A Socratic Dialogue between the Mentor and His Student, on *Human Anatomy and Information Medicine*

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Сократический диалог между наставником и его студентом, по *анатомии человека и информационной медицине*

Рудольф Климек и Адам Острузенски

Opening remarks (by Rudolf Klimek)

Scientific-clinical research is very demanding and requires significant dedication, self-discipline, sacrifices, and preserving scientific-clinical integrity (quality, credibility, creativity, and appropriate transparency. Professor Ostrzenski's discoveries of new structures in the anatomy and developments of gynaecologic surgical techniques put him on the clinical-scientific world's stage. In 1978 Prof. Ostrzenski with his family repatriated to the USA to continue scientific-clinical work with the conviction that his mentor, Prof. R. Klimek, well-prepared him to be ready for his independent scientific-clinical journey. He well-understood the teaching and became who he is today, saying, quote: *"I still follow my mentor, Prof. Rudolf Klimek, teaching very closely..."*. Prof. Ostrzenski's authority and authentical accomplishments in the international arena influence me to invite him to discuss his contribution to the progress in medicine. My particular interest was how those achievements in the human anatomy, I can incorporate from the medical viewpoint into the jubilee work (authored by **K.S. Khroutski**), devoted to "**the era of Integralism and the North-Eastern (Noospheric) civilization vector in the world (peaceful) evolvement** [*BCnA* 2020,10(1&2): pp. 5–150].

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Two professors in dialogue : Mentor-Prof. Rudolf Klimek (RK), Poland, and Prof. Adam Ostrzenski (AO), USA

RK (question №1 – Q1): You, Prof. Ostrzenski, demonstrates a unique ability to present accurate facts openly without any personal attack on the opposing debater; indeed, it is a unique feature. Not many scientific-clinical researchers have this ability. You understand well my philosophical interpretation of your new anatomical discoveries, which I classified as informative medicine. In 1983, I served as the honorary Vice-President of the 1st World Congress of Endoscopy organized by the American Association of Gynecologic Laparoscopists. Later, you introduced several new laparoscopic techniques in the gynecologic field. I like to compare your newly developed laparoscopic surgical interventions to the highest pic (Mont Everest) of a Himalayan mountain, witnessed you performing very complex laparoscopic surgery, which lasted several hours with a great final surgical outcome. I know the feeling of introducing discoveries that contribute to progress in medicine. In 1954, I was a medical student and isolated from bacteria new cytochrome-S, which differentiates this type of metalloproteins from animal cytochromes-C, -B, -C, or cytochrome-F present in plants.

AO: Your biochemical enzymatic method of oxytocinase identification in blood revolutionized the symptomatic clinical diagnosis of hypothalamic dysfunction.

RK (Q2): At that time, clinical biochemistry concentrated on the pituitary hormones, but not on hypothalamic neurohormones. Oxytocinase did not get the researchers' attention, while Prof. Kurt Semm from Germany introduced the diagnosis of hypothalamic dysfunction based on the physiologic methods. Later, Prof. Semm and you, Prof. Ostrzenski, pioneered the gynecologic laparoscopic field and educated worldwide numerous pelvic surgeons. How was your way to developing successful clinical research that the medical globe is fascinating with it?

AO: In the USA, I have to pave the way myself to establish recognizable clinical-scientific research. I structured my clinical and scientific step stones very carefully. The first step was to get the US physician's diploma and license to practice medicine and surgery. The second step was to go through the US specialty training, which I did at the State University of New York in Buffalo, NY. After meeting clinical and theoretical criteria, I received the American Board certification as a specialist in obstetrics and gynecology. Upon receiving formal specializations in obstetrics and gynecology and an identified specialist of reproductive endocrinology in the State of

Maryland, now it was time to establish my clinical-scientific research field. I joined Georg Washington University in Washington, DC, was elevated to the rank of assistant and later associate clinical professor. The Obstetrics and Gynecology Department of Howard University in Washington, DC, recruited me for a full-time faculty member position and promoted me to university full professor rank. At the same time, I accepted the responsibility of the Operative Gynecology Division director. The next in our family educational line was my wife, Maria. She successfully graduated from the Georg University Law School with a master's degree in comparative law. Our daughter Katarzyna became a physician and an internal medicine specialist, while son Bartosz chooses the law profession as his mother and runs a law firm.

