



Azərbaycan Respublikası
Səhiyyə Nazirliyi



Azərbaycan
Tibb Universiteti

2026-cı il "Səhərsalma və Memarlıq İli"

SAĞLAMLIQ VƏ TEXNOLOGİYANIN ZİRVƏSİ

6–8 May 2026

Azərbaycan Tibb Universiteti

TEZİSLƏR TOPLUSU

**AZƏRBAYCAN RESPUBLİKASI SƏHIYYƏ NAZİRLİYİ
AZƏRBAYCAN TİBB UNİVERSİTETİ**

**2026-CI İL “ŞƏHƏRSALMA VƏ MEMARLIQ İLİ” HƏSR OLUNMUŞ
“SAĞLAMLIQ VƏ TEXNOLOGİYANIN ZİRVƏSİ” ADLI YEKUN
BEYNƏLXALQ ELMİ-PRAKTİK KONFRANSIN**

TEZİSLƏR TOPLUSU

6-8 MAY 2026, BAKI, AZƏRBAYCAN

**MINISTRY OF HEALTH OF THE REPUBLIC OF AZERBAIJAN
AZERBAIJAN MEDICAL UNIVERSITY**

**FINAL INTERNATIONAL SCIENTIFIC-PRACTICAL CONFERENCE
"HEALTH AND TECHNOLOGY SUMMIT" DEDICATED TO THE
“YEAR OF URBANIZATION AND ARCHITECTURE – 2026”**

ABSTRACTS BOOK

6-8 MAY 2026, BAKU, AZERBAIJAN

BAKI – 2026

KONFRANSIN FƏXRİ SƏDRİ

Professor Gəray Gəraybəyli

ATU-nun Rektoru

KONFRANSIN HƏMSƏDRLƏRİ

Professor Anar Ağayev

*ATU-nun Tədris işləri
üzrə prorektoru*

Professor Mələhət Sultan

*ATU-nun Elmi işlər
üzrə prorektoru*

Dosent Orxan İsayev

*ATU-nun Beynəlxalq
Əlaqələr üzrə prorektoru*

TƏŞKİLAT KOMİTƏSİ:

Sədrlik:

İlqar Mehrabov

*ATU-nun İnzibati - təsərrüfat
işləri üzrə prorektoru*

Dosent Mahir Səfərov

*ATU-nun Tərbiyə
işləri üzrə prorektoru*

Nizami Adilov

*ATU-nun Ümumi işlər
üzrə prorektoru*

Professor Eldar Qarayev

*ATU-nun Elmi
Departamentinin sədri*

TƏŞKİLAT KOMİTƏSİNİN ÜZVLƏRİ:

Rəsmi inzibati heyət

Dosent Cahangir Qasimov
Professor Rizvan Məmmədov
Professor Fatimə Seyidbəyova
Dosent Kamandar Yaqubov
Dosent Törə Sadıqova
Dosent Elşad Novruzov

Dosent Fərah Mədətli
Dosent Qalina Qəniyeva
Dosent Nərgiz Məmmədova
Dosent Rəşad Talışinskiy
Dosent Ayət Cəfərova
Dosent Aygün Babayeva

Dosent İlhamə Mustafayeva
Dosent İsrail Məhərrəmbəyli
Dosent Elmira Əliyeva
Natiq Bayramov
Polkovnik Məharət Rzayev

TEXNİKİ TƏŞKİLATI HEYƏT:

Professor Səbinə Şadlinskaya
T.e.d. Elman Əzimov
Dosent Tamara Quliyeva
Dosent Fuad Rzayev
Dosent İnara Əlixanova
Dosent Həqiqət Vəliyeva
Dosent Günel Eyyubova
Dosent Gülay Məmmədova
Dosent Rəna Rzayeva
Dosent Səid Əhmədov
Dosent Mirvari Əliyeva
Dosent Gülarə Kərimova
Dosent Əsədulla Sultanov
Dosent Rauf Qasimov
Dosent Gültəkin Cavadova

