---|---|
| 10:00–10:15 AM | A decade of Neurosurgical service in Eastern Nepal: Institutional and personal perspectives | Prakash Kafle |
| 10:15–10:30 AM | Functional outcomes in anterior cervical spine surgery | Om Bikram Shah |
| 10:30–10:45 AM | Beyond the operating room: Building a comprehensive Neurosurgical service in Resource-limited tertiary care centre | Prakash C Adhikari |
| 10:45–11:00 AM | From stereotaxy to neuromodulation: evolution of functional neurosurgery at Bir Hospital Nepal | Namrata Khadka |
| 11:00–11:15 AM | Outcomes of DHC in severe TBI in pediatric population: My experience over a decade in Eastern region of Nepal | Ashish J Thapa |
| 11:15–11:30 AM | Cervical spine surgery across the spectrum from trauma to tumor | Gaurav Chhetri |
| 11:30–11:45 AM | Traumatic skull fractures involving major dural venous sinuses: Pattern and clinical outcomes | Deepak Yadav |
| 11:45–12:00 PM | Beyond acute care: The critical impact of early physiotherapy on long-term stroke rehabilitation | Narendra P Joshi |
| 12:00–12:15 PM | Post operative care of Pituitary tumor | Shudha Bhandari |

HALL C · CONTINUED

## SESSION XIII Young Surgeons Award Papers — 12:15–1:25 PM

**CHAIRPERSONS** Kishore Manandhar, Bikal Ghimire, Rakesh Gupta, Suresh Shah, Nishnata Koirala

| | | |
|---|---|---|
| 12:15–12:25 PM | Surgical Outcomes of Inguinal Hernia Repair Using Desarda's Technique: Interim Results of a Prospective Study | Shiva Bhandari |
| 12:25–12:35 PM | Factors Predicting Infectious Complications Following Percutaneous Nephrolithotomy | Md. Imran Ansari |
| 12:35–12:45 PM | Predictors of Clinically Relevant Postoperative Pancreatic Fistula Following Pancreaticoduodenectomy: A Five-Year Single-Centre Retrospective Cohort Study | Basant Kumar Yadav |
| 12:45–12:55 PM | Laparoscopic Hernia Surgery in Janakpur: A Clinical Audit of Outcomes, Complications, lesson learned and Best Practices | Bijay Kumar Yadav |
| 12:55–1:05 PM | Freys Procedure for Chronic Pancreatitis: an institutional perspective | Arun Gnyawali |
| 1:05–1:15 PM | Sarcopenia, its prevalence and effects on early outcome in patients with lung cancer in Nepalese population. | Mahesh Mani Adhikari |
| 1:15–1:25 PM | Fate of dialysis access in CKD cases undergoing dialysis amongst patients presenting to Dhulikhel Hospital | Deni Khadka |

**1:25–1:45 PM** Lunch Break

## SESSION XIV Breast session — 1:45–3:00 PM

**CHAIRPERSONS** Kapendra Amatya, Utsab Man Shrestha, Jyoti Rayamajhi, Suzita Hirachan

| | | |
|---|---|---|
| 1:45–2:00 PM | After Neoadjuvant Therapy: How Much Surgery Does the Patient Still Need? | Sarada Khadka |
| 2:00–2:15 PM | Image-guided breast ablation: Expanding the interventional radiologist's role-from diagnosis to definitive therapy | Amrit Koirala |
| 2:15–2:30 PM | Hereditary Breast Cancer: Where Do We Stand in 2026 | Soniya Dulal |
| 2:30–2:45 PM | Breast Cancer Genetic Testing – Why? Who? And How Surgeons View It | Akash Raya |
| 2:45–3:00 PM | After Mastectomy: Does Every Patient Need Radiotherapy? | Ashmita Rayamajhi |

## SESSION XV Vascular Session — 3:00–4:00 PM

**CHAIRPERSONS** Akriti Sharma, Deepak Thapa Magar, Praman Sharma

| | | |
|---|---|---|
| 3:00–3:15 PM | Learning curves in Endovenous ablation of varicose veins | Sandeep Raj Pandey |
| 3:15–3:30 PM | EVLA with foam: a day-care alternative to open surgery | Santosh Shah |

HALL C · CONTINUED

SESSION XV

## Vascular Session (continued)

| | | |
|---|---|---|
| 3:30–3:45 PM | Outcome of revascularization in critical limb ischemia | Bijay Sah |
| 3:45–4:00 PM | Arterial and Venous Disorders: Current Treatment Strategies | Krishna Prasad Basyal |

# Hall D

Friday 27 November 2026 · Oral presentations

**9:00–10:00 AM** KEYNOTE Session in Hall A

## SESSION XVI Residents Best Paper Award -I

10:00–11:30 AM

**CHAIRPERSONS** Akanand Singh, Bidur Acharya, Sarada Khadka, Ram Babu Khadka, Abdullah Rain

| | | |
|---|---|---|
| 10:00–10:10 AM | Application of Indocyanine Green-based Fluorescence Imaging in Bowel Anastomosis | Prabin Ghimire |
| 10:10–10:20 AM | Clinical Profile and Outcomes of Fistula-in-Ano: A Five-Year Retrospective Study at a Tertiary Care Hospital in Nepal | Raiesh Shrestha |
| 10:20–10:30 AM | Spectrum of colorectal surgery cases | Bijay Kumar Gupta |
| 10:30–10:40 AM | Comparative Study of Short Term Surgical Outcomes Following D2 Versus D3 Lymph-Node Dissection in Patients Undergoing Surgery for Colonic Carcinoma | Bishal Pokharel |
| 10:40–10:50 AM | Correlation Between Fine Needle Aspiration Cytology And Histopathological Find | Ranjan Kumar Barnawal |
| 10:50–11:00 AM | Outcomes In Admitted Chest Trauma Patients Using Chest Trauma Scoring System | Birat Basnet |
| 11:00–11:10 AM | Systemic Immune-Inflammation Index in predicting complicated from uncomplicated appendicitis in children | Abhaya Mahto |
| 11:10–11:20 AM | Prognostic Nutritional Index (PNI) Versus ACEF II Risk Score In Predicting 30-day Morbidity And Mortality In Patients Undergoing Coronary Artery Bypass Graft Surgery: A Prospective Observational Study | Milan Adhikari |
| 11:20–11:30 AM | Whipple's Pancreaticoduodenectomy: Five-Year Experience at Dhulikhel Hospital [2021–2026] | Rahul Singh |

## SESSION XVII Residents Best Paper Award -II

11:30 AM – 12:40 PM

**CHAIRPERSONS** CS Agrawal, Pukar Maskey, Rikesh Jung Karki, Deepak Thakur, Robin Bahadur Basnet

| | | |
|---|---|---|
| 11:30–11:40 AM | Laser Cystolithotripsy for Urinary Bladder Stones: A Single-Centre Retrospective Experience | Sandeep Basnet |
| 11:40–11:50 AM | Correlation Between Visual Prostate Symptom Score ( VPSS) And Uroflometry Parameter (Qmax) In Men With BEP | Sandesh Neupane |
| 11:50–12:00 PM | Anticipating Ureteric Stone Impaction during URSL: How does pre operative clinical and radiological parameters help us? – | Alisha Prajapati |

HALL D · CONTINUED

## SESSION XVII Residents Best Paper Award -II (continued)

| | | |
|---|---|---|
| 12:00–12:10 PM | Acute Urinary Retention After Ureteroscopic Lithotripsy": Can We Predict It? | Puja Nepal |
| 12:10–12:20 PM | Efficacy of tamsulosin versus tadalafil for expulsion of stones less than 10 mm in diameter in patients with lower ureteric stones in a tertiary care hospital. | Dinesh Raj Joshi |
| 12:20–12:30 PM | Single-Session Stone Clearance by Laparoscopic-Assisted Percutaneous Nephrolithotomy for a large calculi in Pelvic Ectopic Kidney | Harshit Agrawal |
| 12:30–12:40 PM | Outcome Of Retrograde Intrarenal Surgery Using Flexible And Non-flexible Ureteral Access Sheath In Patients With Proximal Ureteral And Renal Stones | Azhar Hussain ansari |

**1:00–1:30 PM** Lunch Break

## SESSION XVIII Residents Best Paper Award -III 1:30–2:20 PM

**CHAIRPERSONS** Ram Babu Shah, Ganesh Simkhada, Bharat Mani Pokharel

| | | |
|---|---|---|
| 1:30–1:40 PM | Evaluation of Chronic Inguinal Pain After Mesh Fixation by Polypropylene Versus Polyglactin in Lichtenstein Hernia Repair | Shilpa Basnet |
| 1:40–1:50 PM | Comparative study of skin stapler versus suture in abdominal wound closure | MD. Abdil Aziz |
| 1:50–2:00 PM | A Comparative Study On Alvarado Score Versus Appendicitis Inflammatory Response Score In Acute Appendicitis | Sailesh Ghimire |
| 2:00–2:10 PM | Prediction Of The Outcome Of Intracerebral Hemorrhage By Blood Neutrophil-to-lymphocyte Ratio | Sarokar Parajuli |
| 2:10–2:20 PM | Evaluation Of Clinical-radiological Predictors For Expansion Of Hematoma In Patients With Primary Intracerebral Hemorrhage | Sunil Kumar Jha |

## SESSION XIX Nursing Session-II 2:30–3:30 PM

**CHAIRPERSONS** B. C. Shrestha, Ayushma Shakya, Suniti Singh, Rabin Ratna Ranjitkar

| | | |
|---|---|---|
| 2:30–2:45 PM | Stoma care in rectal cancer case: marking, counseling and follow up | Omkala Rai |
| 2:45–3:00 PM | Safe intraoperative handovers: Bridging communication between OT, PACU and wards | Monika Regmi |

HALL D · CONTINUED

SESSION XIX

## Nursing Session-II (continued)

| | | |
|---|---|---|
| 3:00–3:15 PM | Role of IPC nurse in surgical site infection prevention | Sangita Rai |
| 3:15–3:30 PM | Catching Deterioration Early: The Post-operative ICU Nurse's Role | Anjana Budathoki |

# Day 2 at a Glance

Saturday 28 November 2026 · Oral presentations by hall

## Hall A

**8:00–9:00 AM**
XX · General Session-III

**9:00–9:30 AM**
Keynote Session

**9:30–11:15 AM**
XXI · Gall Bladder session

**11:15 AM – 12:00 PM**
Acute Pancreatitis

**1:30–2:45 PM**
XXII · Liver Session

**2:45–4:00 PM**
XXIII · Liver Transplant session

## Hall B

**8:00–9:00 AM**
XXIV · General Session-IV

**9:30–10:30 AM**
XXV · Colorectal session-I

**10:30 AM – 12:00 PM**
XXVI · Colorectal session-II

**1:30–2:15 PM**
Multidisciplinary Team Meeting

**2:15–3:30 PM**
XXVII · Pancreas session-II

## Hall C

**8:00–9:00 AM**
XXVIII · Residents Best Paper Award -IV

**9:30–11:00 AM**
XXIX · Residents Best Paper Award -V

**11:00 AM – 12:00 PM**
XXX · Residents Best Paper Award -VI

**1:30–3:20 PM**
XXXI · Free Papers session

**12:00–1:00 PM** SSN Annual General Meeting

**Hall E** Poster Presentations · both days

# Hall A

Saturday 28 November 2026 · Oral presentations

## SESSION XX General Session-III — 8:00–9:00 AM

**CHAIRPERSONS** Kishore Manandhar, Rupesh Mukhiya, Akanand Singh, Basu Dev Devkota

| | | |
|---|---|---|
| 8:00–8:15 AM | Impact of Surgery on environment | Pradeep Ghimire |
| 8:15–8:30 AM | From Challenges to Frugal Innovation: Starting Advanced Laparoscopic Surgery in Western Nepal | Sujan Shrestha |
| 8:30–8:45 AM | The Surgeon in the Witness Box – how surgical complications are evaluated medico-legally | Sarmistha Dhoubadel |
| 8:45–9:00 AM | Robotic Surgery program initiation and expansion across multiple surgical specialties at CMC | Pratik Man Singh Gurung |

## KEYNOTE Keynote Session — 9:00–9:30 AM

**CHAIRPERSONS** Manohar Lal Shrestha, Rakesh Verma, Ambuj Karna

| | | |
|---|---|---|
| 9:00–9:30 AM | Changing Landscape of Surgical Oncology – Past, Present and Future | SVS Deo |

## SESSION XXI Gall Bladder session — 9:30–11:15 AM

**CHAIRPERSONS** Sanjaya Poudyal, Pradeep Ghimire, Narayan Basnet, Muza Shrestha, Ashok Koirala, Akash Raya

| | | |
|---|---|---|
| 9:30–9:45 AM | Difficult Laparoscopic Cholecystectomy: Challenges, Surgical Strategies and Safe Bailout Techniques | Abhijeet Kumar |
| 9:45–10:00 AM | Handling a difficult gallbladder with stone | Pravin Joshi |
| 10:00–10:15 AM | Role of AI in safe cholecystectomy (AI-assisted CVS identification, real-time anatomy recognition) | Uttam Laudari |
| 10:15–10:30 AM | Ca-GB – does Nepal need a data registry and guideline? | Narayan Belbase |
| 10:30–10:45 AM | Management of complex bile duct injuries | Prasan Kansakar |
| 10:45–11:00 AM | Current surgical approach in carcinoma gallbladder | Suresh Prasad Sah |
| 11:00–11:15 AM | MIS for Gallbladder Carcinoma: Oncological Concerns and Current Evidence | Parbatraj Regmi |

## PANEL DISCUSSION Acute Pancreatitis — 11:15 AM – 12:00 PM

**MODERATOR** Kunal Bikram Deo

**PANELISTS** Paleswan Joshi Lakhey, Lalit Rajbanshi, Anuj Taparia, Pawan Parajuli, Batsalya Arjyal

| | |
|---|---|
| 11:15 AM – 12:00 PM | Acute Pancreatitis |

HALL A · CONTINUED

**12:00–1:00 PM** SSN Annual General Meeting

**1:00–1:30 PM** Lunch Break

## SESSION XXII Liver Session — 1:30–2:45 PM

**CHAIRPERSONS** Ramesh Singh Bhandari, Prasan Kansakar, Sagar Khatiwada, Roshan Ghimire, Akanand Singh

| | | |
|---|---|---|
| 1:30–1:45 PM | Evolving concepts in the management of Advanced perihilar cholangiocarcinoma | Mukunda Raj Joshi |
| 1:45–2:00 PM | Glissonean approach in hepatic resection | Jainendra Chaudhary |
| 2:00–2:15 PM | ICG-guided laparoscopic liver surgery: current perspective and future directions | Dhiresh Kumar Maharjan |
| 2:15–2:30 PM | Recent Concepts In Non Cirrhotic Portal Hypertension | Nabin Pokharel |
| 2:30–2:45 PM | Modern Minimally Invasive Alternatives to General and Gastrointestinal Surgery | Manish Raj Pathak |

## SESSION XXIII Liver Transplant session — 2:45–4:00 PM

**CHAIRPERSONS** Mahesh Khakurel, Rakesh Verma, Mukund Raj Joshi, RK Saboo, Pravin Joshi

| | | |
|---|---|---|
| 2:45–3:00 PM | Liver transplant for hepatocellular carcinoma | Akanand Singh |
| 3:00–3:15 PM | Donor liver outcome | Roshan Ghimire |
| 3:30–3:45 PM | Complex Surgical Decision-Making in Liver Transplantation – Lessons from a National Transplant Center | Ram Babu Sah |
| 3:45–4:00 PM | Challenges in Acute Liver Failure Management and Transplantation in Nepal | Ganesh Simkhada |

# Hall B

Saturday 28 November 2026 · Oral presentations

## SESSION XXIV General Session-IV — 8:00–9:00 AM

**CHAIRPERSONS** Rakesh Verma, Robin Joshi, Lalit Rajbanshi, Sudip Khaniya, Ajay Parajulee, Batsalya Arjyal

| | | |
|---|---|---|
| 8:00–8:15 AM | Beyond technical skills: Are we training complete surgeons? (virtual) | Abdul Majid Chaudhary |
| 8:15–8:30 AM | Early experience of advanced laparoscopic GI surgery in Birat Medical College and teaching hospital | Nitish Koirala |
| 8:30–8:45 AM | Bariatric Surgery in Nepal: Experience, Outcomes and Lessons Learned | Koshish Nandan Pokharel |
| 8:45–9:00 AM | Damage control resuscitation: the modern approach to the exsanguinating trauma patient | Bishal Gaurav |

## SESSION XXV Colorectal session-I — 9:30–10:30 AM

**CHAIRPERSONS** Brikh Raj Joshi, Nabin Pokharel, Romi Dahal, Bimarsha Adhikari, Bishwodeep Timilsina

| | | |
|---|---|---|
| 9:30–9:45 AM | Minimally invasive colorectal cancer surgery | Vivek Mangla |
| 9:45–10:00 AM | Colorectal cancer with liver metastases | Mukti Devkota |
| 10:00–10:15 AM | Peritoneal Surface Malignancy: Evolving Role of CRS, HIPEC and PIPAC in Colorectal Peritoneal Metastases | Deep Lamichhane |
| 10:15–10:30 AM | Approach to complex perianal fistula | Anuj Parajuli |