My clinical-scientific research interest commenced when I was a medical student, and I was interested in the secretion of electrolytes in apocrine glands. I evaluated differences in their secretion in a menstrual cycle before and after the women's ovulation and later during a complicated pregnancy. I introduce the results of this study in my Ph. D. dissertation. In 1972, I was looking to determine my new research field. I came across a newly published book entitled "**Clinical Neuroendocrinology**." Using this occasion, I request a meeting with you, Prof. Klimek. I was very much impressed with your scientific-clinical caliber during our session, and I like to follow in your footsteps. From our meeting, I concluded that a simple laboratory would be the only option for me and not the endocrine laboratory. Mycotic infections of the female genitalia were on my mind for a long. During this time in Poland, only a few established mycotic scientific-clinical laboratories existed, and the leading one was at the Jagiellonian University (JU) in Cracow. I asked you again to help me establish contact with this JU institution, and you did without any hesitation. Prof. Marta Dolezal and Prof. Marian Dolezal from the Mycology Department shared their experiences and offered me scientific consultation. The next step was to develop scientific cooperation with the Department of Pathomorphology. I discovered that mycotic infection could affect the endometrium, cause irregular uterine bleeding, and compromise female fertility. I developed therapies by irrigating the endometrial cavity with antifungal medication applied directly to the uterine cavity in the menstrual cycle's first phase. The work was well received and accepted for presentation in two consecutive International Federation of Gynecology and Obstetrics (FIGO) congresses in Moscow and Mexico City. This research and international recognition of this study's results gave me confidence in being an independent scientific-clinical researcher.

I like to take this opportunity and express my deepest gratitude to You, Prof. Klimek, for being my scientific-clinical mentor and my example of how to represent a scientific community with honor and dignity. *Your finishing touch in my career progress was your encouragement and advice on being an independent clinical-*

scientific researcher, independent teacher, and independent clinician. You, Prof. Klimek, successfully directed my doctor habilitate, the post Ph.D. degree, the process that you completed at the oldest and most prestigious university in Poland, Jagiellonian University. Thank you again, Prof. Klimek, for supervising and modulating me in clinical endocrinology. Your teaching allows me to become a certified subspecialist in the human endocrinology field. Throughout my entire professional life, I did consider you as my clinical and scientific parent. Limited vocabulary does not allow me to express my feeling and everlasting gratitude for your unselfish and spontaneous help, so you are my professional guru. My scientific-clinical accomplishments belong to you too, professor.

Polish reality was very antagonistic against any scientist who was not a member of the communist party. This situation forces me to make my decision to repatriate to the USA since I was a US citizen by birth (my mother was a USA citizen). In the USA, a new beginning has commenced! Professionally, I must start by getting a US physician (MD) diploma, going through US training in my specialty, and supporting my family.

RK (Q3): From the perspective of time, how do you see the influence, if any, of Polish scientific-clinical accomplishments in your worldwide success?

AO: In my view, the Polish experiences prepared me for independent clinical-scientific research. You in my young professional life, gave me direction, which I will use for the rest of my professional life. You prepared me how to materialize my ideas into scientific work. It is like a child who learns in her/his youth to be productive and respectful. I discovered a new medical entity in Poland that mycotic pathogens can infect the women's endometrium and cased uterine irregular and heavy menstrual bleeding. Indeed, it was the first taste of scientific triumph. The medical community in Poland suppressed the echo of this scientific research success in the international arena.

RK (Q4): What was your scientific research in the USA?

AO: After stabilizing myself in my profession and establishing comfortable support for my family, the time came to return to my scientific-clinical research. I commenced studying the female urogenital structure of gross and topographic anatomy on human female cadavers. My learning from anatomical dissections anatomy, I start implementing it to gynecologic surgical procedures. I established cooperation with US gross anatomy departments. However, my study's best materials were on healthy and suddenly dead women. Such subjects were only available in a forensic medicine

department. I couldn't get permission from a forensic department in the USA to do my study due to the law governing forensic medicine. I approach many institutions in Europe and got a few permissions to continue my research there. Among those forensic medicine departments was Warsaw Medical University in Poland. I used to work at this Polish University before my departure to the USA.

