6. Jinekoloji ve Obstetrikte Tartışmalı Konular Kongresi

02-06 Ekim 2024

NG Phaselis Bay Kemer, Antalya

www.obstetrikjinekolojitartismalikonular.org

BİLİMSEL PROGRAM ve BİLDİRİ ÖZETLERİ KİTABI

İÇİNDEKİLER

ÖNSÖZ

6. Jinekoloji ve Obstetrikte Tartışmalı Konular Kongresi, Kadın Sağlığı alanındaki en güncel tartışmalı konularla ilgilenen, konuşmacılarla katılımcıların birbiri ile etkileşimini yüz yüze görüşebilmesini önemseyen ve buna çok zaman ayrılmasını sağlayan, liyakata dayalı, kaliteyi ön planda tutan bir kongre olacaktır.

Kongremiz, dünya ve ülkemizin en seçkin bilim adamlarının katılımı, onların günlük pratiklerinde klinik ve tedavi konusunda deneyimleri ve karşılaştıkları sorunları etkin bir şekilde tartışma fırsatını sundukları bir ortam hazırlayacaktır.

6. Jinekoloji ve Obstetrikte Tartışmalı Konular Kongresi, Kadın Sağlığı alanında çalışan profesyoneller arasında; bilimsel, eğitsel ve sosyal alışveriş için en yüksek standartta bir forum sunmayı, araştırma ve eğitimi teşvik etme, yeni bilgiyi yayma şeklinde bir misyon üstlenmiştir.

6. Jinekoloji ve Obstetrikte Tartışmalı Konular Kongresine katılın ve şunları yapın:

Obstetrik ve Jinekolojide dünya ve ülkemizin liderleri ile tanışın. Benzersiz bir network platformunda, mesleğinizin diğer uzmanlarıyla görüşmeler sağlayın. Farklı bakış açıları ile diğer uzmanlık alanlarındaki profesyonellerle fikirleri paylaşın. Alanınızla ilgili konular hakkında daha fazla bilgi edinerek uygulamalarınızı zenginleştirin. Sadece 4 gün içinde Obstetrik ve Jinekolojide en yeni bilgilerle buluşun. Birçok konuda lider uzmanları sorgulama fırsatlarına sahip, etkileşimli oturumlara katılın. Diğer ülkelerden en iyi uygulamaları öğrenerek kendi pratiğinizi geliştirin. İlgi alanlarınıza odaklanmış oturumlara katılarak özel bilgilerle donanın. Alışılmışın dışında sunum teknikleri ve oturumları keşfedin. Fikir liderleriyle ilgilendiğiniz konuları birebir sorma şansını yakalayın. Jinekoloji ve Obstetrikte en son çalışmalarınızı poster sunumu veya oral sunumlarla bol bol paylaşın.

Bu toplantı Obstetrik ve Jinekolojide çığır açacak görüldüğü gibi birçok dernek ve fikir liderinin oluşturduğu birleştirici unsurları yüksek bir toplantı olacaktır. Tüm yan dallarla ilgili bilimsel kurullarımız ilgili derneklerimizin yönetimlerinin kararlarıyla oluşturulacaktır. Biz fikir liderleri sadece aracıyız. Tüm derneklerimizin yönetim ve üyeleri ise asıl gücümüz.

Bu derneklere ek katılmak isteyen her dernek veya alanımızdaki kuruluşa da kapımız daima açıktır.

Saygılarımızla,

Kongre Düzenleme Kurulu

JİNEKOLOJİ VE OBSTETRİK TARTIŞMALI KONULAR DERNEĞİ

Başkan
Nejat Özgül

Başkan Yardımcısı
M. Faruk Köse

Genel Sekreter
Mete Güngör

Sayman
M. Murat Naki

KONGRE DÜZENLEME KURULU

KONGRE BAŞKANI

Mete Güngör

KONGRE GENEL SEKRETERİ

M. Murat Naki

KONGRE BİLİMSEL PROGRAM DÜZENLEME KURULU

MATERNAL FETAL TIP
Recep Has
Özlem Pata

ÜREME ENDOKRİNOLOJİSİ VE İNFERTİLİTE
L. Cem Demirel
Murat Sönmezer

MİNİMAL İNVAZİV CERRAHİ
Çağatay Taşkıran
Kemal Özerkan

ONKOLOJİ
Ali Ayhan
U. Fırat Ortaç

GENEL JİNEKOLOJİ
Yakup Kumtepe
Yaprak Üstün

6. Jinekoloji ve Obstetrikte Tartışmalı Konular Kongresi

02-06 Ekim 2024 I NG Phaselis Bay Kemer, Antalya

KONGRE BİLİMSEL KURULU

Abdulkadir Bakay
Ahmet Akın Sivaslıoğlu
Ahmet Aydın Özsaran
Ahmet Barış Güzel
Ahmet Demir
Ahmet Fatih Durmuşoğlu
Ahmet Göçmen
Ahmet Tevfik Yoldemir
Ahmet Zeki Işık
Ali Ergün
Ali Haberal
Ali Küçükmetin
Arif Serhan Cevrioğlu
Atıl Yüksel
Barış Ata
Bülent Urman
Cem Batukan
Cemal Tamer Erel
Cenk Yasa
Cihat Ünlü
Çağatay Taşkıran
Çetin Çelik
Davut Güven
Demir Özbaşar
Derman Başaran
Doğan Vatansever
Ebru Çelik
Emine Karabük
Engin Çelik
Ercan Baştu
Erhan Şimşek
Erkut Attar
Esat Orhan
Esra Bulgan Kılıçdağ
Evrim Erdemoğlu
Fatih Güçer
Fuat Demirkıran
Fulya Kayıkçıoğlu
Gürkan Bozdağ
Gürkan Kıran
Gürkan Uncu
Hakan Seyisoğlu
Hakan Timur
Hakkı Gökhan Tulunay
Hale Göksever Çelik
Hamdullah Sözen
Hasan Onur Topçu
Hüseyin Akıllı
Hüsnü Çelik
Hüsnü Görgen
Işıl Kasapoğlu
Işın Üreyen
İbrahim Bildirici
İbrahim Yalçın
İlkkan Dünder
İsmet Gün
Kadir Güzin
Kayhan Yakın
Kemal Güngördük
Kemal Özerkan
Kutay Ömer Biberoğlu
Levent Keskin
Mehmet Ali Narin
Mehmet Ali Vardar
Mehmet Gökçü
Mehmet Harma
Mehmet Levent Şentürk
Mehmet Macit Arvas
Mehmet Mutlu Meydanlı
Mehmet Vedat Atay
Mehmet Yavuz Salihoğlu
Mete Işıkoğlu
Muhittin Tamer Mungan
Murat Api
Murat Emanetoğlu
Murat Gültekin
Murat Muhcu
Murat Öz
Mustafa Bahçeci
Müfit Cemal Yenen
Müge Harma
Nasuh Utku Doğan
Nilüfer Çetinkaya Kocadal
Nuray Bozkurt
Nuri Danışman
Oğuzhan Kuru
Oluş Api
Orhan Ünal
Osman Fadıl Kara
Ozan Doğan
Ömer Erbil Doğan
Ömer Lütfi Tapısız
Özay Oral
Özcan Balat
Özgüç Takmaz
Özgür Öktem
Özlem Dural
Pınar Çilesiz Göksedef
Ramazan Mercan
Recep Has
Rıza Madazlı
Rifat Hakkı Gürsoy
Ruşen Aytaç
Salih Taşkın
Samet Topuz
Selcan Bahadır
Serdar Aydın
Serkan Erkanlı
Serkan Kahyaoğlu
Servet Özden Hacıvelioğlu
Sinan Beksaç
Sinan Berkman
Suat Dede
Süleyman Engin Akhan
Süleyman Eserdağ
Şadıman Kıykaç Altınbaş
Şafak Olgan
Şevki Göksun Gökulu
Talat Umut Kutlu Dilek
Tansu Küçük
Tayup Şimşek
Tevfik Tugan Beşe
Turgut Aydın
Uğur Fırat Ortaç
Ülkü Özmen
Üzeyir Kalkan
Veli Mihmanlı
Veysel Şal
Yakup Kumtepe
Yakup Yalçın
Yalçın Kimya
Yavuz Emre Şükür
Yılmaz Güzel
Yusuf Üstün
Yücel Karaman
Zeliha Fırat Cüylan

İsimler alfabetik sıralanmıştır.

BİLİMSEL PROGRAM

www.obstetrikjinekolojitartismalikonular.org

2 Ekim 2024, Çarşamba — SALON A

13:00-14:00 — **Panel: Obstetrik Ultrasonografi**

Moderatör: *Atıl Yüksel*

Panelistler: *Özgür Deren, Recep Has, Umut Dilek*

- Normal Bir 2. Trimester Muayenesi Bizi Ne Kadar Güvende Hissettirmeli?
- İntrapartum Yönetimde Ultrasonografi Klinik Muayenenin Yerini Alabilir mi?
- Üçüncü Trimester Ultrasonografisi Sadece Biyometriden mi İbaret Olmalı?
- İlk Trimester Ultrasonografisi ile Preeklampsi ve SGA Tahmini ve Önlenmesi
- Sezaryenle Doğumun Uzun Dönem Komplikasyonlarında Ultrasonografi

14:00-15:00 — **Panel: Polikistik Over Sendromu**

Moderatör: *Rıfat Gürsoy*

Panelistler: *Engin Oral, Gürkan Bozdağ, Ahmet Zeki Işık, Yaprak Üstün*

- Uluslararası Guideline Update
- PKOS'ta Farklı Genotipler Metabolik Sendrom
- Adölesanda PKOS Fertiliteye Etkisi
- PKOS ve Endometrium
- Perimenopozda PKOS
- Tedavi (OK, Miyo-İnositol vs.)

15:00-15:30 — **KAHVE ARASI**

15:30-16:30 — **Panel: Laparoskopik ve Robotik Histerektomi**

Moderatör: *M. Ali Vardar*

Panelistler: *Çağatay Taşkıran, Kemal Özerkan, Salih Taşkın, Derman Başaran*

- vNOTES: Uygulama Alanları, Set-up, Tips &Tricks
- Trokar Yerleşimleri ve Sayısı
- Manipülatör Kullanımı
- Üreter Diseksiyonu
- Kolpotomi Tekniği
- Vagen Kafının Kapatılması
- Zor Histerektomideki Püf Noktaları
- Enerji Modaliteleri
- Adezyon Önleme Yöntemleri

16:30-17:00 — **UYDU SEMPOZYUMU**

Jinekolojik Cerrahide Yenilikler: İleri Mühürleme Teknikleri

Konuşmacı: *Nejat Özgül*

Medtronic

17:00-17:30 — **Açılış Töreni ve Anılarla Prof. Dr. Ali Ayhan**

3 Ekim 2024, Perşembe — SALON A

08:30-09:30

Panel: Preterm Doğum ve Kısa Serviks

Moderatör: *Rıza Madazlı*
Panelistler: *Özgür Deren, Sabahattin Altınyurt, İbrahim Bildirici*

- Birinci ve İkinci Trimesterde Kısa Serviksin Tanımı ve Yol Açtığı Riskler: Servikal Yetmezlik - Erken Doğum
- Asemptomatik Kısa Servikste Tedavi: Progesteron vs. Serklaj vs. Pesser
- Transvajinal vs. Transabdominal Serklaj: Farkları, Kimlere, Ne Zaman?
- Preterm Doğum Eyleminin Tedavisi: Batı Cephesinde Değişen Bir Şey Var mı?
- Preterm Doğum Tehdidinde İdame Tokoliz
- Çoğul Gebeliklerde Erken Doğumu Nasıl Önleyelim?
- Preterm Doğum Kaçınılmaz Olduğunda: Kortikosteroid ve MgSO4'ın Optimal Kullanımı
- Gebelikte Kullanılabilecek Yeni Teknolojiler (Glukoz Takip Cihazları, Tansiyon Takip Cihazları)
- Preterm Doğumu Önlemede Pesser Kullanımı

09:30-10:30

Panel: Histeroskopi

Moderatör: *Bülent Urman*
Panelistler: *Turgut Aydın, Erhan Şimşek, Akın Usta, İlkbal Temel Yüksel*

- Histeroskopi Tekniği - Enstrümanlar
- İnfertilitede Septum Rezeksiyonu; Endikasyonu Var mı?
- H/S Myomektominin Sınırları Nedir? Morselatörlerin Yeri
- Ofis Histeroskopide Ağrı Yönetimi
- Histeroskopide Adezyon Önleme Teknikleri, Jeller
- Menopozal Dönemde H/S; Endikasyonlar & Zorluklar
- Anormal Uterin Kanamada H/S'nin Yeri Ne Olmalı?
- Onkolojide H/S Kullanımının Yeri

10:30-11:00 — **KAHVE ARASI**

11:00-11:45 — **UYDU SEMPOZYUMU**
HPV, İlişkili Hastalıklar ve Kanserler, HPV Aşılarında Güncel Durum
Konuşmacı: *M. Murat Naki*

MSD INVENTING FOR LIFE

3 Ekim 2024, Perşembe — SALON A

11:45-12:45 — **Panel: Menopoz**

Moderatör: *Hakan Seyisoğlu*

Panelistler: *Cihan Uras, Esat Orhon, Fatih Durmuşoğlu, Levent Şentürk*

- AMH Menopozu Öngörmedeki Yeri
- Kardiak ve Metabolik Risklerin Yönetimi
- Vulvo-vaginal Atrofi, Genitoüriner Semptomlar
- Seksüalite
- Menopozda Genel Sağlık
- Menopozal Yakınmaların Klinik Önemi ve Yönetimi
- Menopozal Hormon Tedavisinde Prensipler
- Postmenopozal Osteoporoz ve Tedavide Yenilikler
- MHT ve Meme
- Menopozda Yeni Tedavi Modaliteleri
- Kanser Hastalarında HRT
- HRT Kanser Riskini Artırır mı?
- Erken Menopoz Tedavi Edilmeli mi?

12:45-13:30 — **ÖĞLE YEMEĞİ**

13:30-14:30 — **Panel: Ovulasyon İndüksiyonu**

Moderatör: *Cem Demirel*

Panelistler: *Murat Sönmezer, Davut Güven, Burak Karadağ*

- Anovulasyonun En Rasyonel Tanısı Hangisidir?
- Gonadotropin Tedavisi; Ne Zaman, Hangi Hastaya, Hangi Gonadotropin, Hangi Protokol?
- Fonksiyonel Tedavilerin Yeri (Koenzim Q10 ve Antioksidanlar, Omega 3, D Vitamini)
- Ovulasyon İndüsiyonunda Monitorizasyon; Ultrasonografi mi, Serum Estradiol mü, Oral Preparatlarda da Gerekli mi?
- OHSS ve Çoğul Gebeliklerden Kaçınma Stratejileri Nelerdir?
- Ovulasyon İndüksiyonu Over ve Meme Kanseri Riskini Artırır mı?

3 Ekim 2024, Perşembe — SALON A

14:30-15:00 — **UYDU SEMPOZYUMU**
Uzman Görüşleriyle Vajinitte Güncel Yaklaşımlar
Moderatör: *Fatih Durmuşoğlu*
Konuşmacı: *Koray Görkem Saçıntı*

15:00-15:30 — **KAHVE MOLASI**

15:30-16:00 — **UYDU SEMPOZYUMU**
YASMİN PLUS: Bir OK'dan Daha Fazlası
Konuşmacılar: *Yaprak Üstün, Cihat Ünlü, U. Fırat Ortaç, Özlem Pata*

16:00-17:00 — **Panel: Kontrasepsiyon**
Moderatör: *Erbil Doğan*
Panelistler: *Funda Güngör Uğurlucan, Murat Gültekin, Yaşam Kemal Akpak*

- Oral Kontrasepsiyonda Yenilikler
- Rahim İçi Sistemler
- Cilt Altı Kontrasepsiyon Yöntemleri
- Perimenopozal Kontrasepsiyon

17:00-18:00 — **Canlı Cerrahi (vNOTES Histerektomi)** LIVE
Moderatör: *Salih Taşkın*
Cerrah: *Murat Yassa*

3 Ekim 2024, Perşembe — SALON B

11:45-12:45 — **Video-Sözlü Bildiri Oturumu (SS-01 / SS-10)**
Moderatörler: *Demir Özbaşar, Mehmet Ceyhan*

16:00-17:00 — **Video-Sözlü Bildiri Oturumu (SS-11 / SS-20)**
Moderatörler: *Hamdullah Sözen, Tuğba Tekelioğlu*

4 Ekim 2024, Cuma — SALON A

09:00-10:00

Panel: Ürojinekoloji

Moderatör: *Yusuf Üstün*
Panelistler: *Yakup Kumtepe, Akın Sivaslıoğlu, Cenk Yasa*

- Üriner İnkontinans Hastasında: Doğru Tanı - Doğru Endikasyon
- TOT, TVT Teknikleri Nelerdir, Doğru Teknik Nasıl Olmalıdır?
- Mini-Slingler Alternatif Tedavi midir? (SRS İmplantların Yeri)
- Pelvik Taban Hastalıklarında Kollagen Kullanımının Yeri
- İnkontinansta Laser ve Radyofrekansın Yeri
- Üriner İnkontinansta Doğal Doku Kullanımı: Otolog Fasya ile Pubovajinal Sling
- Arka Kompartman Hastalıkları (Enterosel, Perineal Desensus Sendromu): Tanı ve Tedavisi
- Pelvik Organ Prolapsus Tedavisinde En Uygun Teknik hangisidir? Sakropeksi-Pektopeksi- Lateral Süspansiyon
- Sakrospinöz Ligament Fiksasyonu
- LeFort Parsiyel Kolpoklezis-Total Kolpoklezis

10:00-11:00

Panel: Anormal Uterin Kanamalar

Moderatör: *M. Faruk Köse*
Panelistler: *Hüsnü Çelik, Doğan Vatansever, Emine Karabük, Nil Atakul*

- Anormal Uterin Kanama Sınıflandırması (PALM-COEIN)
- Endometrial Polip-Myom
- Endometrial Hiperplazi (EIN)
- EIN Dışı Hiperplazilere Yaklaşım
- Endometrial Hiperplazi ve Fertilite Korunması
- Medikal Tedaviler (Oral Kontraseptif veya Progesteron Kullanımı)

11:00-11:30 — KAHVE ARASI

11:30-12:00 — UYDU SEMPOZYUMU
Gebelikte Reflü Kontrolü
Konuşmacı: *Ayda Yılmaz*

12:00-13:30 — ÖĞLE YEMEĞİ

4 Ekim 2024, Cuma — SALON A

13:30-14:30 — **Panel: Antenatal Tarama ve Takip**
Moderatör: *Recep Has*
Panelistler: *İnanç Mendilcioğlu, Özlem Pata, Cenk Sayın, Hakan Erenel*
- İleri Anne Yaşı Kavramını Artık Revize Etme Zamanı Gelmedi mi?
- Gestayonel Diabet Taraması Gerekli mi? Gestasyonel Diyabet Taraması Etkinliğini Nasıl Tanımlarız?
- Gestasyonel Diabette Devamlı Glukoz Monitörizayonu
- NIPT Günlük Klinik Pratiğe En Doğru Nasıl Entegre Edilebilir?
- Çoğul Gebeliklerde Anöploidi Taramasını Nasıl Yapalım?
- TORCH Enfeksiyonlarını Rutin Tarayalım mı?
- Gebelikte İmmünizasyonda Güncel Öneriler
- Obezite
- Preklampside Diagnostik Markerlar

14:30-15:00 — **UYDU SEMPOZYUMU**
Cerrahi Alan Enfeksiyon Önlemede PICO ile Yeni Yaklaşım
Moderatör: *M. Murat Naki*
Konuşmacı: *Gürkan Uncu*
Smith+Nephew

15:00-15:30 — **KAHVE MOLASI**

15:30-16:30 — **Panel: Laparoskopik ve Robotik Myomektomi**
Moderatör: *Gürkan Uncu*
Panelistler: *Ahmet Göçmen, Suat Dede, Yılmaz Güzel*
- Trokar Yerleşimi ve Sayıları
- Myomektomi Tekniği
- Sütürasyon Tekniği
- Myomektomide Kanamayı Azaltıcı Yöntemler
- Morselasyon Yöntemleri
- Myomektomi Sonrası Rekürrensin Önlenmesi
- Myomektomi Sonrası Gebelikte Rüptür Riski

16:30-17:30 — **Canlı Cerrahi (Laparoskopik Histerektomi)**
Moderatör: *M. Faruk Köse*
Cerrah: *M. Murat Naki*
LIVE

4 Ekim 2024, Cuma — SALON B

13:30-14:30 — **Video-Sözlü Bildiri Oturumu (SS-21 / SS-30)**
Moderatörler: *Kemal Güngördük, Mustafa Melih Erkan*

15:30-16:30 — **Video-Sözlü Bildiri Oturumu (SS-31 / SS-40)**
Moderatör: *Seda Şahin*

5 Ekim 2024, Cumartesi — SALON A

08:30-09:30

Panel: Endometriozis

Moderatör: *Cihat Ünlü*
Panelistler: *Bülent Urman, Gürkan Uncu, Ayşe Seyhan, Aylin Kuş*

- Endometrioziste Gelecek Biomarkerlar
- Endometrioma-Ağrı İlişkisi
- Endometriozis ve Adenomiyoziste Görüntüleme
- Derin İnfiltratif Endometriozis (Barsak, Mesane, Siyatik Sinir Tutulumları)
- Fertiliteyi Koruma Stratejileri
- Endometriozis İlişkili Over Kanseri
- Cerrahi Tedavi ve Zamanlaması

09:30-11:00

Panel: Fonksiyonel Tıp

Moderatör: *Pınar Yalçın Bahat*
Panelistler: *Mustafa Atasoy, Zuhal Dilek Şanlı, Ekin Fettahoğlu Ünlüer*

- Fonksiyonel Tıp Nedir? Giriş
- Laboratuvar (Östrojenler, Östrojen Metabolitleri, Progesteron, Testosteron, DHEA, SHBG)
- Östrojen Detoksifikasyonu ve Östrojen Dominansı
- Kadında Osteoporoz ve FT: Değerlendirme - Önlem - Geri Çevirme
- Bifosfonat ve Diğer Osteoporoz İlaçları: Kullanmayarak Hastamı Bir Şeyden Mahrum Bırakıyor muyum? Hasta ve İlaç Seçiminde Asgari Bilmemiz Gerekenler
- Menopozda Destek Ürünler Seçerken Nelere Dikkat Edilmeli?
- Jinekolojide Fonksiyonel Tıp Uygulamaları
- Omega 3 Kullanımının Yeri
- Fonksiyonel Tıp Bakışıyla Polikistik Over Sendromu
- Anormal Uterin Kanamalarda Fonksiyonel Tıp ve Progesteron
- Premenstrüel Sendromda Fonksiyonel Tıp
- İnfertilite Tedavilerinde Antioksidanlar
- Obstetrikte Fonksiyonel Tıp Uygulamaları
- Kadın Hastalıkları ve Doğumda Magnezyum
- Gebelik Bulantı-Kusmasında Güncel Yaklaşımlar
- Gebelikte Besin Takviyesi (İyot, D Vitamini, Omega 3

5 Ekim 2024, Cumartesi — SALON A

11:00-11:30 KAHVE ARASI

11:30-12:00 UYDU SEMPOZYUMU
Kadın Sağlığının Yolculuğu: İnfertiliteden Longevity'e
Moderatör: *M. Murat Naki*
Konuşmacı: *Pınar Yalçın Bahat*

12:00-13:00 Panel: Doğum
Moderatör: *Namık Demir*
Panelistler: *Deniz Karçaaltıncaba, Şevki Çelen, Mucize Eriç Özdemir*

- Doğum İndüksiyonunda Doğru Zaman, Hangi Hafta?
- Obstetrik ve Medikal Komplikasyonlarda Doğum Zamanlaması
- İntrapartum Yönetimde Bazı Alışkanlıkları Değiştirmenin Zamanı Geldi mi?
- Omuz Distosisi
- Doğumda Vakum, Forceps Uygulamaları
- Sezaryen Düşünüldüğü Kadar Basit Bir Cerrahi Operasyon mu?
- Sezaryen Sonrası Vajinal Yolla Doğum