Dosent Hicran Əsgərova
Dosent Şəhla Məlikova
Dosent Fəxriyyə Məmmədova
Dosent Svetlana Babayeva
Dosent Gülşən Zeynalova
Dosent Səadət Səfərova
Dosent Sevinc Muxtarova
Dosent Sevinc Pənahova
Baş müəllim Aytən Şükürova
Baş müəllim Pərvin Zülfüqarova
Baş müəllim Nərmən Bayramova
t.ü.f.d. Məryəm Qasimova
t.ü.f.d. Mədinə Hacıyeva
t.ü.f.d. İlhamə Hüseynova
t.ü.f.d. Xatirə Rəhimova

t.ü.f.d. İmran Ağayev
t.ü.f.d. Afaq Axundova
t.e.d. Aytən Cəfərova
t.ü.f.d. Azər Hümətov
Səyyəddin Atakişizadə
Aytən Şixəliyeva
Şəlalə Əliyeva
Kəmalə Bədəlova
Könül İsmayılova
Könül Ağamirzəyeva
Nərmən Quliyeva
Şəhanə Quliyeva
Vaqif Cəlilov

ELMI KATİB

Dosent Aygün Kazımlı

KATİBLİK:

Püsən Məmmədova
Nailə İsmayılova

Gültən Əlibəyova
Rəna Mahmudova

MƏTBUAT XİDMƏTİ:

Həqiqət İsabəliyeva
Kənan Zülfüqarov

Material and Methods. An analytical review of the literature was conducted using databases including PubMed and Scopus. Publications from the past two decades were screened, including case reports, small case series, and review articles. Particular attention was given to patient demographics, etiological factors, clinical presentation, imaging characteristics, and treatment approaches. Both conservative and interventional management strategies were analyzed to identify current trends and gaps in evidence. Studies focusing on portal venous aneurysms with specific reference to splenic vein involvement were prioritized to ensure relevance.

Results. Available data indicate that most splenic vein aneurysms are detected incidentally during imaging performed for unrelated abdominal conditions. Symptomatic presentation is relatively uncommon and is typically associated with larger aneurysms or the presence of complications such as thrombosis or compression effects. Cross-sectional imaging techniques, especially CT and MRI, are essential for accurate diagnosis, allowing detailed assessment of aneurysm morphology, size, and relationship to surrounding structures. Doppler ultrasound may serve as an initial diagnostic tool but is often supplemented by advanced imaging for confirmation. Management strategies vary widely and depend on individual patient characteristics. Asymptomatic and stable aneurysms are frequently managed conservatively with regular imaging follow-up, whereas symptomatic cases or those with complications may require endovascular intervention or surgical treatment. In recent years, there has been a gradual shift toward minimally invasive approaches when technically feasible.

Conclusion. Splenic vein aneurysm is a rare but clinically relevant condition that requires careful evaluation. Due to the absence of standardized guidelines, management should be individualized, taking into account aneurysm size, symptomatology, and potential risk of complications. Minimally invasive techniques are increasingly preferred in appropriate cases; however, surgical intervention remains necessary in selected patients. Further accumulation of clinical data and long-term follow-up studies are needed to better understand the natural course of this condition and to establish evidence-based management recommendations. Collaborative multicenter studies may play a key role in improving future clinical decision-making.

Keywords: *splenic vein aneurysm, diagnosis, thrombosis, endovascular treatment, surgery.*

PREDICTION AND PREVENTION OF LATE COMPLICATIONS OF CHOLECYSTECTOMY IN SIMULTANEOUS BARIATRIC SURGERY: DEVELOPMENT AND CLINICAL VALIDATION OF THE BACH-RISK SCALE AND A THERAPEUTIC-DIAGNOSTIC ALGORITHM

Sattarov Oybek Toxirovich, Djumaev Elbek Ilxomovich

*Department of Bariatric and Metabolic Surgery Clinic of Tashkent State Medical University
Tashkent, Uzbekistan*

Objective of the study: To improve the outcomes of cholecystectomy during simultaneous bariatric surgeries by developing and implementing a therapeutic and diagnostic algorithm for predicting and preventing its late complications.

Materials and Methods, Study design: Single-center, comparative, sequential (retrospective control + prospective main) clinical study conducted at the Department of bariatric surgery, Tashkent State Medical University (2022–2025). Ethical approval was obtained from the local ethics committee; informed consent was obtained from prospective participants.

Patients: Inclusion criteria: morbid obesity with indications for bariatric surgery, confirmed chronic calculous cholecystitis, simultaneous laparoscopic CCE + SG or MGB, age >18 years, ≥12-month follow-up. Exclusion criteria: acute biliary complications, mechanical jaundice, malignancy, prior biliary reconstruction, severe organ failure. Total cohort: 167 patients (control n=82, main n=85). Groups were comparable in age (42.4±9.1 years), sex (70.1% female), BMI (44.7±6.9 kg/m²), and baseline biliary characteristics. BACH-Risk scale development. The scale