I researched the gross ovarian anatomy by slicing them longitudinally and exploring stratum-by-stratum structures under surgical loupe magnification. My particular interest was polycystic ovary. Observations from this investigation, I applied to treat polycystic ovarian disease (Stein-Leventhal syndrome) by vaporizing the 1 cm strip longitudinally on the free ovarian edge. Results showed that ovulation was induced in the high range, with 62% baby taking home in this study's group. As a young surgeon, I observed Prof. Klimek operating and applying the wedge resection procedure on patients who suffered from this disease. I adopted this method and successfully executed this operation at the Warsaw Medical University with good results in Poland's pre-Clomid area. It was natural for me to continue this mode of practice and change the approach from abdominal to laparoscopic. I published the study's results in the mainstream peer-review journal in the USA. This study was well-received in the USA, and the "Book Year" editors included it in its text of this book. This medical scientific-clinical research success in the USA rebuilt my confidence in entrusting myself to develop a new surgical concept that the international community notices and promotes. Indeed, it motivated me to dedicate my professional life to clinical-scientific research, and I am cultivating it until today.

RK (Q5): We learned about your motivation and the continuation of your clinical-scientific research. How did you develop such an impressive number of new surgical technics in classic abdominal, vaginal, laparoscopic, and hysteroscopic surgery?

AO: In scientific investigations, the very first step is to establish the field of a researcher's interest and to organize the specific and independent necessary laboratory to execute the study. In my case was to have access to the anatomical dissection and operating room to do surgeries. The next step was to explore an option scientifically how in-depth knowledge of anatomy influences a surgical procedure and its outcomes. An example of a late complication is total vaginal prolapse following a total hysterectomy, because it requires understanding this surgical intervention's anatomical consequences. I identified all suspensory and supportive structure mechanisms by doing stratum-by-stratum anatomical dissections on female cadavers to establish responsible structures for maintaining the vagina in two different topographic natural positions. Applying these anatomical findings at the time of hysterectomy with vaginal

vault suspension and posterior cul-de-sac reconstruction, utilizing only the native tissue, provide a very high degree of total vaginal prolapse prevention. It is essential to remember about natural mechanisms that must rebuild a) to resuspend a lateral vaginal cuff to the cardinal ligament bilaterally; the posterior vaginal to a uterosacral ligament, and the anterior vaginal wall to the endopelvic fascia; b) the supporting anatomical structure of the posterior cul-de-sac must (the pouch of Douglas) be reconstructed as well as anterior, posterior, and lateral vaginal existing defects; c) the posterior perineum integrity is vital to restore. These multiple procedures will maintain the vagina in the proper topographic position at the time of hysterectomy and then after. Those procedures, I published in the mainstream, peer-review journals. The world accepted my clinical approach. As a result of this popularity, I received significant invitations to demonstrate and teach others of these surgical interventions. Leading surgical textbooks in the USA included these surgical techniques in their text.

RK (Q6): So, which scientific-clinical accomplishment in the traditional gynecologic surgery, you consider as the number one?

AO: At most, I treasure the urethral stabilization procedure for female urinary stress incontinence (SUI). I based this new surgical technique on my anatomical discovery of the urethral stabilizing mechanism's intricate anatomy. That two research allow me to define the etiology of female SUI. Determining how the urethra is anatomically suspended-support, and translating it into surgical intervention was challenging. The surgical outcomes were emotional and pleasing. Then, waiting three years for final follow-up results was merely unbearable. Still, when I opened the last subject's envelope with a three-year evaluation in it for final analysis, it brought a sense of scientific satisfaction. I developed the urethral stabilization procedure without using a surgical sling, meshes, or permanent sutures. This way, I can help women worldwide with this devastating medical entity was the highest price in my life.