13:00-14:00 ÖĞLE YEMEĞİ

14:00-15:00 Panel: Servikal Preinvaziv Lezyonlar Tarama ve Takibi
Moderatör: *U. Fırat Ortaç*
Panelistler: *Nejat Özgül, Çetin Çelik, Coşkun Salman, Oğuzhan Kuru*

- Servikal Kanser Taramasında Güncel Durum
- ASCCP Yeni Sitolojik Yönetim
- ASCCP Yeni Histolojik Yönetim
- Kolposkopi
- Eksizyonel Tedaviler

15:00-15:30 UYDU SEMPOZYUMU
Jinekolojik Cerrahiler Öncesi ve Sonrası Nutrisyonel Stratejiler
Konuşmacı: *Murat Yassa*

15:30-15:45 KAHVE MOLASI

5 Ekim 2024, Cumartesi — SALON A

15:45-16:45 — **Panel: Vaginitler**
Moderatör: *Süleyman Engin Akhan*
Panelistler: *Levent Keskin, M. Baki Şentürk, Seda Şahin*

- Vagen Mikrobiyomu, Vaginal Enfeksiyonlar, Probiyotikler
- Mikrobiyom Analizleri Doğrultusunda Modülasyon
- Vaginit Tanı ve Tedavisi
- Etyoloji, Risk Faktörleri, Semptomlar
- İnflamatuar/Atrofik Vaginit
- Kronik Vaginitlere Yaklaşım
- Rekürren Vulvovaginitler

16:45-17:45 — **Panel: Olgularla Adneksiyel Kitlelere Yaklaşım**
Moderatör: *İlkkan Dünder*
Panelistler: *Müfit C. Yenen, Esra Kuşçu, Samet Topuz, Hamdullah Sözen*

- Adneksiyel Kitlelerin Değerlendirilmesi
- Şüpheli Adneksiyel Kitlelere Yaklaşım
- L/S vs Laparotomi
- Adölesanda Adneksiyel Kitleler
- Gebelikte Adneksiyel Kitleler
- Menopozda Adneksiyel Kitleler

5 Ekim 2024, Cumartesi — SALON B

09:00-11:00 — **Canlı USG Kursu**

12:00-13:00 — **Video-Sözlü Bildiri Oturumu (SS-71 / SS-78)**
Moderatör: *Emine Karabük*

14:00-15:00 — **Video-Sözlü Bildiri Oturumu (SS-41 / SS-50)**
Moderatörler: *Alev Özer, Utku Akgör*

15:45-16:45 — **Video-Sözlü Bildiri Oturumu (SS-51 / SS-60)**
Moderatörler: *Özgüç Takmaz, Ekin Fettahoğlu Ünlüer*

16:45-17:45 — **Video-Sözlü Bildiri Oturumu (SS-61 / SS-70)**
Moderatörler: *Oğuzhan Kuru, Murat Yassa*

6 Ekim 2024, Pazar — SALON A

10:00-11:00

Panel: Kozmetik jinekoloji

Moderatör: *Ozan Doğan*
Panelistler: *Murat Emanetoğlu, Süleyman Eserdağ, Özgüç Takmaz*

- Genital Kozmetik İşlemler İçin Anatomik Değerlendirme
- Kozmetik, Fonksiyonel ve Rejeneratif Jinekolojiye Genel Bakış
- Labioplasti, Klitoral Hoodoplasti ve Frenuloplasti Teknikleri
- Mons Pubis - Venüs Tepesi Estetiği, Labium Majör Hipotrofilerine Cerrahi Yaklaşım
- Kozmetik Jinekolojide Komplikasyon Yönetimi ve Revizyon Uygulamaları
- Genital Bölge Mezoterapisi ve Anti-Aging Uygulamaları (Kollajen, DNA Işıltıları)
- Genital Bölge Rejuvenasyonu ve Renk Açma Teknikleri
- Genital Bölge Kök Hücre ve PRP Uygulamaları (O-Shot, V-Shot, G Noktası Uygulamaları)

11:00-11:30 — KAHVE ARASI

11:30-12:30

Panel: Postpartum Kanama

Moderatör: *Hüsnü Çelik*
Panelistler: *Nuri Danışman, Ali Acar, M. Mutlu Meydanlı*

- Uterin Atoniye Bağlı Kanamayı Nasıl Önleyebiliriz?
- Plasental İnvazyon Anomalilerinde Koruyucu Cerrahi, Plasentayı Yerinde Bırakmak, Histerektomi
- Postpartum Kanama: Eski Yöntemlere Dönüş (PPH Tampon, Balon Tamponad)
- Geç Postpartum Kanama

SÖZLÜ BİLDİRİLER

www.obstetrikjinekolojitartismalikonular.org

SS-001

Endoscopic Removal of Migrated Intrauterine Device From the Bladder

Muhterem Melis Cantürk, Burak Giray, OYTUN Turkkan, Emin Erhan Donmez, Dogan Vatansever, Cagatay Taskiran
Department of Gynecologic Oncology, Koc University Hospital, Istanbul, Turkey

OBJECTIVE: We aim to demonstrate the removal of migrated intrauterin device from the bladder.

METHOD: The video article demonstrates the management of 53 year-old woman who has a history of perforating intrauterine device within the bladder. She had cystoscopic IUD removal three years ago, but en-bloc removal was not achieved. During her follow-up, she complained of hematuria and pelvic pain. Thus total laparoscopic hysterectomy with concurrent cystoscopic removal of IUD was planned. During laparoscopic hysterectomy, pararectal and paravesical spaces were developed. Dense adhesions between the bladder and uterus were present due to the history of the previous two C-sections. The bladder was mobilized, and complete ureteral dissection was performed until the ureterovesical junction. Urinary stones formed around the IUD were removed with YAG Holmium Laser during concurrent cystoscopic examination. IUD was removed from the bladder wall using the advanced bipolar energy system. The defect on the bladder wall was repaired with 3/0 barbed suture. Total laparoscopic hysterectomy with bilateral salpingo-oophorectomy was completed at the end.

CONCLUSION: Although IUD's are safe and effective means of contraception, it may lead rare complications like bladder perforation and migration. Laparoscopy with subsequent cystoscopy is a safe and effective way to manage this rare complication.

Keywords: migrated intrauterine device, cystoscopy, laparoscopy, minimal invasive surgery

SS-002

Total laparoscopic hysterectomy and bilateral salpingo-oophorectomy for suspected bilateral adnexal mass

Nazlı Aylin Vural
Department of Gynecologic Oncology, Yozgat State Hospital, Yozgat, Turkey

A 59-year-old postmenopausal woman, G1P1, with a 7-year history of menopause, presented to the gynecology clinic with complaints of abdominal and lower back pain.

CLINICAL FINDINGS: On vaginal examination, the vulva, vagina, and cervix appeared normal with no gross pathology observed. Ultrasound revealed a normal uterus with a regular endometrial lining. The right ovary measured 45 x 36 mm, and the left ovary measured 36 x 30 mm. Both ovaries exhibited thick and irregular walls with complex cystic formations; the left ovary contained a complex cyst with thin septations. Tumor markers were within normal limits. Further evaluation with pelvic Doppler ultrasound and contrast-enhanced abdominal MRI was performed.

Based on clinical and imaging findings, Total Laparoscopic Hysterectomy (TLH) and Bilateral Salpingo-Oophorectomy (BSO) with intraoperative frozen section analysis were planned. The intraoperative frozen section of the solid areas within the ovarian masses was reported as fibrothecoma. Following this result, the surgery was concluded without further intervention.

CONCLUSION: This case emphasizes the importance of accurate imaging and intraoperative pathology in the management of complex ovarian cysts, especially in postmenopausal women, to differentiate between benign and potentially malignant conditions.

Keywords: complex ovarian cysts, fibrothecoma, laparoscopy

SS-003

Laparoscopic single port ovarian detorsion

Pelin Değirmenci Ayçiçek, Sertaç Ayçiçek
Clinic of Gynecology and Obstetrics, Health Sciences University Gazi Yaşargil EAH, Diyarbakır

CLINICAL PRESENTATION: The patient, a 29-year-old female with three living children, presented to the emergency department with acute abdominal pain. Clinical examination and sonography raised suspicion of right adnexal torsion.

SURGICAL PROCEDURE: A decision was made to proceed with surgical intervention due to the high suspicion of adnexal torsion. Under general anesthesia, a 2 cm incision was made at the umbilicus. The fascia was then extended, and the Gel-Point (Applied Medical, USA) platform was introduced to facilitate single-port laparoscopic surgery. During the procedure, the adnexa was successfully detorsed, and no further complications were e ncountered.Outcome: The patient was successfully treated using single-port laparoscopic surgery, which provided a minimally invasive approach with the advantages of reduced scarring and faster recovery. Postoperatively, the patient had an uneventful recovery and was discharged in stable condition.

DISCUSSION: Adnexal torsion is a gynecological emergency that requires prompt surgical intervention to prevent loss of ovarian function. Single-port laparoscopic surgery offers an effective and cosmetically favorable option for the management of such cases. The use of the Gel-Point platform allows for enhanced maneuverability and visualization through a single incision, which is beneficial in emergency situations like adnexal torsion.

Keywords: Adneksial torsion,Natural orifice surgery,Single port laparoscopy

SS-004

Laparoscopic Management of Isolated Bulky Pelvic Lymph Node

Kerem Yur, Mehmet Öztürk, Seda Şahin
kayseri şehir hastanesi

Laparoscopic Management of Isolated Bulky Pelvic Lymph Node

Keywords: Bulky, Lymph Node, laparoscopic

SS-005

Total laparoscopic hysterectomy with decreasing the uterine size in two steps

Cagla Bahar Bulbul
Department of Gynecology and Obstetrics, Balikesir Ataturk City Hospital, Balikesir, Turkey

BACKGROUND: Laparoscopic hysterectomy is a minimally invasive gynecological surgery that is commonly performed today. The size of the enlarged uterus due to myomas affects the decision to perform hysterectomy laparoscopically or laparotomically. In this video case, laparoscopic hysterectomy was performed after by excising the giant uterine myomas laparoscopically.

OBJECTIVE: To demonstrate laparoscopic hysterectomy of the huge uterus with multiple myomas.

METHODS: We present a 46-year-old G2P2 (C/S) patient evaluated in the gynecology clinic for menometrorrhagia for 2 years despite the LNG-IUD. According to the MRI report, the size of the uterus has increased significantly. Heterogeneous enhancing myomas, the largest of which reached 4 cm, were observed in the enlarged uterus. The patient underwent laparoscopic hysterectomy, after decreasing the size of the uterus with laparoscopic myomectomy.

RESULTS: After excision of 15 myomas, the patient was successfully performed laparoscopic hysterectomy with no acute complication and bleeding.

CONCLUSION: This video reviews the laparoscopic management of a huge uterus with multiple myomas. Minimally invasive gynecological surgeries are preferred by patients over laparotomic surgeries in terms of reduction in postoperative pain, shorter hospital stay and faster healing. Hysterectomy operation for the enlarged uterus due to myomas can be performed as laparoscopic hysterectomy by decreasing the size of the uterus.

Keywords: laparoscopy, hysterectomy, myomas

SS-006

Minimally invasive surgical treatment of cornual ectopic pregnancy

Pelin Değirmenci Ayçiçek, Abdullah Acar, Fuat Bozan, Sertaç Ayçiçek
Gazı Yaşargil Training and Research Hospital, Diyarbakır, Turkey

CASE PRESENTATION: Patient Information:Age: 32 years oldGravida: 2Parity: 1 (1 living child)Obstetric

HISTORY: Previous tubal ectopic pregnancy treated with left salpingectomy.Presenting Complaint: The patient presented to our emergency department with vaginal bleeding. She had been referred from another center due to persistent high beta-hCG levels, despite having undergone two dilation and curettage (D&C) procedures.

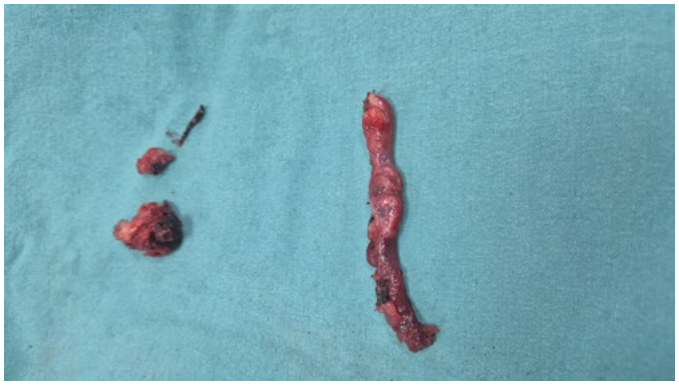
CLINICAL FINDINGS: Ultrasound Examination: Transabdominal and Transvaginal Ultrasound: Free fluid in the endometrial cavity.Both ovaries appeared normal. A suspicious gestational sac, potentially containing an embryo, was identified in the right cornual region of the uterus.Surgical Intervention:Procedure: The patient underwent laparoscopic surgery under general anesthesia.A right cornual pregnancy was excised.The cornual defect was closed with 1-0 Vicryl sutures.A right salpingectomy was also performed.The surgical specimen was removed using a Gel-Point (Applied Medical, USA) platform through the umbilicus, within an endobag.

DISCUSSION: Cornual Pregnancy and Minimally Invasive Surgery: Cornual pregnancies are rare and account for 2-4% of ectopic pregnancies. They are associated with a high risk of rupture due to the myometrial stretching capacity of the uterine cornua, which can lead to life-threatening hemorrhage. Minimally invasive surgery, particularly laparoscopy, is the preferred method for the management of cornual pregnancies when feasible. Laparoscopy offers several advantages, including reduced postoperative pain, shorter hospital stays, and quicker recovery times compared to open surgery.During the laparoscopic approach, care must be taken to excise the gestational sac completely, followed by meticulous suturing of the cornual defect to prevent future uterine rupture, especially in cases where the patient desires future fertility. In this case, the use of 1-0 Vicryl sutures ensures proper closure of the defect. Furthermore, the surgical removal of the specimen using an endobag prevents spillage and potential spread of trophoblastic tissue, reducing the risk of postoperative complications.

CONCLUSION: This case highlights the successful management of a cornual pregnancy via laparoscopic surgery, demonstrating the effectiveness of minimally invasive techniques in treating this rare and potentially dangerous condition.

Keywords: Cornual ectopic pregnancy,Minimal invasive surgery, Umblicus natural orifice

Cornual ectopic pregnancy and salpenx specimen



SS-007

Umblikal Natural Orifice Transluminal Endoscopic Hysterectomy

Sertaç Ayçiçek, Pelin Değirmenci Ayçiçek
Gazı Yaşargil Training and Research Hospital, Diyarbakır, Turkey

Abnormal uterine bleeding (AUB) is a common gynecological issue, particularly among women approaching menopause. When conservative treatments fail, surgical management becomes necessary. In this case, we discuss a 49-year-old female with treatment-resistant AUB and a pathology report indicating simple endometrial hyperplasia without atypia.

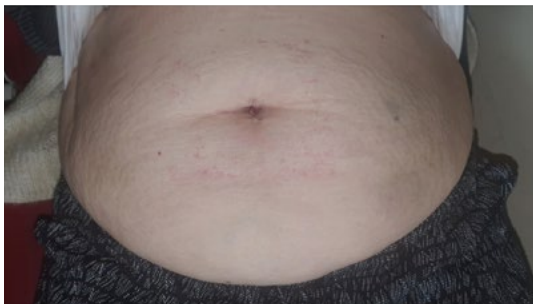
CASE PRESENTATION: The patient, a 49-year-old female, presented with persistent abnormal uterine bleeding unresponsive to medical management. Histopathological examination revealed simple hyperplasia without atypia. Given the chronicity of symptoms and histopathological findings, a hysterectomy was indicated. The surgical team opted for a Single Port Laparoscopic Hysterectomy, utilizing a single port (Applied Medical, USA) inserted through the umbilicus. This natural orifice approach was chosen to enhance recovery, reduce postoperative pain, and improve cosmetic outcomes. The procedure was completed successfully without intraoperative or postoperative complications.

Single Port Laparoscopic Hysterectomy has emerged as an effective minimally invasive surgical option, particularly advantageous in cases requiring uterine removal due to its reduced morbidity compared to traditional methods. The use of the umbilicus as a natural orifice for port entry minimizes visible scarring and accelerates recovery. This technique is supported by studies indicating favorable outcomes in terms of patient satisfaction, reduced pain, and shorter hospital stays.

For patients with treatment-resistant AUB and benign pathology, Single Port Laparoscopic Hysterectomy via a natural orifice offers a promising surgical approach with minimal invasiveness. This case underscores the efficacy and safety of the technique in managing complex gynecological cases.

Keywords: Abnormal Uterine Bleeding, Single port laparoscopy, Umblicus natural orifice

Post-operative 10. Days



SS-008

Laparoscopic isthmosel surgery

Sertaç Ayçiçek, Pelin Değirmenci Ayçiçek, Ahmet Değirmenci
Clinic of Gynecology and Obstetrics, Health Sciences University Gazi Yaşargil EAH, Diyarbakır

A 32-year-old female with a history of three previous cesarean sections presented to our clinic with complaints of abnormal uterine bleeding. Given her surgical history and clinical presentation, further evaluation was necessary to determine the underlying cause.

The patient underwent a thorough diagnostic workup, including a transvaginal ultrasound and a saline infusion sonohysterography (SIS). These imaging studies revealed the presence of an isthmocele, a defect at the site of the previous cesarean scar. According to the PALM-COEIN classification system, this condition falls under the “N” (Not otherwise classified) category, specifically related to structural abnormalities.

The diagnosis of isthmocele was confirmed based on the imaging findings, which showed a significant defect in the myometrium at the site of the previous cesarean scar. This defect was consistent with the patient’s symptoms of abnormal uterine bleeding, as the isthmocele can lead to blood pooling and subsequent irregular bleeding patterns.

Given the confirmed diagnosis and the patient’s symptoms, surgical management was recommended. The patient underwent laparoscopic isthmocele repair under general anesthesia. This minimally invasive approach was chosen to repair the defect and alleviate her symptoms, with the goal of improving her overall quality of life and reducing the risk of further.

The laparoscopic surgery was completed successfully with no intraoperative or postoperative complications. The patient was discharged in stable condition and scheduled for follow-up visits to monitor her recovery and ensure the resolution of her symptoms.

This case highlights the importance of considering isthmocele as a differential diagnosis in patients with a history of cesarean sections who present with abnormal uterine bleeding. Laparoscopic repair under general anesthesia offers a safe and effective treatment option for this condition, leading to symptomatic relief and improved patient outcomes.

Keywords: İsthmosel, Minimal invsive surgery, Vaginal bleedding

SS-009

V-NOTES Hysterectomy + left salphingoopherectomy + right salphingectomy

Merve Savaş, Çiğdem Koç Doğrul, Duygu Çoban, Nayif Çiçekli, Fatih Celik
Department of Obstetrics and Gynecology, Afyonkarahisar Health Sciences University

In this case report, A 49-year-old female patient applied to us due to abnormal uterine bleeding. In the patient’s anamnesis, her Gravida was 4,Parity was 2 (spontaneous vaginal delivery). In the transvaginal ultrasound, the uterus was antevert and anteflex, an intramural myoma of approximately 3 cm in size was observed in the corpus anterior, and an intramural myoma of approximately 4 cm in the corpus posterior was observed. Multiple subserous myomas, the largest of which was approximately 3 cm, were observed in the fundus. The endometrium double wall thickness was 10 mm, the right ovary was normofollicular, and an approximately 3 cm anechoic cyst was observed in the left ovary. As endometrial polyp was observed in the patient’s endometrium curettage material and the patient’s bleeding complaints continued, treatment options were offered to the patient. The patient was admitted to the ward for the operation.

Keywords: v-notes, hysterectomy, oophorectomy, naturalorificesurgery

SS-010

Vaginal Natural Orifice Transluminal Endoscopic Hysterectomy

Sertaç Ayçiçek, Pelin Değirmenci Ayçiçek
Gazı Yaşargil Training and Research Hospital, Diyarbakır, Turkey

Surgical Case Presentation

Patient Profile:

Age:52

Parity: 3 living children

Medical History:Abnormal Uterine Bleeding (AUB)

Additional Medical History:Premenopausal, no history of systemic diseases or major surgical interventions.

Allergies:No known drug allergies.

Chief Complaints: The patient presented with progressively worsening heavy and irregular vaginal bleeding for the past 6 months.

The bleeding often occurred outside of menstrual periods, was clot-heavy, and sometimes painful. Recently, the intervals between periods have shortened, and the duration of bleeding has increased. The patient also reported fatigue, weakness, and dizziness.

Diagnostic Evaluation:

Physical Examination: Bimanual pelvic examination revealed a midline, enlarged, and tender uterus.

Ultrasonography: Transvaginal ultrasound showed the uterus to be of 12-week gestational size with an increased endometrial thickness. Heterogeneity in the myometrium was noted, raising suspicion for an endometrial polyp or submucosal fibroid.

Laboratory Tests: Hemoglobin level was 10.2 g/dL, with other routine biochemical parameters within normal limits.
Endometrial Biopsy:Histopathological evaluation showed hyperplastic endometrium with no evidence of malignancy.

Surgical Indication:

The abnormal uterine bleeding did not respond to conservative management.

Given the uterine enlargement and potential risk of malignancy, a hysterectomy was recommended.
Considering the patient's preference and clinical condition, a Vaginal Natural Orifice Transluminal Endoscopic Surgery (vNOTES) hysterectomy was planned.

Surgical Procedure:

Surgical Technique: Vaginal Natural Orifice Transluminal Endoscopic Surgery (vNOTES)

Procedure:

The patient was positioned in the lithotomy position under general anesthesia.

A vaginal cuff incision was made to gain access to the peritoneal cavity via the vaginal route.

Endoscopic ports were placed, and CO2 insufflation was performed.

Laparoscopic instruments were used to free the uterus, bilateral fallopian tubes, and ovaries.
The uterus was removed via the vaginal route.
Hemostasis was carefully achieved with minimal intraoperative bleeding.

The vaginal cuff was closed using absorbable sutures.

Postoperative Care:

Early Postoperative Period:The patient was awakened from anesthesia without issues. The bleeding was minimal.
First 24 Hours:Oral intake was well tolerated, and mobilization was achieved. Postoperative pain was successfully managed with oral analgesics.

Discharge:The patient was discharged on postoperative day 2 without complications.

Histopathological Examination:** The histopathological analysis of the uterus and adnexa revealed no malignancy, with findings of diffuse adenomyosis and simple endometrial hyperplasia.

Outcome:

The patient presented for follow-up at 6 weeks postoperatively with no complaints. Complete healing of the surgical site was observed.

The vNOTES approach was successfully applied in this patient group, proving to be a safe and effective surgical method.

DISCUSSION:

-Hysterectomy via vNOTES provides the advantages of a minimally invasive approach, including less postoperative pain, faster recovery, and cosmetic benefits, along with a low complication rate.

-This case highlights the effectiveness of the vNOTES technique in the surgical management of abnormal uterine bleeding in patients transitioning to menopause.

Keywords: Abnormal Uterine Bleeding, Hysterectomy,V-NOTES

SS-011 [Endoskopi]

Bladder injury in a difficult (highly adherent and previous three cesarean sections and appendectomy) laparoscopic hysterectomy case

Sertaç Ayçiçek, Pelin Değirmenci Ayçiçek
Gazı Yaşargil Training and Research Hospital, Diyarbakır, Turkey

A 49-year-old female patient presented with treatment-resistant abnormal uterine bleeding. Her surgical history was notable for three previous cesarean sections and an appendectomy. During preoperative evaluation, the patient tested negative for HPV, and an endometrial biopsy revealed simple hyperplasia without atypia. Ultrasonographic examination identified a 3 cm subserosal fibroid located laterally in the uterus.

The patient's history of multiple abdominal surgeries, combined with the presence of a subserosal fibroid and uterine hyperplasia, presented a complex case requiring surgical intervention. Given the persistent symptoms and the ultrasound findings, a laparoscopic hysterectomy was indicated.

During the laparoscopic hysterectomy, significant adhesions were encountered due to the patient's previous surgeries, particularly around the lower uterine segment and bladder. These adhesions made the dissection challenging, increasing the risk of complications. During the procedure, a bladder injury occurred, necessitating immediate repair. The patient's surgery was continued with a laparotomy. The damage to the bladder dome was sutured 2 layers with 2.0 Vicryl.