was derived from multivariate logistic regression of predictors identified in the control group: Clinical-anamnestic (2 points each): ≥ 2 episodes of biliary colic, history of complicated cholecystitis. Laboratory cholestasis ($>1.5 \times \text{ULN}$; 2–3 points): total bilirubin, ALP, GGT. MRCP morphological (3 points each): CBD dilation ≥ 9 mm, intrahepatic duct dilation, delayed bile passage, terminal CBD narrowing. Total score: 0–22 points. Categories: 0 (no risk), 1–9 (low), ≥ 10 (high). ROC analysis confirmed high accuracy (AUC=0.911). Therapeutic-diagnostic algorithm (TDA). No risk (0 points): Standard simultaneous CCE + bariatric procedure. Low risk (1–9 points): Simultaneous CCE + modified SG (antral segment preserved 4–5 cm proximal to pylorus vs. standard 2–3 cm) to reduce functional biliary load. High risk (≥ 10 points): Staged approach — first biliary correction (ERCP/sphincterotomy if needed), re-assessment, then bariatric surgery only after score reduction to ≤ 9 . Surgical technique. Laparoscopic CCE was standard. Modified SG: extended antral preservation maintained more physiological gastric emptying.

Outcome measures: Primary late CCE complications (>30 days, within 12 months) — recurrent biliary pain, nausea/vomiting, biliary reflux, pancreatitis, strictures, cholangitis. Secondary: %EWL, BAROS score, hospital/ambulatory resource use. Statistics. SPSS v.26. Quantitative data: mean \pm SD or median; categorical: χ^2 /Fisher exact test. Multivariate logistic regression for predictors. $p < 0.05$ considered significant.

Results. Patient characteristics. Groups were balanced (Tables 1–2). Most had symptomatic cholelithiasis (60.5%); 30.5% had CBD >7 mm on ultrasound. Late complications. Overall rate: 64.6% (control) vs. 16.5% (main, $p < 0.001$). Specific reductions: Recurrent pain: 46.3% \rightarrow 10.6% ($p < 0.001$). Nausea/vomiting: 43.9% \rightarrow 12.9% ($p < 0.001$). Biliary reflux: 47.6% \rightarrow 16.5% ($p < 0.001$). Structural complications (strictures, pancreatitis): 0% in main group vs. 14.6% in control. No differences by bariatric procedure type when TDA was applied. Bariatric efficacy. %EWL at 12 months: 63.8 \pm 7.9% (main) vs. 55.7 \pm 8.4% (control, $p < 0.001$). BAROS score: 6.5 \pm 0.7 vs. 4.3 \pm 0.8 ($p < 0.001$), driven by higher weight-loss, comorbidity resolution, and quality-of-life components, plus fewer penalty points for complications. Healthcare utilization. Primary stay: 6.2 \pm 1.4 vs. 7.8 \pm 1.9 days ($p < 0.001$). Rehospitalizations: 0.4 \pm 0.3 vs. 1.3 \pm 0.6 per patient ($p < 0.001$). Total bed-days per patient: 8.9 \pm 3.6 vs. 16.2 \pm 4.8 (1.8-fold reduction, $p < 0.001$).

Discussion: This study is the first to propose and validate an integrated preoperative risk model (BACH-Risk) specifically for late CCE complications in simultaneous bariatric surgery. Previous works focused on early complications or isolated gallstone formation post-bariatric procedures.^{8–10} The BACH-Risk scale combines accessible clinical, biochemical, and MRCP parameters, achieving excellent discriminatory power (AUC=0.911), superior to single-domain models reported elsewhere. The TDA with antral-preserving modified SG in low-risk patients addresses functional discoordination of bile flow caused by rapid gastric emptying and altered neurohumoral regulation — a key mechanism of post-cholecystectomy syndrome in bariatric settings. Preservation of a longer antrum reduces early ketogenesis intensity and biliary overload, explaining the marked reduction in functional complications without compromising %EWL. Staged management in high-risk patients prevents additive stress on an already compromised biliary system, aligning with expert consensus favoring selective rather than routine concomitant CCE. Economic benefits (reduced rehospitalizations) further support routine implementation. Limitations include single-center design and 12-month follow-up; longer-term validation is warranted.

Conclusion: The BACH-Risk scale and TDA enable personalized surgical tactics, significantly reducing late CCE complications, improving bariatric outcomes, and decreasing healthcare costs. Routine preoperative application of this system is recommended in bariatric centers

Keywords: *cholecystectomy, bariatric surgery, post-cholecystectomy syndrome, risk prediction, sleeve gastrectomy modification, BACH-Risk scale, simultaneous surgery.*