## SESSION XXVI Colorectal session-II — 10:30 AM – 12:00 PM

**CHAIRPERSONS** Satyadeep Bhattacharya, Anuj Parajuli, Rohit K Mishra, Rakesh Shah, Sujan Shrestha

| | | |
|---|---|---|
| 10:30–10:45 AM | Towards a Nepal-Specific Colorectal Cancer Screening Strategy: Evidence, Gaps and a Practical Roadmap | Arbin Joshi |
| 10:45–11:00 AM | Rectal Cancer MRI: A Surgeon's Roadmap to Staging, Surgical Planning and Treatment Decision-Making | Ajay Yadav |
| 11:00–11:15 AM | Total Neoadjuvant Therapy (TNT) in Rectal Cancer: A Paradigm Shift in Management | Ambuj Karn |
| 11:15–11:30 AM | Organ preservation strategies in rectal cancer | Kapendra Shekhar Amatya |
| 11:30–11:45 AM | Rectal lesions: scope of management through transanal approach | Sanjay Paudyal |
| 11:45–12:00 PM | Video presentation on robotic pelvic lymphadenectomy | Birendra Bhagat |

**12:00–1:00 PM** SSN Annual General Meeting

HALL B · CONTINUED

**1:00–1:30 PM** Lunch Break

MDT MEETING

## Multidisciplinary Team Meeting

1:30–2:15 PM

Sponsored by **Nepal Cancer Hospital & Research Center**

NEPAL CANCER HOSPITAL & Research Center Ltd. "Care with Excellence"

**MODERATOR** Vivek Mangla

**PANELISTS** Dhiresh K Maharjan, Ambuj Karn, Satyadeep Bhattacharya, Anuj Taparia, Ramila Shilpakar, Ajaya Yadav, Lahar Maya Bhasinka

| | | |
|---|---|---|
| 1:30–2:15 PM | Rectal Cancer (Low rectal cancer)<br>Borderline Resectable Pancreatic Cancer | |

SESSION XXVII

## Pancreas session-II

2:15–3:30 PM

**CHAIRPERSONS** Paleshwan Joshi Lakhey, Dhiresh K Maharjan, Saroj Rajbanshi, Narayan Belbase, Nirajan Subedi

| | | |
|---|---|---|
| 2:15–2:30 PM | Pancreatic cystic neoplasms-Current updates | **Vivek Mangla** |
| 2:30–2:45 PM | Pancreatic trauma: current diagnostic modalities and management strategies | **Sudip Khaniya** |
| 2:45–3:00 PM | Indications for distal pancreatectomy; key procedural considerations | **Romi Dahal** |
| 3:00–3:15 PM | Selective Pancreatic Duct Exteriorization During Pancreaticoduodenectomy: When, Why and How | **Rohit Mishra** |
| 3:15–3:30 PM | Pancreatic surgery in BPKMCH, Nepal – challenges, outcomes, way forward | **Sunil Dhakal** |

# Hall C

Saturday 28 November 2026 · Oral presentations

## SESSION XXVIII Residents Best Paper Award -IV 8:00–9:00 AM

**CHAIRPERSONS** Balaram Malla, Deep Lamichhane, Dipendra Thakur, Bishal Acharya

| | | |
|---|---|---|
| 8:00–8:10 AM | Role of Platelet to Lymphocyte ratio(PLR) in predicting acute appendicitis | Bhuwan Rayamajhi |
| 8:10–8:20 AM | Role of C-Reactive Protein/Albumin Ratio (CAR) as a predictor of Surgical Site Infections after Major Abdominal Surgery | Krishna Neupane |
| 8:20–8:30 AM | AIR Score And Its Relation In Predicting Perioperative Outcome In Patients Undergoing Emergency Laparoscopic Appendectomy | Pranita Joshi |
| 8:30–8:40 AM | Evaluation Of Accuracy Of Total Leukocyte Count, C-reactive Protein, And Erythrocyte Sedimentation Rate In The Diagnosis Of Acute Appendicitis | Pragya Jha |
| 8:40–8:50 AM | Hyperbilirubinemia as a predictor of acute appendicitis | Ajay pariyar |
| 8:50–9:00 AM | Role Of Serial Lactate Measurement To Predict 28 Day Mortality In Patient Undergoing Surgery For Perforation Peritonitis | Ratan Subedi |

**9:00–9:30 AM** KEYNOTE Session in Hall A

## SESSION XXIX Residents Best Paper Award -V 9:30–11:00 AM

**CHAIRPERSONS** Hemanta Batajoo, Santosh Shah, Punya Kharbuja, Yoshika Bhattarai

| | | |
|---|---|---|
| 9:30–9:40 AM | Neutrophil-to-Lymphocyte Ratio as aasuri Predictor of Severity in Acute Cholecystitis: A Cross-Sectional Study | Surya Kiran Lama |
| 9:40–9:50 AM | Comparative Study of Port Site Infection Following Gallbladder Retrieval With and Without an Endobag in Laparoscopic Cholecystectomy | Saroj Kumar Bhagat |
| 9:50–10:00 AM | Early Laparoscopic cholecystectomy (TG 18) for Acute Cholecystitis: A Two-Year Single-Center Experience | Milan Nayak |
| 10:00–10:10 AM | Pancreaticoduodenectomy: A Five Year Clinical Experience in Tertiary Care Center | Rajendra Dhakal |
| 10:10–10:20 AM | Postoperative Port Site Infections in Laparoscopic Cholecystectomy Patients With and Without Intraoperative Bile Spillage: A Hospital Based observational study. | Ranbir Yadav |
| 10:20–10:30 AM | Evaluation And Outcome Of intervention In hepatocellular carcinoma (HCC) In Eastern Part Of Nepal | Bikash Mandal |

HALL C · CONTINUED

## SESSION XXIX Residents Best Paper Award -V (continued)

| | | |
|---|---|---|
| 10:30–10:40 AM | CholeS Score versus Surgical Cholecystectomy Score for Prediction of Difficult Laparoscopic Cholecystectomy in Post-ERCP Patients | Rahul Singh |
| 10:40–10:50 AM | Early Outcomes of Vascular Access Grafts in CKD Patients with Poor Vascular Anatomy and Multiple Access Failure | Shreeyash Chandak |
| 10:50–11:00 AM | Incidence of Acute Pancreatitis and Necrotising Complications Requiring Necrosectomy: A Single-Centre Experience From Nepal | Sanjay Kumar Yadav |

## SESSION XXX Residents Best Paper Award -VI 11:00 AM – 12:00 PM

**CHAIRPERSONS** Sunil Chandra Adhikari, Nitish Koirala, Shashi Shekhar Adhikari, Arun Gyanwali

| | | |
|---|---|---|
| 11:00–11:10 AM | The Mirizzi Challenge | Abhiraj Mishra |
| 11:10–11:20 AM | Predictive Value of C-Reactive Protein-to-Albumin Ratio Predicting Prognosis and Severity of Acute Biliary Pancreatitis | Bhavesh Kumar Yadav |
| 11:20–11:30 AM | Dry Mopping versus Saline Irrigation of Gall Bladder fossa after Bile spillage during Laparoscopic Cholecystectomy | Lokendra Bahadur Thapa |
| 11:30–11:40 AM | Outcomes of Open Gastrectomy: A Retrospective Case Series of 81 Patients at a Tertiary Care Centre in Chitwan Nepal | Subhash Kumar Jha |
| 11:40–11:50 AM | Our Experience With Surgery For Carcinoma Esophagus In A Tertiary Care Center | Shreeyash Chandak |
| 11:50–12:00 PM | Individualized Surgical Management of Gastric Cancer: A Single-Centre Retrospective Case Series of 11 Patients | Shashi Deo Yadav |

**12:00–1:00 PM** SSN Annual General Meeting

**1:00–1:30 PM** Lunch Break

HALL C · CONTINUED

## SESSION XXXI Free Papers session 1:30–3:20 PM

**CHAIRPERSONS** Pranil Rai, Ravi Bastakoti, Bishal Gaurav, Sujit Mainali

| | | |
|---|---|---|
| 1:30–1:40 PM | Prognostic Value of Preoperative Neutrophil-to-Lymphocyte Ratio, Platelet-to-Lymphocyte Ratio and Systemic Immune-Inflammation Index in Hepatocellular Carcinoma After Curative Hepatectomy: A Systematic Review and Meta-Analysis | Shankar Poudel |
| 1:40–1:50 PM | Laser Hemorrhoidoplasty For Treatment Of Grade II & III Hemorrhoids: A Prospective Observational Study From Eastern Nepal | Amit Bhattarai |
| 1:50–2:00 PM | Risk of conversion in minimally invasive surgery for acute groin hernia: A Meta-Analysis | Bishal Subedi |
| 2:00–2:10 PM | Management Of Massive Ventral Hernia With Loss Of Domain By Preoperative Botulinum Toxin: Experience At A Rural Hospital In Nepal | Ranjis Pahari |
| 2:10–2:20 PM | Preoperative Nutritional Risk and Postoperative Outcomes after Emergency Abdominal Surgery: A Systematic Review and Meta-Analysis | Shankar Poudel |
| 2:20–2:30 PM | Medical Humanities in Medical School Curricula: A Necessity for LMICs | Mohammad Adnan Adil |
| 2:30–2:40 PM | An Assessment Of Blood Utilisation In Neurosurgical Procedures Using Crossmatch Transfusion Ratio (CTR) At A Tertiary Care Centre In Nepal | Dikshya Pant |
| 2:40–2:50 PM | Perioperative Outcomes and Long-Term Survival Following Bronchoplastic Resection for Neoplastic Lesions of the Lung: A Single-Center Retrospective Study | Manoj Tiwari |
| 2:50–3:00 PM | The Scars We Carry: Personal Injury Marks as Lifelong Identifiers and Lessons in Surgical Awareness | Rabin Rachalica |
| 3:00–3:10 PM | Simulation-Based Surgical Training in Undergraduate Medical School: Awareness, Skills Confidence, and Student Interest in Low-Cost Innovation | Prapti Lakhey |
| 3:10–3:20 PM | Digital WHO Surgical Safety Checklists as Cognitive Decision-Support Tools for Junior Doctors: Enhancing Interdisciplinary Collaboration and Perioperative Safety — A Narrative Review | Eva Shrestha |

# Poster Presentations

Day 1 · Friday 27 November 2026 · Hall E

| | | |
|---|---|---|
| 1 | Complete Pancreatic Neck Transection Following Bicycle Handlebar Trauma in a Child: A Case Report | Chandresh Kumar Singh |
| 2 | Isolated left-lobe metastatic hepatic abscess due to portal pyemia from microperforated ascending colon carcinoma: a rare case report | Suman Supratik |
| 3 | Emergency Pancreaticoduodenectomy: Indications, Challenges and Outcomes-A Case Series | Kundan Singh |
| 4 | Retrograde migration of a pancreaticojejunostomy stent into the oral cavity after pancreaticoduodenectomy: a case report and literature review | Saurabh Tiwari |
| 5 | Post-Pancreatectomy Haemorrhage after Pancreatoduodenectomy requiring Re-exploration: Our Experience at Chitwan Medical College Teaching Hospital | Sonu Shrestha |
| 6 | A Cyst at the Crossroads: Laparoscopic Excision of a Hepatoduodenal Ligament Lymphatic Cyst with Cholecystectomy | Niraj Kumar Yadav |
| 7 | Pancreas-Sparing Resection for Presumed Benign Ampullary and Duodenal Masses: A Case Series | Shivani Pakhrin |
| 8 | Complex biliovascular injury following cholecystectomy and its management : A case report | Harshit Agrawal |
| 9 | The Broken Biliary Confluence: A Surgical Challenge Requiring Bilateral Reconstruction: A Case Report | Amisha Silwal |
| 10 | Giant Hepatic Hemangioma Managed by Right Posterior Sectionectomy | Divansh thakur |
| 11 | Hepatic Hydatid Cyst with Cystobiliary Communication Presenting as Obstructive Jaundice: A Case Report | Amar Das |
| 12 | Pseudoaneurysm in acute pancreatitis | Shashi Deo Yadav |
| 13 | Advanced Anterior Chest Wall Soft Tissue Sarcoma with Cutaneous Ulceration: a case report | Ranbir Yadav |
| 14 | Malignant Phyllodes Tumour in a Young Lactating Breast: A Diagnostic Pitfall | Era Phoju |
| 15 | Immune Check(mate): Durvalumab's Success In Gallbladder Carcinoma – A Case Report | Nikesh Jaiswal |
| 16 | Giant Hemorrhagic Sclerosing Pneumocytoma Presenting with Pneumothorax and Pneumomediastinum Requiring Pneumonectomy: A Rare Case Report | Birendra Raut |

# Poster Presentations

Day 2 · Saturday 28 November 2026 · Hall E

| | | |
|---|---|---|
| 17 | A Fatal Case of Multivisceral Necrosis Following Corrosive Ingestion: Surgical management with Total Gastrectomy with Esophagostomy and Pancreaticoduodenectomy | Bibek Kumar Das |
| 18 | Diagnostic pitfall in Duodenojejunal perforation : A case series of Four patient | Santosh Yadav |
| 19 | Surgical Management of Iatrogenic Duodenal Perforation During ERCP Results in Significant Clinical Improvement: A Case Report | Ranbir Yadav |
| 20 | Beyond Explantation: Saving An Infected Mesh With NPWT In Incisional Hernia With Loss Of Domain | Milan Adhikari |
| 21 | Beyond the Liver: Primary Appendiceal Hydatid Disease with Disseminated Peritoneal, Ovarian, and Uterine Involvement Mimicking an Appendiceal Neoplasm | Tilak Dangi |
| 22 | Trapped Within: A Rare Case Report of Idiopathic Abdominal Cocoon Syndrome in an Adult Female | Aashish Baniya |
| 23 | Spontaneous Perforation of Meckel's Diverticulum Unmasked during Appendectomy: A Case Report and Review of Literature | Bishal Kunwarni |
| 24 | Retroperitoneal Filarial Cyst Presenting as Acute Abdomen: A rare case report | Abhaya Mahto |
| 25 | Abdominal Cocoon Syndrome – | Saruja Bhattarai |
| 26 | Individualized Surgical Management of Mesenteric Cyst: A Single-Centre Retrospective Case Series of 3 Patients | Lalu Prasad Yadav |
| 27 | Stercoral Perforation of the Proximal Colon: A Rare Case of Cecal Perforation | Ghanshyam Yadav |
| 28 | Delayed Rupture of Splenic Injury Following Blunt Trauma Abdomen in a Patient with Mitral Valve Replacement on Anticoagulation: A Case Report | Shree Ram Roy |
| 29 | Rare Presentation of Restrain Injury over Bilateral Axillae | Bhuwan Rayamajhi |
| 30 | From Segmental resection to Total Colectomy: A Surgical Challenge of Late-Diagnosed Hirschsprung Disease in an Adolescent | Gaurav Bharadwaj |
| 31 | Successful Management of Gastroschisis in a Newborn: A Case Report | Sarokar Parajuli |
| 32 | De Garengeot Hernia with Strangulated Richter's Hernia: An Exceptionally Uncommon Presentation in a 100-Year-Old Woman | Pahari Ranjis |
| 33 | Delayed Presentation of Handlebar Hernia in a 13-Year-Old Child: A Case Report | Mohammad Adnan Adil |
| 34 | Fournier's Gangrene Masked by Diabetic Ketoacidosis in a Young Man with Type 1 Diabetes Mellitus: A Surgical Case Report | Mohammad Adnan Adil |

# 24 Abstracts

SOCIETY OF SURGEONS OF NEPAL (SSN)

## XV$^{th}$ National Conference (SSNCON 2026)

**BOOK OF SCIENTIFIC ABSTRACTS — SOUVENIR EDITION**

Total Submitted Abstracts: **102** | Oral Presentations: **62** | Poster Presentations: **40**

## ORAL PRESENTATIONS (62 Abstracts)

**ABSTRACT 1** AB-000015 **ORAL PRESENTATION**

### Surgical Outcomes of Inguinal Hernia Repair Using Desarda's Technique: Interim Results of a Prospective Study

**AUTHOR** Dr. Shiva Bhandari (Bharatpur Hospital, Chitwan)

**CO-AUTHORS** *None*

**Introduction:** Mesh repair is the most common operation for inguinal hernia, but chronic groin pain occurs in around 10–12% of patients. Desarda's repair is a pure tissue repair that uses a strip of external oblique aponeurosis (EOA) to make a new posterior wall without mesh.

**Methods:** This is an ongoing prospective single-centre study at Bharatpur Hospital (target 100 patients). Adult males with primary inguinal hernia were included. All were operated under spinal anaesthesia using an undetached EOA strip fixed with Polyporpylene suture. The primary outcome is recurrence. We also record VAS pain, wound infection, seroma, hematoma, urinary retention, chronic groin pain and testicular atrophy, at 7 days, 28 days, 6 months and 1 year follow up.

**Results:** Ten patients are enrolled so far. Mean age was 50 years (20–78). Three had bilateral hernia and one was incarcerated. Seven have completed one year follow-up. Mean VAS was 4.3 on day 1, 2.1 on day 7 and 0.7 on day 28. All returned to normal activity within one week. There was no wound infection, hematoma, seroma or urinary retention. No recurrence so far, and none of the seven with one year follow-up has chronic groin pain or testicular atrophy. In one bilateral case the EOA was thin and friable on one side, so mesh was used.

**Conclusion:** In our early experience, Desarda repair was feasible and safe with good early recovery. It can be a useful option for general surgeons, especially when mesh is not suitable. More patients and longer follow-up are needed.

**Keywords:** Chronic Pain; Hernia, Inguinal; Herniorrhaphy; Recurrence

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**ABSTRACT 2** AB-000016 **ORAL PRESENTATION**

### Neutrophil-to-Lymphocyte Ratio as a Predictor of Severity in Acute Cholecystitis: A Cross-Sectional Study

**AUTHOR** dr. surya kiran lama (nepal medical college)

**CO-AUTHORS** *None*

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**ABSTRACT 3** AB-000018 **ORAL PRESENTATION**

### LASER HEMORRHOIDOPLASTY FOR TREATMENT OF GRADE II AND III HEMORRHOIDS: A PROSPECTIVE OBSERVATIONAL STUDY FROM EASTERN NEPAL

**AUTHOR** Dr Amit Bhattarai (Nobel Medical College Teaching hospital)

**CO-AUTHORS** *None*

Laser hemorrhoidoplasty is a minimally invasive treatment associated with short operative time, limited postoperative complications, and satisfactory patient-reported outcomes. It appears to be an effective option for selected patients with grade II and III hemorrhoids.