The surgery was completed successfully despite the complications, and the patient was transferred to the recovery room in stable condition. Postoperative follow-up included monitoring for urinary complications and ensuring the integrity of the bladder repair. The patient's recovery was uneventful, and her symptoms of abnormal uterine bleeding were resolved.

This case illustrates the challenges of performing laparoscopic hysterectomy in patients with a history of multiple abdominal surgeries. The presence of significant adhesions and a subserosal fibroid added to the complexity of the procedure, leading to a bladder injury. In this case, laparotomy was decided and the bladder injury was repaired by open surgical technique.

Keywords: Bladder injury, Difficult hysterectomy, Minimal invasive surgery

SS-012

Single porte salphingooferektomi

Halil İlhan[1], Sertaç Ayçiçek[2]
[1]Firat University Faculty of Medicine Gynecology and Obstetrics Clinic, Elazığ, Turkey
[2]Gazi Yasargil Training and Research Hospital Gynecology and Obstetrics Clinic, Diyarbakır, Turkey

Single-port laparoscopy was developed in minimally invasive surgery about thirty-five years ago. Single-port laparoscopy has had a positive impact on standard laparoscopy. Undoubtedly, single-port laparoscopy is technically more challenging than straight laparoscopy, even with flexible instrumentation, but we are still on the initial learning curve. Single port laparoscopy is superior to conventional laparoscopy in terms of tissue removal. In addition, surgery has become easier with recently developed instruments. Especially in large adnexal or uterine masses, single port surgery through the umbilicus has made tissue removal very easy.

In this video case presentation, we removed a twelve centimeter adnexal cyst that met the benign criteria very easily through a single port surgical platform from the umbilicus. In the subsequent controls, the patient's abdominal incision remained as a minimal scar.

A 52-year-old, menopausal patient presented to our clinic with abdominal pain. On examination and sonographic examination, a cystic structure of approximately 120 mm in diameter without solid areas was observed in the left adnexal area. According to IOTA criteria, the patient had a benign mass with negative tumor markers and left unilateral salphingooferectomy was planned in the absence of uterine pathology.

Under general anesthesia, the patient underwent left USO with a GelPoint (Aplied Medical, USA) apparatus placed through a 2 cm incision made in the umbilicus region and the surgical specimen was removed through the same incision. No complications were encountered during and after the operation.

Keywords: Adnexal surgery, Single port laparoscopy, Tissue removal techniques

SS-013

Treatment of recurrent POP with vaginal assisted laparoscopic hysterectomy and modified lateral suspension

Hümeyra Elif Ateş Eminoğlu, Sertaç Ayçiçek
Clinic of Gynecology and Obstetrics, Health Sciences University Gazi Yaşargil EAH, Diyarbakır

Laparoscopic lateral suspension using mesh is a minimally invasive technique that effectively treats POP. We present a modified technique of laparoscopic lateral suspension that differs from previously described methods. The prominent differences are as follows: first, our modified technique uses Mersilene tape on a 48-mm round-bodied needle (Ethicon Inc, Somerville, NJ,USA). We suspend the vaginal vault, taking a double bite using Mersilene tape without knotting placed as a transversal hammock. Thanks to the Mersilene tape, meshes, sutures, tackers, or fasteners are not needed. Mersilene tape ensures much easier suturing and an inexpensive artificial material. The second difference is that port placement sites. The third difference is the number of incisions we make. We do not need 2 additional incisions as used in previously described methods references. We use the same incision for lateral trocar insertion and for pulling out the distal end of the Mersilene tape, which is 2 cm above the iliac crest and 4 cm posterior to the anterior superior iliac spine. Our technique has the potential to be easier, shorter, more cost-efficient, less invasive, and safer when compared with previously described methods.

45 years old, G4P4A0Y4. 2 times c/s, abdominal sacrohysteropexy 8 years ago in an external center, L/S Lateral süspansiyonàbatın intra süspansiyonàbatın advanced degree yapışıklıkàSSLP history 1 year ago. No systemic disease. JM: Elongated cervix, stage 3 anterior and stage 3 apical prolapse. Stage 1 posterior prolapse. No symptoms of stress or urge incontinence. USG and Pelvic MRI: Uterine endometrium intracavitary 59 mm submucous myoma was observed. Smear and HPV: negative. P&C: Endometrial polyp? TLH+ Modified Lateral Suspension in GAA'' Mülayim Technique'' was performed. Intra-abdominal advanced omentum and intestinal adhesions were removed. Operation time: 120 minutes. Amount of bleeding: 300 cc. Used manipulator: Rumià Curette. Energy modulator used: Ligasure. Abdominal access technique: Direct trochear through the upper 3 cm of the umbilicus.

Keywords: Laparoscopic hysterectomy, laparoscopic lateral suspension, Recurrent POP

SS-014

Step-by-step guide to performing in-bag morcellation in gynecologic surgery

Gozde Unsal[1], Mehmet Ceyhan[2], Ozguc Takmaz[1], Mete Gungor[1]
[1]Department of Obstetrics and Gynecology, Acibadem MAA University, Istanbul,Turkey
[2]Department of Obstetrics and Gynecology, Acibadem Maslak Hospital, Istanbul,Turkey

In-bag morcellation is a surgical technique used during minimally invasive gynecologic procedures, such as fibroid or uterus removal. The goal is to minimize the risk of spreading tissue, especially in cases where undiagnosed cancer may be present. This technique involves isolating the tissue inside a sterile containment bag before it is morcellated.

The process begins after the tissue is detached from the surrounding structures. A morcellation bag is inserted into the abdomen through a small incision. The tissue is placed inside the bag, and the opening of the bag is pulled through the incision, leaving the tissue contained. The bag is then inflated, allowing the surgeon better visibility and room to work.

Using a morcellator, the tissue is cut into smaller fragments, all while remaining inside the containment bag. This prevents any tissue from spreading into the abdominal cavity. Once morcellation is complete, the tissue fragments are removed along with the bag, ensuring that no tissue escapes.

In-bag morcellation reduces the risk of tissue dissemination, providing a safer option for tissue removal in minimally invasive surgeries, especially when there is a potential cancer risk.

Keywords: in-bag morcellation, fibroid, leiomyoma, minimally invasive surgery

SS-015

Ovarian Torsion, Tell me ICG *Death or Alive?*

Mustafa Melih Erkan
Department of Obstetrics and Gynecology, Medicana International Izmir Hospital, Izmir, Turkey

It is very important to evaluate ovarian reperfusion after ovarian detorsion. Today, this decision is made only by clinical evaluation. Unfortunately, this routine practice is not considered sufficient. Using indocyanine green represents a valid option to evaluate ovarian perfusion after detorsion. This practice could help the surgeon decide to preserve the ovary and thus allow fertility-sparing surgery. Here, we describe the successful intraoperative use of ICG in a 30-year-old female patient with adnexal torsion who underwent a robotic detorsion and cystectomy and ovary-preserving surgery.

Keywords: adnexal torsion, fluorescence guides surgery, indocyanine green, ovarian conservation

SS-016

Case Series of Laparoscopic Modified Radical Hysterectomy for Advanced Endometriosis Conducted at a Single Center

Emre Biton, Kemal Güngördük
Division of Gynecologic Oncology, Department of Obstetrics and Gynecology, Faculty of Medicine, Muğla Sıtkı Koçman University, Muğla, Turkey.

AIM: To describe the feasibility and detail the particular method employed for performing laparoscopic modified radical hysterectomy in a study conducted at a single center, which included patients with advanced endometriosis and obliterated pouch of Douglas.

METHOD: Our facility conducted a review of laparoscopic modified radical hysterectomy procedures carried out between 2016 and 2024. These surgeries were all conducted by a single surgeon, and patient data was gathered in a retrospective manner.

RESULTS: Twenty-three women diagnosed with severe endometriosis underwent a minimally invasive surgical procedure. The average age of the patients was 42.5 ± 5.2 years, and 39.1% of them were nulliparous. Among these patients, 39.1% had rectal shaving (n = 9), 8.7% had discoid resection (n = 2), and 8.7% underwent rectal resection (n = 2), with protective ileostomy performed in 2 cases. All women received ureterolysis and extensive adhesiolysis. The average duration of hospital stay was 3.9± 0.9 days. Complications following surgery were observed in 30.4% of the patients (n = 7). Self-catheterization was necessary for two patients for less than 21 days. One patient experienced ureteral injury and was managed using double J catheterization and observation. The emergency reoperation rate was 8.7% due to anastomosis leakage. Two patients were readmitted and received treatment with antibiotics and drainage for a Douglas hematoma. The surgeon's report from the operation indicated that endometriosis resection was successfully completed in 91.3% of the 21 patients. The average follow-up period lasted 24 months (interquartile range: 4 to 56 months), and around 83% of the patients showed signs of improvement.

CONCLUSION: Conducting a hysterectomy on patients diagnosed with advanced endometriosis and complete obliteration of the pouch of Douglas necessitates highly skilled and trained surgeons due to its inherent complexity. Laparoscopic modified radical hysterectomy is a reliable procedure with a low rate of severe complications.

Keywords: Endometriosis, Laparascopy, Hysterectomy,

SS-017

Laparoscopic removal of multiple fibroids from the umbilicus, a natural embryologic orifice

Pelin Değirmenci Ayçiçek, Sertaç Ayçiçek
Clinic of Gynecology and Obstetrics, Health Sciences University Gazi Yaşargil EAH, Diyarbakır

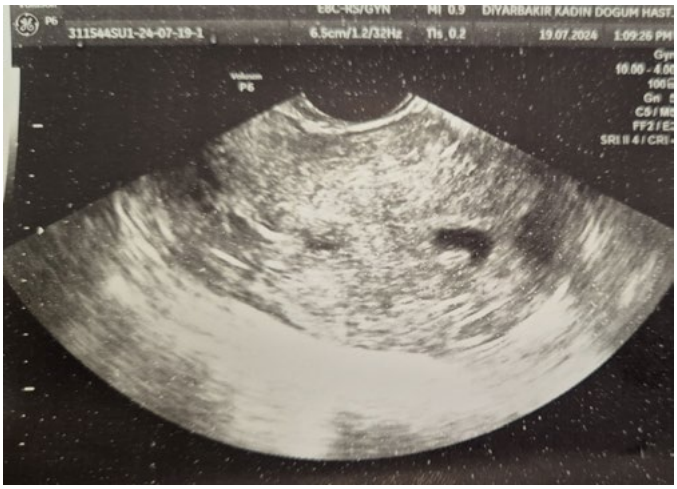
CLINICAL FINDINGS: The patient, a 35-year-old nulliparous woman, presented with a history of treatment-resistant abnormal uterine bleeding. Transvaginal ultrasound revealed the presence of multiple uterine fibroids (myomas) of varying sizes.Surgical Procedure: Under general anesthesia, a 2 cm incision was made at the umbilicus, and the fascia was widened to facilitate the laparoscopic approach. A conventional laparoscopic myomectomy was performed, during which multiple myomas were excised. The myoma beds were sutured in 2-3 layers to ensure hemostasis and minimize the risk of adhesions. To remove the excised myomas from the abdominal cavity, a Gel-Point (Applied Medical, USA) system was utilized. The tissue was enclosed in an Endobag and extracted through the umbilical port. Fascia repair was performed at the end of the procedure.

DISCUSSION: Laparoscopic myomectomy is a minimally invasive surgical procedure that allows for the removal of uterine fibroids while preserving the uterus. This approach is particularly beneficial for women who wish to retain their fertility. The use of single-port laparoscopy, especially through the umbilical route, offers cosmetic advantages due to the hidden scar within the umbilicus and may reduce postoperative pain and recovery time.In this case, the Gel-Point system was used to facilitate the removal of multiple fibroids via the umbilical incision. This technique helps minimize tissue trauma and reduces the risk of spreading potentially malignant cells during morcellation. Studies have shown that this method is safe and effective for the extraction of large or multiple fibroids during laparoscopic myomectomy.

CONCLUSION: The combination of conventional laparoscopic myomectomy with single-port tissue extraction via the umbilicus provides a feasible and cosmetically superior approach for the management of multiple uterine fibroids. The technique described in this case highlights the importance of advanced surgical methods in optimizing patient outcomes and preserving reproductive potential.

Keywords: Natural orifice surgery, Myomectomy, Single port laparoscopy, Umblicus,

Post-operative 10. Days



SS-018

The relationship between follicular fluid melatonin level and age in patients with low ovarian reserve

Ömer Fatih Koparir, Nil Atakul, Ayşe Nur Işık Aydın
Istanbul Training and Research Hospital

The etiological and pathological mechanisms of is low ovarian reserve (LOR) depend on multifactorial factors, mainly including age, immunity, genetics, chemoradiation and environmental factors. However, the actual cause is still unknown. Follicle fluid is directly related to the quality of the oocyte and the formation and development of the embryo. Follicle fluid content is closely related to follicular development and oocyte quality and can be used to investigate various ovarian dysfunctions. In our study, we aimed to investigate the relationship between follicular melatonin levels and age and sex hormone levels in LOR patients. Our prospective case-control study was conducted between January 2024 and May 2024 in 48 and 49 patients diagnosed with LOR and tubal factor infertility patients, using data from the follicular fluid obtained during oocyte retrieval. In the LOR group, no statistically significant difference was found between the levels of melatonin and Anti-Mullerian hormone (AMH), follicle stimulating hormone (FSH), luteinizing hormone (LH), eaterdiol (E2), thyroid stimulating hormone (TSH), prolactin (PRL). The LOR group was divided into 4 main age groups (24-30, 31-35, 36-40, > 40 years). The lowest melatonin level was found in the 24-30 age group, although no statistical significance was found (165.24(93.11-238.05) (pg/mL).

The presence of free oxygen radicals in the follicular fluid and the lack of molecules that act as antioxidants can negatively affect the oocyte. It is known that the function of melatonin on reproduction is a result of its antioxidant effect against oxidative stress. Pierre-Emmanuel Bouet et al. In their study in 2020, they compared two subgroups of 15 young LOR patients and 15 old normal ovarian reserve, PDGF-BB concentration was found to be significantly lower in the follicular fluid of 15 young LOR patients compared to 15 old NOR (normal ovarian reserve) patients ($p = 0.0079$). With this result, they emphasized the decrease in PDGF-BB concentration in the follicular fluid regardless of chronological age. Although it was not statistically significant in four age groups in DOR patients, the lowest melatonin level was found in patients between the ages of 25-30. In this case, we think that oxidative damage may play a role in the etiopathogenesis of DOR regardless of age and that early therapeutic strategies may increase reproductive success. In our study, no correlation was found between follicular fluid melatonin level and AMH, FSH, and other hormones. Zheng et al. In their study, follicular fluid melatonin concentrations can be significantly and positively correlated with serum AMH levels and lower basal serum FSH levels. as follicular fluid melatonin protects preantral follicles and small antral follicles from atresia Melatonin concentration in follicular fluid is correlated with antral follicle count (AFC) and in vitro fertilization (IVF) outcomes in women undergoing assisted reproductive technology (ART) procedures. However, in their study, the relationship between sex hormone and follicular fluid melatonin levels was not evaluated on a group basis. Since our study was an evaluation conducted only in the LOR group, it provides a better understanding of the oxidant-antioxidant mechanism of LOR.

Keywords: Low ovarian reserve, Melatonin, Age

Correlation Analysis Between Melatonin Level and Other Parameters in LOR Case Group-I

		AMH	FSH	LH	E2	TSH	PRL
Melatonin level	r	-0,187	0,021	-0,116	0,185	0,066	0,172
	p	0,204	0,887	0,434	0,209	0,655	0,242

SS-019

Analysis of research trends on antioxidant therapy for female infertility based on a bibliometric analysis (1994-2024)

Serap Topkara Sucu
Ankara City Hospital, Gynaecology and Obstetrics Clinic

AIM: Infertility is defined as the inability of a couple to become pregnant after one year of unprotected sexual intercourse. About 8% to 12% of couples of reproductive age worldwide suffer from infertility problems. There is an ongoing debate about the addition of extra antioxidants in the treatment of infertility and which supplement is better, and numerous studies have been conducted on the subject. Oxidative stress and free radicals significantly affect ovulation, folliculogenesis, oocyte maturation, implantation, and embryo development. Therefore, it is recognized as one of the main factors for infertility. Bibliometrics is a quantitative statistical analysis method used to analyze and evaluate research points and trends. This approach has already been applied in various fields, including basic medicine, surgery, and psychology. The aim of this study is to facilitate the identification of some future research directions and to highlight trends and gaps in the field by systematically summarizing the existing literature on antıoxıdant therapies for infertility through a bibliometric analysis.

MATERIAL-METHODS: The article search was conducted in the Web of Science Core Collection (WoSCC) database on July 28, 2024. Bibliometric data on different types of publications with the keywords antioxidants and female infertility between 1995 and 2024 were retrieved.

RESULTS: Between 1995 and 2024, a total of 519 publications on antioxidants and infertility were found in WOS. The peak years were 2022 (66 publications), 2023 (60 publications) and 2020 (56 publications); the type of publication was mainly original articles (380), review articles (137) and book chapters (8); the most analyzed countries were the USA (82), Iran (69) and China (66); the publications were mainly in English (510); most publications were included in the SCI-E (408), ESCI (105) and BKCI-S (5) indices.

DISCUSSION: There are numerous studies on using antioxidants in ovarian hyperstimulation protocols to improve ART outcomes, delay ovarian aging caused by repeated ovarian hyperstimulation, and reduce inflammation. Resveratrol, N-acetylcysteine, curcumin, coenzyme Q10, alpha lipoic acid (ALA), vitamin C, vitamin E, melatonin, and growth hormone are the most studied antioxidant agents for reducing oxidative stress associated with ovarian reserve used in various protocols in the treatment of infertility. In our analysis, vitamin E was the most studied compound with 12 studies, melatonin 11, selenium 8, vitamin C 6, resveratrol 6, coenzyme Q 6, sirtuins 4, quercetin 3, lycopene 3.

CONCLUSION: This study uses a bibliometric analysis to show current research characteristics and trends in reproductive medical treatment. The research focuses mainly on infertility and antioxidant therapy. These findings are valuable to researchers as they help them identify future research directions and recognize and solve potential challenges.

Keywords: Infertility,Antioxidants,Bibliometrics

The cluster of keywords related to antıoxıdants and infertility

Tablo 1: Top 10 productive journals

Rank	Journal title	Article count	Citation
1	Antioxidants	16	241
2	International Journal of Molecular Sciences	15	181
3	Reproductive Sciences	10	151
4	Reproductive Biology and Endocrinology	9	2346
5	Reproductive Biomedicine Online	8	789
6	Oxidative Medicine and Cellular Longevity	8	468
7	Andrologia	8	132
8	Fertility and Sterility	7	1462
9	Human Reproduction	7	557
10	International Journal of Reproductive Biomedicine	7	114

Tablo 2: Top 10 productive countries

Rank	Country	Article count	Citation
1	USA	81	7009
2	IRAN	68	717
3	CHINA	65	1571
4	ITALY	38	1013
5	TURKEY	29	1355
6	EGYPT	25	386
7	BRAZIL	23	422
8	PAKISTAN	23	389
9	SAUDI ARABIA	21	269
10	NIGERIA	18	275

SS-020

Evaluatıon of the Melatonın Level in the Follıcle Fluıd of Infertılıty Patıents wıth Low Ovarıan Reserve

Emine Öngüç
Istanbul Training and Research Hospital

It has been observed that the oocyte quality of women diagnosed with low ovarian reserve (LOR) decreases as the number of oocyte decreases. As a result of recent studies, it has been shown that oxidative stress negatively affects fertilization due to its negative effects on the oocyte. Melatonin (N-acetyl-5-methoxytryptamine) is a natural neurotransmitter synthesized from tryptophan, secreted mostly from the pineal gland, affected by the circadian rhythm, and therefore secreted especially at night. Although it is known to be secreted mostly from the pineal gland, it is also known to be secreted from places such as follicle cells, bone marrow and retina. It protects cells from intracellular oxidative stress such as DNA damage and lipid peroxidation. In our study, we aimed to investigate the difference between the melatonin levels in the follicular fluid of infertility patients diagnosed with LOR and control patients. Our prospective case-control study was conducted between January 2024 and May 2024.. The diagnosis of LOR was made by examining the data in the follicular fluid obtained during the oocyte retrieval proces from 48 LOR patient and 49 women with tubal factor infertility who applied to our infertility clinic. The diagnosis of LOR was defined according to the Bologna criteria.

The value of melatonin level in the control group [267.11(151.67-1094.58)] was found to be significantly higher than the value of the LOR patient group [196.56(151.57-231.38)]. Yan Huang et al. In 2023, examined the glutathione level in 46 patients diagnosed with LOR and 56 patients with normal ovarian reserve, which acts as an antioxidant in the follicular fluid, and the value of proinflammatory cytokines, a marker of oxidative stress. It was found that the glutathione level was low and the inflammatory cytokine levels were high in LOR patients. He concluded that oxidative stress is high in patients diagnosed with LOR and that antioxidants that will reduce the damage caused by free oxygen radicals are low. Again, in the same study, they found a negative correlation between glutathione level and fertilization rates, and they attributed this to the increased amount of glutathione to balance intrafollicular oxidative damage. However, in our study, we did not find a correlation between melatonin level and fertilization and M2 oocyte number. We thought that the reason for this situation may be the increase in the destruction of melatonin due to increased oxidative stress and thus the oxidant-antioxidant balance in the intrafollicular microenvironment. Liang et al. In a study conducted in 2021 with a total of 40 patients, 20 patients diagnosed with LOR and 20 patients with normal ovarian reserve, they examined the level of oxylipin, an oxidative metabolite produced by autoxidation in the follicular fluid, and it was found to be significantly higher in patients diagnosed with LOR than in patients with normal ovarian reserve. Melatonin is thought to be involved in the pathogenesis of many diseases, so research on melatonin continues.

Keywords: melatonin, low ovarian reserve, oxidative stress

Difference in melatonin levels between low ovarian reserve and control groups

Variables (n=)	LOR (n=48)	CONTROL (n=49)	p
Melatonin Levels (pg/mL)	196,56(151,57-231,38)	267,11(151,67-1094,58)	0,003µ

SS-021

Comparison of Progesterone Priming and Gnrh Antagonist Treatment Protocols in Patients Undergoing Ivf Treatment

Abdulhalim Ayaz[1], Süleyman Murat Bakacak[1], Alev Özer[1], Aslı Yaylalı[2]
[1]Kadın hastalıkları ve doğum ABD, Sütçü İmam Üniversitesi Tıp Fakültesi, Kahramanmaraş, Türkiye
[2]Histoloji ve embryoloji ABD, Sütçü İmam Üniversitesi Tıp Fakültesi, Kahramanmaraş, Türkiye

AIM: The aim of our study was to retrospectively compare progesterone priming and GnRH antagonist treatment protocols used to prevent premature LH elevation in patients receiving IVF treatment.

MATERIAL-METHOD: The women who underwent IVF treatment for tubal factor, polycystic ovary syndrome, low ovarian reserve, unexplained infertility and mild to moderate male factor were recruited. Group 1 (n=136) and Group 2 (n=136) were formed by patients receiving GnRH antagonist (cetrotide) and progestin (duphaston) respectively.

RESULTS: The groups were similar regarding mean age, mean AMH level and antral follicle counts. The mean parameters of induction time, M1, M2, GV, EZ, DJ, 2PN, day 3 embryo and day 5 embryo were not significantly different between the progesterone priming and GnRH antagonist groups ($p > 0.05$). The difference between the mean total GnRH doses was significantly higher in favor of the progesterone priming group ($p = 0.015$).

CONCLUSION: Pregnancy rates achieved with progesterone priming are similar to the success rate of the antagonistprotocol

Keywords: IVF, progestin priming, GnRH antagonist, pregnancy rates, mature oocytes

SS-022

Can adjusting the antagonist dosage based on LH levels on the administration day improve reproductive outcomes in ART?