The second place belongs to my surgical reconstructive technique for total vaginal prolapse. This technique is the reconstruction of site-specific defects and anatomical suspension-support of the vagina in its natural topography. This technique is highly appreciated globally and won a monetary prize awarded by the German-Turkish Gynecologic Society.

Next, the lateral vaginal wall can prolapse into the vaginal canal and become symptomatic (dyspareunia, fillings of the vaginal fullness, and heaviness). I develop a new surgical technique to reconstruct this anatomical defect with outstanding clinical results, curing deep dyspareunia and other symptoms. It is essential to emphasize that supporting and surrounding structures of the lateral vaginal wall are much different

from the anterior-posterior vaginal wall. I demonstrated that the surgical fascia (the vaginal wall's adventitia) fuses with the superficial fascia pubovaginalis muscle. Historically, this study is the first clinical-scientific research globally, showing the necessity to treat the symptomatic lateral vaginal prolapsing into the vaginal canal.

My study also establishes that the pelvic organ prolapse quantification system is inadequate because the perineal body is located under the posterior-distal vaginal wall in the horizontal orientation and rests on the rectovaginal septum. Additionally, this investigation documented that the perineal body site-specific defects of the anterior surface differ from the posterior surface in the same subject. I reconstruct both surfaces separately to treat female urinary or fecal incontinence or superficial dyspareunia.

RK (Q7): So, which one new laparoscopic surgical technique, you consider the most important?

AO: Laparoscopic total hysterectomy with the prophylactic suspension of the vaginal cuff and reconstruction of the posterior culdoplasty created the base for developing a radical laparoscopic hysterectomy with pelvic lymphadenectomy for oncologic diseases. My new surgical technique, complexity for total vaginal prolapse, delivers the most personal satisfaction for its excellent international recognition. This surgical intervention also won a monetary prize awarded by the German-Turkish Gynecologic Society. I developed this surgical operation using the concept that all site-specific defects need repair with native tissue without utilizing surgical meshes. Reconstruction of the Douglas' pouch and suspend the vaginal cuff laterally to the cardinal ligament bilaterally; the posterior vaginal vault to the uterosacral ligaments; the endopelvic fascia suspends the anterior part of the vaginal cuff. Additionally, I do repair all identifiable site-specific defects of the posterior perineum and vaginal walls. There are too many new anatomical discoveries and too many new surgical interventions that I described, but it would take time to present them.

RK (Q8): How did you react when you learned that The Indian Cosmetic-Reconstructive Gynecologic Society presented you with the title of the "Father of Cosmetic-Plastic Gynecology?
Warm Congratulations!!

AO: Thank you! Cosmetic-Plastic Gynecologic field is a new branch of the gynecologic field. The word "gynecologic" suggests that a gynecologist should be the one who is offering such a service for women. It is not as simple as it sounds because

gynecology does not provide cosmetic, topographic, and surgical anatomy principles. Recently, we observe a trend for self-appointed-plastic surgeries. Plastic surgeons are knowledgeable in cosmetic-plastic general principles but do not have training in gynecologic surgeries or gross, functional, experts who neither have formal training in teaching surgeries, anatomy, nor applied ethics. This very neglected field leads to very deceptive practices and teaching and clinical research without respecting scientific-clinical integrity. Such a situation leads to severe, debilitating, catastrophic, and irreversible surgical functional and esthetic complications due to under-educated practitioner-experts. In many instances, esthetic surgery gives priority over the preserving function; it usually results in irreparable complications. Gynecologic Societies around the globe do not provide any formal postgraduation teaching or training. I teach both gynecologists and plastic surgeons and fill this educational gap so that both specialties can minimize occurrences of severe complications. I teach courses/workshops with good results, but one educational center is a drop in the bucket.

RK (Q9): Can you please present some of your new surgical interventions?