ABSTRACT 4 AB-000019 ORAL PRESENTATION

## PREDICTION OF THE OUTCOME OF INTRACEREBRAL HEMORRHAGE BY BLOOD NEUTROPHIL-TO-LYMPHOCYTE RATIO

AUTHOR Dr. Sarokar Parajuli (Pokhara Academy of Health sciences)
CO-AUTHORS *None*

ABSTRACT 5 AB-000021 ORAL PRESENTATION

## Bridging skill, Technology and Context: Advancing Safe, Equitable Surgery in Nepal

AUTHOR Pradeep Ghimire (Fishtail Hospital and Research Centre, Pokhara, Nepal)
CO-AUTHORS *None*

**Introduction:** Surgery in increasingly team-based and technology-supported. Safety, precision and outcomes now guide standards. There is shift from purely operative skill to multidisciplinary, tech-integrated practice emphasizing continuous learning mindset.

**Methods:** Global surgical excellence were explored in literature. Nepal's journey so far in surgical field was documented along with surgical technological advancements. Documentation of surgical excellence in Nepal was investigated locally and nationally.

**Results:** Gaps in surgical excellence in Nepal were identified and recommendations were made. A national surgical network vision was proposed along with a 10-year vision for surgical advancement were projected.

**Conclusion:** Surgical excellence includes combination of technology, skill and co-ordination. Training and teamwork must guide surgical field progression. Surgical advancement is a shared national responsibility.

**Keywords:** safe surgery; equitable surgery, Surgery in Nepal

ABSTRACT 6 AB-000022 ORAL PRESENTATION

## Impact on environment by surgery

AUTHOR Pradeep Ghimire (Fishtail Hospital and Research Centre, Pokhara, Nepal)
CO-AUTHORS *None*

**Introduction:** Surgical services are resource-intensive and waste generating. Surgery saves lives but has an environmental cost with operating theatres being the most energy-intensive area of the hospital generating up to one-third of the total hospital waste. A single surgery produces up to 14 kg of waste.

**Methods:** Literature was explored to assess environmental impact of surgical practice along with carbon footprint of surgery. Surgical waste generation was also explored.

**Results:** Single-use devices and consumables produce up to 86% of surgical carbon emissions. Surgical services across several countries generate ~9.7 million tonnes of $CO_2$ annually highlighting the large environmental footprint of surgical care worldwide. Contributing components in surgery were identified and listed including anesthetic equipment, single-use surgical instruments. Open surgery contributes to lowest footprint whereas robotic surgery the most.

**Conclusion:** Environmental sustainability is the current unmet need in surgical practice. Basic principles should be reduce, reuse, recycle, rethink and research that will help minimize environmental impact of surgery.

**Keywords:** sustainability in surgery, environmental impact, surgical waste, carbon footprint in surgery

ABSTRACT 7 AB-000023 ORAL PRESENTATION

## EVALUATION OF CLINICAL-RADIOLOGICAL PREDICTORS FOR EXPANSION OF HEMATOMA IN PATIENTS WITH PRIMARY INTRACEREBRAL HEMORRHAGE

AUTHOR Sunil Kumar Jha (Manipal College Of Medical Sciences)
CO-AUTHORS *None*

ABSTRACT 8 AB-000025 ORAL PRESENTATION

## Factors Predicting Infectious Complications Following Percutaneous Nephrolithotomy

AUTHOR Dr Md. Imran Ansari (Department of Urology Birat Medical college & Teaching Hospital)
CO-AUTHORS Dr.Deepak Thakur, Dr.Ashok yadav, Dr Bhupendra Malla

A total of 104 patients with renal or upper ureteric calculi who underwent PCNL between December 2022 to December 2023 were included in the study. Infectious complications included fever due to Urinary tract infection and septicemia. The patients were divided into Group A and B depending on whether they developed fever or did not. Patient, stone, renal, and procedure-related factors were compared between the two groups

ABSTRACT 9 AB-000030 ORAL PRESENTATION

## Comparative Study of Port Site Infection Following Gallbladder Retrieval With and Without an Endobag in Laparoscopic Cholecystectomy

AUTHOR Saroj Kumar Bhagat (Department of General Surgery, Kathmandu Medical College Teaching Hospital, Sinamangal, Kathmandu, Nepal)
CO-AUTHORS *None*

**Introduction:** Port site infection is a recognised complication of laparoscopic cholecystectomy, and extracting the gallbladder through a port may contaminate the wound. Prospective local data on endobag use are lacking in Nepal. We compared port site infection with and without an endobag.

**Methods:** This prospective, non-randomised comparative study was conducted at Kathmandu Medical College Teaching Hospital from January to April 2025. Adults undergoing elective laparoscopic cholecystectomy were allocated by consecutive calendar period to endobag retrieval (n=74) or retrieval without a bag (n=74); diabetic and immunocompromised patients were excluded. Infection was defined by CDC criteria and assessed on postoperative days 7 and 30. Groups were compared using chi-square and Fisher's exact tests, with exploratory logistic regression.

**Results:** Among 148 patients (mean age 46.5 years; 72.3% female), 24 developed port site infection (16.2%), all superficial; Escherichia coli was the commonest isolate. Infection was less frequent with an endobag (9.5% vs 23.0%; p=0.026; Fisher's p=0.043; relative risk 0.41, 95% CI 0.18–0.93). After adjusting for sex, age and BMI, this was not significant (adjusted OR 0.40, 95% CI 0.15–1.09). Time to suture removal (median 8 vs 8 days) and return to work (10 vs 10.5 days) did not differ between groups. Infection delayed return to work (median 22 vs 9 days; p<0.001). Male sex independently predicted infection.

**Conclusion:** Endobag retrieval was associated with fewer port site infections, but the result was statistically fragile and allocation was non-randomised, so a protective effect is suggested rather than established. Adequately powered randomised trials are needed.

ABSTRACT 10 AB-000032 ORAL PRESENTATION

## Selective Pancreatic Duct Exteriorisation after Pancreaticojejunostomy in Pancreaticoduodenectomy: Experience from a Tertiary Centre in Nepal

AUTHOR Dr Rohit Kumar Mishra (Chitwan Medical College and Teaching Hospital)
CO-AUTHORS *None*

Institutional Pancreaticojujunostomy techniques.

ABSTRACT 11 AB-000035 ORAL PRESENTATION

## Evaluation of Chronic Inguinal Pain After Mesh Fixation by Polypropylene Versus Polyglactin in Lichtenstein Hernia Repair

AUTHOR Dr. Shilpa Basnet (Pokhara Academy of Health Sciences)
CO-AUTHORS *None*

ABSTRACT 12 AB-000036 ORAL PRESENTATION

## Early Laparoscopic cholecystectomy (TG 18) for Acute Cholecystitis: A Two-Year Single-Center Experience

AUTHOR Dr Milan Nayak (Janaki Medical College & Teaching Hospital)

CO-AUTHORS Dr Shashi Shekhar Adhikari, ,Dr Milan Nayak, Dr Bipin Kumar Yadav, Dr Bijay Kumar Yadav, Dr Krishna Adhikari, Dr Bipul Thakur

**BACKGROUND:** Acute cholecystitis is surgical emergency, and optimal timing of Laparoscopic cholecystectomy (LC) has long been debated. The Tokyo Guidelines 2018 (TG18) recommend early surgery for suitable patients. We evaluated outcomes of early LC in acute cholecystitis managed according to TG18.

**METHODS:** This retrospective observational study was conducted at (JMCTH) from August 2024 to July 2026. Patients diagnosed with acute cholecystitis by (TG18) severity criteria who underwent LC within 7 days of symptom onset were included. Demographics, (TG18 grade), intraoperative findings, postoperative complications were recorded and analyzed.

**RESULTS:** 50 patients were included. The mean age was 46.8 years. 24% male, 76% female. Based on the TG18 grading, 41patients had Grade I disease, 7 patients had Grade II disease and only 2 patients had Grade III disease. 2 patients (4% ) needed to have the surgery converted to open because of intraoperative bleeding and adhesions in the Calot's triangle. The Critical View of Safety was achieved in 82% of the cases.There was a morbidity rate of 14% with specific complications like bile leaks (8%) , intra-abdominal abscess (4%) and port-site infection (2%) noted.There was no evidence of bile duct injury. The average operative time was 71.80 (65 to 135 )minutes, and the median hospital stay after surgery was 3 days(2.44 to 7).

**CONCLUSION:** Early LC for TG18-managed acute cholecystitis was feasible, with no bile duct injury . Bile leak and conversion rates (4% each) support careful patient selection. Larger prospective studies are needed.

**Keyword :** Bile ducts, Cholecystitis, Laparoscopic cholecystectomy

ABSTRACT 13 AB-000037 ORAL PRESENTATION

## Evaluation of Chronic Inguinal Pain After Mesh Fixation by Polypropylene Versus Polyglactin in Lichtenstein Hernia Repair

AUTHOR Dr. Shilpa Basnet (Pokhara Academy of Health Sciences)

CO-AUTHORS *None*

ABSTRACT 14 AB-000042 ORAL PRESENTATION

## Application of Indocyanine Green-based Fluorescence Imaging in Bowel Anastomosis

AUTHOR Dr. Prabin Ghimire (Kathmandu Medical College)

CO-AUTHORS *None*

**Introduction:** Anastomotic leak (AL) remains the most feared complication of gastrointestinal surgery and is linked to higher morbidity and mortality. Inadequate perfusion of the bowel ends is a major modifiable cause, but its assessment by colour, bleeding and pulsation is subjective. Indocyanine green (ICG) fluorescence angiography offers an objective, real-time view of bowel perfusion.

**Objectives:** To study the application of ICG fluorescence imaging in bowel anastomosis during upper gastrointestinal and lower gastrointestinal/colorectal surgery, by comparing the transection line chosen by clinical assessment with that chosen after ICG imaging, and by determining the 30-day AL rate.

**Methods:** This hospital-based prospective observational study was conducted in the Department of General and Gastrointestinal Surgery, Kathmandu Medical College Teaching Hospital, from November 2024 to October 2025. Adults undergoing elective gastrointestinal resection with anastomosis were enrolled by purposive sampling (calculated sample size 49). After the surgeon marked the planned transection line, 5 mg ICG was injected intravenously and the bowel was examined with a Karl Storz near-infrared system. Any change in the transection line was recorded and patients were followed for 30 days. Data were analysed with SPSS version 21; $p<0.05$ was considered significant.

ABSTRACT 14 · CONTINUED

**Results:** Of the 49 patients (mean age 60.6 ± 8.2 years; 61.2% male), 28 underwent upper GI anastomosis (gastrojejunostomy 17, esophagojejunostomy 11) and 21 lower GI/colorectal anastomosis (colorectal 12, ileocolic 6, colocolic 3). ICG imaging was successful in all patients, with a mean time to fluorescence of 41.5 ± 9.1 s, a mean additional operative time of 4.8 ± 1.2 min and no adverse reactions. ICG showed inadequate perfusion at the clinically chosen line and led to a change of the transection line in 13 patients (26.5%; 95% CI 16.2–40.3%): 5/28 (17.9%) in upper GI and 8/21 (38.1%) in lower GI/colorectal surgery (p = 0.112). The mean distance of change was 2.65 ± 0.88 cm and was greater in colorectal surgery (3.20 vs 1.78 cm, p < 0.001). Anastomotic leak occurred in 2 patients (4.1%): none after upper GI and 2/21 (9.5%) after lower GI/colorectal anastomosis (p = 0.179). Both were colorectal anastomoses, ISREC grade B, managed without re-operation. Leak occurred in 1/13 (7.7%) patients with a changed line and 1/36 (2.8%) with an unchanged line (p = 0.464). There was no re-operation or 30-day mortality.

**Conclusion:** ICG fluorescence angiography is safe, quick and feasible. It identified inadequate perfusion missed by clinical assessment in about one in four patients, and the anastomotic leak rate after ICG-guided anastomosis was low. Routine perfusion assessment with ICG is recommended for gastrointestinal anastomoses, particularly colorectal and esophagojejunal anastomoses.

**Keywords:** Anastomotic leak; Colorectal surgery; Fluorescence angiography; Gastrectomy; Indocyanine green; Perfusion

ABSTRACT 15 AB-000043 ORAL PRESENTATION

## Pancreaticoduodenectomy: A Five Year Clinical Experience in Tertiary Care Center

AUTHOR Dr Rajendra Dhakal (Chitwan Medical College)
CO-AUTHORS Dr Rohit Kumar Mishra, Dr Akash Raya, Dr Alok Shrestha, Dr Basant Yadav

**Background:** Pancreaticoduodenectomy is a major operation. Once a high-mortality procedure, it now carries a mortality of 2-4%, but morbidity remains 30-40%, chiefly from pancreatic fistula. We describe our five year experience of 115 PDs and factors associated with clinically relevant postoperative pancreatic fistula (CR-POPF).

**Methods:** This retrospective study included 115 patients undergoing PD over five years. POPF was classified using the 2016 International Study Group of Pancreatic Surgery definition; grades B and C were clinically relevant. Delayed gastric emptying and post-pancreatectomy haemorrhage used International Study Group definitions. Major complications were Clavien–Dindo grade III or higher. Associations were assessed with multivariable logistic regression.

**Results:** Mean age was 58.9 ± 14.7 years; 72 patients (62.6%) were male. Malignancy accounted for 102 cases (88.7%); ampullary carcinoma (33, 28.7%) and distal cholangiocarcinoma (30, 26.1%) were commonest. A soft gland was recorded in 34 patients (29.6%), and duct diameter was below 3 mm in 13 (11.3%). CR-POPF occurred in 20 patients (17.4%), including grade B in 14 and grade C in six; 34 patients (29.6%) had a biochemical leak. Delayed gastric emptying occurred in 22 (19.1%), haemorrhage in eight (7.0%), and surgical-site infection in 42 (36.5%). Ten patients (8.7%) underwent re-exploration. Major complications occurred in 38 (33.0%), and eight patients (7.0%) died within 30 days. Median hospital stay was 11 days. Soft gland texture and blood loss ≥500 mL were independently associated with CR-POPF.

**Conclusion:** PD was feasible at this centre, with a CR-POPF rate of 17.4%. Soft gland texture and greater blood loss identified patients at increased fistula risk. These findings support prospective audit, early sepsis management, and coordinated multidisciplinary HPB care.

ABSTRACT 16 AB-000044 ORAL PRESENTATION

## Predictors of Clinically Relevant Postoperative Pancreatic Fistula Following Pancreaticoduodenectomy: A Five-Year Single-Centre Retrospective Cohort Study

AUTHOR Dr Basant Kumar Yadav (Chitwan Medical College Teaching Hospital (CMCTH), Bharatpur, Nepal)
CO-AUTHORS Dr Rohit Kumar Mishra[1], Dr Akash Raya[1], Dr Alok Shrestha[2], Dr Rajendra Dhakal[1]

**Background:** Postoperative pancreatic fistula (POPF) is a complication of pancreaticoduodenectomy (PD). This study aimed to identify predictors of clinically relevant POPF (CR-POPF) at Chitwan Medical College Teaching Hospital (CMCTH), Bharatpur, Nepal.

ABSTRACT 16 · CONTINUED

**Methods:** This retrospective cohort study included 102 patients who underwent PD during a five-year period ending 15 October 2026. POPF was graded using the 2016 International Study Group of Pancreatic Surgery definition. Grades B and C were classified as CR-POPF; biochemical leak or no fistula was classified as No-POPF. Groups were compared using Mann–Whitney U, chi-square, or Fisher's exact tests. Receiver operating characteristic (ROC) analysis identified cut-offs for continuous variables. Variables significant on univariable analysis were entered into Firth-penalised multivariable logistic regression.

**Results:** CR-POPF occurred in 18 patients (17.6%): 12 grade B (11.8%) and six grade C (5.9%). Mortality was higher with CR-POPF than without it (27.8% vs 1.2%; $p < 0.001$). Age, sex, body mass index, bilirubin, albumin, biliary drainage, operation type, and anastomosis type did not differ significantly. Soft pancreatic texture, main pancreatic duct diameter ≤3 mm (AUC 0.798), operative time ≥320 minutes (AUC 0.781), blood loss ≥550 mL (AUC 0.664), and transfusion were associated with CR-POPF on univariable analysis. Multivariable analysis identified soft pancreatic texture (OR 6.96, 95% CI 1.38–35.08; $p = 0.019$) and operative time ≥320 minutes (OR 8.81, 95% CI 1.85–41.96; $p = 0.006$) as independent predictors.

**Conclusion:** In this five-year CMCTH cohort, soft pancreatic texture and prolonged operative time independently predicted CR-POPF after PD. High-risk patients may benefit from fistula-mitigation strategies and closer postoperative surveillance.

**Keywords:** Pancreaticoduodenectomy; postoperative pancreatic fistula; pancreatic texture; operative time; risk factors.

ABSTRACT 17 AB-000045 ORAL PRESENTATION

## Postoperative Port Site Infections in Laparoscopic Cholecystectomy Patients With and Without Intraoperative Bile Spillage: A Hospital Based observational study.

AUTHOR Ranbir Yadav (Pokhara Academy of Health Sciences, Western Regional Hospital, Pokhara, Nepal)
CO-AUTHORS *None*

**Introduction:** Laparoscopic cholecystectomy (LC) is widely used for the treatment of symptomatic gallstone disease. Gallbladder perforation with bile spillage is a common intraoperative event, but its association with postoperative port site infection (PSI) remains an important clinical concern. This study aimed to assess the relationship between bile spillage and PSI following elective LC.