Şeyma Osmanlıoğlu[1], KORAY GÖRKEM SAÇINTI[2], Bülent Berker[2]
[1]Ankara Medipol University, School of Medicine, Department of Obstetrics and Gynecology
[2]Ankara University, School of Medicine, Department of Obstetrics and Gynecology

INTRODUCTION: While estrogen levels and follicle size primarily guide antagonist administration, the role of LH levels remains underexplored. This study investigated the association between LH levels on the antagonist administration day, laboratory parameters, and pregnancy outcomes.

MATERIALS-METHODS: The retrospective study was conducted in women between 20-40 years of age who underwent in-vitro fertilization (IVF) or intracytoplasmic sperm injection (ICSI) and fresh embryo transfer following a GnRH antagonist protocol, at a university-based infertility clinic between January 2016 and June 2020. Participants with normal basal FSH and TSH levels were eligible for inclusion. Exclusion criteria included recurrent abortions, uterine abnormalities, PCOS diagnosed by Rotterdam criteria, and Poor responders identified according to POSEIDON criteria. Patients were stratified into two groups according to their LH levels on the initial day of antagonist administration; Group A: LH ≥4 mUI/ml, group B: LH <4 mUI/ml.

RESULTS: Age, AMH, FSH and estradiol levels on D3 were comparable in both groups. There were significant differences between both groups in terms of antral follicle count (AFC) (Group A: 11 [7-1]; Group B: 8 [4.75-11.25]; p=0.002), basal LH levels (Group A: 5 [4-7]; Group B: 3.9 [3-5]; p<0.001), starting day of antagonist administration (Group A: 8 [7-9]; Group B: 7 [7-8]; p=0.013), progesterone on antagonist administration day (Group A: 0.8 [0.54-1.1]; Group B: 0.61 [0.45-0.87]; p=0.04), estradiol on antagonist administration day (Group A: 586 [403-997.6]; Group B: 419 [216.5-645.95]; p=0.001), Follicles ≥14 mm on trigger day (Group A: 7 [4-11]; Group B: 5 [3.75-7]; p=0.007), number of oocytes retrieved (Group A: 9 [4-14]; Group B: 7 [3-10]; p=0.039), and number of MII oocytes (Group A: 7 [2.25-12]; Group B: 5 [2-8]; p=0.038). There were no differences between the quality of the embryos, pregnancy, clinical pregnancy, miscarriage, and live birth rates.

CONCLUSION: Although there was no difference in AMH, basal FSH, and estradiol levels between groups, AFC values were significantly higher in the group with higher LH. Moreover, women in this group were younger (Group A: 31 [27-

36]; Group B: 34 [28-38]; p= 0.076). In addition to elevated LH levels on the day of antagonist initiation, patients in this group also exhibited significantly higher progesterone and estradiol levels. While not statistically significant, patients with lower LH levels tended to require shorter stimulation durations. Despite a higher number of follicles ≥14 mm on the trigger day, a greater number of oocytes retrieved, and MII oocytes in patients with higher LH levels, the absence of significant differences in embryo quality and pregnancy outcomes suggests that the stimulation outcomes were not adversely affected despite the low LH levels. We suggest that optimizing antagonist addition based on LH levels could potentially enhance fresh transfer success rates.

Keywords: assisted reproductive technology, controlled ovarian stimulation, LH level, GnRH antagonist, pregnancy outcomes

Tablo 1

Table 1: Demographic data of the study population as well as the comparison of cycle and transfer characteristics of all the patients

	Group A (LH on antagonist administration day ≥4 mUI/ml)	Group B (LH on antagonist administration day <4 mUI/ml)	p
	(n=63)	(n=66)	
Age (Years)	31 [27-36]	34 [28-38]	0.076[2]
AMH (ng/ml)	1.7 [0.55-4.42]	1.3 [0.6-3]	0.237[2]
AFC	11 [7-15]	8 [4.75-11.25]	**0.002[2]**
FSH on D3 (mUI/ml)	7.7 [6-8.8]	7 [6-9]	0.754[2]
Estradiol on D3 (pg/ml)	47 [34-65]	43 [32.5-63.8]	0.548[2]
LH on D3 (mUI/ml)	5 [4-7]	3.9 [3-5]	**<0.001[2]**
Endometrial thickness on hCG day	10.5±2.08	9.83±2.49	0.1[1]
Total FSH/hMG (IU)	2400 [1800-2700]	2250 [1828.13-3000]	0.768[2]
Starting day of antagonist administration	8 [7-9]	7 [7-8]	**0.013[2]**
Progesterone on antagonist administration day (nmol/L)	0.8 [0.54-1.1]	0.61 [0.45-0.87]	**0.04[2]**
Oestradiol on antagonist administration day (pg/ml)	586 [403-997.6]	419 [216.5-645.95]	**0.001[2]**
LH on antagonist administration day (mUI/ml)	6.1 [5-10.6]	2.2 [1.9-3]	**<0.001[2]**
Total days of stimulation	10 [8-11]	9 [8-10.25]	0.072[2]
Follicles ≥14 mm on trigger day	7 [4-11]	5 [3.75-7]	**0.007[2]**
Follicles ≥17 mm on trigger day	3 [2-6]	3 [2-4]	0.301[2]
No. of oocytes retrieved	9 [4-14]	7 [3-10]	**0.039[2]**
No. of MII oocytes	7 [2.25-12]	5 [2-8]	**0.038[2]**
No. of embryos	2 [1-5]	2 [1-4]	0.574[2]
QTE	1 [1-2]	1 [0.5-2]	0.778[2]
Abbreviations: AMH: Anti-Müllerian hormone; AFC: Antral follicle count; FSH: Follicle stimulating hormone; D3: Day 3; LH: Luteinizing hormone; TSH: Thyroid stimulating hormone; MII: Metaphase II oocyte; TQE: Top quality embryo/ Total embryo rate; hMG: Human menopausal gonadotropin			
[1]T-test; Mean ± SD; [2]Mann-Whitney-U-Test; Median [Q25-75]			

Demographic data of the study population as well as the comparison of cycle and transfer characteristics of all the patients

Tablo 2

Table 2: The outcomes of the IVF treatment

	Group A (LH on antagonist administration day ≥4 mUI/ml)	Group B (LH on antagonist administration day <4m UI/ml)	p
	(n=63)	(n=66)	
Pregnancy rate (n=60)	32	28	0.341
Clinical pregnancy (n=45)	23	22	0.838
Miscarriage rate (n=13)	6	7	0.587
Live Birth rate (n=26)	22	17	0.28

Table 2: The outcomes of the IVF treatment

SS-023

Retrospective Comparison of the Effects of Fresh and Frozen Embryo Transfers on Cumulative Live Birth Rates in Patients with Poor Ovarian Response According to Bologna Criteria and POSEIDON Subgroups

Bilal Esat Temiz[1], Onur Ince[2], Neslihan Coskun Akcay[3], Lale Karakoc Sökmensüer[3], Sezcan Mumusoglu[4]
[1]Hacettepe University, Obstetrics and Gynecology, Ankara, Turkey
[2]Hacettepe University, Reproductive Endocrinology and Infertility, Ankara, Turkey
[3]Hacettepe University, Histology and Embryology, Ankara, Turkey
[4]Department of Gynecology, Obstetrics, and Reproductive Medicine, Anatolia IVF Center, Ankara, Turkey

Study question: Do cumulative delivery rates (CDRs) per aspiration cycle differ in low-prognosis patients according to the Bologna and POSEIDON (Patient-Oriented-Strategies-Encompassing IndividualizeD-Oocyte-Number) classification criteria?

Summary answer: The CDR was 8.7% in Bologna and 22.7% in POSEIDON. The odds of achieving live-birth were ~3-fold higher in POSEIDON than in the Bologna group.

What is known already: Bologna criteria were generated to address the heterogeneity in the definition of the Poor Ovarian Response (POR). However, patients meeting these criteria may not be homogeneous in terms of the number of oocytes retrieved and live birth rate. Subsequently, as a more inclusive classification, the POSEIDON criteria were proposed to stratify low-prognosis patients according to female age and suboptimal response to ovarian stimulation. To our knowledge, there is a paucity of data comparing CDRs between the POSEIDON and Bologna groups.

Study design, size, duration: Retrospective cohort study including 1250 patients undergoing their first ovarian egg retrieval cycle at Hacettepe University IVF Center in Ankara between 2017 and 2023. Exclusion criteria were female age >45 years old, body mass index >35 kg/m2, azoospermia, pre-implantation genetic testing (PGT) for structural rearrangement or monogenic disorders, fertility preservation cycles, dual-stimulation cycles, premature ovarian insufficiency, and hypogonadotropic hypogonadism. The primary outcome measured was CDR defined by ICMART (International Committee for Monitoring Assisted Reproductive Technologies). Participants/materials, setting, METHODS: The Bologna patients have at least two of the following three features; female-age ≥40 or prior ovarian surgery, AMH<1.1ng/ml or antral-follicle-count (AFC)<5-7, and obtaining ≤3 oocytes in prior conventional stimulation. POSEIDON patients were categorized into four groups; younger(<35) and older(≥35) women with AMH≥1.2/AFC≥5 experiencing an unexpected poor(<4 oocytes-retrieved) or suboptimal(4–9 oocytes-retrieved) response, along with respective younger and older counterparts with AMH<1.1/AFC<5. Non-POSEIDON patients were those with AMH≥1.2/AFC≥5 and >9 oocytes-retrieved. General-Estimated-Equation(GEE) analysis was employed.

Main results and the role of chance: Out of 1250 patients, 79.6% were classified as POSEIDON, with sub-groups as follows: 5.28% Group 1a, 23.4% Group 1b, 3.6% Group 2a, 10.1% Group 2b, 14.64% Group 3, and 22.48% Group 4. The number of patients meeting Bologna criteria was 17.4% (218). For POSEIDON patients, median[IQR] values were: age 34 [30-38], AMH 1.33 [0.65-2.69], oocytes retrieved 4 [2-6], and embryo transfers 1 [1-2]. For non-POSEIDON patients: age 30 [27-33], AMH 4.63 [2.93-7.07], oocytes retrieved 13 [11-15], and embryo transfers 2 [1-3]. In Bologna patients: age 40 [36-42], AMH 0.46 [0.20-0.76], oocytes retrieved 2 [1-3], and embryo transfers 1 [0-1]. For non-Bologna patients: age 31 [28-36], AMH 2.30 [1.17-4.29], oocytes retrieved 6 [3-9], and embryo transfers 1 [1-2]. CDR for non-POSEIDON: 49.8%; Group 1a, 24.2%; Group 1b, 34.1%; Group 2a, 15.6%; Group 2b, 27.6%; Group 3, 20.8%; Group 4, 10.7%. In clustered-GEE analysis, using non-POSEIDON as reference, odds ratios (ORs) for live birth were: Group 1a OR 0.32 [0.18 - 0.60]; Group 1b OR 0.52 [0.37-0.74]; Group 2a OR 0.19 [0.08-0.43]; Group 2b OR 0.38 [0.24-0.61]; Group 3 OR 0.26 [0.17-0.41]; Group 4 OR 0.12 [0.08-0.19]. CDR for the Bologna group: 8.7% (OR: 0.10, 0.06-0.16); non-Bologna patients: 32.4% [OR: 0.48, 0.39-0.60].

Keywords: Poor ovarian response, cumulative live birth rate, POSEIDON classification,Bologna criteria

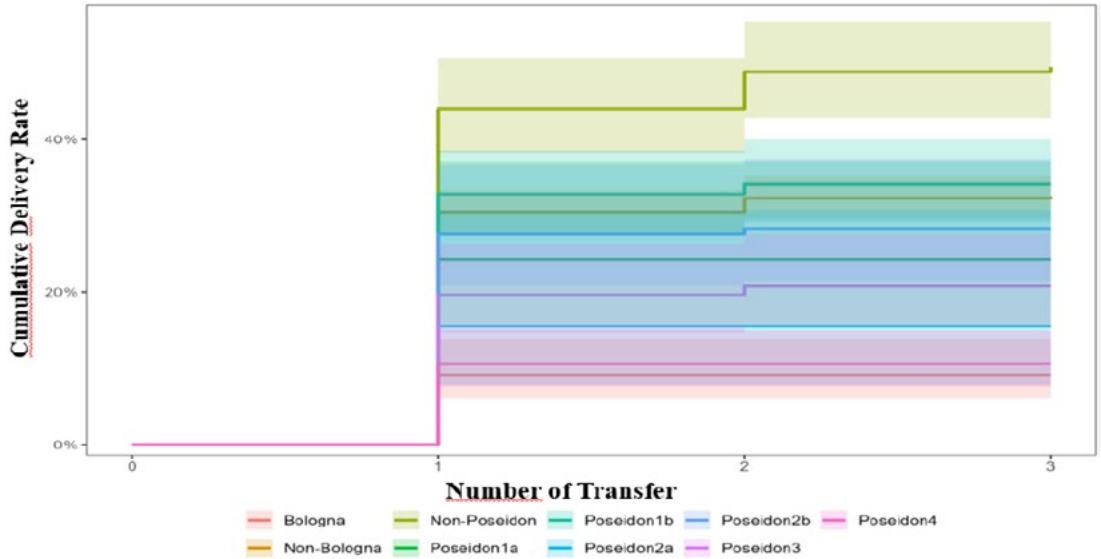
Demographic Characteristics and Key Findings of the Study

Table-1

	POSEIDON Groups						BOLOGNA Groups		
	Group 1a n=66	Group 1b n=293	Group 2a n=45	Group 2b n=127	Group 3 n=183	Group 4 n=281	Group 5 (NP) n=255	Bologna n=218	Non-Bologna n=1032	p-value
Female age, years	31[28-32] 2a,2b,4,B,NB	30[27-32] 2a,2b,4,B,NB	38[36-40] 1a,1b,3,NP,NB	37[36-39] 1a,1b,3,4,NP,NB	30[28-32] 2a,2b,4,B,NB	39[37-41] 1a,1b,2b,3,NP,NB	30[27-33] 2a,2b,4,B,NB	40[36-42] 1a,1b,3,NP,NB	31[28-36] 1a,1b,2a,2b,3,4,B	<0.001
BMI, kg/m2	25,2[22,4-29,7]	24,2[22,0-27,7]	25,4[22,4-29,8]	24,0[22,2-28,0]	24,0[21,45-26,67]	24,1[21,9-27,4]	23,8[21,6-26,5]	24,8[22,3-28,2]	24,1[21,7-27,4]	0,06
Infertility duration, months	39[26-61] 2b	48[31-75] 3	40[23-75]	50[26-99] 1a,3	35[21-54] 1b,2b,NP,B,NB	36[14-74]	44[27-67] 3	38[18-77] 3	41[26-68] 3	<0.001
Ovarian reserve										
AMH, ng/ml	2,27[1,67-4,30] 2a,3,4,NP,B	2,98 [2,08-4,75] 2a,2b,3,4,NP,B,NB	1,59 [1,42-2,08] 1a,1b,2b,3,4,B,NB	2,23 [1,64-3,13] 1b,2a,3,4,NP,B,NB	0,72 [0,39-0,93] 1a,1b,2a,2b,4,NP,NB	0,49 [0,23-0,80] 1a,1b,2a,2b,3,NP,NB	4,63 [2,93-7,07] 1a,1b,2a,2b,3,4,B,NB	0,46 [0,20-0,76] 1a,1b,2a,2b,NP,NB	2,30 [1,17-4,29] 1b,2a,2b,3,4,NP,B	<0.001
AFC, n	15[11-23] 2a,2b,3,4,NP,B,NB	15[11-23] 2a,2b,3,4,NP,B,NB	8[5-11] 1a,1b,2b,4,B,NB	11[8-16] 1b,2a,3,4,NP,B	6[4-9] 1a,1b,2b,4,NP,B,NB	4[3-7] 1a,1b,2a,2b,3,NP,B,NB	22[14-31] 1a,1b,2a,2b,3,4,B,NB	4[2-6] 1a,1b,2a,2b,3,4,NP,NB	13[7-21] 1b,2a,3,4,NP,B	<0.001
Total gonadotropin dose (IU)	2663[2063-3300] 3,NP	2400[1800-3000] 2a,2b,3,4,B,NB	2700[2400-3300] 1b,NP	2775[2250-3375] 1b,3,NP,B	3300[2700-4125] 1a,1b,2b,NP,NB	3000[2100-3900] NP,1b,NB	2063[1688-2700] 1a,2a,2b,3,4,B,NB	3188[2275-4125] 1b,2b,NP,NB	2588[1995-3300] 1b,3,4,NP,B	<0,001
N. of of oocytes retrieved	2[2-3] 1b,2b,3,NP,NB	7[5-8] 1a,2a,3,4,NP,B	2[2-3] 1b,2b,3,NP,NB	6[5-8] 1a,2a,3,4,NP,B,NB	3[2-4] 1a,1b,2a,2b,4,NP,B,NB	2[1-3] 1b,2b,3,NP,NB	13[11-15] 1a,1b,2a,2b,3,4,B,NB	2[1-3] 1b,2b,3,NP,NB	6[3-9] 1a,2a,2b,3,4,NP,B	<0,001
N. of metaphase II oocytes	2[1-2] 1b,2b,3,NP,NB	5[4-7] 1a,2a,3,4,NP,B	2[1-2] 1b,2b,3,NP,NB	5[3-6] 1a,2a,3,4,NP,B	2[1-3] 1a,1b,2a,2b,4,NP,B,NB	1[1-3] 1b,2b,3,NP,NB	10[9-12] 1a,1b,2a,2b,3,4,B,NB	1[1-2] 1b,2b,3,NP,NB	5[2-8] 1a,2a,3,4,NP,B	<0,001
N. of embryos obtained	1[0-1] 1b,2b,NP,NB	1[1-2] 1a,2b,3,4,NP,B,NB	1[0-2] 2b,NP,NB	2[1-2] 1a,1b,2a,3,4,NP,B	1[0-1] 1b,2b,NP,NB	1[0-2] 1b,2b,NP,NB	2[1-3] 1a,1b,2a,2b,3,4,B,NB	1[0-1] 1b,2b,4,NP,NB	1[1-2] 1a,1b,2a,3,4,NP,B	<0,001
N. of embryos transferred	1[1-1] 2a,2b,4,NP,B,NB	1[1-1] 2b,3,4,NP,NB	1[1-2] 1a,2b,3	2[1-2] 1a,1b,2a,3,4,NP,B,NB	1[1-1] 1b,2a,2b,4,NP,B,NB	1[1-2] 1a,1b,2b,3,B	1[1-2] 1a,1b,2b,3	1[1-2] 1a,2b,3,4	1[1-2] 1a, 1b, 2b, 3	<0,001
Type of transfer, n (%)										
FET only	11(16,7%) NP	75(25,6%) 3,4,NP,B	5(11,1%) NP,NB	25(19,7%) NP	18(9,8%) 1b,NP,NB	40(14,2%) 1b,NP,NB	149(58,4%) 1a,1b,2a,2b,3,4,B,NB	29(13,3%) NP,1b,NB	294(28,5%) 2a,3,4,NP,B	<0,001
Fresh only	36(54,5%)	186(63,5%) 3,4,NP,NB	26(57,8%)	87(68,5%) 4,NP,B,NB	117(63,9%) 4,NP,B	127(45,2%) 1b,2b,3,NB	89(34,9%) 1b,2b,3,NB	93(42,7%) 1b,2b,3,NB	575(55,7%) 1b,2b,4,NP,B	<0,001
Fresh and FET	0(0%)	5(1,7%)	0(0%)	1(0,8%)	0(0%)	1(0,4%)	4(1,6%)	0(0%)	11(1,1%)	-
Cycle cancellation	19(28,8%) 1b,NP	27(9,2%) 1a,3,4,B,NB	14(31,1%) NP	14(11%) 3,4,B	48(26,2%) 1b,2b,NP,B,NB	113(40,2%) 1b,2b,NP,NB	13(5,1%) 1a,2a,3,4,B,NB	96(44%) 1b,2b,3,NP,NB	152(14,7%) 1b,3,4,NP,B	<0,001
Clinical pregnancy rate, n (%)	22 (33,3%) NP	142 (48,5%) 3,4,NP,B	13 (28,9%) NP	56 (44,1%) 4,NP,B	51 (27,9%) 1b,NP,NB	51 (18,1%) 1b,2b,NP,NB	148 (58%) 1a,1b,2a,2b,3,4,B,NB	23(10,6%) 1b,2b,NP,NB	390 (37,8%) 3,4,NP,B	<0,001
Ongoing pregnancy rate, n (%)	17 (25,8%) NP	102 (34,8%) 3,4,NP,B	7 (15,6%) NP,NB	35 (27,6%) 4,NP,B	38 (20,8%) 1b,NP,B,NB	30 (10,7%) 1b,2b,NP,NB	130 (51%) 1a,1b,2a,2b,3,4,B,NB	19(8,7%) 1b,2b,3,NP,NB	340 (32,9%) 2a,3,4,NP,B	<0,001
Live birth rate per fresh transfer, n/n (%)	11/36 (30.6%)	66/186 (35.5%) 4,B	5/26 (19.2%)	22/87 (25.3%)	29/117 (24.8%)	22/127 (17.3%) 1b,NP,NB	40/89 (44.9%) 4,B	13/93 (14.0%) 1b,NP,NB	182/575 (31.7%) 4,B	<0,001
Live birth rate per FET transfer, n/n (%)	6/13(46.2%)	35/97 (36.1%)	2/7(28.6%)	11/30 (36.7%)	15/25 (60%) 4,B	8/41(19.5%) 3,NP,NB	96/215(44.7%) 4	7/31(22.6%) 3	165/395 (41,8%) 4	0,008
Cumulative live birth rate, n (%)	16 (24,2%) NP	100 (34,1%) 3,4,NP,B	7 (15,6%) NP	35 (27,6%) 4,NP,B	38 (20,8%) 1b,NP,B,NB	30 (10,7%) 1b,2b,NP,NB	127 (49,8%) 1a,1b,2a,2b,3,4,B,NB	19 (8,7%) 1b,2b,3,NP,NB	334 (32,4%) 3,4,NP,B	<0,001

BMI: Body mass index; AMH: Anti-Müllerian Hormone; AFC: Antral Follicle Count; NP: Non-POSEIDON
The superscripts "1a", "1b", "2a", "2b", "3", "4", "NP", "B", "NB" indicate the respective groups as POSEIDON Group-1a, Group-1b,It states that there is a statistically significant difference between Group-2a, Group-2b, Group-3, Group-4, Non-POSEIDON, Bologna and Non-Bologna patients
Data are presented as median (25%–75%; range of quartiles), number (n), or percentage (%) unless otherwise stated

The effect of number of transfers on cumulative live birth rates according to POSEIDON and Bologna classifications is shown with confidence intervals



The effect of number of transfers on cumulative live birth rates according to POSEIDON and Bologna classifications is shown with confidence intervals

SS-024

Unusual case of vulvar leiomyoma

Harika Bodur Öztürk, Mehmet Murat Naki
Department of Obstetrics and Gynecology, Medipol Acıbadem District Hospital, Istanbul, Turkey

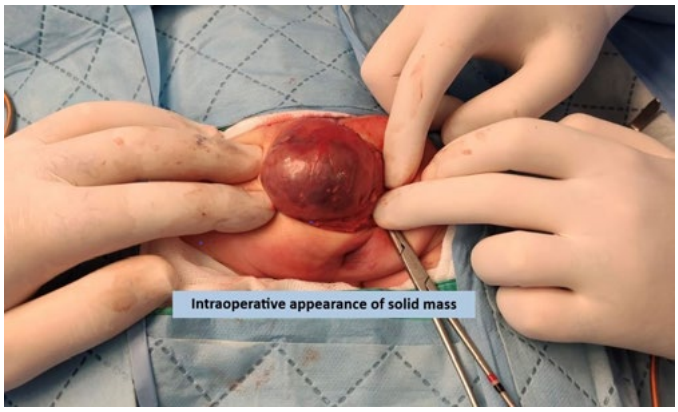
Extra uterine leiomyoma is a very rare medical condition and vulvar leiomyoma is a benign tumor that originated from the smooth muscles and generally affect premenopausal women with a history of uterine myoma. We report a case of vulvar myoma.

CASE: 48 years old G1 P1 women was admitted to Gynecology Department at for vulvar swelling and discomfort. A 4*5 cm of painless solid and mobil mass was palpated on the right labia majora. Her pelvic ultrasound and the cervical cytology were normal. We decided for an excisional surgery under general anesthesia. The mass was rubbery, firm and pale pink color which is consistent with myoma-like appearance during the operation. Pathology report revealed benign leiomyoma. The patient was discharged from the hospital the day after the surgery and no relapse occured.