AO: The most demanding procedures are those which require corrective methods for a botched surgery. **Labiolysis of the labia minora** is one of them. This surgical intervention releases the labium minus from unnatural fusion with the interlabial crease and the labium majus. Labial over-resection is the cause of severe complications leading to dysfunction or neuropathy. This corrective procedure restores the natural anatomy function; although, it is simple but technically demanding. **A frenuloreduction** is a surgical procedure that trims down the length of the frenulum of the clitoris. I discovered a new anatomy structure within the frenulum and termed it „the infrafrenulum fascial bundle." Additionally, I documented that the clitoral frenulum structure consists of two layers a) superficial skin stratum and b) the deep layer of the infrafrenulum fascia bundle. The deep stratum is responsible for maintaining the stability of the clitoris, particularly the clitoral glans. Before this discovery, surgeons excised the deep structure, destroying the clitoris stability and leading to difficult clitoral stimulation and pain. My surgical technique eliminated such complications. **G-spotplasty** restores or improves the function of the G-spot.

G-spotplasty restores or improves the function of the G-spot. The **G-spot-spot discovery** (neurovascular complex) earned popularity worldwide to the point that I could not handle it daily. Scientifically, BioMedLib® classified my article on this discovery as the number one in the world and selected it from 23 million scientific-clinical articles. The International Study Group on G-spot verified the G-spot anatomy and established histologic characteristics features. The French MRI study group

confirmed the G-spot existence within the original anatomical location described by me.

Additionally, I discovered and published the G-spot's role in the genesis of the anterior-distal vaginal enlargement. I utilized all these discoveries regarding the G-spot and developed G-spotplasty, a surgical intervention to cure neurovascular (the G-spot) secondary dysfunction. All my scientific articles on these very subjects are available on my website at www.cosmetic-gyn.com. I established and published the classification (the anterior, lateral, and posterior vaginal introitus) and its connection to numerous different anatomical structures. Reconstructing the defective vaginal introitus eradicates feelings of the wide or smooth vagina requires intimate anatomical knowledge.

RK (Q10): In the old methods, surgeons resect the skin and fatty tissues with the adipose sac without other reconstructions of the labia majora. Your technique provides an option for a surgeon to reverse the flat appearance to the natural and rounded look of the tissues, does it?

AO: The surgical technique that I developed and published in peer-review journals restores the integrity of the adipose sac and eliminates the unpleasing esthetic look. **Prepucioplasty and commissure anterior reconstructions**, **Labiopexy, Labioplasty, Introidoplasty, Subdermal prepuciplasty,** and **Rejuvenation of the vaginal columnar rugae** with a CO_2 laser and **Hydrodissection** assists in removing adhesions. The reductive procedure also can correct the unnatural look of the clitoral hood.

RK (Q11): I am under the strong influence of your accomplishments in creating numerous new surgical techniques for female urogenital structures. As a gynecologist, I understand developing several new surgical procedures; however, you discovered multiple new anatomical structures; as a gynecologist, I can't comprehend it. Indeed, it is spectacular, breathtaking, and it surprises me that in the 21. Century, new anatomy discovery can occur. Here, the question is, what are anatomists doing? The professor of gynecology makes anatomical discoveries. How has it happened?

AO: At the beginning of my professional life, I decided to learn more about human anatomy. Late on, I tried to implement acquired anatomical knowledge to gynecologic surgery and noticed that the anatomy is disregard in many procedures. Furthermore, I identified anatomical misinformation in traditional textbooks and surgical atlases as

well as in scientific-clinical articles. When I noticed a deficiency in honoring the anatomy, I went to the anatomy dissection room and revisited my specific anatomical concerns during anatomical dissections. The rest is history!

RK (Q12): Which one discovery in anatomy are you assigning the highest rank, and does your ranking correspond with global interest?

AO: I have never contemplated this aspect of my work; although, it is an interesting question. From the clinical perspective, the "urethral stabilizing anatomy" is the number one discovery in my judgment. Based on this discovery, I developed the novel surgical technique for female stress incontinence, which I termed "**urethral stabilization procedure**." Moreover, the actual anatomy study results help me create this technique without using surgical slings or meshes and establish the etiology of female stress incontinence, the most common form of incontinence in women. Other clinicians and scientific-clinical researchers should and will scrutinize those findings, and I am waiting for it very impatiently for any fact. Although the most popular of my work among scientific researchers and media is my discovery of the G-spot anatomy and histology. Nonetheless, satisfied women are the best in my work promotion. Whoever likes to make familiar with my work will find my scientific-clinical articles published in the mainstream peer-review journals and abstracted in PubMed on my website at www.f-sui.com

RK (Q13): Your anatomy studies fundamentally changed our thinking in formulating surgical concepts in gynecology. Can you, professor, furnish us with examples that the anatomy changes the ideas of surgical concepts?