**Methods:** This prospective observational study was conducted at Pokhara Academy of Health Sciences, Western Regional Hospital, Pokhara, Nepal. A total of 202 patients aged >18 years undergoing elective LC were included. All patients received 1 g intravenous ceftriaxone at induction. Intraoperative bile spillage, operative duration, and bile culture results were recorded. Patients were followed for 30 days, and PSIs were assessed using CDC criteria. Seven patients were lost to follow-up, leaving 195 patients for final analysis.

**Results:** Bile spillage occurred in 46 (22.8%) patients. Among the 195 patients followed, 10 (5.1%) developed PSI. The infection rate was higher in patients with bile spillage than in those without spillage (13.3% vs. 2.7%; $p = 0.011$; OR = 5.62, 95% CI: 1.51–20.89). All infections were superficial incisional SSIs and were managed conservatively. Bile cultures were positive in 10 (5.0%) patients, with Escherichia coli being the most common isolate (3.5%). Operative duration was longer in the spillage group (92.4 ± 25.6 vs. 53.3 ± 14.6 minutes; $p < 0.001$).

**Conclusion:** Bile spillage was associated with a higher rate of PSI and longer operative duration. Careful gallbladder handling and appropriate peritoneal lavage may help reduce postoperative infections.

**Key words:** Laparoscopic Cholecystectomy; Surgical Site Infection; bile spillage , bacteriobilia

ABSTRACT 18 AB-000046 ORAL PRESENTATION

## Title – Evaluation And Outcome Of intervention In hepatocellular carcinoma (HCC) In Eastern Part Of Nepal

AUTHOR Bikash Mandal (Birat Medical College Teaching Hospital)
CO-AUTHORS Narendra pandit, Department of GI surgery ,BMCTH

ntroduction: Liver transplantation or resection are the treatment modality of choice for HCC with curative intent in appropriately selected patients. Liver resection, when possible is preferred due to organ shortage, costs and complexity of the procedure.

ABSTRACT 18 · CONTINUED

**Methods:** The study is a retrospective review of all patients diagnosed with HCC of liver in eastern part of Nepal by a single unit of Department of GI surgery over 9 years (2016-2025). Etiology, demographics, patient needing intervention for HCC were analysed.

**Results:** Among 65 patients, only 12 patients had non-metastatic, child A disease requiring some form of intervention. The remaining 53 patients were metastatic (n=20) or Child C category(n=21). Two patients presented with ruptured HCC. The median age of the patient was 60 years (40-85 years). There were 9 male and 3 female who required interventions (10 - liver resection; 2- TACE). Seven patients among 12 were hepatitis B and C virus infected; only one cirrhotic and four sporadic case. The mean tumour size requiring intervention was 12 cm (8-15 cm). The patients with viral infected HCC were all large size (> 8cm). Liver resection performed were; right hepatectomy- 4; extended right hepatectomy-1; left lateral segmentectomy- 3; wedge resection- 2. There were one 90-day mortality due to post- hepatectomy liver failure. The median survival were 38 months (11-90 months).

**Conclusion:** Resection in properly selected patient is curative in case of HCC with good outcome.

**Keywords:** - HCC, Hepatectomy , liver resection

ABSTRACT 19 AB-000047 ORAL PRESENTATION

## Laser Cystolithotripsy for Urinary Bladder Stones: A Single-Centre Retrospective Experience

AUTHOR Dr Sandeep Basnet (Dhulikhel hospital - KUSMS)
CO-AUTHORS Dr Sujan Makaju Shrestha

We retrospectively reviewed 38 registered cases (2022 to 2026) at Dhulikhel Hospital and included 27 patients who had laser cystolithotripsy for bladder stones. Mean stone size was 20.5 mm, and mean operative time was 81.3 minutes. Median postoperative stay was 1 day, and three patients (11.1%) had minor complications, none above Clavien–Dindo grade II. The procedure was feasible and safe in this series. Stone clearance on follow-up imaging was not assessed.

ABSTRACT 20 AB-000048 ORAL PRESENTATION

## Perioperative Outcomes and Long-Term Survival Following Bronchoplastic Resection for Neoplastic Lesions of the Lung: A Single-Center Retrospective Study

AUTHOR Manoj Tiwari (B.P. Koirala Memorial Cancer Hospital, Bharatpur, Chitwan)
CO-AUTHORS Binay Thakur, Sagar Khatiwada, Shachee Bhattarai, Mahesh mani Adhikari, Sandeep Sapkota, Saujan Raut

**Background:** Bronchoplastic pulmonary resection is an established lung-preserving surgical technique for centrally located pulmonary neoplasms involving the lobar or main bronchus. Sleeve lobectomy and related bronchoplastic procedures permit complete tumor resection while preserving functional pulmonary parenchyma and potentially avoiding pneumonectomy. We evaluated the perioperative outcomes and long-term survival following bronchoplastic resection for neoplastic lung lesion at a tertiary cancer center in Nepal.

**Methods:** A retrospective single-center study of consecutive patients undergoing bronchoplastic pulmonary resection for neoplastic lesions between 2001 and 2025. Of 40 patients undergoing bronchoplastic or sleeve pulmonary resection, five patients who underwent mid-tracheal resection were excluded, leaving 35 patients for analysis. Demographic, clinical, operative, pathological, postoperative and survival data were retrieved from institutional records. The primary outcome was postoperative morbidity. Secondary outcomes included completeness of resection, pathological stage and overall survival.

ABSTRACT 20 · CONTINUED

**Results:** Among 512 radical surgeries for pulmonary neoplasms performed during the study period. The mean age of the 35 analyzed patients was 54 years (range, 26–77 years), with 21 males and 14 females. Twenty-three patients were smokers. Cough was the commonest presenting in 91%. Sleeve lobectomy was performed in 28 patients (80.0%), bronchoplasty in six (17.1%), and trachea carinal resection in one (2.9%). Thirty-two procedures (91.4%) were performed by open thoracotomy and three (8.6%) by VATS. Mean operative time was 140 minutes and mean blood loss was 515 ml. Squamous cell carcinoma was the commonest histology 57.1%, followed by typical carcinoid 11.4%, atypical carcinoid 8.6%, adeno squamous carcinoma 8.6%, adenocarcinoma 5.7%, adenoid cystic carcinoma 5.7% and large-cell carcinoma with neuroendocrine differentiation 2.9%. R0 resection was achieved in 33 patients (94.3%). Postoperative complications occurred in 28.6%; atelectasis was the most frequent complication (8.6%). The median overall survival was 56 months and the estimated 5-year overall survival was 52%. Median survival was 85 months for stage I, 65.5 months for stage II and 42 months for stage III disease; this difference was not statistically significant (P=0.29).

**Conclusion:** Bronchoplastic pulmonary resection was associated with a high R0 resection rate and acceptable postoperative morbidity in this single-center series. Despite a substantial proportion of patients presenting with stage III disease, long-term survival was favorable, with a 5-year overall survival of 52%. Bronchoplastic resection represents a useful lung-preserving approach for appropriately selected patients with centrally located pulmonary neoplasms.

**Keywords:** bronchoplasty; sleeve lobectomy; non-small cell lung cancer.

ABSTRACT 21 AB-000049 ORAL PRESENTATION

## Role of Platelet to Lymphocyte ratio(PLR) in predicting acute appendicitis

AUTHOR Dr. Bhuwan Rayamajhi (Pokhara Academy of Health Sciences)
CO-AUTHORS *None*

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ABSTRACT 22 AB-000050 ORAL PRESENTATION

## CORRELATION BETWEEN FINE NEEDLE ASPIRATION CYTOLOGY AND HISTOPATHOLOGICAL FIND

AUTHOR Dr. Ranjan Kumar Barnawal (Nepal Manipal Teaching Hospital)
CO-AUTHORS *None*

**Background:** Breast diseases, including benign and malignant conditions, are common in women, with breast lumps being a frequent symptom necessitating diagnostic evaluation.

**Objective:** To investigate the correlation between fine needle aspiration cytology [FNAC] and histopathological examination [HPE] findings in diagnosing breast lumps in female patients.

**Study Design:** Cross-sectional study conducted at Manipal Teaching Hospital, Pokhara, involving 75 female patients with breast lumps.

ABSTRACT 23 AB-000051 ORAL PRESENTATION

## PROGNOSTIC NUTRITIONAL INDEX (PNI) VERSUS ACEF II RISK SCORE IN PREDICTING 30-DAY MORBIDITY AND MORTALITY IN PATIENTS UNDERGOING CORONARY ARTERY BYPASS GRAFT SURGERY: A PROSPECTIVE OBSERVATIONAL STUDY

AUTHOR Milan Adhikari (Maharajgunj Medical Campus, TUTH, IOM)
CO-AUTHORS Prof. Dr.Anil Bhattarai, Asst.Prof. Dr.Prabhat Khakural

**Introduction:** Conventional cardiac surgical risk scores exclude nutritional and immune status. We compared the Prognostic Nutritional Index (PNI) with the ACEF II score for predicting 30-day mortality and morbidity after coronary artery bypass grafting (CABG).

ABSTRACT 23 · CONTINUED

**Methods:** This prospective observational study enrolled 64 consecutive adults undergoing elective isolated CABG at Manmohan Cardiothoracic Vascular and Transplant Centre, Kathmandu. PNI and ACEF II were calculated preoperatively and patients were followed for 30 days. Discrimination was assessed with receiver operating characteristic (ROC) curves, areas under the curve (AUC) were compared and predictors of mortality were examined with logistic regression.

**Results:** Mean age was 58.7 ± 10.5 years. Thirty-day mortality was 6.3% (4/64). Non-survivors had lower PNI (median 33.1 vs 51.8; p = 0.011) and higher ACEF II (4.36 vs 1.13; p = 0.005). The AUC for mortality was 0.867 (95% CI 0.603–1.000) for PNI and 0.896 (95% CI 0.709–1.000) for ACEF II, a non-significant difference (p = 0.52). PNI < 40 identified three of four deaths (sensitivity 75.0%, specificity 91.7%, negative predictive value 98.2%). For Clavien–Dindo grade ≥ III complications, the AUCs were 0.808 and 0.782 respectively (p = 0.61). When both scores were modelled together, only ACEF II remained independently associated with mortality (odds ratio 3.40, 95% CI 1.26–9.21).

**Conclusion:** PNI predicted early mortality and major morbidity after CABG with accuracy comparable to ACEF II. As a simple, inexpensive marker of modifiable nutritional risk, PNI complements rather than replaces ACEF II in preoperative assessment.

**Keywords:** ACEF II score, Coronary artery bypass grafting, Mortality, Prognostic nutritional index, Risk

ABSTRACT 24 AB-000053 ORAL PRESENTATION

## CORRELATION BETWEEN VISUAL PROSTATE SYMPTOM SCORE ( VPSS) AND UROFLOMETRY PARAMETER (Qmax) IN MEN WITH BEP

AUTHOR Dr. Sandesh Neupane (KISTMCTH)

CO-AUTHORS Dr. Krishna Nagarkoti, Prof. Dr Robin Joshi

**Background:** Benign enlargement of the prostate (BEP) is one of the most common urological conditions in aging men, causing significant lower urinary tract symptoms (LUTS) that impair quality of life. The Visual Prostate Symptom Score (VPSS) is a pictorial alternative to the IPSS, but data correlating VPSS with Qmax in Nepalese men with BEP remain limited.

**Methods:** A cross-sectional observational study was conducted at KIST Medical College and Teaching Hospital, Lalitpur, Nepal (December 2024–May 2026). Men aged 40 years and above with a provisional diagnosis of BEP were enrolled by purposive sampling (n = 58). The VPSS was administered using a pictorial chart, and Qmax was measured by uroflowmetry (minimum voided volume 150 mL). The primary analysis was Spearman's correlation between VPSS and Qmax (Fisher 95% CI); all other analyses were secondary and exploratory.

**Results:** Fifty-eight men (mean age 57.4 ± 4.1 years) were included. Mean VPSS was 11.3 ± 2.5 and mean Qmax 13.4 ± 5.2 mL/s; 74.1% had severe VPSS scores and 25.9% had Qmax < 10 mL/s. VPSS correlated strongly and negatively with Qmax (Spearman's r = −0.71, 95% Fisher CI −0.82 to −0.55, p < 0.001), independent of age, prostate volume and voided volume (partial r = −0.61, p < 0.001). Mean Qmax was lower in severe than moderate VPSS categories (11.6 vs 18.5 mL/s, p < 0.001).

**Conclusion:** Higher VPSS was associated with lower Qmax in this single-centre sample of men aged 50–65 years with BEP. VPSS explained about half of the variability in Qmax, and Qmax is a flow measurement, not a diagnosis of obstruction; VPSS should complement, not replace, uroflowmetry.

**Keywords:** Benign Enlargement of Prostate, Visual Prostate Symptom Score, Uroflowmetry, Maximum Flow Rate, Lower Urinary Tract Symptoms

ABSTRACT 25 AB-000055 ORAL PRESENTATION

## CholeS Score versus Surgical Cholecystectomy Score for Prediction of Difficult Laparoscopic Cholecystectomy in Post-ERCP Patients

AUTHOR Rahul Singh (Dhulikhel Hospital-Kathmandu University School Of Medical Sciences)

CO-AUTHORS Singh R*,Payangu B ,Gnyawali A,Shrestha S,Shakya YR,Malla BR

**Introduction:** Prior endoscopic retrograde cholangiopancreatography (ERCP) causes inflammation and adhesions in Calot's triangle, making subsequent laparoscopic cholecystectomy (LC) difficult. Preoperative difficulty scores aid planning, but their performance after ERCP is not established. We compared the CholeS score and the Surgical Cholecystectomy Score (SCS) in predicting difficult LC in post-ERCP patients.

ABSTRACT 25 · CONTINUED

**Methods:** Retrospective analytical study of 40 consecutive patients who underwent LC after ERCP at Dhulikhel Hospital from January to October 2026. Both scores were calculated from preoperative clinical, laboratory and ultrasound data. Difficult LC was defined as [operative time >90 minutes, Parkland grade ≥4, bailout procedure or conversion to open]. Predictive performance was assessed with receiver operating characteristic curves; areas under the curve (AUC) were compared using the DeLong test, and optimal cut-offs derived by Youden's index.

**Results:** Of 40 patients (24 female; median age 44.5 years), indications included chronic calculus cholecystitis (7), empyema (4) and Mirizzi syndrome (2). Median operative time was 100 minutes; 21 (52.5%) operations exceeded 90 minutes and one (2.5%) was converted to open.

**Conclusion:** Surgical Cholecystectomy score better predicted difficult LC after ERCP. Routine preoperative scoring may help schedule post-ERCP cholecystectomy with senior surgeons and plan bailout strategies.

**Keywords:** Cholangiopancreatography, Endoscopic Retrograde; Cholecystectomy, Laparoscopic; Choledocholithiasis; Risk Assessment; ROC Curve

ABSTRACT 26 AB-000056 ORAL PRESENTATION

## Whipple's Pancreaticoduodenectomy: Five-Year Experience at Dhulikhel Hospital [2021–2026]

AUTHOR Rahul Singh (Dhulikhel Hospital-Kathmandu University School Of Medical Sciences)

CO-AUTHORS Payangu B ,Gnyawali A,Shrestha S,Shakya YR,Malla BR

**Introduction:** Pancreaticoduodenectomy (PD) remains the only potentially curative treatment for periampullary and pancreatic head neoplasms but carries substantial morbidity. We updated our institutional series to assess how volume, case mix and outcomes have evolved over five years.

**Methods:** Retrospective review of all patients who underwent Whipple's PD at Dhulikhel Hospital from August 2021 to September 2026, compared as Phase I (August 2021–October 2023, n=17) and Phase II (January 2024–September 2026, n=37). Demographic, perioperative, histopathological and outcome data were analysed. Postoperative pancreatic fistula (POPF), delayed gastric emptying (DGE) and post-pancreatectomy haemorrhage (PPH) were graded by ISGPS definitions and complications by Clavien–Dindo.

**Results:** Fifty-four patients (28 male; mean age 55.4±9.8 years) underwent PD. Monthly volume rose from 0.65 to 1.1 cases. Phase II added benign indications (groove/mass-forming chronic pancreatitis, n=5), portal vein resection or repair (n=2), multivisceral resection (n=1) and Braun's jejunojejunostomy (n=4). Mean operative time was 509±89 minutes. Final histopathology showed [distal cholangiocarcinoma 4%, ampullary 60%, pancreatic head 35%, duodenal 1%], Clinically relevant POPF occurred in 10%, DGE in 20% and PPH in 1%.

**Conclusion:** With rising volume, our unit has extended PD to benign and locally advanced disease, including vascular and multivisceral resection, [with morbidity and mortality comparable to national and international series]. DGE remains the commonest complication, and [Braun's jejunojejunostomy is being evaluated as a mitigating strategy].

**Keywords:** Ampulla of Vater; Nepal; Pancreatic Fistula; Pancreaticoduodenectomy; Postoperative Complications

ABSTRACT 27 AB-000057 ORAL PRESENTATION

## Anticipating Ureteric Stone Impaction during URSL: How does pre operative clinical and radiological parameters help us?

AUTHOR Alisha Prajapati (Nepal Medical College Teaching Hospital)

CO-AUTHORS *None*

**Introduction:** Intraoperative ureteric stone impaction complicates ureteroscopic lithotripsy (URSL), increasing operative time and risk of ureteral injury. We evaluated whether preoperative clinical and radiological parameters independently predict intraoperative stone impaction during URSL to identify optimal diagnostic thresholds.