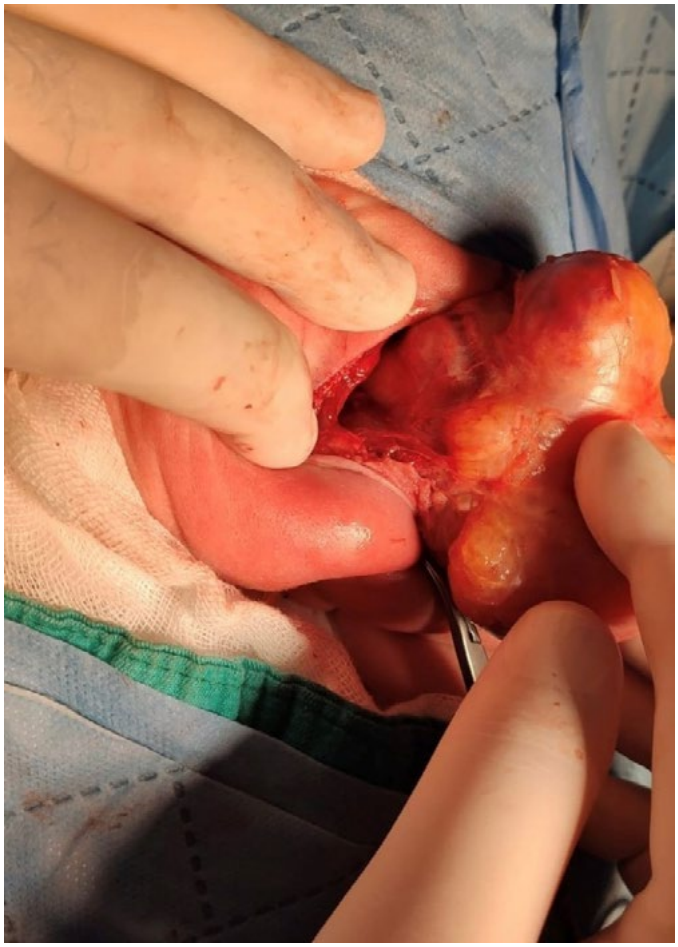
CONCLUSION: Although this is a very rare pathology, surgical treatment is definitive and curative. Transperineal ultrasound and/or magnetic resonance imaging (MRI) maybe helpfull fo understands the differential diagnosis includes Bartholin cyst and nuck canal herniation. In our case we did not use imaging modalities before surgery. Definitive diagnosis was made following histopathological analysis.

Keywords: leiomyoma, vulva, extrauterine leiomyoma

Vulvar myoma



Vulvar myoma



SS-025

Methotrexate administration in ectopic pregnancy cases with high Beta HCG levels: a retrospective observational study

Nurşen Kurtoğlu, Gülhan Özüm
Department of Obstetrics and Gynecology, Health Sciences University, Bagcilar Training and Research Hospital, Istanbul, Turkey

Ectopic pregnancy is a potentially life-threatening condition. Treatment options for confirmed ectopic pregnancies include medical, surgical, and expectant management. Surgery is the main treatment but in early and selected cases medical therapy with methotrexate (MTX) can be used. This treatment should be done in close follow up frequently with hospitalization. Surgical treatment is performed in hemodynamically unstable cases and/or suspicion of tubal rupture. Also if serum HCG is over 5000 mIU/ml or TVUSG shows fetal cardiac activity surgery is offered. Some clinicians treat with MTX for patients with hCG >5000 to ≤10,000 mIU/mL if the following criteria are met: no pathologic levels of free fluid in the pelvic cul-de-sac or abdomen, TVUSG meets criteria for MTX, and the patient has minimal pelvic or abdominal pain. Fetal cardiac activity in ectopic focus reduces the treatment success with MTX, although it is not a definite contraindication for MTX therapy. Our aim is to discuss the success, course and results of MTX administration in ectopic pregnancies with high Beta HCG values as over 5000 mIU/ml.

In our clinic, all patients who were hospitalized with the diagnosis of ectopic pregnancy in the last 1 year were screened. 100 patients who were treated with MTX were identified. Nineteen patients (19%) whose values were over 5000 were identified. Demographic characteristics of the patients, USG and laboratory findings, treatments performed, if surgery was required, and hospital stay duration were noted from the patient files and computer record system (Table 1).

The mean age of the patients was 33 (25-42). The mean BetaHCG value was 9353 (5249-21573). The hemodynamics of the patients were stable, and there was no sign of active intra-abdominal bleeding or rupture. MTX was administered as one dose protocol. In TVUSG, an ectopic focus was visualized in the adnexal region in 16 patients (84%); cornual pregnancy was diagnosed in 1 patient (5%), and cesarean scar pregnancy was diagnosed in 2 patients (10.5%). Fetal cardiac activity was observed in 4 cases (21%). Only Yolk sac was also observed in 4 cases (21%). There were 8 patients (42%) with yolk sac and/or fetal cardiac activity. 5 patients (26%) required emergency surgery (due to acute abdomen and hemoperitoneum findings). The average hospital stay of the patients was 12 (7-30) days. When the 5 patients who underwent emergent surgery were analyzed, the average Beta HCG values were 12988 (7034-21573). Salpingectomy was performed in 4 of the 5 patients, and scar pregnancy excision was performed in 1. The patients who underwent emergent surgery were operated on an average of 11 (5-19) days after MTX. YS and/or FKA were observed in 4 of the 5 patients (80%) that undergone emergent surgery. MTX treatment can be offered to the patients with some criteria even the Beta HCG levels over 5000 Mıu/ml. The presence of yolk sac and or fetal cardiac activity in ectopic mass appears to be a factor that increases the need for emergency surgery in follow up of patients who were administered MTX.

Keywords: ectopic pregnancy, ectopic pregnancy treatment, high Beta HCG values, methotrexate

Tablo 1

patient no	Age	Beta HCG mIU/ml	Ectopic place in USG/ diameter/if exist FKA/YS	MTX 4-7. Days decrease persentage	2. MTX	Emergency operation/if operated how many days of MTX	Hospitalization time (days)
1	40	5249	Adnex/20 mm	25%	none	none	8
2	35	5329	Adnex/23 mm	19%	none	none	7
3	25	5385	Adnex/19 mm	38%	none	none	18
4	42	5418	Kornual/20 mm	75%	none	none	8
5	33	5526	Adnex/11 mm	63%	none	none	7
6	41	5874	Adnex/20 mm	increased	yes	none	18
7	29	6095	Adnex/22 mm	17%	none	none	22
8	33	6165	Adnex/18mm/FKA exist	65%	none	none	8
9	36	7034	Adnex/14 mm/yolk sac exist	increased	yes	LS left salpengectomy, 11th days of MTX	15
10	26	7315	Adnex/14 mm	65%	none	none	8
11	34	8568	Adnex /10 mm/fka exist	72%	none	none	8
12	35	9254	Adnex/22 mm	47%	none	none	12
13	29	9881	Adnex/15 mm	not measured	none	LT right salpenjectomy/5th days of MTX	7
14	32	11731	Adnex/10 mm/yolk sac exist	25%	none	none	14
15	37	12970	istmosel scar pregnan-cy10 mm/yolk sac exist	24%	none	LS exsicion of scar pregnancy region/19th days of MTX	30
16	25	13483	Adnex/30 mm/FKA exist	20%	none	LS left salpenjectomy/7th days of MTX	9
17	31	15020	Adnex/? mm	42%	none	none	12
18	34	15838	İstmosel scar pregnancy/ FKA exist	not measured	none	RC with control of LS and USG	6
19	33	21573	Adnex/28 mm/yolk sac exist	29%	none	LS right salpengectomy/12th days of MTX	20

The analysis of patients who were adminestered MTX. USG: Ultrasonography, MTX: Methotraxate, YS: Yolk Sac, LS: Laparoscopy, LT:Laparatomy, RC: Curettage

SS-026

Control pathologies of inflammatory findings in PAP-Smear results

Elif Ece Öztürk Özen, Batuhan Aslan, Elif Aylin Taşkın, Yaprak Üstün
Ankara Etlik Zubeyde Hanım Women's Health Training and Research Hospital, Ankara, Turkey

INTRODUCTION: Inflammatory findings on Pap smear results can be a concerning diagnosis for patients, often leading to further investigation and potential treatment. However, the significance and interpretation of these findings can be complex, as they may represent either a true inflammatory process or an artifact of the sample collection or preparation. The aim of this study was to examine the potential relationship between inflammatory findings and possible premalignant lesions.

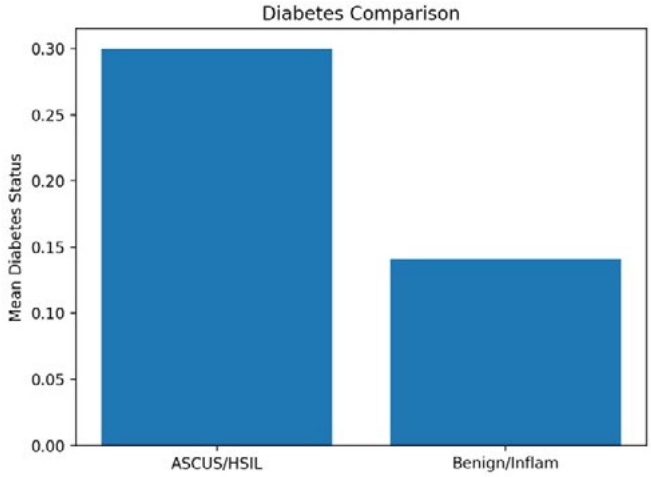
METHODOLOGY: This retrospective study aimed to evaluate the follow-up Pap smear results of patients whose initial Pap smear was reported as having inflammatory findings. The study included patients between December 2022 and July 2024. The Pap smear results, cytology reports, and patients' clinical characteristics were obtained from their medical records. Patients with additional abnormal cytology results accompanying the inflammatory changes were excluded from the study. Only patients who underwent a repeat smear within 1 year were included.

RESULTS: A total of 95 patients met the inclusion criteria. The average age at the time of the first smear was 45.72 years. Fifteen patients (15.8%) had diabetes. Age distribution: 50-60 years: 34.57%, 40-50 years: 25.93%, 30-40 years: 18.52%, <30 years: 12.35%, 60+ years: 8.64%. Approximately 15.8% (15 out of 95) of the patients with inflammatory changes on their first smear also had diabetes mellitus.The mean time until the second smear test is approximately 5.93 months.25% of patients had their second smear within 1 month, 50% of patients had their second smear within 3 months, 75% of patients had their second smear within 10 months. The vast majority of patients (80%) still showed inflammatory changes in their second smear test. This suggests that the inflammatory condition tends to persist in most cases. Benign Results About 9.47% of patients had a benign result in their second smear, indicating an improvement or resolution of the inflammatory changes. ASCUS Approximately 8.42% of patients showed Atypical Squamous Cells of Undetermined Significance (ASCUS) in their second smear. This represents a slight progression from inflammatory changes to a more concerning, though still relatively minor, abnormality. HSIL a small percentage (2.11%) of patients progressed to High-grade Squamous Intraepithelial Lesion (HSIL). LSIL Interestingly, there were no cases of Low-grade Squamous Intraepithelial Lesion (LSIL) reported in the second smear results. Menopausal status, diabetes, parity, age, and the time between smears did not significantly affect the pathological results of the second smear. No significant difference was found between the ASCUS+HSIL group and the benign findings+inflammatory changes group.

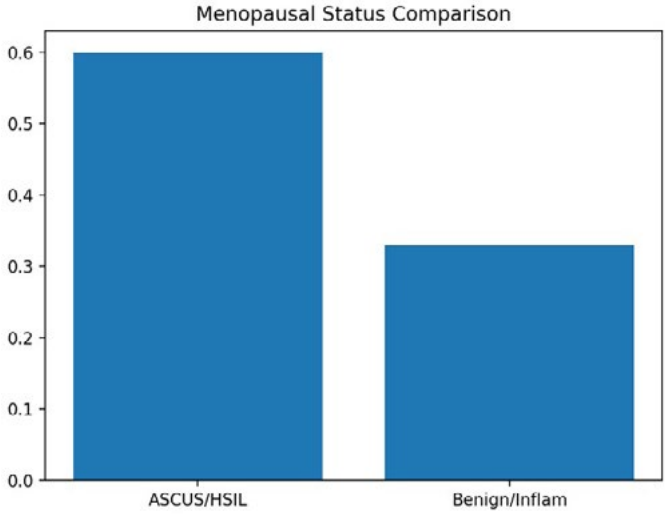
CONCLUSION: These findings suggest that while inflammatory changes in smear tests are more common in middle-aged women, they can occur at any age. These findings emphasize the importance of follow-up smear tests after initial inflammatory results. While most cases remain inflammatory or improve, a significant minority progress to more concerning states, justifying the practice of close monitoring and repeat testing. The results also suggest that patients with inflammatory changes on their first smear should be educated about the importance of attending their follow-up appointments, given the potential for both improvement and progression of their condition.

Keywords: PAP-Smear, Inflammation, Vaginal Atrophy, Cervical Malignancy

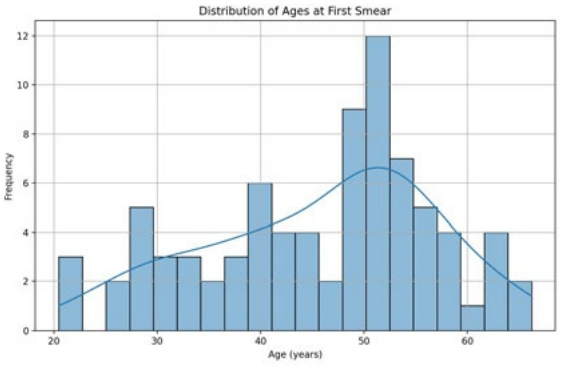
Comparison of features between ASCUS/HSIL and Benign/ Inflammatory groups



Comparison of features between ASCUS/HSIL and Benign/ Inflammatory groups



Distribution of ages at first smear



SS-027

Assessment of endometrial biopsy results with systemic inflammation response index, pan-immune-inflammation value and plateletcrit: a retrospective study

Muradiye Yildirim, Hasan Altinsoy, Mustafa Canbulut, Eylem Unlubilgin, Yaprak Engin-Ustun
Department of Obstetrics and Gynecology, Etlik Zübeyde Hanım Women's Health Training and Research Hospital

AIM: Endometrial polyps (EP) are exophitic mass lesions that may arise from the endometrial cavity's gland, stroma, or vascular tissue. They are often seen in reproductive ages and are mostly benign uterine disorders that can be in different sizes. The majority of cases are asymptomatic, abnormal uterine bleeding is the most prevalent symptom, though it is not associated with the size or number of polyps. Although the etiology is still not clearly known, advanced age, hormonal imbalance, endometritis, and inflammation are some risk factors. The inflammatory response stimulates neutrophils and accelerates lymphocyte apoptosis. In addition to their known roles in thrombosis and hemostasis, thrombocytes have recently been recognized to have functions in the host response to systemic inflammation. Therefore, indices obtained from complete blood count (CBC) have been investigated in the prediction and prognosis of many diseases. In this study, we aimed to compare endometrial biopsy results with CBC indices.

MATERIAL-METHODS: The study was conducted at Ankara Etlik Zübeyde Hanım Women's Health Training and Research Hospital between January and August 2024. Patients who underwent office hysteroscopy and endometrial biopsy were retrospectively investigated. Fifty-two women were included in the EP group and 54 women diagnosed with secretory and proliferative endometrium were included in the control group. Twenty patients diagnosed with hyperplasia and malignancy were excluded from the study. Preoperative laboratory, sociodemographic, and clinical characteristics were obtained from hospital records. For systemic- inflammation response index (SIRI), the product of neutrophil and monocyte counts was divided by the lymphocyte count. The pan-immune-inflammation value (PIV) was obtained by dividing the product of neutrophil, platelet, monocyte counts by the lymphocyte count. Parametric data were presented as mean ± standard deviation. Independent samples t-test and Mann-Whitney U test were used to compare groups. P values below 0.05 were considered significant.

RESULTS: Age, gravida, parity, and abortion numbers were similar between the case and control groups. CBC parameters such as wbc, neutrophil count and percentage, lymphocyte, monocyte, eosinophil and basophil counts, hemoglobin, and

hematocrit values were found to be similar. Thrombocyte count and plateletcrit were significantly higher in the case group ($p<0.05$). There was no significant difference between SIRI and PIV indices.

CONCLUSION: This study showed that there was an increase in platelet count and plateletcrit values in patients diagnosed with EP compared to those without endometrial pathology, and there was no difference in SIRI and PIV values, which are systemic inflammatory indicators. The results obtained can be explained by the multifactorial etiology of endometrial pathologies.

Keywords: Endometrial biopsy, endometrial polyp, systemic inflammation response index, pan-immune-inflammation value, plateletcrit

Comparison of data between case and control groups

	Case (n=52)	Control (n=54)	p value
Age	45±9	46±9	.735*
Gravidity (n)	2±1	2±1	.834*
Parity (n)	2±1	2±1	.532*
Abortus (n)	1±0	1±0	.264*
Wbc	7.31±1.65	6.64±1.94	.055*
Neutrophil (x10^9/L)	4.60±1.60	6.64±1.94	.129*
Neutrophil (%)	61±10	60±9	.538*
Lymphocyte (x10^9/L)	2.12±0.63	2.03±0.75	.484*
Hb (g/dL)	12.6±1.6	12.4±1.0	.614*
Hematocrit	38.3±4.4	37.4±.3	.236*
Thrombocyte (x10^9/L)	293.1±50.9	268.9±72.5	.049*
Pct (%)	0.30±0.04	0.28±0.06	.022*
Monocyte	0.41±0.12	0.38±0.12	.142*
Eosinophil	0.15±0.10	0.12±0.09	.098*
Basophil	0.06±0.01	0.04±0.02	.117*
SIRI (x10^9/L)	1.02±0.64	1.01±0.87	.989*
PIV (x10^9/L)	300.1±196.6	272.7±96.9	.711*

*Parameters were presented as mean+/-standard deviation. *Groups were compared with independent T test. wbc: white blood cells SIRI: systemic inflammation response index PIV: pan-immune-inflammation value*

SS-028

Comparison of VAS Pain Scores and Biopsy Adequacy Among Different Endometrial Sampling Techniques: Pipelle, Yellow, Green, and Blue Cannulas

Bilal Emre Erzeneoğlu
Department of Obstetrics and Gynecology, Cankiri State Hospital, Ankara, Turkey

INTRODUCTION: Endometrial biopsy is essential for diagnosing gynecological conditions such as abnormal uterine bleeding, endometrial hyperplasia, and cancer. Various techniques are used to obtain endometrial tissue samples, each differing in patient comfort, sample adequacy, and procedure-related pain. Commonly used methods include the Pipelle biopsy and different Karman cannulas, which vary in diameter and design, potentially affecting both patient pain and sample quality.

The Pipelle cannula, a flexible instrument with a small diameter (about 3 mm), is favored for its minimally invasive nature and lower pain scores. In contrast, Karman cannulas are available in larger sizes (yellow: 4 mm, green: 5 mm, blue: 7 mm), which may provide more substantial tissue samples but can increase discomfort due to their size and rigidity.

This study compares pain scores and biopsy adequacy between the Pipelle and yellow, green, and blue Karman cannulas to help clinicians select the most appropriate technique for individual patients.

METHODOLOGY: This study prospectively evaluates endometrial biopsies performed at Cankiri State Hospital between July 2024 and September 2024. After the biopsy procedure was completed, patients rated their pain using a Visual Analog Scale (VAS), and the nurse recorded the type of cannula used. The Chi-square test was employed to assess the adequacy of different cannulas, while a one-way ANOVA was used to compare the mean VAS scores. Tukey post hoc analysis was conducted to determine the statistical significance of the results, with a p-value of less than 0.05 considered statistically significant.

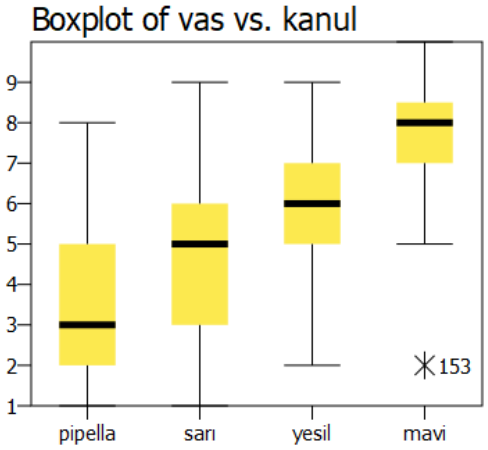
RESULTS: A total of 161 patients were initially enrolled in the study; however, data from 1 patient was excluded due to withdrawal of consent. Among the remaining 160 participants, 66 underwent biopsy with the Pipelle cannula, 34 with the yellow cannula, 44 with the green cannula, and 16 with the blue cannula. The number of inadequate samples was 6 for Pipelle, 6 for the yellow cannula, 2 for the green cannula, and 2 for the blue cannula. The Chi-square test used for comparing sample adequacy yielded a p-value of 0.26. The average VAS scores were as follows: Pipelle 3.62, yellow

cannula 4.70, green cannula 5.86, and blue cannula 7.37. A one-way ANOVA showed a statistically significant difference in mean VAS scores among the groups, with a p-value of 0.001. Post hoc analysis revealed a significant difference between the Pipelle and yellow cannula ($p = 0.022$) and between the yellow and green cannula ($p = 0.025$).

DISCUSSION: The study findings indicate a statistically significant difference in VAS scores between the groups, with pain scores increasing as the cannula size increased. However, there was no statistically significant difference in sample adequacy among the different cannula types. Based on these results, clinicians may consider using the Pipelle cannula for diagnostic endometrial biopsies, as it provides adequate samples while also being associated with lower pain scores. This approach allows clinicians to avoid starting with thicker cannulas, which are associated with higher pain, without compromising diagnostic adequacy. Further studies with larger sample sizes are warranted to confirm and expand upon these findings.

Keywords: Pipelle, Karman canulla, endometrial biopsy, VAS, pain score

boxplot vas score



avreage vas score of different cannulas

SS-029

Determination of Malignancy Risk in Patients Undergoing Endometrial Polypectomy

İbrahim Buğra Bahadır
Ankara Sincan Eğitim ve Araştırma Hastanesi

OBJECTIVE: Endometrial polyps are localized tissue extensions that develop from the surface of the endometrium and contain glandular and stromal structures. The prevalence in endometrial biopsies or hysterectomy specimens is reported to be between 10-24%. They are more common in the premenopausal period compared to the postmenopausal period. Although they are often asymptomatic, the most common symptom is abnormal uterine bleeding. The aim of this study is to investigate the factors affecting malignancy risk in patients without a diagnosis of malignancy and whose pathology results were malignant after polypectomy.

METHODS: The data of 316 patients who underwent polypectomy at the Gynecology Clinic 2 of Ankara Bilkent City Hospital between 2019 and 2023, without additional malignancy risk factors and without tamoxifen use, were retrospectively examined. Patients with a previous pathological diagnosis of malignancy or premalignancy and those using tamoxifen were excluded from the study. The demographic data of the patients (age, height, weight, BMI (kg/m²), presence of uterine bleeding before surgery, pathology results, and surgical notes) were recorded and compared regarding the examined parameters. In all statistical analyses, $p \leq 0.05$ was considered significant.

RESULTS: The mean age of all cases was 45.2 ± 4.9 (range 28-74). The mean gravida and parity were 3 (range 1-6) and 3(range 1-6), respectively. The mean height, weight, and BMI of the cases were 162.3 ± 5.6 (range 142-178) cm, 66.8 ± 8.7 (range 47-110) kg, and 29.2 ± 3.9 (range 21.5–36.8) kg/m², respectively. A total of 113 (35.7%) cases had abnormal uterine bleeding before surgery. The mean surgical duration was 28.3 ± 13.8 (range 20-90) minutes. In three cases, a hysterectomy was performed during the polypectomy procedure (0.94%). According to the pathology results, carcinoma was observed in 6 cases (1.8%), endometrial intraepithelial neoplasia (EIN) in 9 cases (2.8%), and atypical endometrial hyperplasia in 7 cases (2.2%) (p values >0.05). When polyp size was evaluated, 121 (38.2%) cases with <1 cm polyp, 3 (13%) malignant-premalignant; 143 (45.2%) cases with 1-2 cm polyp, 12 (54.5%) malignant-premalignant; 52 (16%) cases with >2 cm polyp, and 7 (31.8%) malignant-premalignant. In the chi-square and Spearman correlation analysis, no significant relationship was found between polyp pathology and polyp size and any parameter compared (p values >0.05).