AO: I do consider the anatomy like a "Holy Grail" in surgeries. The anatomy of the urethral stabilizing mechanism in women is a very complex structure. In brief, anatomical suspension and support consist of three independent structures a) Retzius' space, also called the retropubic space; b) subpubic area; c) prepubic space. In the retropubic space, the pelvic ligaments, peri- and para-urethral ligaments, and ischiocavernosus and bulbocavernosus muscles suspense and support the urethra. The pubourethral ligament attaches the urethra to the posterior margin of the pubic bone. The ventral perineal membrane stabilizes the prepubic urethra (the perineal urethra) to the pubic bone, symphysis pubis, and the pubocervical fascia. Laterally, the pubourethral ligament and superior fascia of the levator ani muscle connect the urethral wall. The bulbs of the vestibule surround the proximal perineal urethra. The vaginourethral ligaments, the lateral anterior-distal vaginal wall, and the dorsal perineal

membrane support the posterior urethra. My articles are available on the website (www. F-sui. com). Before my discovery of the adipose sac and my new surgical intervention development, surgeons offered partial resection of the skin and fat of the labia majora. This traditional surgical approach made the labia majora flat and did not correct the underlying cause for labial anatomical deformity. In summary, I like to emphatically stress that the right executed surgery does not exist without intimate knowledge of gross, topographic, functional, and surgical anatomy!!!

Continuation of the dialogue

RK: A language is a tool consisting of an infinite number of words and grammatical rules, but it can generate numerous possible meanings, which allows us to "peek" future elements, e.g., according to the prof. Ryszard Tadeusiewicz's cognitive resonance by using mathematical linguistics, in which statistics can explain a lot but also hide some of the information about words. His independent contribution to science was initiated in 1971 by publishing, quote: "Ontological status of the concept of information." This work was in harmony with the state at that time of physics and philosophy of three types of matter: mass (solids, liquid, gaseous, plasma), energies (not separate from the mass as its kinetic, potential, radial properties), and the third type of matter – information, because a particular structure is always a source of information. Unfortunately, this work was not published despite its acceptance as a philosophy exam in his doctoral procedures. It was also thought that neither mass nor energy could appear or disappear, but that is history. Speaking of information as a third type of matter from a bio-cybernetic perspective, Prof. Tadeusiewicz even considered the principle of entropy to be artificial. But later, he became the first in the world who illustrated it not only by the mathematical presentation.

A while ago, I documented both the existence of information radiation and the time-space information field or Biocosmos in the formula $E=^{i}mc^{2}$. Thus, raising the quantum equivalence of energy (E) and mass (m) to the power of information, I added the information ($=^{i}$) to the existing two properties: energy and mass. This cheng combines the two measurable values of mass and energy, including isolated being, by integrating it into the environment. The boundary separates each being (the isolated part of the cosmos) from the rest of the Biocosmos. The informational space-time is unavoided, but we see the same information, for example, as a horizon line that defines the space still visible by the observer from the part already obscured by the Earth. The boundary line is variable because the horizon plane is perpendicular to the local vertical axis and depends only on its height. After all, every person in the mirror can see his/her

informative multi-dimensional figure. Scientists could recreate the silhouette of the crucified man based on a three-dimensional image fixed on the heavy canvas, the creation of which could be understood after the rediscovery of information radiation as the possible mechanism of the creation of this image on the shroud.[3]

Our theory of cosmic existence has recently been institutionalized by the news that my pupil Prof. Adam Ostrzenski from the USA has been awarded the title of "Visiting Professor" at Padua University, Italy. It is one of the most recognized and sanctified 800-tradition universities globally, where he will teach students and doctors undergoing internships and specializing in gynecological surgery. Padua University also entrusted him with conducting scientific research with the university teams. So, Prof. Ostrzenski, your scientific achievements have contributed to the progress of world medicine, clinical knowledge, and new operating techniques put you firmly into multiple tasks in the Padua University programs and again on the global stage.