**Methods:** This cross-sectional analytical study included 119 patients undergoing URSL at Nepal Medical College Teaching Hospital between October 2024 and September 2025. Stone impaction was defined operationally as failure of first-attempt retrograde guidewire passage across the stone. Univariate, multivariate, and Bayesian logistic regressions identified independent predictors. Receiver operating characteristic (ROC) analysis determined the optimal UWT cut-off.

ABSTRACT 27 · CONTINUED

**Results:** Impaction occurred in 40 patients (33.6%). Demographic and baseline parameters were comparable between groups. UWT was significantly greater in the impacted cohort ($p < 0.001$) and was the sole parameter independently associated with impaction on multivariate analysis; stone density, size, location, and hydronephrosis were not significant. ROC analysis demonstrated high discriminative accuracy for UWT (AUC 0.889, 95% CI: 0.817–0.948) with an optimal threshold of 3.2 mm. Bayesian analysis confirmed this association (posterior probability >99.9%; median odds ratio: 6.82–7.53 per mm).

**Conclusion:** Preoperative UWT on NCCT is a non-invasive, independent predictor of stone impaction during URSL. Incorporating a 3.2 mm threshold into routine preoperative surgical planning helps anticipate operative complexity and improve procedural risk stratification.

ABSTRACT 28 AB-000058 ORAL PRESENTATION

## MANAGEMENT OF MASSIVE VENTRAL HERNIA WITH LOSS OF DOMAIN BY PREOPERATIVE BOTULINUM TOXIN: EXPERIENCE AT A RURAL HOSPITAL IN NEPAL

AUTHOR Ranjis pahari (Bhaktapur hospital)
CO-AUTHORS Prakriti Bhattarai, Ganesh kumar bista

**Aim:** To study the role of Preoperative Botulinum Toxin A injection in Abdominal wall Reconstruction for management of loss of domain ventral hernia.

**Methods:** 9 cases presenting with incisional hernia with loss of domain calculated by tanaka score of more than 0.25 at bhaktapur hospital in the last 3 years were included who underwent Botulinum Toxin A injection followed by abdominal wall reconstruction with or without some form of component separation. Cases were done by same consultant and assistant surgeon and Botox injections were given 2 to 4 weeks preoperatively under ultrasound guidance.

**Results:** All cases were incisional midline ventral hernias with 4 female and 5 male patients. 1 case was recurrent after previous onlay mesh repair. Out of 9 cases, tension free retrorectus mesh repair was possible in 5 patient with rives stoppa dissection alone, 2 underwent peritoneal flap hernioplasty and 2 underwent Transversus Abdominis Release (1Bilateral and 1 unilateral ). Average operating time was 210+/-30 mins, average blood loss 350+/-50 ml, average day of admission 4+/-2 days, early postoperative complications were pain (average vas 7 +/-1 within first 48 hrs and 4+/-1 in 5th POD), mild seroma (in 4 patients), pulmonary complications(atelactasis) in 3 patients and fever in 2 patients. Late complications were mild superficial SSI in 3 patient and chronic pain in 1 patient. None had recurrence in 1 year follow up.

**Conclusion:** Botulinum Toxin is effective in tension free abdominal wall reconstruction of large incisonal hernia and can help avoid component separation.

**Keywords:** incisonal hernia, loss of domain, component separation, botulinum toxin , TAR

ABSTRACT 29 AB-000059 ORAL PRESENTATION

## Role of C-Reactive Protein/Albumin Ratio (CAR) as a predictor of Surgical Site Infections after Major Abdominal Surgery

AUTHOR KRISHNA NEUPANE (Pokhara Academy of Health Sciences, Pokhara)
CO-AUTHORS *None*

**Introduction:** Surgical site infections (SSIs) remain a major cause of morbidity following gastrointestinal interventions. This study evaluated the predictive accuracy of the postoperative day 1 C-reactive protein-to-albumin ratio (CAR) for estimating SSI risk after major abdominal surgery and compared its performance against independent biomarkers.

**Methods:** A prospective observational study was conducted in Nepal involving 93 consecutive patients who underwent major open abdominal surgery. Quantitative C-reactive protein (CRP) and serum albumin levels were measured on postoperative day 1 (POD1). Patients were monitored for SSI development during hospital stay and up to 30 days postoperatively. Statistical analyses calculated optimal cut-offs, area under the curve (AUC), sensitivities, and specificities.

ABSTRACT 29 · CONTINUED

**Results:** The postoperative SSI rate was 29.0% (n = 27/93). The optimal clinical threshold for CAR was ≥ 48.0, yielding 77.8% sensitivity and 74.2% specificity. Patients with a CAR ≥ 48.0 experienced a significantly higher rate of SSI than those below the threshold (55.3% vs. 10.9%; p < 0.001). Although CRP (AUC = 0.744, p < 0.001) and albumin (AUC = 0.725, p = 0.001) could also independently predict SSI, CAR is superior with an AUC of 0.775 (p < 0.001). Patients who developed SSIs experienced significantly longer hospital stays compared to those without infections (14.4 ± 10.1 vs. 7.0 ± 3.5 days; p < 0.01).

**Conclusion:** A high CAR on the first postoperative day serves as a robust predictor of SSI following major abdominal surgery. A threshold of CAR ≥ 48.0 offers a zero-added-cost risk-stratification index to guide clinical care.

**Keywords:** Biomarkers; C-Reactive Protein/Albumin Ratio; Major Abdominal Surgery; Postoperative; Surgical Site Infection.

ABSTRACT 30 AB-000060 ORAL PRESENTATION

## AIR SCORE AND ITS RELATION IN PREDICTING PERIOPERATIVE OUTCOME IN PATIENTS UNDERGOING EMERGENCY LAPAROSCOPIC APPENDECTOMY

AUTHOR Dr Pranita Joshi (KUSMS)

CO-AUTHORS *None*

abstract for AIR SCORE AND ITS RELATION IN PREDICTING PERIOPERATIVE OUTCOME IN PATIENTS UNDERGOING EMERGENCY LAPAROSCOPIC APPENDECTOMY

ABSTRACT 31 AB-000063 ORAL PRESENTATION

## Incidence of Acute Pancreatitis and Necrotising Complications Requiring Necrosectomy: A Single-Centre Experience From Nepal

AUTHOR Dr Sanjaya Kumar Yadav (Kathmandu Medical College Teaching Hospital, Sinamangal, Kathmandu, Nepal)

CO-AUTHORS *None*

**Introduction:** Acute pancreatitis is a common surgical emergency. Most cases are mild, but a minority progress to severe disease with acute necrotic collection (ANC) and walled-off necrosis (WON), which carry high morbidity and may require necrosectomy. We report the incidence of acute pancreatitis and of necrotising complications requiring necrosectomy at our centre.

**Methods:** We conducted a prospective, observational study at KMCTH from August 2025 to August 2026. All adults with acute pancreatitis were included. Diagnosis and severity were classified using the revised Atlanta criteria. We recorded aetiology, severity, development of ANC and WON, and management.

**Results:** Of 60 patients with acute pancreatitis, 36 (60%) had mild and 14(23.3%) had moderately severe disease and 10 (16.7%) had severe disease. ANC developed in 8 patients, progressing to WON in 5. Five patients (8.3% of all cases; 50% of severe cases required necrosectomy, by a median of 12 weeks after onset. Biliary aetiology accounted for 40%. Complications occurred in 20% patient, with no deaths. Median hospital stay was 6 days.

**Conclusion:** Most patients with acute pancreatitis had mild or moderate disease, but one in six developed severe disease and half of these needed necrosectomy. Early recognition of severe pancreatitis and a step-up approach in a multidisciplinary setting may improve outcomes. Larger multicentre studies are needed.

**Keywords:** Acute Necrotic Collection, Acute Necrotizing Pancreatitis, Necrosectomy, Walled off necrosis

ABSTRACT 32 AB-000065 ORAL PRESENTATION

## Laparoscopic Hernia Surgery in Janakpur: A Clinical Audit of Outcomes, Complications, lesson learned and Best Practices

AUTHOR Bijay Kumar Yadav (Janaki Medical College)

CO-AUTHORS Dr Shashi Shekhar Adhikari ,Dr Bijay Kumar Yadav,Dr Bipin kumar Yadav,Dr krishna Adhikari , Dr Bipul Thakur,Dr Milan Nayak,Dr Ved Prakash Jha

**BACKGROUND:** Groin and abdominal wall hernias represents a significant portion of the surgical workload in Nepal. Over the past three decades, minimally invasive repair like TEP, TAPP and IPOM techniques has gained popularity.According to the EHS guidelines laparoscopic hernia repair offers a lower post-operative complications with faster recovery .

**Methods:** This is a retrospective observational study conducted at Janki Medical College in patients who underwent laparoscopic hernioplasty for different inguinal and ventral hernias. Patient demographics, intraoperative findings,and postoperative complications were recorded and analyzed.

**Results:** 40 patients were included . The age ranged from 18 to 71 years ( median 44.5 years). 70% male and 30% female . In 20 patients(50%) (TEP) repair was performed , in 15 patients(37.5%) IPOM) repair was done and in 5 patients(12.5%) (TAPP) repair was done. The length of hospital stay was 1.2 days with TEP repair ,2.1 days with IPOM repair and 1.6 days with TAPP repair . The time to ambulation was 8.5 hours with TEP repair , 14.2 hours with IPOM repair and 10.8 hours with TAPP repair. the time required to return to normal activities was 7.4 days with TEP repair , 12.3 days with IPOM repair and 9.1 days with TAPP repair . complications include seroma,postoperative pain & mesh infection.

**Conclusions:** Laparoscopic hernia surgeries has shown minimum length of hospital stay, least time required to return to normal activities and lowest total postoperative complications but has long learning curve.

ABSTRACT 33 AB-000066 ORAL PRESENTATION

## The Mirizzi Challenge

AUTHOR Dr Abhiraj Mishra (Dhulikhel Hospital, KUSMS)

CO-AUTHORS *None*

The Mirizzi Challenge

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Abstract

**Introduction:** Mirizzi Syndrome is a rare complication of chronic gallstone disease involving extrinsic compression or erosion of the common hepatic duct by impacted calculi. Due to altered anatomy, dense adhesions, and fistulization, it poses major diagnostic hurdles and high surgical complication rates. This study highlights the clinical presentation, diagnostic limitations, management strategies, and surgical outcomes of Mirizzi Syndrome at a tertiary center in Nepal.

**Methods:** A retrospective review of stone-related biliary disease managed at Dhulikhel Hospital between 2020 and 2026 was conducted. Clinical demographics, diagnostic modalities, Csendes/Beltrán classifications, surgical interventions, and postoperative outcomes were analyzed, including complex Type III and Type V fistulae.

**Results:** Among 3,600 stone-related biliary cases, 29 patients were diagnosed with Mirizzi Syndrome (0.83% incidence). The mean patient age was 53 years, with a female predominance (72.4%, n=21). Most cases presented with obstructive jaundice, epigastric/RUQ pain, and high-grade fever. Preoperative ERCP suggested the condition in only 15% (3/20) of endoscopy cases, showing routine imaging frequently fails to establish a definitive preoperative diagnosis. Out of 14 attempted laparoscopic cholecystectomies, 4 required open conversion (28.57% conversion rate). The overall complication rate was 24%, with four ICU admissions and a 6-day average hospital stay.

**Conclusion:** Mirizzi Syndrome remains a major diagnostic and surgical hurdle. Preoperative imaging often underestimates cholecystobiliary fistulae. Management should be undertaken by experienced hepatobiliary surgeons at tertiary centers to minimize morbidity and conversion risks.

**Keywords:** Mirizzi Syndrome, Obstructive Jaundice, Cholecystocholedochal Fistula, Choledochoplasty, Laparoscopic Conversion, Csendes Classification, Dhulikhel Hospital.

ABSTRACT 34 AB-000067 ORAL PRESENTATION

## Breast Cancer Genetic Testing WHY? WHO? And How Surgeons View

AUTHOR Akash Raya (Chitwan Medical College)
CO-AUTHORS *None*

About 5% to 10% of breast cancers are hereditary, mostly from pathogenic variants in high and moderate risk genes like BRCA1 and BRCA2. A positive result guides systemic treatment, helps with surgical planning, with frequent screening, and also opens door of screening for relatives. Not everyone needs testing. The best candidates are patients with young onset disease, triple negative breast cancer, male breast cancer, or a strong family history. An actionable pathogenic variant, a variant of uncertain significance (VUS), and a negative result may be interpreted differently. A VUS should never justify prophylactic surgery. For surgeons, a positive result informs the plan but doesn't automatically mean a bilateral or contralateral mastectomy. Some patients can still have breast conserving therapy, and others may choose risk reducing mastectomy or salpingo-oophorectomy. The decision is made together with the patient. In our context testing has to be practical: screen family history at clinic registration, test the highest yield patients first, and keep referral pathways simple.

ABSTRACT 35 AB-000068 ORAL PRESENTATION

## Outcomes of Open Gastrectomy: A Retrospective Case Series of 81 Patients at a Tertiary Care Centre in Chitwan Nepal

AUTHOR Dr Subhash Kumar Jha (Chitwan Medical College)
CO-AUTHORS Dr Rohit Kumar Mishra, Akash Raya, Dr Alok Shrestha, Dr Basant Kumar Yadav, Dr Rajendra Dhakal

**Introduction:** Gastrectomy remains the cornerstone of curative treatment for gastric malignancy. It is also performed for gastrointestinal stromal tumor, complicated benign disease and trauma. This study aimed to describe the indications, procedures and early postoperative outcomes of gastrectomy at a tertiary teaching hospital in Nepal.

**Methods:** This retrospective study reviewed the records of all patients who underwent gastrectomy in the Department of Surgery, Chitwan Medical College Teaching Hospital, over 2022 August to 2026 october. Data on demographics, preoperative diagnosis, type of resection and postoperative complications were analysed descriptively.

**Results:** Eighty-one patients aged 24 to 82 years were included. Preoperative diagnosis was established by endoscopic biopsy in 25 (30.9%) and by contrast-enhanced computed tomography in 56 (69.1%). Five patients (6.2%) were trauma cases. Distal (subtotal) gastrectomy was performed in 35 (43.2%), total gastrectomy in 31 (38.3%) and wedge resection for gastrointestinal stromal tumour in 15 (18.5%); all procedures were open. Delayed gastric emptying occurred in 15 (18.5%) patients and surgical site infection in 10 (12.3%). Esophagojejunal leak developed in 3 of 31 (9.7%) total gastrectomies and gastrojejunal leak in 3 of 35 (8.6%) distal gastrectomies. Re-laparotomy was required in 3 (3.7%) patients.Mortality was seen in 2 (2.5%) patients.

**Conclusion:** Delayed gastric emptying was the most frequent complication after open gastrectomy in our series. Anastomotic leak and surgical site infection rates were higher than those reported from high-volume centres, while the re-operation rate was low. Standardised perioperative care and prospective audit may improve outcomes.

**Keywords:** Anastomotic Leak; Gastrectomy; Gastroparesis; Stomach Neoplasms; Surgical Wound Infection

ABSTRACT 36 AB-000069 ORAL PRESENTATION

## "Acute Urinary Retention After Ureteroscopic Lithotripsy": Can We Predict It?

AUTHOR Dr Puja Nepal (Nepal Medical College Teaching hospital)
CO-AUTHORS *None*

ABSTRACT 37 AB-000070 ORAL PRESENTATION

## EVALUATION OF ACCURACY OF TOTAL LEUKOCYTE COUNT, C-REACTIVE PROTEIN, AND ERYTHROCYTE SEDIMENTATION RATE IN THE DIAGNOSIS OF ACUTE APPENDICITIS

AUTHOR Dr. Pragya Jha (Nepal medical college)
CO-AUTHORS *None*

ABSTRACT 38 AB-000071 ORAL PRESENTATION

## Efficacy of tamsulosin versus tadalafil for expulsion of stones less than 10 mm in diameter in patients with lower ureteric stones in a tertiary care hospital.

AUTHOR DR DINESH RAJ JOSHI (Patan academy of health sciences, Lalitput)
CO-AUTHORS *None*

**Background:** Lower ureteric stones can cause significant pain and urinary obstruction. Medical expulsive therapy (MET) facilitates spontaneous stone passage. Tamsulosin, an α1-blocker, and tadalafil, a PDE-5 inhibitor, promote ureteric smooth muscle relaxation through different mechanisms. This study compares their efficacy in managing lower ureteric stones less than 10 mm.

**Objectives:** To compare stone expulsion rates, mean time to stone expulsion, and analgesic requirements between tamsulosin and tadalafil.

**Methods:** This prospective comparative study was conducted at Patan Academy of Health Sciences, Nepal. A total of 120 patients aged ≥15 years with a single lower ureteric stone ≤10 mm were enrolled and allocated to tadalafil (5 mg) or tamsulosin (0.4 mg) groups using odd and even serial numbers, respectively. Both groups received ketorolac analgesia and were followed up for four weeks. The primary outcome was stone expulsion within four weeks. Secondary outcomes included time to expulsion, surgical intervention, analgesic requirement, and adverse events. Data were analyzed using SPSS version 27.

**Results:** Among 108 evaluable patients, stone expulsion rates were 87.5% with tadalafil and 76.9% with tamsulosin, without a statistically significant difference (p=0.2342). Mean time to expulsion was shorter with tadalafil (13.52 ± 7.84 days) than tamsulosin (15.40 ± 7.63 days), but the difference was not significant (p=0.1374). Analgesic requirements were also lower with tadalafil (10.93 ± 3.27 doses) compared to tamsulosin (11.57 ± 3.54 doses), without statistical significance (p=0.3146).

**Conclusion:** Both drugs demonstrated comparable efficacy in facilitating lower ureteric stone expulsion. Tadalafil showed a numerical advantage in stone expulsion rate, time to expulsion, and analgesic requirement; however, none of these differences were statistically significant.