DISCUSSION: In our study, the malignancy risk in

patients undergoing polypectomy was found to be 1.8%, and the premalignancy risk was 5%, which is consistent with the literature. It was shown that demographic data, as well as the presence of abnormal uterine bleeding before surgery, surgical duration, polyp size, and transition to hysterectomy during surgery did not affect malignancy risk. Keywords: Abnormal Uterine Bleeding, Endometrial Polyp, Malignancy

Keywords: Abnormal Uterine Bleeding, Endometrial Polyp, Malignancy

SS-030

The effect of Anti-Müllerian Hormone level in making the decision for oophorectomy

Haticegul Tuncer[1], Hasan Volkan Ege[2], Murat Gültekin[2]
[1]Hacettepe University, Department of Obstetrics and Gynecology, Ankara, Turkey
[2]Hacettepe University, Department of Obstetrics and Gynecology, Division of Gynecologic Oncology, Ankara, Turkey

OBJECTIVE: Oophorectomy were performed at an early age may be associated with increased risks, particularly cardiovascular risks. Physicians typically make the decision to perform bilateral oophorectomy in patients undergoing total abdominal hysterectomy for benign reasons based not only on patient-specific factors but also on their own professional experience Anti-Müllerian Hormone (AMH) is a serum marker produced by granulosa cells and is indicative of ovarian reserve. The aim of this study is to evaluate the impact of preoperative AMH levels on the decision-making process for bilateral salpingo-oophorectomy in patients undergoing hysterectomy.

METHODS: A total of 100 patients were included in the study, with 50 patients undergoing total abdominal hysterectomy with bilateral salpingectomy and 50 undergoing total abdominal hysterectomy with bilateral salpingo-oophorectomy for benign indications between February, 2020 and September, 2024. Preoperative measurements of Anti-Müllerian Hormone (AMH), Follicle-Stimulating Hormone (FSH), Luteinizing Hormone (LH) and Estradiol (E2) levels were available for all patients. Patients with malignant conditions requiring oophorectomy and certain benign conditions (such as endometrioma) were excluded.

RESULTS: A total of 100 reproductive-age patients, aged 40-50, who underwent hysterectomy for benign reasons were included in the study. Patients were divided into two groups: 50 patients who underwent bilateral oophorectomy and 50 who did not undergo oophorectomy. All hysterectomy procedures were evaluated preoperatively by the same surgeon, who also performed all the surgeries. The most common indication for hysterectomy was fibroids. The mean age in total abdominal hysterectomy with bilateral salpingectomy group was 43,8 years, and the mean age in the total abdominal hysterectomy with bilateral salpingo-oophorectomy group was 46,4 years. Among the serum markers analyzed, only AMH levels were found to be significantly different, with higher AMH values observed in the non-oophorectomy group. (0,19 vs. 0,47 years, $p<0,01$). No significant differences were detected between the groups in terms of FSH, LH or E2 levels.

CONCLUSION: In this retrospective study, serum AMH levels may play a role in the decision to perform oophorectomy

in women aged 40-50 undergoing hysterectomy for benign gynecological reasons. Larger studies, including patients from different surgeons, could provide more robust evidence regarding the influence of AMH on surgical decision-making.

Keywords: Anti-Mullerian Hormone, Hysterectomy, Salpingectomy, Salpingo-oophorectomy

Table-1: Laboratory findings

	Oophorectomy – (n:50)	Oophorectomy + (n:50)	P value
AMH (min-max) mcg/L	0,47 (0,01-2,5)	0,19 (0,01-0,98)	<0,01
FSH (min-max) mIU/mL	10,6 (0,3-67,9)	16,7 (0,3-134,1)	0,13
LH (min-max) mIU/mL	8,8 (0,07-64,3)	9,7 (55,3-9,7)	0,71
E2 (min-max) pg/mL	120,8 (11,8-530,3)	103,8 (0,1-543)	0,41

SS-031

Impact of Adding Misoprostol to Prophylactic Transamine in Myomectomy Operations

Anıl Karakılınç[1], Onur Atakul[1], Hasan Volkan Ege[1], Ayşe Sena Küçükkayıkçı[2], Derman Basaran[1]
[1]Department of Obstetrics and Gynecology, Hacettepe University, Ankara, Turkey
[2]Department of Obstetrics and Gynecology, Etlik City Hospital, Ankara, Turkey

OBJECTIVE: Uterine fibroids (Myomas) are the most frequently detected benign neoplasms of the uterus. Since some patients are asymptomatic, the true incidence is not clearly known. Surgical treatments are often applied to myomas that cause many symptoms such as abnormal uterine bleeding, pelvic pressure and infertility. Myomectomy operations are associated with serious blood loss. Medical or mechanical methods are used to prevent blood loss. In our study, the effect of adding prophylactic misoprostol (Cytotec®) on blood loss in patients who received intravenous transamine during myomectomy was investigated.

MATERIAL-METHODS: 79 patients who underwent laparotomic myomectomy at Hacettepe University Hospital between 2019 and 2024 were included in the study. While all patients were given 1000 mg transamine (IV) intraoperatively, 400 mcg rectal misoprostol was administered to an additional 29 patients in the preoperative operating room. They were compared in terms of hemoglobin decrease percentages and transfusion needs. Total myoma size was obtained by adding the diameters of the 3 largest myomas.

RESULTS: The average age of the patients included in the study was 37.6 (min: 26, max: 52). More than one myoma (maximum 24) was surgically removed in 52 patients. Blood transfusion was required in 27.5% (n: 22) of the patients. There was no significant difference in preoperative and postoperative day 1 hemoglobulin values, age, number of myomas removed, and total myoma diameters between the misoprostol-administered group and the non-administered group. The primary result of this study that there is no significant difference between the two groups in terms of the percentage decrease between preoperative and postoperative hemoglobin values and the need for blood transfusion (p: 0.467, p: 0.280, respectively). While the number of myomas in the group requiring blood transfusion was found to be significantly higher than in the group not requiring blood transfusion (p:.023), no significant difference was observed in terms of total myoma diameters in terms of blood transfusion requirement (p:.096).

CONCLUSION: Myomectomy operations are associated with blood loss. Administration of intraoperative transamine is associated with decreased blood loss. In this study, there

is no significant difference between two groups in terms of percentage decrease between preoperative and postoperative hemoglobin values, neither in terms of blood transfusion requirement.

Keywords: Uterin fibroids, Myomectomy, Misoprostol, Transamine, Blood Loss

Comparison between Misoprostol (+) group and Misoprostol (-) group

	Misoprostol (-)	Misoprostol (+)	p value
Age	37.4 (5.3)	37.9 (6.2)	.662
Total number of fibroids	2 (1-24)	2 (1-13)	.939
Total diameter of fibroids	9.85 (2.2- 24.5)	8.5 (2.0- 27.0)	.641
Preoperative Hemoglobin	12.9 (1.2)	11.8 (1.8)	.005
Postoperative Hemoglobin in first day	10.6 (1.1)	9.9 (1.3)	.024
Percentage of hemoglobin decrease (%)	18.3 (5.7)	16.7 (10.0)	.467
Need of Transfusion Yes No	 16 (32.0 %) 34 (68.0 %)	 6 (20.7 %) 23 (79.3 %)	.280

SS-032

Anti-Mullerian Hormon and Decreased Bone Mineral Density in Premenopausal Women

Mehlika Beste Yücedağ, Murat Cengiz, Zafer Selcuk Tuncer
Obstetrics and Gynecology Department, Hacettepe University, Ankara, Turkey

OBJECTIVE: Ovarian function is important for bone health. It is known that the decrease in bone mineral density, along with reduced estrogen levels after menopause, leads to an increased predisposition to osteoporosis. Osteoporosis is less frequently reported during the premenopausal period and not routinely screened.The indirect methods used to assess ovarian function and reserve are anti-mullerian hormon (AMH), folicule-stimulating hormone(FSH), and luteinizing hormone(LH). In our study, we aimed to evaluate the effects of these three hormone levels in predicting pathological decrease in bone mineral density in women of reproductive age.

METHODOLOGY: In our study DEXA (Dual-Energy X-ray Absorptiometry) technique is used to measure bone mineral density. Between 2020 and 2023, patients who applied to the Hacettepe University Gynecology and Obstetrics Outpatient Clinic were retrospectively screened. Those aged 40-50 years who had simultaneous DEXA tests and serum AMH, FSH, LH, and E2 tests, along with their clinical information, were included in the study. The exclusion criteria for the study were being in menopausal status, pregnancy situation, history of osteoporosis treatment, history of steroid-derived drug use, presence of endocrine disorders (Cushing's syndrome, hyperprolactinemia, hyperthyroidism), presence of ovarian and uterine malignancies, and history of hysterectomy). Patients categorized into two groups according to their DEXA tests; Healthy bone group and pathologic bone group (osteopenic and osteoporotic patients). We compared these two groups in terms of Body Mass Index (BMI), smoking history, FSH, LH, AMH, estriol, calcium, and phosphorus levels. Statistical data were analyzed using the Chi-Square test, and p-values were calculated.

RESULTS: Among the 94 patients, pathologic bone group was detected in 50, while no bone loss was found in the other 44 patients. In the comparison, BMI was found to be significantly lower in the group with pathological bone loss ($p = 0.03$). While serum FSH levels were significantly higher in the group with pathological bone diagnosis ($p = 0.08$), no statistically significant differences were found between the groups in terms of serum AMH and E2 values in our study group (Table-1).

CONCLUSION: In women under 50 years of age in the reproductive period, we found a significant relationship between FSH levels, one of the markers indicating ovarian reserve, and pathological bone loss. In this age group, attention should be

given to bone loss in women with elevated FSH levels. We did not detect a relationship between pathological bone diagnosis and AMH or estradiol levels. We concluded that AMH has no role in predicting bone health in these women. Although the number of patients in our study represents a significant limitation, further studies would be beneficial.

Keywords: antimullerian hormon, osteopenia, bone density

Table-1

	Healthy Group (n=44)	Pathologic Bone Group (n=50)	p value
Age	46,1 (+/- 3,07)	45,2 (+/- 3,5)	.21
BMI	28,4 (+/- 5,3)	25,6 (+/- 3,2)	.003
AMH	0,3 (0,01-1,69)	0,39 (0 – 3,1)	.41
FSH	18,03 (1,34 – 90,9)	34,5 (2,91 – 141,8)	.008
E2	108,8 (11,8 – 456,4)	93,4 (11,8 – 384,8)	.42
Ca	11,5 (8,6 – 98,5)	9,56 (8,9 – 10,4)	.34
P	3,2 (2,2 – 4,04)	3,3 (1,4 – 4,9)	.71
Smokers Nonsmokers	8 (18 %) 36 (81%)	18 (36 %) 32 (64 %)	.052

SS-033

Malignancy potential of endometrial polyps in asymptomatic postmenapausal patients

Zeki Cihad Akkuş, Batuhan Aslan, Fulya Kayıkçıoğlu, Yaprak Üstün
ETLİK ZÜBEYDE HANIM GYNECOLOGY TRAINING AND RESEARCH HOSPITAL

INTRODUCTION: The prevalence of endometrial polyps in asymptomatic, postmenopausal women remains unclear, with no established clinical guidelines on their management or significance.Postmenopausal women often experience various gynecological issues, including the formation of endometrial polyps, which can be detected through ultrasonographic examination. These polyps are non-cancerous growths within the uterine lining, but it is crucial to assess their malignancy potential, as they can potentially develop into endometrial cancer. This research paper aims to evaluate the malignancy potential of incidentally detected endometrial polyps in asymptomatic postmenopausal women using ultrasonographic imaging.

METHODOLOGY: The study included patients who underwent operative hysteroscopic polypectomy between December 2022 and August 2024. The study population consisted of asymptomatic postmenopausal women who underwent routine ultrasonographic examinations. Patients with incidentally detected endometrial polyps were further evaluated through hysteroscopy, and their polypectomy specimens were histopathologically examined. Premenopausal patients, those with a history of abnormal uterine bleeding at the time of presentation or any stage of the postmenopausal period, and those with abnormal cervical cytology findings were excluded from the study.

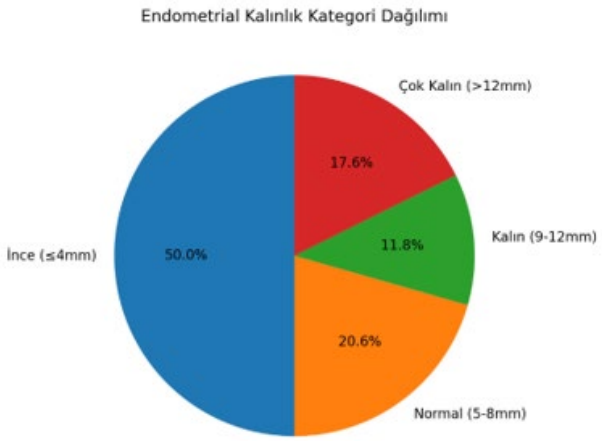
RESULTS: A total of 34 asymptomatic postmenopausal women were included in the study. The mean age of the patients was 58.59 ± 7.08 years. The average BMI of the patients was 29.02 ± 3.42. Only two patients were nulliparous, and the mean parity was 2.71 ± 1.08. Only one patient had a family history of gynecologic malignancy. While 12 patients had no comorbidities, 13 had one, 6 had two, and 3 had three comorbidities. Hypertension and diabetes were the most commonly observed comorbidities. The average endometrial thickness was 6.91 ± 4.73 mm, with a notable degree of variability. When categorized by endometrial thickness, 17 patients had thin endometrium, 7 had normal, 4 had thick, and 6 had very thick endometrium. Histopathological examination revealed 28 cases of endometrial polyp, 4 cases of hyperplastic polyp, 1 case of adenomyomatous polyp, and 1 case of endometrial intraepithelial neoplasia.

CONCLUSION: The findings of this study suggest that the

malignancy potential of incidentally detected endometrial polyps in asymptomatic postmenopausal women is low. Until more data is available, expectant management may be a reasonable strategy for incidentally discovered, asymptomatic polyps.

Keywords: endometrial, polyps,asymptomatic,postmenapausal,patients

Endometrial thickness



SS-034

Efficacy of colchicine and melatonin in the treatment of rat endometriosis model: An animal study

Serkan Oral[1], Yaşam Kemal Akpak[2], Gulay Turan[3], Duygu Lafcı[4], Mehmet Ferdi Kinci[5], Ceyda Sancaklı Usta[4]
[1]Halic Univercity, Faculty of Medicine, Department of Obstetrics and Gynecology, Türkiye
[2]University of Health Sciences, Izmir Faculty of Medicine, Izmir City Hospital, Department of Obstetrics and Gynecology, Türkiye
[3]Balıkesir University Medical Faculty Medical Pathology Department, Türkiye
[4]Balikesir University, Faculty of Medicine, Department of Obstetrics and Gynaecology, Türkiye
[5]Izmir City Hospital, Department of Obstetrics and Gynecology, Türkiye

OBJECTIVE: This study investigates the therapeutic effects of colchicine and melatonin on endometriotic implants in an experimentally created endometriosis model in rats. Study design: Forty-four adult female Wistar albino rats weighing between 260 and 300 g, 8 weeks old, were selected for the study. The unilateral uterine horn of rats with a bicornuate uterus was excised for 1 cm, washed with sterile saline, incised longitudinally, and the endometrium was exposed. A 0.5*0.5 cm endometrial tissue sample taken with a scalpel was implanted with suturing (4/0 Vicryl) to the abdominal wall. Forty-four rats were divided into four groups. Group 1 was randomized as the endometriosis group (control), Group 2 as endome- triosis + colchicine treatment, Group 3 as endometriosis + melatonin treatment, and Group 4 as the endome- triosis + melatonin + colchicine treatment group. The colchicine (Sigma Chemical Co., St Louis, Missouri) group was administered orally at a dose of 0.1 mg/kg, and the Melatonin group orally at a dose of melatonin (20 mg/kg per day). Treatment continued daily for 30 days.

RESULTS: In the post-treatment focal diameter measurements, the endometrial focal diameter in the colchicine and colchicine + melatonin group was significantly lower than the control group (p=0.026). Bcl-2 levels of the colchicine group were lower than the control group and the melatonin group (p=0.021).

CONCLUSION: Colchicine and melatonin reduce adhesion to the peritoneal surface in ectopic endometrial cells. It also acts by increasing apoptosis and decreasing cell survival.

Keywords: Endometriosis, Colchicine, Melatonin, Rat model

SS-035

Evaluation of postoperative outcomes of patients who underwent laparoscopic burch colposuspension during total laparoscopic hysterectomy

Cagla Bahar Bulbul, Volkan Karatasli
Department of Gynecology and Obstetrics, Balikesir Ataturk City Hospital, Balikesir, Turkey

OBJECTIVE: To present the postoperative results of patients who underwent at the same time laparoscopic Burch colposuspension during total laparoscopic hysterectomy.

MATERIALS-METHODS: 35 patients aged 45-65 who applied to Balıkesir Atatürk City Hospital Department of Obstetrics and Gynecology between 2021-2024 and who had hysterectomy indications due to benign reasons and had stress urinary incontinence complaints underwent Total laparoscopic hysterectomy (with or without BSO) and laparoscopic Burch colposuspension in the same session.

RESULTS: A total of 35 patients were included in the study (mean age was 52 years (range 45-65 years). The operation time varied between 58 and 121 minutes. The estimated blood loss varied between 210 and 450 ml. The decrease in hemoglobin values was 1.2 g/dl on average. All patients were discharged from the hospital after 48 hours. Bladder injury occurred in 1 patient. Except for this patient, the urinary catheter was removed at the postoperative 24th hour. The catheter was removed with bladder exercises 10 days later in the patient with bladder injury. At the postoperative 1st week, 1st month and 6th month controls, 30 out of 35 patients (85.7%) stated with satisfaction that their stress incontinence complaints had regressed. At the 6th month control of the patient with bladder injury, stress incontinence complaints had regressed. A minimal decrease in stress incontinence complaints was reported in 5 out of 35 patients (14.3%). Kegel exercises were recommended to all patients in the postoperative period.

CONCLUSION: Patients who require hysterectomy for benign gynecological reasons should be asked in their medical history whether they have incontinence complaints. In patients with stress incontinence, the Burch procedure, which is the gold standard treatment for this type of incontinence, can be safely performed laparoscopically.

Keywords: laparoscopic Burch colposuspension, laparoscopy, hysterectomy, incontinance

SS-036

Features of polycystic ovary syndrome in adolescence

Mujde Can Ibanoğlu, Elif Dilsah Yasar, Yaprak Üstün
ETLİK ZUBEYDE HANIM WOMENS HEALTH AND OBSETRICS HOSPITAL

INTRODUCTION: Polycystic ovary syndrome is a complex endocrine disorder that affects women of reproductive age, characterized by a combination of hormonal imbalances, metabolic disturbances, and ovarian dysfunction. It is one of the most common female endocrine disorders, affecting an estimated 5-20% of women worldwide. For adolescents, assessing PCOS can be challenging, as the clinical manifestations may not be specific.Therefore, we aimed to examine more detailed characteristics in the clinical management and diagnosis of PCOS.

METHODOLOGY: We retrospectively evaluated adolescent patients who presented to the PCOS outpatient clinic between December 2022 and July 2024. Patients under the age of 18 were included in the study. The diagnosis of PCOS was made according to the Rotterdam criteria. The normal menstrual cycle was defined as occurring between 21-35 days. All hormonal assessments were performed on the 3rd day of the menstrual cycle. Clinical hirsutism was defined as mFG>8. The PCOS phenotypes were categorized as: A: HA+OD+PCOM, B: HA+OD, C: HA+PCOM, D: OD+PCOM. Patients with additional endocrine disorders or systemic comorbidities were excluded from the study.

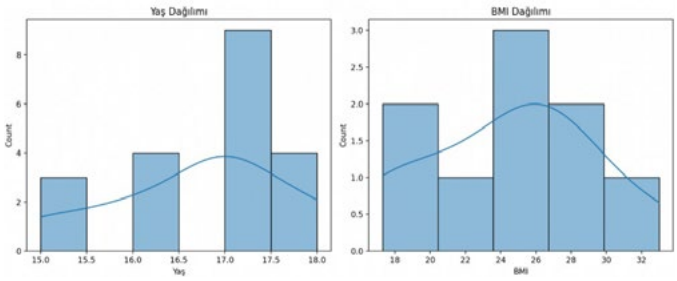
RESULTS: The study included 20 patients, with a mean age of 16.7 ± 0.98 years and a mean BMI of 24.53±5.02. The primary reasons for presentation were irregular menstrual cycles (9 patients), hirsutism (9 patients), acne (1 patient), and weight concerns (1 patient). Of the total 20 patients, 15 presented with polycystic ovarian morphology, while 5 did not. Mild hirsutism was observed in 12 patients, while 40% of the patients exhibited more pronounced hirsutism.

The most common phenotype observed was type C, followed by types A, B, and D. Examination of the hormonal values revealed an average FSH of 3.79 ± 1.19, LH of 9.95±4.3, LH/FSH ratio of 2.55±1.2, AMH of 7±5.16, 17-OHP of 2.4±1.65, TSH of 3.27±1.5, and PRL of 14.33+7.23. Phenotype D shows the highest mean LH levels (10.225 mIU/mL) and E2 levels (79.1 pg/mL). Among the PCOS phenotypes, Phenotype A exhibited the highest mean AMH levels and HOMA-IR. Furthermore, Phenotype A had the highest mean LH/FSH ratio, closely followed by Phenotype C.

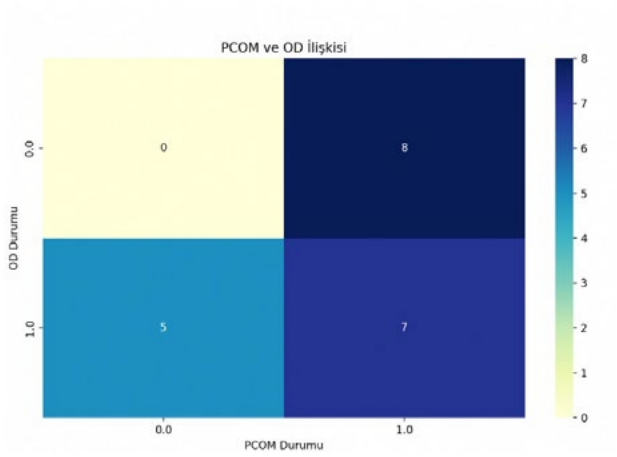
CONCLUSION: In this study, we have evaluated the demographic and clinical characteristics of adolescent patients with PCOS. The most common phenotype observed was type C, characterized by hyperandrogenism and polycystic ovarian morphology, which is consistent with previous reports.