AO: May I ask how you, as my mentor, how did you react to this nomination?

RK: Your scientific achievements establish your unquestionable reputation of contributing to the progress of medicine worldwide; your outstanding clinical knowledge and new surgical techniques that you developed gave sound, international clinical recognition by offering you a Visiting Professor position at the Padua University; although, you had held this position in several universities in the globe. I accepted your appointment at such a premier university in Europe with a great deal of emotion and satisfaction. Many scientific and didactic centers around the world have unbridled respect for your scientific and clinical achievements. Respect in the world for achievements is the biggest prize for the mentor and his student.

What was your reaction to the news of your elevation to the rank of a Visiting Professor?

AO: I declined many invitations from different universities for various reasons, but knowing from the literature that Padua University is proud of having Nicolaus Copernicus as a Polish student. I could not resist such an opportunity to be an educator and clinical-scientific researcher in this institution. Before my final decision, I asked you, dear teacher, what do you think about it, and received a short reply: "there is no

[3] *See* the "Additional materials to the Socratic Dialogue", previously held with Prof. Rudolf Klimek; devoted to "*Man's self-portrait image on Turin Shroud*" : *BCnA*_Vol.10(1&2),2020:299. Also, see another publication : Klimek R. *Turin Shroud and* $E=^{i}mc^{2}$ (DOI/doi.org/10.33140/ATCP.04.01.02)

reason to wonder"; and at this point, I knew that it was the correct distinction. Padua University included and embraced me in the academic faculty family and didactic staff of this unique university with great traditions. Today I thank you for another valuable piece of advice.

RK: Padua University Faculty of Medicine is one of the world's oldest universities with enormous scientific and didactic accomplishments and traditions. It was in this institution that Professor Alexandro Benedetti, specializing in human anatomy and surgery who first described the urogenital organs in women and published it in 1493. By doing so he put an end to anatomical comparisons of the urogenital organs in women as underdeveloped male structures. His anatomical works were continued by famous successors such as Gabrielo Fallopian (in the XVI century he discovered fallopian tubes) or Giovanni Battista Morgagni (in the XVIII Century he developed a surgical treatment for vaginal fistulas). Today, Prof. Ostrzenski changed the traditional belief anatomy by combining it inextricably with the information that directs every visible being. What is more, you will be collaborating with the well-known the Department of Human Anatomy at Padua University that is headed by Prof. Rafael De Caro, a well-known anatomist, patho-morphologist, and pathologist in the field of forensic medicine. Additionally, you have been working with Prof. Erich Cosmi from Padua University, the son of my friend late Prof. Ermolando Cosmi. Prof. R. De Caro with his team are researching to verify your new anatomical discoveries. You and Prof. Erich Cosmi conducting a study on how to modify the classic episiotomy and episiorrhaphy. Today traditional episiotomy is responsible for 40% of serious postpartum diseases, particularly superficial dyspareunia. Also, you are one of the lecturers of electronically conducted education by Padua University that These international educations are broadcast all over the world!

AO: With Prof. Erich Cosmi, we are in the process of introducing my new concept of episiotomy that differs from the traditional incision of the perineum and the vagina during natural vaginal delivery. My new surgical idea is to make a small excision of the tissue ring, which creates resistance during the delivery of the fetus. In this method, no perineum muscle is incised, and the hymeneal ring and occasionally the hymeneal plate participate in this excision. Preliminary results of our study indicate excellent surgical outcomes of this new method. Additionally, we evaluate tissue resistances using 5-D ultrasound (manufactured by GE) and recording changes occurring before and after the traditional episiotomy and the new one.

RK: In the middle of the 20th century, I introduced perineum protection at birth using mechanical compression on the perineum while determining the exact one day of the delivery by using the neurohormones and enzymes rather than statistically the week of expecting childbirth, and now you, Prof. Ostrzenski effectively solve the problem with functional anatomy. Congratulations!

How did you arrive at such a surgical concept to replace traditional episiotomy and episiorrhaphy?