ABSTRACT 39 AB-000073 ORAL PRESENTATION

## hyperbilirubinemia as a predictor of acute appendicitis

AUTHOR Dr Ajay pariyar (KISTMCTH)
CO-AUTHORS *None*

ABSTRACT 40 AB-000074 ORAL PRESENTATION

## Predictive Value of C-Reactive Protein-to-Albumin Ratio Predicting Prognosis and Severity of Acute Biliary Pancreatitis

AUTHOR Dr Bhavesh Kumaf Yadav (KUSMS)
CO-AUTHORS *None*

Abstract

ABSTRACT 41 AB-000076 ORAL PRESENTATION

## AN ASSESSMENT OF BLOOD UTILISATION IN NEUROSURGICAL PROCEDURES USING CROSSMATCH TRANSFUSION RATIO (CTR) AT A TERTIARY CARE CENTRE IN NEPAL

AUTHOR Dikshya Pant (Maharajgunj medical campus, Tribhuvan University, IOM)
CO-AUTHORS Dr. Gopal Sedain, Dr. Arun Bhandari, Dr. Dipendra Shrestha

ABSTRACT 42 AB-000077 ORAL PRESENTATION

## ROLE OF SERIAL LACTATE MEASUREMENT TO PREDICT 28 DAY MORTALITY IN PATIENT UNDERGOING SURGERY FOR PERFORATION PERITONITIS

AUTHOR Ratan Subedi (Nepalgunj Medical College Teaching Hospital, Kohalpur, Banke)
CO-AUTHORS *None*

This hospital-based prospective observational study included 116 patients with perforation peritonitis who underwent emergency surgery at Nepalgunj Medical College Teaching Hospital, Kohalpur.

ABSTRACT 43 AB-000083 ORAL PRESENTATION

## Step by Step Laparoscopic Nephrectomy : How We Do.

AUTHOR Dr. Ashok Yadav (BMCTH)
CO-AUTHORS *None*

ABSTRACT 44 AB-000084 ORAL PRESENTATION

## Dry Mopping versus Saline Irrigation of Gall Bladder fossa after Bile spillage during Laparoscopic Cholecystectomy.

AUTHOR Dr Lokendra Bahadur Thapa (Kathmandu Model Hospital)
CO-AUTHORS Dr Raj Bhai Dongol

Observational study carried out in department of General surgery at Kathmandu Model Hospital among all patients undergoing saline irrigation or dry mopping following biliary spillage when present during laparoscopic cholecystectomy.

**Conclusion:** Dry mopping was found better than saline irrigation in terms of increased surgical site infection.

ABSTRACT 45 AB-000085 ORAL PRESENTATION

## Simulation-Based Surgical Training in Undergraduate Medical School: Awareness, Skills Confidence, and Student Interest in Low-Cost Innovation

AUTHOR Prapti Lakhey (Nepal Medical College)
CO-AUTHORS Sulav Katuwal, Dr. Ashmita Khatri, Dr. Prarthana Subedi, Prof. Mahmoud Loubani, Dr. Bishow Bekhyat Karki

The SimEd Nepal Survey is a cross sectional survey done among 160 medical students of 18 institutes across Nepal, to identify awareness of Simulation Based Training, association between simulation exposure and surgical skills confidence, alongside student interest in developing low-cost simulation models. Findings demonstrate gaps in awareness and institutional access, while emphasizing the potential of locally developed, affordable models to strengthen surgical education in Nepal.

ABSTRACT 46 AB-000087 ORAL PRESENTATION

## Clinical Profile and Outcomes of Fistula-in-Ano: A Five-Year Retrospective Study at a Tertiary Care Hospital in Nepal

AUTHOR Dr. Raiesh Shrestha (B&B Hospital)
CO-AUTHORS Dr. Arbin Joshi

Fistula-in-ano is a chronic condition most commonly associated with cryptoglandular infection. Its surgical management requires a balance between achieving durable fistula healing, minimizing recurrence, and preserving anal continence. Understanding the anatomical characteristics and treatment outcomes of patients managed in local practice may help inform surgical decision-making. This study aimed to describe the clinical profile, anatomical patterns, surgical management, and postoperative outcomes of patients with fistula-in-ano at a tertiary care hospital in Nepal.

ABSTRACT 47 AB-000088 ORAL PRESENTATION

## Spectrum of colorectal surgery cases

AUTHOR Dr bijay kumar gupta (Chitwan medical college)
CO-AUTHORS *None*

ABSTRACT 48 AB-000089 ORAL PRESENTATION

## Comparative Study of Short Term Surgical Outcomes Following D2 Versus D3 Lymph-Node Dissection in Patients Undergoing Surgery for Colonic Carcinoma

AUTHOR Dr. Bishal Pokharel (Nobel Medical College Teaching Hospital)
CO-AUTHORS *None*

ABSTRACT 49 AB-000090 ORAL PRESENTATION

## Freys Procedure for Chronic Pancreatitis: an institutional perspective

AUTHOR Dr. Arun Gnyawali (Dhulikhel Hospital)
CO-AUTHORS Dr Pradeep Yadav, Dr Rahul Singh, Dr Bimas Limbu, Dr Uttam Laudari, Dr Shashank Shrestha, Dr Y R Shakya, Prof. Dr Bala Ram Malla

ABSTRACT 50 AB-000091 ORAL PRESENTATION

## OUR EXPERIENCE WITH SURGERY FOR CARCINOMA ESOPHAGUS IN A TERTIARY CARE CENTER

AUTHOR Prof.Dr Asuri Krishna Associate Prof.Brijesh singh Assistant prof.Dr Sushant Soren (ALL INDIA INSTITUTE OF MEDICAL SCIENCE,NEW DELHI)
CO-AUTHORS Prof.Dr Asuri Krishna Associate Prof.Brijesh singh Assistant prof.Dr Sushant Soren

Esophageal carcinoma poses a challenge with significant morbidity and mortality associated with esophagectomy, curbing which is being aimed through evolving minimal access surgeries while ensuring oncological efficacy.

Esophagectomy is the mainstay of treatment for curative intent of local and locally-advanced esophageal cancer. Multimodality therapy including esophagectomy is the standard of care in locally-advanced cancer. The difficulties associated with esophagectomy are mostly gastrointestinal in nature. Patients have problems with appetite loss, dysphagia, regurgitation, early satiety and consequently,weight loss along with other issues like diarrhoea and fatigue . Thus, the assessment of the effect of treatment on health-related quality of life (HRQOL) before, during and after treatment time is important for patients,and clinicians. There is an association between pretreatment HRQOL and prognosis.

ABSTRACT 51 AB-000093 ORAL PRESENTATION

## OUTCOMES IN ADMITTED CHEST TRAUMA PATIENTS USING CHEST TRAUMA SCORING SYSTEM

AUTHOR Dr Birtat Basnet (DH-KUSMS)
CO-AUTHORS *None*

abstract

ABSTRACT 52 AB-000094 ORAL PRESENTATION

## Comparative study of skin stapler versus suture in abdominal wound closure

AUTHOR MD. ABDUL AZIZ (Nepalgunj Medical College and Teaching Hospital)
CO-AUTHORS *None*

ABSTRACT 53 AB-000095 ORAL PRESENTATION

## Early Outcomes of Vascular Access Grafts in CKD Patients with Poor Vascular Anatomy and Multiple Access Failure

AUTHOR Prof.Dr Asuri Krishna Associate Prof.Brijesh singh Assistant prof.Dr Sushant Soren (ALL INDIA INSTITUTE OF MEDICAL SCIENCE,NEW DELHI)
CO-AUTHORS Prof.Dr Asuri Krishna, Associate Prof.Brijesh singh, Assistant prof.Dr Sushant Soren

Establishing durable haemodialysis access in patients with chronic kidney disease (CKD), poor vascular anatomy, and multiple previous access failures is challenging. Vascular access grafts offer an alternative when conventional access options are limited; however, thrombosis, infection, pseudoaneurysm formation, and the need for reintervention may compromise access durability.

ABSTRACT 54 AB-000096 ORAL PRESENTATION

## A Comparative Study On Alvarado Score Versus Appendicitis Inflammatory Response Score In Acute Appendicitis

AUTHOR Sailesh Ghimire (Nepalgunj Medical College And Teaching Hospital)
CO-AUTHORS *None*

ABSTRACT 55 AB-000098 ORAL PRESENTATION

## Prognostic Value of Preoperative Neutrophil-to-Lymphocyte Ratio, Platelet-to-Lymphocyte Ratio and Systemic Immune-Inflammation Index in Hepatocellular Carcinoma After Curative Hepatectomy: A Systematic Review and Meta-Analysis

AUTHOR Shankar Poudel (Maharajgunj Medical Campus)
CO-AUTHORS Ajay K.C, Latika Giri

**Introduction:** Recurrence after curative hepatectomy for hepatocellular carcinoma (HCC) remains high, and simple preoperative markers could improve risk stratification. We assessed the prognostic value of preoperative neutrophil-to-lymphocyte ratio (NLR), platelet-to-lymphocyte ratio (PLR) and systemic immune-inflammation index (SII).

**Methods:** Following PRISMA 2020, PubMed, Embase, Scopus, Cochrane Library and Google Scholar were searched. Studies reporting multivariable-adjusted hazard ratios (HRs) for overall survival (OS), disease-free survival (DFS) or recurrence-free survival (RFS) after curative hepatectomy were included. Risk of bias was assessed with QUIPS and certainty with GRADE. Categorical HRs were pooled using random-effects models with Hartung-Knapp adjustment.

**Results:** Fifty-one studies were included; 42 (15,877 patients) contributed to pooled analyses. High NLR predicted poorer OS (28 studies; HR 1.58, 95% CI 1.43–1.74), DFS (8 studies; HR 1.43, 1.28–1.58; $I^2$=0%) and RFS (10 studies; HR 1.43, 1.22–1.68). High SII was associated with poorer OS (4 studies; HR 1.76, 1.19–2.62). PLR showed a weaker, heterogeneous association with OS and no significant association with DFS or RFS. NLR associations persisted in studies at low risk of bias. Certainty of evidence was high for NLR–DFS and low to very low for most other outcomes.

**Conclusion:** Preoperative NLR is a consistent, independent predictor of survival and recurrence after curative hepatectomy for HCC. SII is promising but based on few studies. These inexpensive markers may support preoperative risk stratification.

**Keywords:** Blood Platelets; Carcinoma, Hepatocellular; Hepatectomy; Inflammation; Neutrophils; Prognosis

ABSTRACT 56 AB-000100 ORAL PRESENTATION

## Sarcopenia, its prevalence and effects on early outcome in patients with lung cancer in Nepalese population.

AUTHOR Dr. Mahesh Mani Adhikari (BP Koirala Memorial Cancer Hospital)

CO-AUTHORS Dr. Binay Thakur, Dr. Manoj Tiwari, Dr. Sagar Khatiwada, Dr. Shachee Bhattarai, Dr. Sandeep Sapkota, Dr. Saujan Raut

**Introduction:** Sarcopenia is an important prognostic factor in cancer, but data from Nepal are limited. This study assessed its prevalence and association with treatment outcomes, quality of life (QoL), and 1-year overall survival in lung cancer patients.

**Methods:** This prospective observational study was conducted at BP Koirala Memorial Cancer Hospital, Nepal. Patients with histologically confirmed primary lung cancer underwent L3 CT-derived skeletal muscle index (SMI) assessment. Sarcopenia was defined as SMI <52.4 $cm^2/m^2$ in males and <38.5 $cm^2/m^2$ in females. Outcomes included postoperative complications, treatment toxicity and completion, QoL (EORTC QLQ-C30), and 1-year survival.

**Results:** Among 165 patients, sarcopenia prevalence was 77.0% (127/165), highest in squamous cell carcinoma (84.1%) and lowest in adenocarcinoma (62.1%; p=0.028). Sarcopenic patients were older (64.8 vs. 59.5 years; p=0.011) and had lower BMI (p<0.001). Among 41 surgical patients, complications were more frequent with sarcopenia (53.8% vs. 33.3%), without statistical significance. Among 132 chemotherapy recipients, planned cycle completion was lower (61.4% vs. 80.6%; p=0.036). QoL was significantly worse across all functional scales (p<0.002), global QoL (p=0.009), and most symptom scales. One-year mortality was higher (46.2% vs. 14.3%; p=0.001), with shorter mean survival (9.24 vs. 10.99 months; log-rank p=0.002). Radiotherapy complications were not significantly associated with sarcopenia.

**Conclusion:** Sarcopenia is highly prevalent and associated with poorer chemotherapy completion, impaired QoL, and increased 1-year mortality. Routine CT-based screening may facilitate early nutritional and supportive interventions.

**Keywords:** Lung cancer, Sarcopenia, Skeletal muscle

ABSTRACT 57 AB-000111 ORAL PRESENTATION

## Fate of dialysis access in CKD cases undergoing dialysis amongst patients presenting to Dhulikhel Hospital

AUTHOR Deni Khadka (Kathmandu University School of Medical Sciences, Dhulikhel Hospital)

CO-AUTHORS Robin Man Karmacharya, Satish Vaidya, Swechha Bhatt, Mandeep Guragai, Nisha Karki, Bhawana Joshi, Kritika Shrestha, Deepak Sharma, Lili Chan

Cross sectional study in Chronic kidney disease patients depend on replacement therapy via haemodialysis or peritoneal dialysis. It is essential to understand various dialysis access methods and their lifespan. This study aims to estimate

ABSTRACT 58 AB-000112 ORAL PRESENTATION

## Single-Session Stone Clearance by Laparoscopic-Assisted Percutaneous Nephrolithotomy for a large calculi in Pelvic Ectopic Kidney

AUTHOR Harshit Agrawal (Kathmandu Medical College and Teaching Hospital)

CO-AUTHORS Prajwol Poudel

Single-Session Stone Clearance by Laparoscopic-Assisted Percutaneous Nephrolithotomy for a large calculi in Pelvic Ectopic Kidney

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**Introduction:** Pelvic ectopic kidney calculi is rare, and no standard guidelines exist for its management. Abnormal position and overlying bowel restrict conventional percutaneous nephrolithotomy (PCNL). We report a case of large pelvic kidney calculi managed by laparoscopic-assisted PCNL.

ABSTRACT 58 · CONTINUED

**Methods:** A 60-year-old woman presented with recurrent right lower abdominal pain and urinary tract infection. Computed tomography showed a right pelvic ectopic kidney containing a four-centimetre pelvic stone with mild hydronephrosis. After retrograde pyelography, three laparoscopic ports were inserted and bowel was mobilised to expose the kidney. The pelvis was punctured under laparoscopic vision, the tract was dilated to 30 French, and the stone was fragmented with a pneumatic lithotripter and removed. A double-J stent was left after endoscopic and radiological clearance.

**Results:** Operative time was 110 minutes. Haemoglobin fell by 1.2 grams per decilitre without transfusion. The kidney was stone-free after one session, with no visceral injury or sepsis. She was discharged on day four, the stent was removed at two weeks, and she remained stone-free at three months.

**Conclusion:** Laparoscopic-assisted PCNL achieved single-session clearance of a large stone in a pelvic ectopic kidney with minimal morbidity. Direct laparoscopic vision allows safe puncture and protects bowel and vessels.

**Keywords:** Choristoma; Kidney Calculi; Laparoscopy; Nephrolithotomy, Percutaneous; Treatment Outcome

ABSTRACT 59 AB-000113 ORAL PRESENTATION

## Fate of Dialysis Access in Patients with Chronic Kidney Disease Undergoing Dialysis at Dhulikhel Hospital

AUTHOR Deni Khadka (KUSMS, Dhulikhel Hospital)
CO-AUTHORS Robin Man Karmacharya, Satish Vaidya, Swechha Bhatt, Mandeep Guragai, Nisha Karki, Bhawana Joshi, Kritika Shrestha, Deepak, Lili Chan

A cross-sectional study was conducted at Dhulikhel Hospital among 59 chronic kidney disease patients using 212 vascular accesses for haemodialysis. The cohort included 55.9% females with a mean age of 54.10 years; hypertension (84.75%) and diabetes (40.68%) were major comorbidities. The most common initial dialysis access was a temporary catheter (83.63% of patients), with a median duration of 1.5 months, followed by arteriovenous fistula (16.37%) lasting 6 months and tunnelled cuffed catheters lasting approximately 9.96 months. This study highlights that temporary catheters dominate initial dialysis access, underscoring the critical need for vascular surgeons to create permanent arteriovenous fistulas in a timely manner.

ABSTRACT 60 AB-000114 ORAL PRESENTATION

## OUTCOME OF RETROGRADE INTRARENAL SURGERY USING FLEXIBLE AND NON-FLEXIBLE URETERAL ACCESS SHEATH IN PATIENTS WITH PROXIMAL URETERAL AND RENAL STONES

AUTHOR Azhar Hussain ansari (BMCTH)
CO-AUTHORS *None*

ABSTRACT 61 ORAL PRESENTATION

## [Title Not Provided in Submission]

AUTHOR Bishal Subedi (Independent Researchar, BPKIHS)
CO-AUTHORS Parbatraj Regmi, Rakesh Kumar Gupta

ABSTRACT 62 AB-000040 ORAL PRESENTATION

## Systemic Immune-Inflammation Index in predicting complicated from uncomplicated appendicitis in children

AUTHOR Abhaya Mahto (Maharajgunj Medical Campus, IOM)
CO-AUTHORS *None*

## POSTER PRESENTATIONS (40 Abstracts)

ABSTRACT 63 AB-000001 POSTER PRESENTATION

### Complete Pancreatic Neck Transection Following Bicycle Handlebar Trauma in a Child: A Case Report

AUTHOR Dr chandresh Kumar singh (Devdaha medical college and research institute)
CO-AUTHORS *None*

**Background:** Pancreatic trauma in children is uncommon and frequently presents a diagnostic and therapeutic challenge. Delayed recognition of pancreatic ductal injury can result in significant morbidity. We present a case of complete pancreatic neck transection following blunt bicycle handlebar trauma.