Keywords: PCOS, ADOLESCENCE, DEMOGRAPHIC VARIABILITY

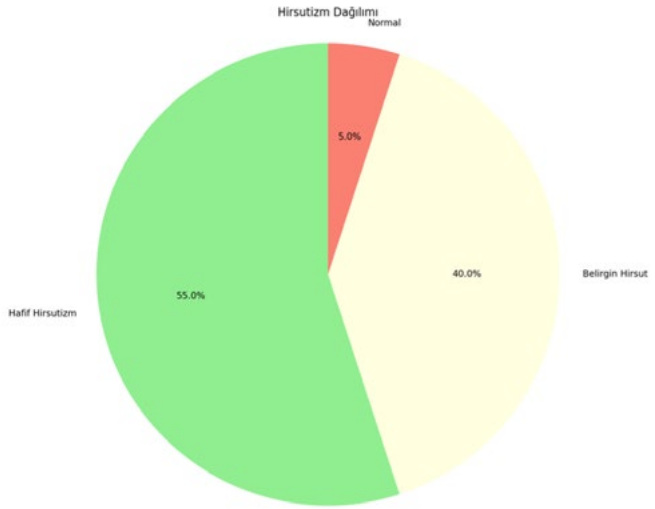
Age and BMI distrubitioun in adolescence patients with PCOS



Distribution of polycystic ovarian morphology and ovulatory dysfunction in adolescent patients with polycystic ovary syndrome



Distrubiton of hirsutism in adolescent patients with polycystic ovary syndrome



SS-037

The Silent Threat: Miscarriage Rates and Pregnancy Risks in Women with Endometriosis

Ayşe Gizem Yıldız, halis Doğukan özkan, Elif Ece Öztürk
Etlik Zübeyde Hanım Gynecology Training and Research Hospital, Ankara

OBJECTIVE: Endometriosis is an inflammatory disease in which endometrial tissue is ectopic outside the uterine cavity. It is most commonly found in the myometrial layer of the uterus (adenomyosis), ovaries and uterine ligaments, but less commonly in the anterior abdominal wall, often in the old cesarean section line, old episiotomy scar, around the umbilicus, anal sphincter or in the liver or lung outside the pelvis. In the most common theory of ectopic endometrial cells (Sampson's theory of retrograde menstruation), endometrial cells flow backwards through the fallopian tubes and into the peritoneal cavity during menses(1).

So, endometriosis is an estrogen-dependent, benign, inflammatory disease that affects females during their premenarcheal, reproductive, and postmenopausal hormonal stages. During pregnancy, small peritoneal endometriosis lesions may undergo decidualization or regression, and the endometriosis-associated pain symptoms often improve.

Although not all studies support this association, evidence suggests that endometriosis adversely affects some pregnancy outcomes(2). Reported outcomes include preterm birth, placenta previa, hemorrhage, and low birth weight. The mechanism behind these associations is not known, and additional surveillance for pregnant individuals with known endometriosis is not advised. In this study, we aimed to evaluate the frequency of abortion in patients with endometriosis and the characteristics of aborting patients.

METHOD: Among 2000 patients with endometriosis who were followed up in Etlik Zübeyde Hanım gynecology training and research hospital gynecology outpatient clinic between 2015 and 2023, 39 patients who had abortion in their first pregnancy after diagnosis and treatment were included in the study.

RESULTS: Out of 2000 patients with endometriosis presenting to the gynecology outpatient clinic, we obtained pregnancy outcomes of 256 patients. 39 (%12) of them had aborted their first pregnancy after diagnosis. The mean age of these patients was 28.7 years at diagnosis. The mean duration of pregnancy after diagnosis was 1 year and 7 months. 5 (12%) of the patients had received medical treatment, 11 (28%) had received surgical treatment for endometriosis. 23 (58%) had not received any treatment. 11 of the patients conceived with assisted reproductive techniques. The average Ca -125 level was 53.6.

CONCLUSION: Pregnancy in women with endometriosis is associated with a higher likelihood of adverse outcomes, thus emphasizing the need for increased clinical awareness.

References

1.Sampson JA Peritoneal endometriosis due to the menstrual dissemination of endometrial tissue into the peritoneal cavity Am J Obstet Gynecol. 1927;14:422.

2.Glavind MT, Forman A, Arendt LH, Nielsen K, Henriksen TB Endometriosis and pregnancy complications: a Danish cohort study. Fertil Steril. 2017 Jan;107(1):160-166.

Keywords: endometriosis, abortion, negative pregnancy outcomes

SS-038

Evaluation Of Cerebrospinal Fluid Protein Levels In Pregnant Women With And Without Proteinuria

Arif Caner Erdoğan
Dr. Ali Kemal Belviranlı Obstetrics And Gynecology Hospital, Department of Gynecology and Obstetrics, Konya, Turkey

OBJECTIVES: To investigate the association between cerebrospinal fluid (CSF) protein levels and perinatal outcomes in pregnant women with and without proteinuria.

METHODS: Our study is a prospective randomised controlled trial. A total of 61 pregnant women, 31 proteinuria-negative and 30 proteinuria-positive, 31 proteinuria-negative and 30 proteinuria-positive, who gave birth by caesarean section with spinal anaesthesia between March 2023 and October 2023 and who applied to Necmettin Erbakan University Obstetrics and Gynaecology Department were included in the study. In our study, cerebrospinal fluid samples obtained from the patients were analysed in the biochemistry laboratory using the turbidimetric method in the C 702 series of the Roche Cobas 8000 model. The data obtained were recorded and analysed using SPSS Statistics 26 software.

RESULTS: No statistically significant difference was found between the groups in terms of socio-demographic characteristics ($p>0.05$). There was no statistically significant correlation between proteinuria and CSF protein levels ($r=-0.014$, $p=0.912$). The sensitivity, specificity, PPV (positive predictive value) 72.73%, NPV (negative predictive value) 82%, AUC (area under the curve) 0.715, sensitivity 47.06%, specificity 93.18%, PPV (positive predictive value) 72.73%, NPV (negative predictive value) 82%, and AUC (area under the curve) 0.715 for neonatal intensive care unit hospitalisation at the cut-off point of 0.86 for spot urine protein/creatinine ratio. The risk of FGR (fetal growth restriction) increased up to 3.9 times in pregnant women with spot urine proteinuria ($p=0.024$). A significant correlation was found between the number of patients requiring neonatal hospitalisation and spot urine protein levels in pregnant women with proteinuria ($r=0.468$, $p=0.001$). Pre-eclampsia was observed in 23.3% (7 patients) and FGR in 16.7% (5 patients) of the patients with positive proteinuria. Higher levels of creatinine and urea were observed in patients with positive proteinuria ($p=0.035$ and $p=0.004$, respectively). There was no significant correlation between age and spot urine protein levels ($r=0.224$, $p=0.083$).

CONCLUSIONS: There is no correlation between spot urine proteinuria and CSF protein. Urine protein testing should be performed routinely in pregnant women and can provide information not only about pre-eclampsia but also about fetal health. Pregnant women with proteinuria should be followed

closely for fetal growth restriction and should be considered for neonatal intensive care unit requirements.

Keywords: Proteinuria, CSF protein level, pre-eclampsia, FGR, neonatal intensive care unit

SS-040

Evaluation of perinatal outcomes according to fasting bile acie level in pregnant women diagnosed with intrahepatic cholestasis

Hayat Terkan, Gizay Serin, Yağmur Acıyiyen
Sağlık Bakanlığı Üniversitesi, Gaziosmanpaşa Eğitim ve Araştırma Hastanesi, Kadın Hastalıkları ve Doğum Kliniği, İstanbul

This study was carried out with 160 pregnant patients who were diagnosed with Intrahepatic Cholestasis and gave birth in the same clinic. Patients are divided into two groups according to fasting bile acid ratios: Group 1 (54 patients) and Group 2 (106 patients), with mild ICP parameters between 10 and 40 micromoles/liter, according to the literature. Levels above 40 micromoles/litre are considered severe ICP. Weeks of birth, delivery methods, cesarean section indications, if any, birth weights, 1st and 5th minute APGAR scores, admission to the neonatal intensive care unit, presence of meconium amniotic fluid at birth and fetal death data were recorded in both groups. compared.

It was determined that the cholestasis diagnosis and birth weeks of the patients with meconium in the amniotic fluid were significantly longer than the group without meconium. It was observed that the rates of ALT values over 75 and AST values over 130 in the patients in Group 2 were significantly higher compared to the group.

Intrahepatic cholestasis of pregnancy causes unforeseen fetal changes. Patients with bile acid levels over 40 and ALT values over 75 and/or amniotic fluid administered meconium during birth should be evaluated carefully due to its association with poor perinatal outcomes

This study aimed to determine perinatal outcomes in pregnant women diagnosed with intrahepatic cholestasis of pregnancy (ICP) according to fasting bile acid concentrations and to evaluate pregnancy management according to fasting bile acid levels.

Keywords: bile acid,itchin,intrahepatic cholestasis of pregnancy,newborn,intensive care

SS-041

Can Late Second Trimester FIB4 Score Predict HELLP Syndrome in Preeclamptic Patients?

Cansu Dağ, Burcu Dinçgez, Gülten Özgen
University of Health Sciences, Bursa Yuksek Ihtisas Research and Training Hospital, Department of Obstetrics and Gynecology, Bursa, Turkey

AIM: HELLP syndrome is a severe obstetric complication characterized by hemolytic anemia, elevated liver enzymes and thrombocytopenia. It occurs in less than 1% of all pregnancies and in 10-20% of severe preeclampsia or eclampsia. Identifying patients who will develop HELLP syndrome in preeclampsia is quite challenging. Thus, researchers have focused on finding predictive markers. FIB-4 score is a non-invasive marker, which reflects liver damage. It compromises age, alanine aminotransferase, aspartate aminotransferase and platelet count. FIB-4 can be utilized to classify different stages of liver fibrosis in patients with viral hepatitis and non-alcoholic fatty liver disease. Since preeclampsia is associated with liver involvement resulting in subcapsular hematoma, infarction and necrosis, researchers reported higher FIB4 levels in preeclampsia. To the best of our knowledge, there is no study evaluating the predictive role of FIB4 for HELLP syndrome in preeclamptic patients. Here, we aimed to evaluate this relationship.

MATERIAL-METHODS: This is a retrospective study which was conducted at University of Health Sciences, Bursa Yuksek Ihtisas Research and Training Hospital between March 2022 and March 2023. A total of 70 preeclamptic patients between 18 to 45 years old were included in the study. The exclusion criteria were composed of multiple pregnancies, patients with known coagulopathy, acute hepatitis, drug-induced liver injury, unavailable perinatal data. Patients were divided into two groups as HELLP syndrome (n=11) and preeclampsia without HELLP syndrome (n=59). Demographic features, serum alanine and aspartate transaminases, platelet levels, obstetric outcomes were recorded and compared between groups. The FIB4 score was calculated using the following formula: FIB4=Age(years)×AST(IU/L)/Platelet count(×109/L)×ALT(IU/L)½. Receiver operating curve analysis was performed to determine the predictive role of FBI4 score for HELLP syndrome.

RESULTS: The demographic, clinic and laboratory characteristics of all patients were presented in Table. No significant difference was detected between two groups in terms of age, body mass index, gravida, systolic and diastolic blood pressure, birth week, birth weight and cesarean section rates. Platelet count was significantly lower in HELLP group while serum transaminases were higher. The median FIB4 score was 2.12 (0.28-3.54) in HELLP group and 0.65 (0.22-3.81) in preeclampsia without HELLP syndrome which was significantly higher (p=0.001). FIB4 score >1.09 predicted HELLP syndrome with 81.8% sensitivity and 84.8% specificity in preeclamptic patients (AUC=0.809, p=0.001).

CONCLUSION: FIB4 score is a cheap and easy available marker to predict HELLP syndrome in preeclampsia. Considering the high mortality and morbidity in HELLP syndrome, we suggest that FIB4 could be used to detect the high risk patients for this syndrome and close monitoring could be applied to these patients.

Keywords: FIB4 score, HELLP syndrome, preeclampsia

Figure. Receiver operating curve evaluating the role of FIB4 for the prediction of HELLP syndrome in preeclampsia

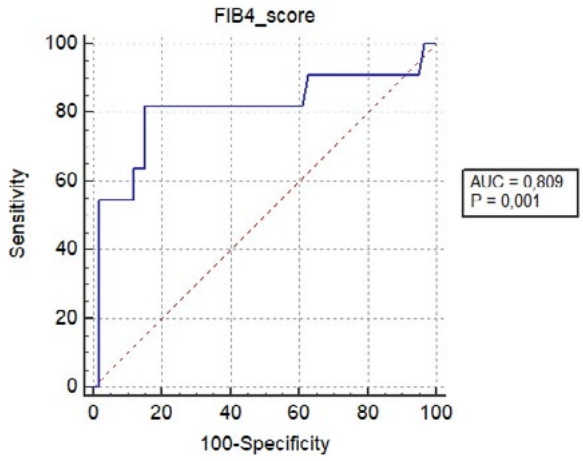


Table. The demographic, clinic and laboratory characteristics of all patients

	Preeclampsia with HELLP syndrome (n=11)	Preeclampsia without HELLP syndrome (n=59)	p
Age (years)	27.9 ± 3.9	31.5 ± 6.6	0.087
BMI (kg/m2)	29.09 ± 3.2	29.37±3.98	0.826
Gravida (n)	2 (1-4)	2 (1-7)	0.562
Systolic blood pressure (mmHg)	150 (140-190)	150 (140-190)	0.377
Diastolic blood pressure (mmHg)	100 (90-100)	100 (90-110)	0.649
Platelet (x103/mm3)	159.4 ± 81.7	253.5 ± 64.03	<0.001
AST (IU/L)	60 (12-385)	20 (5-45)	<0.001
ALT (IU/L)	95 (8-299)	14 (6-58)	0.001
Birth week (week)	32 ± 3.9	32.5 ± 4	0.728
Birth weight (gram)	1560 (540-3990)	1702.5 (550-3720)	0.802
Cesarean section (n,%)	10 (90.9%)	54 (91.5%)	1.000
FIB4 score	2.12 (0.28-3.54)	0.65 (0.22-3.81)	0.001

SS-042

Comparing the Incidence of Episiotomy Wound Complications in Postpartum Patients With and Without Labor Induction

Bilal Emre Erzeneoglu[1], Edip Alptug Kir[2], Isıl Damla Dinc[3], Ozgur Deren[2]
[1]Cankiri State Hospital Department of Obstetrics and Gynecology
[2]Hacettepe University Hospital Department of Maternal Fetal Medicine
[3]Hacettepe University Hospital Department of Obstetrics and Gynecology

Labor induction is a common obstetric procedure used to stimulate uterine contractions before the spontaneous onset of labor. It is typically indicated for a variety of maternal and fetal conditions, including post-term pregnancy, preeclampsia, and fetal growth restriction. Although induction of labor is generally considered safe, it is associated with certain risks, including an increased likelihood of cesarean delivery, prolonged labor, and potential complications such as uterine hyperstimulation. One area of ongoing research and clinical concern is the impact of labor induction on postpartum outcomes, particularly the incidence of episiotomy wound infections and dehiscence. Episiotomy, a surgical incision made in the perineum during childbirth, is often performed to enlarge the vaginal opening and prevent severe perineal tears. However, like any surgical procedure, it carries the risk of infection, which can lead to significant morbidity, including pain, delayed wound healing, and, in severe cases, systemic infection. The relationship between labor induction and the risk of episiotomy wound infection remains unclear, with conflicting evidence in the literature. Some studies suggest that the hormonal and mechanical interventions associated with induction may alter the normal physiology of labor and delivery, potentially increasing the risk of infection and dehiscence at the episiotomy site. This study aims to compare the incidence of episiotomy wound infections among postpartum patients who underwent labor induction versus those who did not. By evaluating the potential association between induction of labor and wound infection rates, this research seeks to contribute to the ongoing discussion regarding the safety and best practices of labor induction.

METHODOLOGY: This study retrospectively evaluates vaginal childbirths that occurred at Hacettepe University Hospital between January 2023 and May 2024. Postpartum examinations were reviewed to identify patients who experienced any degree of suture dehiscence or had any signs of infectious discharge, which were included as wound complications. The Chi-square test was employed to determine the statistical significance of the results, with a p-value of less than 0.05 considered statistically significant.

RESULTS: A total of 520 patients were initially enrolled in the study; however, data from 20 patients were excluded due to insufficient information. Among the remaining 500 participants, 278 underwent labor induction, while 222 did not receive induction. In the non-induction group, 14 out of 222 patients experienced episiotomy complications, whereas in the induction group, 7 out of 278 patients had such complications. The difference between the groups was statistically significant, with a p-value of 0.035.

DISCUSSION: The study findings indicate that there is a statistically significant difference between the induction and no induction groups. This difference may be attributed to the tissue being less edematous during labor, as induction can shorten the duration of labor, potentially reducing edema formation, which in turn may explain the lower incidence of tissue complications. The strengths of this study include the statistical similarity of parity numbers and other independent variables across the groups, as well as the balanced distribution of these variables. Further studies with larger sample sizes are warranted to confirm and expand upon these findings.

Keywords: episiotomy, scar infection, wound complication

SS-043

Ethical analysis of physicians' attitudes towards antenatal aneuploidy screening

Ayse Figen Turkcapar[1], Nüket Örnek Büken[2]
[1]University of Health Sciences Gulhane Faculty of Medicine Ob&Gyn
[2]Hacettepe University Medicine Faculty Department of Medical History and Ethics

The aim of this study was to investigate physicians' behaviours and attitudes when presenting screening tests for aneuploidy in the antenatal period, and to identify the reasons for differences in behaviours and attitudes.

METHOD; The study was designed as a cross-sectional causal epidemiological study. The research was evaluated and approved by Hacettepe University Non-Interventional Clinical Research Ethics Committee (19.11.2019 decision No: 2019/27-07). Participation in the study was voluntary, and the invitation to participate and the electronic questionnaire form, which was prepared anonymously within the framework of the study, were sent by e-mail and message to the gynaecology and obstetrics specialists who are members of the Turkish Gynaecology and Obstetrics Association. Data were collected between 01/02/2021 and 31/07/2021 using an online, anonymous, cross-sectional survey. The responses of 194 participants who answered all questions were included in the analysis.

As a result of our study, we found that the majority of participating physicians recommended prenatal genetic screening tests. When the use of prenatal screening tests and test preferences of the participants were evaluated, it was observed that 86.1% used the 1st trimester combined test and cffDNA analysis with 67.7% in the 2nd place. 56.9% of the participants stated that they obtained written informed consent. Information was given only to the pregnant woman in 26.3%, to the pregnant woman and her husband in 63.8%, and to the pregnant woman, her husband and family in 26.8%.

When the attitudes of the participants were evaluated in terms of medical ethics, based on their answers to questions about the purpose of the tests and informed reproductive preferences, it can be said that the implementation of prenatal screening tests is compatible with their ethical justifications. The differences between the attitudes of the participants and their behaviour in clinical practice can be explained by the short time allotted for information due to working conditions and the feeling that the information given was not understood. The fact that the group with a younger age, and therefore a shorter time in specialisation, had a shorter time allocated to information can be explained by the fact that this group had a higher patient load. These results are in line with similar studies in the literature.

In conclusion, we believe that the results of our study contribute to a better understanding of the many different barriers that may affect patients' informed and free choices about prenatal screening and testing options. In particular, short time available for patient counselling due to busy work schedules and concerns about physicians' level of education and perception of service providers were identified as major barriers. Structured clinical counselling practices that empower and educate women and their families to make informed choices can particularly benefit those who may be overlooked by the busy and overburdened health care system. We also believe that improving health literacy in the community can influence the behaviour of clinicians.

Keywords: Prenatal screening, Ethical decision making, Attitudes and behaviours of Turkish Obstetricians

SS-044

A Rare Case: Uterine Osteosarcoma

Kübra Sevinç, Belma Gözde Özdemir, Çetin Çelik
Selçuk University Faculty Of Medicine, Gynecology And Obstetrics Department, Konya, Turkey

Uterine sarcomas are rare mesodermal-origin tumors, constituting less than 1% of all malignant uterine neoplasms. Among these, heterologous sarcomas, including osteosarcomas, are particularly rare, with only 21 cases reported in the English literature to date. Uterine sarcomas are known to be highly aggressive and are classified into two main groups: homologous sarcomas, composed of uterine-specific tissues, and heterologous sarcomas, composed of tissues foreign to the uterus. This case report presents a 62-year-old postmenopausal woman who presented to the clinic with abnormal uterine bleeding, a common symptom in such cases. Laboratory investigations revealed elevated tumor markers, including CA-125 (103 U/ml) and CA-19.9 (321 U/ml).

Imaging studies, including transvaginal ultrasonography and pelvic magnetic resonance imaging (MRI), revealed an irregular, heterogeneous mass completely filling and expanding the endometrial cavity, measuring approximately 100x45x55 mm. The lesion demonstrated areas of malignancy, with restricted diffusion on MRI, and extended into the proximal endocervical canal. There were no signs of myometrial invasion or lymph node involvement. Subsequent biopsy confirmed a diagnosis of "high-grade adenocarcinoma," and further evaluation led to the decision to perform total abdominal hysterectomy, bilateral salpingo-oophorectomy, retroperitoneal lymph node dissection, and omentectomy.

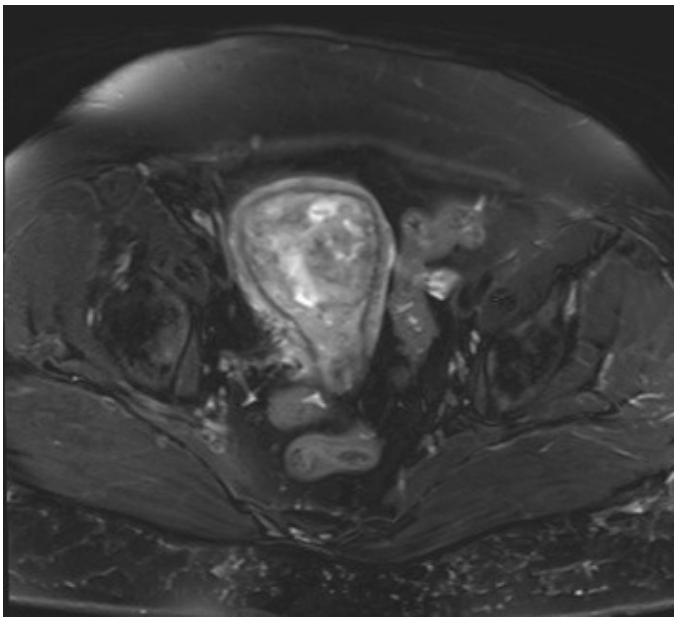
Intraoperative frozen section pathology indicated carcinosarcoma, a malignancy with both epithelial and mesenchymal components. Final histopathological analysis revealed the tumor consisted of an epithelial component of serous carcinoma and a mesenchymal component of high-grade undifferentiated sarcoma with areas of osteosarcoma. Myometrial invasion was observed to be less than 50%, with no involvement of the cervical stroma, serosa, or subserosa. The patient's ovaries were atrophic, and there was no evidence of lymphovascular or ovarian involvement. Additionally, computed tomography (CT) of the thorax revealed fibrotic bands in the lungs and nodules, which were deemed non-metastatic by the pulmonary department.

Following surgery, the patient was referred to the oncology department for further management. A diagnosis of primary uterine osteosarcoma was confirmed, and the patient was prescribed six cycles of chemotherapy. Despite aggressive surgical and medical interventions, uterine osteosarcomas typically follow a poor clinical course, with rapid progression and a high mortality rate. The literature suggests that the survival rates for these tumors are generally low, with the longest reported survival being only 37 months following diagnosis.

This case underscores the rarity and aggressive nature of uterine osteosarcomas and highlights the importance of early recognition, especially in postmenopausal women presenting with abnormal uterine bleeding. Although uterine osteosarcoma is an uncommon malignancy, it should be considered in the differential diagnosis for patients with similar clinical presentations. The prognosis remains poor despite multimodal treatment approaches, including surgery and chemotherapy. Further studies are needed to establish optimal therapeutic strategies for this rare and highly aggressive tumor.

Keywords: postmenopausal bleeding, rare tumor, surgical treatment, uterine carcinosarcoma, uterine malignancies, uterine osteosarcoma

Pelvic MRI findings



A lesion measuring approximately 100x45x55 mm, completely filling and expanding the endometrial cavity, was observed. On T2-weighted images, the lesion appeared slightly hyperintense compared to the myometrium, with intense and heterogeneous contrast enhancement following IV contrast injection. Diffusion-weighted images showed areas of diffusion restriction, suggestive of malignancy

SS-045

The Role of HPV-DNA Testing in the Management of Postcoital Bleeding Cases

Hasan Volkan Ege[1], Neslihan Discioğlu[2]
[1]Department of Obstetrics and Gynecology, Division of Gynecologic Oncology, Hacettepe University, Ankara, Turkey
[2]Clinic of Obstetrics and Gynecology, Bingöl State Hospital, Bingöl, Turkey

INTRODUCTION: Cervical cancer (CC) is the most common gynecological malignancy worldwide. Persistent Human Papillomavirus (HPV) infection plays a role in the etiology of the disease. Most patients are diagnosed through screening programs using HPV DNA testing. However, some are diagnosed due to abnormal bleeding complaints. Postcoital bleeding (PCB) is considered a significant sign of cervical cancer and is often evaluated through colposcopic examination. Nevertheless, PCB is frequently associated with benign pathologies. In this study, we aimed to investigate the importance of HPV DNA testing in the triage of PCB cases.