AO: My documentation supports the fact that Professor R. Klimek from Poland was ahead of us with understanding the functional processes of the posterior perineum during natural vaginal delivery. You genuinely touch me, Prof. Klimek, noticing my anatomical documentation of this natural event. Furthermore, at a very early stage of my scientific-clinical carrier, you taught me a simple principle: "to look and to see," which are two separate parameters in clinical science. Without their understanding, it is impossible to do much in clinical research. I want to share with you, dear mentor, that I have been implementing this simple principle to this day.

And what is more, I have passed it on to my students, and I am sure they are implementing it in their clinical-scientific life. Once again, I sincerely thank you for surrounding me with fatherly care when I needed it at most. Your bits of advice, which were highly relevant in my new scientific discoveries, contributed, as you say – to the progress in medicine and the development of mentioned at the beginning (and referring to the work of Prof. K.S. Khroutski) – the era of integralism and human civilization!

Closing remarks (by Rudolf Klimek)

You correctly stated that only human gross anatomy vision could create an inadequate or fouls picture. Additionally, interpreting the human body through the prism of cell morphology is also an inadequate representation. The proper understanding of human gross, topographic, functional, and surgical anatomy is very demanding. In 1980, utilizing the US advanced technology of nucleus magnetic imaging, I introduced the clinical differentiation between normal and the premalignant and malignant human cells. This observation led me to form quantum theory in which I connected the morphology, energy, and information that built the foundation for the new informative medicine field. In this theory, a surgeon plays an unusual role because she/he is an individual, regardless of the surgical team and available equipment, who makes the decisions, initiates a surgery within the body of another human being. For instance, transverse stretching of the posterior perineum with fingers in a woman increases neurohormones' secretion. Unnecessary episiotomy and inadequate repair

(episiorrhaphy) lead to permanent dysfunction of the perineum and pain. It requires adequate reconstruction of all fourteen anatomical structures that episiotomy creates; however, the posterior perineum, perineal body, and vaginal anatomy must be mastered by surgeons.

A similar situation is with long-lasting conservative medical treatment of polycystic ovarian syndrome (Stein-Leventhal syndrome). This method leads to ovarian, hypothalamic, and pituitary dysfunction and potentially to ovarian cancer, as the preliminary pathomorphological study demonstrates. A very simple ovarian wedge resection by mini-laparotomy approach or laser vaporization of the tunica albuginea (the technique you Prof. Ostrzenski developed) is correct. Additionally, a Cesarian section performing without establishing and verifying indication for this abdominal surgical delivery is responsible for implantation of endometriosis, a devastating illness. I used those well-known facts to promote your, Prof. Ostrzenski, principles of cosmetic-plastic gynecologic surgeries and connect them with information medicine.

A surgeon is responsible for providing care for a woman's healthy life, including esthetic gynecologic surgery. I also emphasized the surgeon's role as a person in my cosmic being theory, which avoids qualifying human beings with artificial intelligence. For the first time in the Swiss mountains, I observed how human beings' artificial intelligence functions within cheese production industries. With this observation, I transfer it to a surgeon who executes a Cesarean section without medical indication and how he isolates himself emotionally from an established medical indication for this procedure. Furthermore, a patient has the privilege of a comfortable life due to the freedom to choose a lifestyle and overcome internal and external obstacles. Thank the rediscovery of information rays and fields. Peoples are most effectively protected by living according to theological principles, which means that man acts by own and socially acceptable ethical and moral values, which are directly connected with the art of the possible protection of life and restoring people's health. The scope of the means for this purpose is vast, ranging from single words or gestures and ending with space equipment. In this perspective, medicine seems to be "the queen" of all sciences, which obliges doctors and patients to track general knowledge and its technological use continuously. Medicine is one of those unique areas of human activity. Not only is its subject but also, at the same time, the subject of interest, mainly all the theoretical (cognitive) achievements are directly connected with the art of the possible protection of life and health. In 1971, it was predicted that the incidence of cancer would be reduced by half before the end of the 20th century. Later on, it would be eliminated, but instead only increased the fear of the lethal disease.