**Case Presentation:** A 7-year-old boy presented following a bicycle handlebar injury to the upper abdomen. Clinical evaluation and imaging suggested significant pancreatic injury. Contrast-enhanced CT demonstrated complete transection of the pancreatic neck, consistent with a high-grade pancreatic injury (AAST grade IV).

**Management:** Considering the complete pancreatic transection and associated ductal injury, the patient underwent operative management with distal pancreatectomy with splenectomy. The postoperative course was complicated by a pancreatic fistula, which was managed appropriately with supportive and conservative measures. The patient subsequently improved and was followed up clinically.

**Conclusion:** Pancreatic injury following blunt abdominal trauma in children requires a high index of suspicion. Early imaging and accurate assessment of pancreatic ductal disruption are essential for appropriate management. Complete pancreatic transection represents a severe injury in which timely operative intervention can prevent potentially serious complications. This case highlights the diagnostic challenges and contemporary surgical management of high-grade pancreatic trauma in children.

ABSTRACT 64 AB-000002 POSTER PRESENTATION

### The Scars We Carry: Personal Injury Marks as Lifelong Identifiers and Lessons in Surgical Awareness

AUTHOR Rabin Rachalica (Bhaktapur Tours Research Centre)
CO-AUTHORS *None*

ABSTRACT 65 AB-000003 POSTER PRESENTATION

### Isolated left-lobe metastatic hepatic abscess due to portal pyemia from microperforated ascending colon carcinoma: a rare case report

AUTHOR Suman Supratik (Department of Surgery, B.P. Koirala Institute of Health Sciences, Dharan, Sunsari, Nepal)
CO-AUTHORS Manaswi Acharya, Abhijeet Kumar

ABSTRACT 66 AB-000005 POSTER PRESENTATION

### Spontaneous Perforation of Meckel's Diverticulum Unmasked during Appendectomy: A Case Report and Review of Literature"

AUTHOR Dr Bishal Kunwar (Universal college of medical science, bhairahawa)
CO-AUTHORS *None*

ABSTRACT 67 AB-000020 POSTER PRESENTATION

## Digital WHO Surgical Safety Checklists as Cognitive Decision-Support Tools for Junior Doctors: Enhancing Interdisciplinary Collaboration and Perioperative Safety—A Narrative Review

AUTHOR Dr. Eva Shrestha (Independent Researcher, Nepal Medical College (MBBS Graduation))
CO-AUTHORS *None*

High cognitive load during rapid emergency turnarounds increases the risk of subtle procedural oversights among junior medical officers. This narrative review evaluates digital, tablet-based WHO Surgical Safety Checklists as interactive cognitive decision-support tools. Studies show digital interfaces increase full verification rates (>90%), automating critical checks like pre-op antibiotic timing (30–60 minutes pre-incision) and site verification while fostering seamless interdisciplinary team collaboration.

ABSTRACT 68 AB-000024 POSTER PRESENTATION

## Giant Hemorrhagic Sclerosing Pneumocytoma Presenting with Pneumothorax and Pneumomediastinum Requiring Pneumonectomy: A Rare Case Report

AUTHOR BIRENDRA RAUT (CHITWAN MEDICAL COLLEGE TEACHING HOSPITAL)
CO-AUTHORS *None*

ABSTRACT 69 AB-000026 POSTER PRESENTATION

## Emergency Pancreaticoduodenectomy: Indications, Challenges and Outcomes-A Case Series

AUTHOR Dr. Kundan Singh (Chitwan Medical college and Teaching Hospital)
CO-AUTHORS Rohit K. Mishra, Alok Shrestha, Basant K. Yadav, Akash Raya, Rajendra Dhakal

Emergency pancreaticoduodenectomy.

Retrospective case series presentation with indications, outcomes and challenges.

ABSTRACT 70 AB-000027 POSTER PRESENTATION

## Retrograde migration of a pancreaticojejunostomy stent into the oral cavity after pancreaticoduodenectomy: a case report and literature review

AUTHOR Dr Saurabh Tiwari (National Acadamy of Medical Sciences (NAMS))
CO-AUTHORS Upasana Bhatta, Bhawani Khanal

**Background:** An internal stent is often placed across the pancreaticojejunostomy (PJ) during pancreaticoduodenectomy to protect the anastomosis. The stent is expected to move forward with the bowel contents and pass in the stool. When it migrates, it usually goes into the bile ducts, the pancreatic duct or through the jejunal wall. Migration upward into the oral cavity is very rare.

**Case presentation:** A 38-year-old man with pancreatic head cancer had undergone pancreaticoduodenectomy with an internal PJ stent 6 weeks prior to the presentation. He presented to the emergency department with features of sore throat, and dry cough. On examination of the oral cavity, a thin tube was seen at the back of the mouth. It was identified as the PJ stent and was removed gently with traction without complication.

**Conclusion:** A migrated PJ stent can travel backward through the jejunum, stomach and oesophagus and reach the oral cavity. In a patient after Whipple surgery who has throat symptoms, gagging or a foreign body feeling, the oral cavity should be examined carefully. High index of suspicion for migration of stent is needed not to miss this rare entity.

**Keywords:** Foreign body migration; Pancreaticoduodenectomy; Pancreaticojejunostomy; Stents

ABSTRACT 71 AB-000028 POSTER PRESENTATION

## Post-Pancreatectomy Haemorrhage after Pancreatoduodenectomy requiring Re-exploration: Our Experience at Chitwan Medical College Teaching Hospital

AUTHOR Sonu Shrestha (Chitwan Medical College)
CO-AUTHORS Rohit K. Mishra, Akash Raya, Basant K. Yadav, Rajendra Dhakal1

**Introduction:** Post-pancreatectomy haemorrhage (PPH) is a life-threatening complication of pancreatoduodenectomy (PD), usually secondary to postoperative pancreatic fistula (POPF). In this study, we describe three cases of PPH who underwent re-exploration after PD at our centre.

**Methods:** Three patients with PPH at Chitwan Medical College Teaching Hospital from 2023 to 2026 who underwent re-exploration after PD were reviewed retrospectively using operative records, discharge summaries and laboratory results. PPH and POPF were graded as per International Study Group of Pancreatic Surgery (ISGPS) criteria.

**Results:** Among three reexplored cases of PPH, one male and two female, drain amylase exceeded 11,000 U/L by postoperative day (POD) 3 in all patients. Two patients with Grade C PPH( late severe) survived emergency re-exploration with GDA stump ligation and revision pancreaticojejunostomy. One patient with Grade B PPH (late mild) had recurrent bleeding after re-exploration at the hepaticojejunostomy site and died on POD 25. Bleeding occurred on POD 4, 11 and 13, were extraluminal in all cases and arose from the gastroduodenal artery (GDA) stump in two patients and the right hepatic artery region/cystic artery stump region in one.

**Conclusion:** Late extraluminal PPH following POPF usually occur around 2nd week postopertaively. Even with a strong emphasis on early resucitation & identification, outcomes following reexploration in late PPH remain poor.

**Keywords:** Pancreatic Fistula; Pancreaticoduodenectomy; Postoperative Hemorrhage

ABSTRACT 72 AB-000029 POSTER PRESENTATION

## A Fatal Case of Multivisceral Necrosis Following Corrosive Ingestion: Surgical management with Total Gastrectomy with Esophagostomy and Pancreaticoduodenectomy

AUTHOR Bibek Kumar Das (Chitwan Medical College)
CO-AUTHORS Shrestha S, Mishra R, Raya A, Yadav B, Dhakal R

**Background:** Severe corrosive ingestion may cause progressive transmural necrosis, perforation, and multivisceral injury, necessitating extensive emergency surgery.

**Case Presentation:** A 23-year-old woman presented after intentional ingestion of approximately 50 mL of a household kitchen cleaner of unknown composition. Upper gastrointestinal endoscopy was unsuccessful because of severe laryngopharyngeal injury. Contrast-enhanced computed tomography (CECT) on hospital day 3 showed markedly reduced or absent mural enhancement of the stomach and proximal duodenum, reduced distal esophageal enhancement, and non-occlusive portal and splenic venous thrombosis without pneumoperitoneum. On day 5, she developed peritonitis. Repeat CECT demonstrated pneumoperitoneum and multiple gastroduodenal perforations. Laparotomy revealed approximately 1 L of bile-stained ascites, gangrene of the stomach and duodenum, and multiple perforations involving the stomach and D1–D3. Total gastrectomy, pancreaticoduodenectomy, diverting tube esophagostomy, Peng's binding pancreaticojejunostomy, and feeding jejunostomy were performed. Postoperatively, bilateral pleural effusions and respiratory failure required chest drainage and reintubation. On postoperative day 7, she developed approximately 400 mL of hematemesis followed by cardiac arrest. Resuscitation was unsuccessful.

**Conclusion:** Extensive corrosive injury may progress rapidly from radiological evidence of transmural necrosis to gastrointestinal perforation and multiorgan failure. Early recognition of non-enhancing gastrointestinal segments, timely surgical evaluation, and individualized damage-control strategies are essential. Despite aggressive operative management, mortality remains substantial in advanced multivisceral injury.

**Keywords:** corrosive ingestion; multivisceral necrosis; gastrectomy; pancreaticoduodenectomy; esophagostomy

ABSTRACT 73 AB-000031 POSTER PRESENTATION

## Beyond the Liver: Primary Appendiceal Hydatid Disease with Disseminated Peritoneal, Ovarian, and Uterine Involvement Mimicking an Appendiceal Neoplasm

AUTHOR tilak dangi (BMCTH)
CO-AUTHORS *None*

hydatid disease with appendiceal involvement is exceptionally rare and may mimic appendicitis, appendiceal abscess, mucocele, or neoplasm, with diagnosis often established only after histopathological examination.

We report an unusual case of primary appendiceal hydatid disease with disseminated involvement of the peritoneum, omentum, right ovary, and uterine serosa, presenting radiologically as an appendiceal neoplasm.

ABSTRACT 74 AB-000033 POSTER PRESENTATION

## Diagnostic pitfall in Duodenojejunal perforation : A case series of Four patient

AUTHOR Dr. Santosh Yadav (Chitwan Medical college)
CO-AUTHORS Dr Rohit k.mishra, Dr. Basant k. Yadav, Dr. Akash Raya

Case series presents four patients with traumatic and non-traumatic duodenal and proximal small-bowel pathologies, highlighting diagnostic challenges, individualized surgical management, and the importance of early recognition and appropriate intervention.

ABSTRACT 75 AB-000034 POSTER PRESENTATION

## A Cyst at the Crossroads: Laparoscopic Excision of a Hepatoduodenal Ligament Lymphatic Cyst with Cholecystectomy

AUTHOR Niraj Kumar Yadav (Department of General Surgery, Nepal Manipal Teaching Hospital, Pokhara, Nepal)
CO-AUTHORS Dr Sujan Shrestha

**Introduction:** Cystic lesions of the hepatoduodenal ligament are rare and frequently mimic choledochal cysts on imaging, making preoperative diagnosis difficult. Their close relationship to the portal triad poses significant operative challenges.

**Methods:** We report the clinical presentation, imaging findings, laparoscopic management, and histopathological evaluation of a patient with a hepatoduodenal ligament cyst treated at our institution.

**Results:** A 40-year-old woman presented with intermittent right upper quadrant pain for six years. Ultrasonography demonstrated a 28 × 23 mm cystic lesion adjacent to the proximal common bile duct, suggestive of a Type II choledochal cyst. Laparoscopy identified a hepatoduodenal ligament cyst measuring approximately 3 × 8 cm with dense adhesions to the duodenum and a short dilated cystic duct. Complete laparoscopic cyst excision with cholecystectomy was successfully performed. Histopathology demonstrated a benign fibrocollagenous cyst wall with flattened epithelium, lymphoid aggregates, chronic inflammatory changes, and no cytological atypia. The gallbladder showed chronic cholecystitis with Rokitansky–Aschoff sinuses. Recovery was uneventful, and the patient was discharged on postoperative day four.

**Conclusion:** Hepatoduodenal ligament lymphatic cysts are rare lesions that can closely resemble choledochal cysts preoperatively. Careful laparoscopic dissection allows safe excision while preserving the biliary and vascular structures of the portal triad. Histopathological confirmation is essential for definitive diagnosis and appropriate follow-up.

**Keywords:** hepatoduodenal ligament; lymphatic cyst; cystic lymphangioma; laparoscopy; cholecystectomy

ABSTRACT 76 AB-000038 POSTER PRESENTATION

## Trapped Within: A Rare Case Report of Idiopathic Abdominal Cocoon Syndrome in an Adult Female

AUTHOR Aashish Baniya (B.P. Koirala Institute of Health Sciences)
CO-AUTHORS Dr Suman Khadka, Dr Roshan Silwal, Dr Suresh Shah, Dr Vijay Shrestha, Dr Sarada Khadka, Dr Dinesh Nalbo

**Background:** Sclerosing encapsulating peritonitis (SEP) is a rare condition where a thick fibrous membrane encases the small intestine, leading to recurrent or acute bowel obstruction. Idiopathic SEP, also known as abdominal cocoon syndrome, is difficult to diagnose due to its unclear cause and nonspecific symptoms.

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**Methods (Case Presentation):** A 33-year-old female presented to the Emergency Department with acute lower abdominal pain and no passage of stool or flatus for one day. She had no comorbidities but had a history of cesarean section two years prior. Physical examination revealed suprapubic tenderness. Laboratory tests showed elevated C-reactive protein (CRP) and mild anemia. Imaging indicated small bowel obstruction.

**Results:** Conservative management failed, and surgery was performed. Intraoperatively, about 100 centimeters of small bowel was found encased in a fibrous membrane. Adhesiolysis was carried out without the need for bowel resection.

**Conclusions:** Idiopathic SEP should be considered in cases of unexplained bowel obstruction. Surgical intervention generally results in a favorable outcome.

ABSTRACT 77 AB-000039 POSTER PRESENTATION

## Retroperitoneal Filarial Cyst Presenting as Acute Abdomen: A rare case report

AUTHOR Abhaya Mahto (Maharajgunj Medical Campus, IOM)
CO-AUTHORS *None*

ABSTRACT 78 AB-000041 POSTER PRESENTATION

## Pancreas-Sparing Resection for Presumed Benign Ampullary and Duodenal Masses: A Case Series

AUTHOR Dr. Shivani Pakhrin (Kathmandu Medical College)
CO-AUTHORS *None*

**Introduction:** Pancreaticoduodenectomy is the standard surgical procedure for resectable ampullary carcinoma and selected complex duodenal lesions; however, pancreas-sparing resection may be appropriate for carefully selected patients with presumed benign lesions. The choice of procedure depends on the lesion's location, size, extent, relationship to the ampulla and pancreas, and associated biliary pathology. This case series describes three patients who underwent pancreas-sparing surgery for presumed benign ampullary and duodenal lesions.

**Methods:** We reviewed three patients who underwent open pancreas-sparing resection for ampullary or duodenal masses considered benign on preoperative assessment. Clinical presentation, working diagnosis, imaging and endoscopic findings, operative findings, and surgical procedures were reviewed.

**Results:** A 42-year-old man was referred with a presumed duodenal gastrointestinal stromal tumour. Intraoperatively, a 10 × 10 $cm^2$ mass involved the D2/D3 region and extended towards the terminal ileum, caecum, and hepatic flexure, with no pancreatic involvement. He underwent pancreas-sparing duodenectomy with limited ileocolic resection, ampullojejunal anastomosis, pyloric exclusion, and gastrojejunostomy. A 45-year-old woman with a 2 × 2 $cm^2$ ampullary adenoma underwent transduodenal ampullectomy. A 70-year-old man with a 3 × 2 $cm^2$ tubulovillous adenoma and a type IVa choledochal cyst underwent ampullectomy, extrahepatic bile duct excision, and Roux-en-Y hepaticojejunostomy in a single operation.

**Conclusion:** Pancreas-sparing surgery is a potential alternative to pancreaticoduodenectomy in carefully selected patients with presumed benign ampullary and duodenal lesions. Operative planning should be individualised according to the working diagnosis, anatomical location, extent of the lesion, relationship to the pancreas, and associated biliary abnormalities. Appropriate preoperative assessment and intraoperative evaluation are essential for selecting the most suitable procedure.

**Keywords:** Ampulla of Vater; Duodenal mass; Organ-Preserving Surgery; Pancreaticoduodenectomy.

ABSTRACT 79 AB-000052 POSTER PRESENTATION

## Complex biliovascular injury following cholecystectomy and its management : A case report

AUTHOR HARSHIT AGRAWAL (Kathmandu Medical College and Teaching Hospital)
CO-AUTHORS Devendra Bist; Roshan Ghimire, Dhiresh Kumar Maharjan, Prabin Bikram Thapa

ABSTRACT 80 AB-000054 POSTER PRESENTATION

## BEYOND EXPLANTATION: SAVING AN INFECTED MESH WITH NPWT IN INCISIONAL HERNIA WITH LOSS OF DOMAIN

AUTHOR Milan Adhikari (Maharajgunj Medical Campus, TUTH, IOM)

CO-AUTHORS *None*

We report a giant incisional hernia with LOD managed by inlay mesh repair with anterior component separation, in which an infected mesh was salvaged using negative pressure wound therapy (NPWT)

ABSTRACT 81 AB-000062 POSTER PRESENTATION

## IMMUNE CHECK(MATE): DURVALUMAB'S SUCCESS IN GALLBLADDER CARCINOMA – A CASE REPORT

AUTHOR Dr. Nikesh Jaiswal (PGIMER, Chandigarh, India)

CO-AUTHORS Dr. Cherring Tandup, Dr. Swapnesh Kumar sahu, Dr. Naveen Pentakota, Dr. Srijita shahu

ABSTRACT 82 AB-000064 POSTER PRESENTATION

## ABDOMINAL COCOON SYNDROME

AUTHOR DR SARUJA BHATTARAI (KATHMANDU UNIVERSITY(DHULIKHEL HOSPITAL))

CO-AUTHORS *None*

ABDOMINAL COCOON: A RARE CAUSE OF SMALL BOWEL OBSTRUCTION

**Introduction:** Abdominal cocoon, also known as idiopathic sclerosing encapsulating peritonitis, is a rare cause of intestinal obstruction characterized by partial or complete encasement of the small bowel within a dense fibrocollagenous membrane.

**Case Presentation:** A 32-year-old male presented with acute, diffuse abdominal pain, multiple episodes of non-projectile vomiting, and obstipation for one day. Physical examination revealed a palpable, mildly tender mass in the right lower quadrant, with localized guarding and rebound tenderness. Computed tomography of the abdomen demonstrated clustered small bowel loops encased within a thin peritoneal membrane in the lower abdomen and pelvis, accompanied by the small bowel feces sign and terminal ileal wall thickening.

**Discussion:** Abdominal cocoon is an uncommon, non-malignant cause of acute or subacute intestinal obstruction. It may be idiopathic or secondary to conditions such as abdominal tuberculosis, peritoneal dialysis, systemic lupus erythematosus, malignancy, or previous abdominal surgery. Although imaging may suggest the diagnosis, definitive confirmation is often established during exploratory laparotomy. Management depends on the severity of obstruction. Conservative treatment with nasogastric decompression, bowel rest, and hydration may be sufficient in selected patients, whereas severe obstruction may require surgical adhesiolysis and excision of the encasing membrane.

**Conclusion:** Abdominal cocoon should be considered in the differential diagnosis of intestinal obstruction, particularly when imaging reveals clustered small bowel loops surrounded by a membrane. Early recognition and appropriate management can help achieve favorable outcomes.

ABSTRACT 83 AB-000072 POSTER PRESENTATION

## THE BROKEN BILIARY CONFLUENCE: A SURGICAL CHALLENGE REQUIRING BILATERAL RECONSTRUCTION: A CASE REPORT

AUTHOR Dr. Amisha Silwal (KU-Dhulikhel Hopsital)

CO-AUTHORS *None*

**Background:** Iatrogenic bile duct injury is a serious complication of cholecystectomy. Complete transection involving the hilar confluence presents a complex reconstructive challenge requiring precise anatomical delineation and meticulous surgical repair.

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**Case Presentation:** A 70-year-old male with history of pulmonary tuberculosis underwent open cholecystectomy for symptomatic cholelithiasis. Five-days-post surgery, he presented with right upper quadrant pain, progressive jaundice and elevated liver enzymes. Magnetic resonance cholangiopancreatography demonstrated complete dissociation of the bile duct proximal to the hilar confluence. Contrast-enhanced computed tomography revealed a gallbladder fossa collection and non-visualization of the primary biliary confluence, common hepatic injury and proximal and mid part of common bile duct. Restoration was performed using bilateral Roux-en-Y hepaticojejunostomy employing the Hepp-Couinaud approach, establishing separate biliary-enteric anastomoses for the right and left hepatic duct systems.

**Case Discussion:** Misidentification of biliary anatomy remains the predominant mechanism underlying bile duct injury, exacerbated by acute inflammation, dense adhesions, anatomic variation, or challenging operative conditions. Prevention requires meticulous surgical technique, consistent attainment of the critical view of safety, and selective use of adjuncts such as intraoperative cholangiography or indocyanine green fluorescence imaging which facilitate biliary anatomical delineation and reduce the risk of inadvertent injury.

**Conclusion:** Complete hilar bile duct transection requires individualized surgical reconstruction. Bilateral Roux-en-Y hepaticojejunostomy is a feasible option for restoring biliary continuity when the right and left hepatic duct systems are completely dissociated.

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ABSTRACT 84 AB-000075 POSTER PRESENTATION

## Individualized Surgical Management of Gastric Cancer: A Single-Centre Retrospective Case Series of 11 Patients

AUTHOR Shashi Deo Yadav (Nobel Medical College Teaching Hospital)
CO-AUTHORS *None*

Gastric cancer presents with variable tumor locations, disease stages and clinical conditions, Requiring individualized surgical management. This case series describes the spectrum of surgical Procedures performed for gastric cancer at a tertiary care centre and evaluates the associated clinicopathological characteristics and postoperative outcomes.

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ABSTRACT 85 AB-000078 POSTER PRESENTATION

## Advanced Anterior Chest Wall Soft Tissue Sarcoma with Cutaneous Ulceration: a case report

AUTHOR Dr. Ranbir yadav (Pokhara Academy of Health Sciences, Western Regional Hospital, Pokhara, Nepal)
CO-AUTHORS Dr. Piyush Giri

A 54-year-old male presented with a giant anterior chest wall soft tissue sarcoma measuring 40×25 cm with cutaneous ulceration after 3 years of painless growth, remarkably sparing underlying ribs and sternum. Multidisciplinary management achieved wide local excision with negative margins without neoadjuvant therapy. Reconstruction required combined latissimus dorsi myocutaneous, vertical rectus abdominis myocutaneous, and transverse rectus abdominis myocutaneous flaps due to the massive defect. Postoperative day 4 revealed zone IV transverse rectus abdominis flap venous congestion with partial necrosis, successfully managed conservatively. The patient was lost to follow-up, precluding long-term oncologic assessment. This case underscores bone-sparing growth patterns, complex reconstructive demands, and follow-up challenges for giant chest wall sarcomas in resource-limited settings.

**Key words:** -soft tissue sarcoma, Anterior chest wall, Wide local excision, Latissimus dorsi flap, Rectus abdominis myocutaneous flap, Chest wall reconstruction, Flap necrosis

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ABSTRACT 86 AB-000079 POSTER PRESENTATION

## Successful Management of Gastroschisis in a Newborn: A Case Report

AUTHOR Dr. Sarokar Parajuli (Pokhara Academy of Health sciences)
CO-AUTHORS Dr Shilpa Basnet

ABSTRACT 87 AB-000080 POSTER PRESENTATION

## Surgical Management of Iatrogenic Duodenal Perforation During ERCP Results in Significant Clinical Improvement: A Case Report

AUTHOR Dr. Ranbir yadav (Pokhara Academy of Health Sciences, Western Regional Hospital, Pokhara, Nepal)

CO-AUTHORS Ranbir yadav1 (ranbiry04@gmail.com), Kalpana Acharya1 (dracharyakalpa@gmail.com), Shilpa Basnet2 (Shilpabasnet31@gmail.com), David Shrestha3 (david.shrestha@poahs.edu.np)

Duodenal perforation is a rare but potentially life-threatening complication of endoscopic retrograde cholangiopancreatography (ERCP). Early detection and prompt surgical intervention can significantly improve patient outcomes. We present the case of a 56-year-old-male who sustained a duodenal perforation during ERCP, which was successfully managed with early surgical intervention, leading to rapid clinical improvement.

ABSTRACT 88 AB-000081 POSTER PRESENTATION

## Delayed Rupture of Splenic Injury Following Blunt Trauma Abdomen in a Patient with Mitral Valve Replacement on Anticoagulation: A Case Report

AUTHOR Dr . Shree Ram Roy (Nobel medical college and teaching hospital)

CO-AUTHORS Dr Amit Bhattarai , Dr Dinesh Adhikari ,Dr Bhola Mishra , Dr Prakash shah ,Dr Ashok koirala

Delayed presentation of splenic injury following blunt trauma Abdomen poses a diagnostic and therapeutic challenge. Management becomes more complex in patients requiring anticoagulation for a prosthetic mitral valve because of the competing risks of hemorrhage and valve-associated thromboembolism.

ABSTRACT 89 AB-000086 POSTER PRESENTATION

## Rare Presentation of Restrain Injury over Bilateral Axillae

AUTHOR Dr. Bhuwan Rayamajhi (Pokhara Academy of Health Sciences)

CO-AUTHORS Dr. Piyush Giri, Dr. Narendra Vikram Gurung

ABSTRACT 90 AB-000092 POSTER PRESENTATION

## From Segmental resection to Total Colectomy: A Surgical Challenge of Late-Diagnosed Hirschsprung Disease in an Adolescent

AUTHOR Dr. Gaurav Bharadwaj (Nobel Medical College Teaching Hospital)

CO-AUTHORS *None*

Hirschsprung disease is a congenital disorder characterized by the absence of ganglion cells in the distal bowel, usually diagnosed during infancy or early childhood. Delayed diagnosis during adolescence is uncommon and may present with chronic constipation, massive colonic dilatation, and acute intestinal obstruction.Advanced presentations can pose significant diagnostic and therapeutic challenges particularly when complicated by perforation.

ABSTRACT 91 AB-000097 POSTER PRESENTATION

## Individualized Surgical Management of Mesentric cyst

AUTHOR Dr Lalu prasad yadav (Nobel medical college,biratnagar)

CO-AUTHORS *None*

ABSTRACT 92 AB-000099 POSTER PRESENTATION

## Preoperative Nutritional Risk and Postoperative Outcomes after Emergency Abdominal Surgery: A Systematic Review and Meta-Analysis

AUTHOR Shankar Poudel (Maharajgunj Medical Campus)
CO-AUTHORS Shankar Poudel* (presenting author), Dibya Raj Yadav, Biswo Shrestha, Aashish Poudel

**Introduction:** Malnutrition is common in emergency abdominal surgery, but studies assess it with screening tools, composite indices or serum albumin, which also falls with acute inflammation. We quantified associations between preoperative nutritional risk and postoperative outcomes and explored variation by assessment method.

**Methods:** This systematic review and meta-analysis followed PRISMA 2020 and was retrospectively registered in PROSPERO. Five databases were searched to September 2026, supplemented by citation searching. Observational studies of preoperative nutritional measures in non-traumatic emergency abdominal surgery were eligible. Random-effects models used restricted maximum likelihood with Hartung–Knapp intervals. Risk of bias and certainty were assessed with QUIPS and GRADE.

**Results:** Nineteen studies were included. Higher nutritional risk was associated with short-term mortality (11 studies; OR 5.88, 95% CI 2.28–15.21), overall complications (eight; OR 2.60, 1.10–6.18), surgical site infection (eight; OR 2.87, 1.19–6.90) and longer hospital stay (three; mean difference 4.94 days, 0.67–9.21). Mortality associations were largest in albumin-only studies (six; OR 10.64, 3.80–29.79) and imprecise when these were excluded (five; OR 4.48, 0.54–37.02). Heterogeneity was substantial ($I^2$ 62–93%), 18 studies had high risk of bias, and certainty was low to very low.

**Conclusion:** Preoperative nutritional risk was associated with substantially higher mortality and complications after emergency abdominal surgery, with possible variation by assessment method. Albumin-based associations may partly reflect acute illness rather than nutritional depletion. Routine nutritional screening deserves evaluation alongside existing surgical risk tools.

**Keywords (MeSH, alphabetical):** Abdomen, Acute; Malnutrition; Meta-Analysis; Nutrition Assessment; Postoperative Complications; Serum Albumin

ABSTRACT 93 AB-000102 POSTER PRESENTATION

## Individualized Surgical Management of Mesenteric Cyst: A Single-Centre Retrospective Case Series of 3 Patients

AUTHOR Dr Lalu prasad Yadav (Nobel medical college Biratnagar)
CO-AUTHORS Dr Kunal Bikram Deo

ABSTRACT 94 AB-000103 POSTER PRESENTATION

## Individualized Surgical Management of Gastric Cancer: A Single-Centre Retrospective Case Series of 11 Patients

AUTHOR Dr Shashi Deo Yadav (Nobel Medical college)
CO-AUTHORS Associate professor Dr Kunal Bikram Deo

ABSTRACT 95 AB-000104 POSTER PRESENTATION

## From Segmental resection to Total Colectomy: A Surgical Challenge of Late-Diagnosed Hirschsprung Disease in an Adolescent

AUTHOR Dr. Gaurav Bharadwaj (Nobel Medical College and Teaching Hospital)
CO-AUTHORS Associate Professor Dr. Kunal Bikram Deo

**Background:** Hirschsprung disease is a congenital disorder characterized by the absence of ganglion cells in the distal bowel, usually diagnosed during infancy or early childhood. Delayed diagnosis during adolescence is uncommon and may present with chronic constipation, massive colonic dilatation, and acute intestinal obstruction.Advanced presentations can pose significant diagnostic and therapeutic challenges particularly when complicated by perforation

ABSTRACT 96 AB-000106 POSTER PRESENTATION

## Giant Hepatic Hemangioma Managed by Right Posterior Sectionectomy

AUTHOR Dr Divansh thakur (Nobel medical college biratnagar nepal)
CO-AUTHORS Associate professor Dr kunal bikram deo

Hepatic hemangioma is the most common benign vascular tumor of the liver, usually detected incidentally and managed conservatively. However, giant hepatic hemangiomas may present with abdominal pain, compression-related symptoms, or other complications. Surgical intervention is considered in selected symptomatic patients after careful evaluation.

ABSTRACT 97 AB-000107 POSTER PRESENTATION

## Pseudoaneurysm in acute pancreatitis

AUTHOR Dr Shashi Deo Yadav (Nobel Medical College)
CO-AUTHORS Associate professor dr Kunal Bikram Deo

Pancreatic pseudoaneurysm is a rare but potentially life-threatening vascular complication of acute pancreatitis. It results from enzymatic destruction of the arterial wall and may present with gastrointestinal bleeding or rupture. Early diagnosis and intervention are essential to reduce mortality.

ABSTRACT 98 AB-000108 POSTER PRESENTATION

## Stercoral Perforation of the Proximal Colon: A Rare Case of Cecal Perforation

AUTHOR Dr. Ghanshyam Yadav (Kathmandu model hospital)
CO-AUTHORS *None*

ABSTRACT 99 AB-000109 POSTER PRESENTATION

## Malignant Phyllodes Tumour in a Young Lactating Breast: A Diagnostic Pitfall

AUTHOR Dr. Era Phoju (Maharajgunj Medical Campus, IOM)
CO-AUTHORS Dr. Suzita Hirachan, Dr. Milan Adhikari

We report a 20-year-old lactating woman with a rapidly enlarging and painful right breast mass for 3 months. Examination showed an 11 × 8 cm multilobulated mass in the upper and lower outer quadrants, with visible veins, nipple deviation and skin fixation, but no axillary lymphadenopathy. Ultrasound showed a 13.4 cm heterogeneous lesion with cystic areas (BI-RADS 4). Core biopsy reported only chronic lymphocytic mastitis, which did not fit the clinical picture. She underwent simple mastectomy. The tumour measured 15 × 12 cm, was solid-cystic and haemorrhagic, and involved the nipple-areolar complex. Histology showed marked stromal cellularity and atypia, stromal overgrowth, infiltrative borders, necrosis and 15 mitoses per 10 high-power fields. Ki-67 was 40 to 50%, and cytokeratin and p63 were negative, supporting malignant phyllodes tumour (pT4). All margins were free (>10mm).

ABSTRACT 100 AB-000110 POSTER PRESENTATION

## Hepatic Hydatid Cyst with Cystobiliary Communication Presenting as Obstructive Jaundice: A Case Report

AUTHOR Dr. Amar Das (Maharajgunj Medical Campus)
CO-AUTHORS Dr Milan Adhikari, Dr Era Phoju, Dr Bikal Ghimire, Dr Dhruba Narayan Sah

ABSTRACT 101 POSTER PRESENTATION

## Delayed Presentation of Handlebar Hernia in a 13 Years Old Child - A Case Report

AUTHOR Dr. Mohammad Adnan Adil (Patan Academy of Health Sciences)

CO-AUTHORS Dr. Riyaz Shrestha, Dr. Artika Pradhan, Dr. Shankar Adhikari, Dr. Bijay Raj Bhatta

Abstract Traumatic abdominal wall hernia (TAWH) following bicycle handlebar injury is a rare consequence of blunt abdominal trauma, particularly in children, and may be easily overlooked due to minimal external signs and subtle clinical manifestations. Here, we report a case of a 13-year-old boy who presented with a painless swelling over the left lumbar region two weeks after an accidental bicycle handlebar injury. Despite minimal initial symptoms and a negative extended Focused Assessment with Sonography for Trauma (e-FAST), clinical examination and Contrast-Enhanced Computed Tomography (CECT) demonstrated a traumatic anterior abdominal wall defect with herniation of preperitoneal fat. Elective surgical exploration confirmed a 2 × 1.5 cm disruption of the abdominal wall musculature, which was successfully managed with primary layered repair without mesh reinforcement. The postoperative course was uneventful, with no recurrence at 10-day follow-up. This case highlights the potential for delayed recognition of handlebar-induced TAWH in children and emphasizes the importance of maintaining a high index of suspicion following blunt abdominal trauma. A negative eFAST and the absence of pain do not exclude a significant musculofascial defect; persistent localized swelling after pediatric handlebar trauma warrants careful palpation and radiological investigations.

ABSTRACT 102 POSTER PRESENTATION

## Fournier’s Gangrene Masked by Diabetic Ketoacidosis in a Young Man With Type 1 Diabetes Mellitus: A Surgical Case Report

AUTHOR Dr. Mohammad Adnan Adil (Patan Academy of Health Sciences)

CO-AUTHORS Sugov Budhathoki, Chandradev Gupta, Dr. Utsab Gautam, Dr. Vivek Kumar Roshan, Dr. Prayash Chand, Dr. Sumod Koirala

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