MATERIAL-METHOD: This study included patients from our center who presented with PCB and underwent colposcopic evaluation, and who also had available HPV DNA test results. In addition to demographic data, HPV DNA and Pap smear results prior to the procedure were assessed.

RESULTS: A total of 225 patients presented to our clinic with a diagnosis of PCB, of whom 140 with available HPV DNA test results were included in the study. The mean age of the patients was 37.7 years (range: 21-57), and 8.6% were postmenopausal. The smoking rate was 29.6%, while 65.2% of the patients reported using contraception. The most commonly used contraceptive method was an intrauterine device (31.5%), while 13.5% of patients used barrier methods (Table 1). After colposcopic evaluation, biopsies were taken from 59.3% (n=83) of the patients. Among those biopsied, five patients had CIN2 or higher-grade lesions (cancer: 1, CIN3: 2, CIN2: 2). All CIN2+ lesions were found in the HPV-positive group, while no CIN2+ lesions were identified in the HPV-negative group (p=0.005) (Table 2). In the group of 85 patients without HPV-DNA test results, CIN2+ lesions were found in two cases (cancer: 2), both of whom had major pathological findings on colposcopy.

DISCUSSION: Benign pathologies are commonly identified in patients evaluated for postcoital bleeding. The likelihood of finding CIN2+ lesions is significantly higher in HPV-positive patients compared to HPV-negative patients. In our study, no CIN2+ lesions were found in the HPV-negative group. The use of HPV-DNA testing in the management of PCB may reduce the rate of cervical biopsies, particularly in HPV-negative cases. However, if suspicious colposcopic findings are present, biopsies should be performed regardless of HPV-DNA status.

Keywords: Cervical Cancer, Cervical Intraepithelial Neoplasms, Human Papillomavirus DNA Test, Vaginal Bleeding

Table 1

	HPV-DNA Negative (n:95)	HPV-DNA Positive (n:45)	p-value
Age (mean)	38,4 ± 7,5	36,1 ± 8,1	.118
Menopause Yes No	 8 (08.4%) 87 (91.6%)	 4 (08.9%) 41 (91.1%)	.926
Parity 0 >1	 9 (10.0%) 81 (90.0%)	 8 (20.0%) 32 (80.0%)	.119
Smoking Yes No	 11 (25.0%) 33 (75.0%)	 10 (37.0%) 17 (63.0%)	.281
Contraception use Yes No	 38 (65.5%) 20 (34.5%)	 20 (64.5%) 11 (35.5%)	.925
Cervical Cytology Result Negative for Intraepithelial Lesion or Malignancy > ASC-US LSIL HSIL No Cervical Cytology	 74 3 0 0 18	 32 6 1 0 6	.030
Cervical biyopsi Yes No	 53 (55.8%) 42 (44.2%)	 30 (66.7%) 15 (33.3%)	.221

Demographic and clinical characteristics of the patients

Table 2

	HPV-DNA Negative (n:53)	HPV-DNA Positive (n:30)	p-value
Cervical Biyopsi < CIN 2 ≥ CIN 2	 53 0	 25 5	.005

Cervical biopsy results (n: 83)

SS-046

Management of Chylous Ascites in Gynecologic Oncology Surgeries

Murat Cengiz, Onur Can Zaim, Derman Basaran
Hacettepe University, Department of Gynecologic Oncology

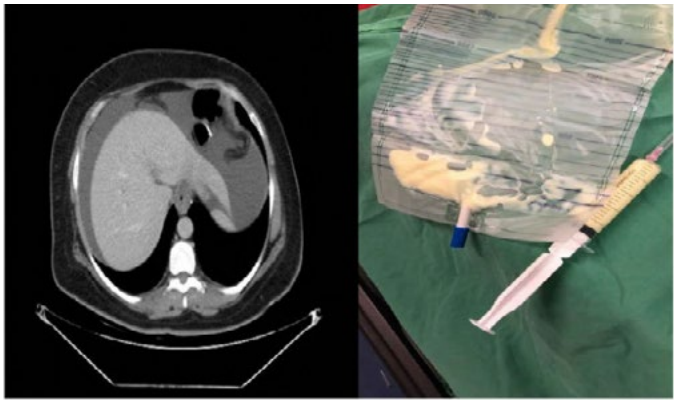
INTRODUCTION: Chylous ascites result from triglyceride-rich lymphatic fluid leakage into the peritoneal cavity. It can occur after gynecologic oncology surgeries and may also arise due to radiotherapy or lymphatic metastasis. This study reviews the incidence and management of chylous ascites in patients treated at Hacettepe University's Gynecologic Oncology Department over the past three years. METHODS: A retrospective analysis was conducted on patients diagnosed with chylous ascites at Hacettepe University between 2022 and 2024. The diagnosis was confirmed by triglyceride levels in ascitic fluid exceeding 150 mg/dL. We examined risk factors, clinical outcomes, surgical details, timing of onset, treatment modalities, and recovery times in relation to cancer type. RESULTS: Chylous ascites developed in 10 patients: 7 in the early postoperative period, 1 in the late postoperative period, and 2 in the very late period. In early cases, the average time to diagnosis was 3.5 days post-surgery. One patient developed ascites on day 25, and two others were diagnosed five years after surgery, following chemotherapy and radiotherapy. The average age was 56.3 years and the average BMI index was 30.1. Six patients had undergone surgery for endometrial cancer and four for ovarian cancer. Pelvic and paraaortic lymph node dissection was performed in 9 patients, with a mean of 23.2 pelvic and 22.7 paraaortic nodes removed. Four patients had lymph node metastases. The diagnosis was made through postoperative drain samples in 7 patients and paracentesis in 3. Triglyceride levels ranged from 237 mg/dL to 1832 mg/dL. Five patients were managed with a low-fat, medium-chain fatty acid diet and drainage; two received diet and somatostatin. Lymphangiography was performed in 2 patients, leading to decreased fluid output and resolution of ascites. One patient was treated with total parenteral nutrition (TPN) and somatostatin.

DISCUSSION: Previous studies report the incidence of chylous ascites in gynecologic oncology patients at 1.7-4%, particularly after paraaortic lymph node dissections near the renal vein. It can also occur after adjuvant therapies, even in the absence of lymphadenectomy. While conservative treatment, including dietary management, is sufficient for most patients, resistant cases may require additional interventions. Our data suggest that lymphangiography, which uses fat-based contrast agents, can effectively treat refractory cases.

CONCLUSION: Chylous ascites is a rare but manageable complication in gynecologic oncology, particularly following paraaortic lymphadenectomy. While most cases improve with conservative treatment, fat-based lymphangiography, which can also be performed for diagnostic purposes in refractory cases, seems to be a treatment option.

Keywords: Chylous Ascites, lenfandectomy, gynecologic oncology surgery

CT scan image of a patient with chylous ascites and intra-abdominal drainage catheter



Characteristics of patients who develop chylous ascites

	N:10
Age	56,3 Std. Deviation (5,3)
BMI	30,1 Std. Deviation (3,1)
Diagnosis - Endometrium Cancer - Ovarian Cancer	 6 4
Surgery - TAH + BSO - TAH + pelvic + para-aortic LND	 1 9
Duration (Post-operation) - 1-7 days - 7-30 days - 30 days and beyond	 7 1 2
Treatment - Diet - Diet + Somatostatin - TPN + Somatostatin - Lymphangiography	 5 2 1 2
• TAH; Total Abdominal Hysterectomy, BSO; Bilateral Salpingo-Oophorectomy, LND; Lymph Node Dissection, TPN; Total Parenteral Nutrition, BMI; Body Mass Index	

SS-047

Robotic-assisted Secondary Cytoreductive Surgery and Primary Rectal Repair in Recurrent Ovarian Cancer

Hasan Volkan Ege[1], Murat Cengiz[1], Nezih Akkapulu[2], Utku Akgor[1], Nejat Ozgul[1], Derman Basaran[1]
[1]Department of Obstetrics and Gynecology, Division of Gynecologic Oncology, Hacettepe University, Ankara, Turkey
[2]Department of General Surgery, Hacettepe University, Ankara, Turkey

Ovarian cancer is considered a serious cause of mortality, with approximately 207,000 deaths per year worldwide. Most patients are diagnosed at an advanced stage. Despite adequate adjuvant therapy after surgery, recurrent disease occurs in the majority of patients, especially those diagnosed in advanced stages. Successful secondary cytoreductive surgery (SCS) in selected cases is associated with increased survival. There are studies indicating that the use of HIPEC in recurrent ovarian cancers may have a positive effect on survival.

Our case is a 67-year-old female diagnosed with high-grade serous ovarian cancer in March 2022. After three cycles of neoadjuvant chemotherapy, she underwent interval cytoreductive surgery, and her chemotherapy was completed in six cycles. Seventeen months after the end of chemotherapy (February 2024), a follow-up abdominal computed tomography (CT) scan revealed two metastatic lesions on the sigmoid colon and its mesentery. Robotic-assisted SCS with Hyperthermic intraperitoneal chemotherapy (HIPEC) was planned.

The da Vinci Xi Surgical System™ (Intuitive Surgical Inc., Sunnyvale, CA, USA) was used for the surgery. Three robotic trocars and one assistant trocar were used in the operation. Following massive adhesiolysis, recurrent masses were observed on the liver, sigmoid colon, pelvic peritoneum, and rectovaginal space. After removal of the implants in liver segments 4 and 6, the pelvis was evaluated. Adhesions between the sigmoid colon, ileum, and pelvic peritoneum were dissected, exposing an implant between the vaginal cuff and rectum. After pelvic peritonectomy, the implants on the sigmoid and ascending colon were excised. The rectovaginal space was opened to remove the implants on Douglas and the rectum. While the implant was excised with sharp and blunt dissections, a full-thickness defect in the rectum occurred. After achieving optimal cytoreduction, general surgery was included in the operation. The defect was closed primarily using 4-0 Polydioxanone. Subsequently, HIPEC was performed using the robotic trocar sites. After HIPEC with cisplatin (100 mg/m2) for 60 minutes, the operation was finished.

The drain was removed on postoperative day 5, and the patient was discharged on day 8. Final pathology revealed high-grade serous carcinoma metastases in implants excised from the liver, peritoneum, cecum, and rectovaginal area.

The patient was started on adjuvant Doxorubicin and Carboplatin. No recurrence was detected on postoperative 3rd month control tomography. After the control, it was decided to continue chemotherapy.

Keywords: Cytoreductive Surgery, Intestinal Perforations, Intraoperative Complication, Ovarian Cancer, Robotic-Assisted Surgery

Figure-1

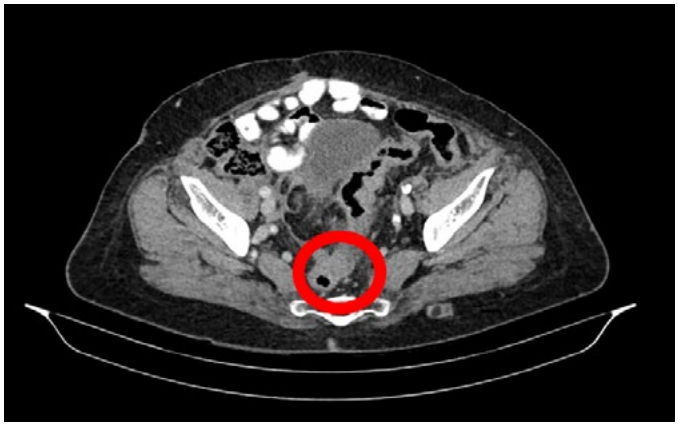


Image of recurrent mass in preoperative assessment

SS-048

Single Center Experience in Gynecologic Neuroendocrine Tumors: Case Series

Belma Gözde Özdemir, Rabia Nur Sağlam, Rrezarta Cungu, Ahmet Bilgi, Çetin Çelik
Obstetrics And Gynecology Department,Selçuk University Faculty Of Medicine,Konya,Turkey

BACKGROUND-AIM: Neuroendocrine tumors, which are rare among gynecological tumors, can be found in the endometrium, ovary, and cervix. The pathological and clinical reflections of these tumors are different. Immunohistochemical stainings are important for diagnosis. For this reason, we aimed to present the neuroendocrine tumor series seen in our clinic.

METHODS: Data were collected from patients with neuroendocrine pathological diagnosis who underwent hysterectomy and salpingo-oophorectomy between 2010 and 2024 at Selçuk University Faculty of Medicine Hospital. We created a case series in which we evaluated neuroendocrine tumor pathologies involving the endometrium, ovary and cervix in total.

Case Series: Although neuroendocrine tumors of the endometrium, ovary and cervix have similar clinical features, the cervix neuroendocrine tumor was more aggressive. NET-specific immunohistochemical stainings showed similar characteristics. In our case-based evaluation, overall survival was found to be good. Chemotherapy was applied to one patient. This was a pathology with a more aggressive component, with vaginal recurrence later detected. Immunostainings are common. Clinically, neuroendocrine-specific findings were not detected in any case.

CONCLUSION: Examining tumors that can metastasize, especially the lung, is important in terms of the primary focus. Diagnostic treatments for primary or mixed tumors are very important, especially in the postoperative period. Therefore, individual treatment should be emphasized, especially in rare tumor classes. Preoperative symptoms should be evaluated carefully.

Keywords: Neuroendocrine Tumors, Gynecology, Oncology, Case

SS-049

Cyberchondria Levels in Women with HPV Positivity Undergoing Colposcopy: The Impact of HPV 16/18

Gökçen Ege, Hande Nur Öncü, Vakkas Korkmaz
Etlik City Hospital, Ankara

AIM: The widespread use of the internet for health information has recently become a subject of research due to its potential negative consequences. The impact of online health information seeking on anxiety has been termed “cyberchondria,” and a standardized scoring system has been developed to document it. However, the significance of this scoring system in gynecologic oncology has yet to be established. Therefore, this study aimed to evaluate the effect of HPV type 16/18 positivity on cyberchondria levels in women undergoing colposcopy for HPV positivity.

METHODS: A total of 333 women who tested positive for HPV 16/18 or other high-risk HPV (hr-HPV) types and underwent colposcopy at a gynecologic oncology clinic were included in the study. The participants were divided into two groups: those positive for HPV 16/18 (Group 1, n=201) and those positive for other hr-HPV types (Group 2, n=132). Both groups were assessed using the short form of the Cyberchondria Severity Scale (CSS-12). Demographic data, clinical findings, and cyberchondria scores were compared between the two groups.

RESULTS: The median ages of the study groups were 36 years (range 26–59) and 40 years (range 25–63), respectively ($p=0.004$). Both groups were similar in terms of body mass index (BMI), parity, menopausal status, and educational level ($p>0.05$). When comparing the four subscales of cyberchondria and the total CSS-12 score, significant differences were observed in the “Excessiveness” subscale [11 (range 3–15) vs. 9 (range 3–15), $p<0.001$, respectively] and the total CSS-12 score [31 (range 12–55) vs. 28 (range 12–49), $p=0.002$, respectively].

CONCLUSIONS: Women who tested positive for HPV 16/18 and underwent colposcopy exhibited higher levels of cyberchondria. Excessive information seeking, in particular, was a key factor contributing to this elevated level.

Keywords: Cyberchondria, Colposcopy, Human Papillomavirus

figure 1

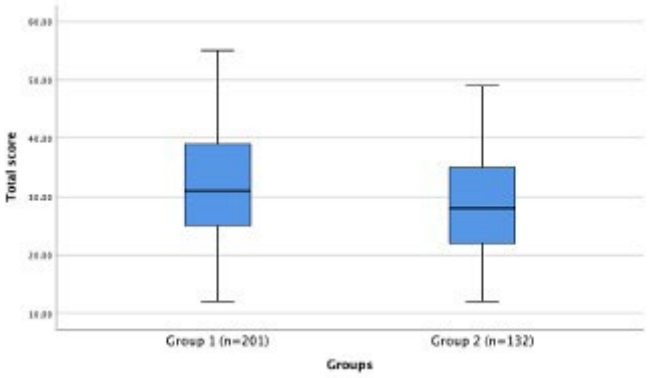


Figure 1: The total cyberchondria level of Group 1 and Group 2

SS-050

Presurized Intraperitoneal Aerosol Chemotherapy (PIPAC) Case Reports

Cemile Bilgenur Aşıcı, Seda Şahin Aker
DEPARTMENT OF GYNECOLOGICAL ONCOLOGY, KAYSERI CITY HOSPITAL

The most common route of ovarian cancer spread is within the peritoneal cavity. The rationale for administering chemotherapy directly into the peritoneal cavity is supported by preclinical, pharmacokinetic, and pharmacodynamics data. Compared with intravenous (IV) treatment, intraperitoneal (IP) administration permits a several-fold increase in drug concentration to be achieved within the abdominal cavity. In addition, some clinical trials have demonstrated a survival advantage to the incorporation of IP treatment in the upfront management of ovarian cancer. In our clinic we perform PIPAC in selected groups of patients with epithelial ovarian cancer.

Keywords: CANCER, CASE, CHEMOTHERAPY, LAPAROSCOPY, OVER, PIPAC

PIPAC

PIPAC case

SS-051

Investigation of the relationship between nutritional support and postoperative IL-10 and neopterin levels in cases with high nutritional risk index

Fazıl Avcı[1], Belma Gözde Özdemir[1], Aysegul Kebapcılar[1], Mehmet Kulhan[1], Ahmet Bilgi[1], Fikret Akyurek[2], Çetin Çelik[1]
[1]Gynecology And Obstetrics Department, Selçuk University Faculty Of Medicine, Konya, Turkey
[2]Department of Biochemistry, Selcuk University, Faculty of Medicine, Konya, Turkey

BACKGROUND-AIM: To investigate the relationship between nutritional support and postoperative IL-10 and neopterin levels in gynecological oncology cases with high nutritional risk index.

MATERIALS-METHODS: Cases with a high nutritional risk index according to the nutritional risk index (Nutritional Risk Score-2002) were included in this retrospective study. The cases were divided into two groups: those who received nutritional support (group 1) and those who did not receive nutritional support (group 2). Demographic data, cancer type, preoperative and postoperative laboratory values and surgical characteristics of the cases were recorded. IL-10 and neopterin levels were measured from the blood taken from the patients during control examinations 1 week postoperatively. The data were analyzed statistically.

RESULTS: Out of a total of 43 cases, 23 cases who received nutritional support and 20 cases who did not receive nutritional support were analyzed. There was no statistical difference between the two groups in terms of demographic data, surgical characteristics and laboratory data. Cases that received nutritional support had higher neopterin levels (p=0.025), interleukin 10 levels (p=0.041), shorter wound healing time (p=0.022), higher postoperative ferritin (p=0.018) and albumin levels than cases that did not receive nutritional support. A statistically significant difference was found in terms of (p=0.001). Additionally, there was a difference between the two groups in terms of postoperative wound complications and urinary tract infection (p>0.05).

CONCLUSION: In gynecological oncological cases with high nutritional risk index, nutritional support is associated with well-being and high IL-10 and neopterin levels in postoperative cases. Providing nutritional support shows its importance postoperatively.

Keywords: gynecology, interleukin 10, neopterin, nutritional risk index, oncology

SS-052

Lymph Node Metastasis Above the Inferior Mesenteric Artery in Patients with Intermediate-High Risk Endometrioid Type Endometrium Cancer

Abdurrahman Alp Tokalıoğlu[1], Okan Oktar[2], Derya Leblebici[1], Okan Aytekin[1], Dilek Yüksel[2], Günsu Kimyon Cömert[1], Burak Ersak[2], Fatih Kılıç[1], Cigdem Kılıç[3], Caner Çakır[2], Sevgi Koç[3], Taner Turan[1]
[1]Department of Gynecologic Oncology, Ankara Bilkent City Hospital, University of Health Sciences, Ankara, Turkey
[2]Department of Gynecologic Oncology, Ankara Etlik City Hospital, Faculty of Medicine, University of Health Sciences, Ankara, Turkey
[3]Department of Gynecologic Oncology, Etlik Zubeyde Hanim Women's Health Training and Research Hospital, Faculty of Medicine, University of Health Sciences, Ankara, Turkey

OBJECTIVE: The primary objective of this study was to identify the risk of metastasis to lymph nodes above the inferior mesenteric artery (IMA) in endometrioid-type endometrial cancer (EC) and the factors that influence metastasis.

METHODS: The study included patients who had been operated on for endometrioid-type EC in three gynecological oncology centers between 2007 and 2023. The supramesenteric lymph node (SM-LN) is the region between the left renal vein and the IMA, whereas the inframesenteric lymph node (IM-LN) is the region between the IMA and the aortic bifurcation, as determined by the level of the IMA.

RESULTS: The study sample comprised 412 patients. The median number of lymph nodes excised per patient was 58. The median count was 37 for pelvic lymph nodes, 21 for para-aortic lymph nodes, 8 for IM-LN, and 13 for SM-LN. In the univariate analysis, the factors that were found to be statistically significant in determining SM-LN metastasis included tumor size, depth of myometrial invasion, uterine serosal invasion, lymphovascular space invasion (LVSI), cervical invasion, peritoneal cytology, adnexal metastasis, omental metastasis, non-nodal extrauterine metastasis, pelvic lymph node metastasis, and IM-LN metastasis. In the multivariate analysis, SM-LN metastasis was independently associated with tumor size, LVSI, pelvic lymph node metastasis, and IM-LN metastasis.

CONCLUSION: In conclusion, in cases of intermediate-high risk EC, it is important to know that the disease spreads to SM-LN in 7.3% of patients. The efficacy of postoperative adjuvant treatment may be inadequate due to a lack of information regarding the SM-LN region.

Keywords: Endometrial Cancer, Inferior Mesenteric Artery, Lymph Node Metastasis

SS-053

Mismatch repair protein deficiency and its relationship with clinicopathological factors in endometrial cancer: A retrospective study

Okan Aytekin[1], Nesibe Cesur[2], Sercan Gözel[1], Sezin Eda Karsli[1], Abdurrahman Alp Tokalıoğlu[1], Fatih Kılıç[1], Zeliha Fırat Cüylan[1], İlker Selçuk[1], Günsu Kimyon Cömert[1], Fazlı Erdoğan[2], Taner Turan[1]

[1]Department of Gynecologic Oncology, Ankara Bilkent City Hospital, University of Health Sciences, Ankara, Turkey

[2]Department of Pathology, Ankara Bilkent City Hospital, University of Health Sciences, Ankara, Turkey

OBJECTIVE: The present study aimed to determine the frequency of mismatch repair (MMR) protein expression loss, as identified using immunohistochemistry (IHC), of tumor cells in cases of endometrial cancer, and the potential associations between this loss of expression and various clinicopathological characteristics.

METHODS: The preparations were considered positive if tumor cells showed equal or stronger immunoreactivity than positive controls, and negative if tumor cells completely lost immunoreactivity. MMR proficiency was defined as the presence of all four proteins [MutL homolog 1 (MLH1), MutS homolog 2, MutS homolog 6 and PMS1 homolog 2 (PMS2)] exhibiting positive IHC staining. If at least one of them showed negative IHC staining, this was interpreted as MMR deficiency (dMMR).

RESULTS: A total of 154 patients who met the criteria were included in the study. The most common stage was FIGO IA, which was observed in 78 (50.6%) patients. The most common tumor type was the endometrioid type, which was observed in 141 (91.6%) patients. In 16 (10.4%) patients, the extent of myometrial invasion was classified as 'no invasion', whereas in 5 (3.2%) patients, serosal invasion was identified. Additionally, lymph node metastasis was observed in 18 (17.8%) patients, peritoneal cytology in 4 (2.6%) patients, adnexal metastasis in 7 (4.5%) patients, omental metastasis in 4 (2.6%) patients, parametrial involvement in 4 (2.6%) patients and lymphovascular space invasion in 43 (27.9%) patients. dMMR was observed in 54 (35.1%) patients in the study group. The MLH1 and PMS2 proteins were the most frequently lost in 44 (28.8%) and 43 (27.9%) patients, respectively. dMMR was observed in one protein in 13 (8.4%) patients, in two proteins in 37 (24%) patients, in three proteins in 3 (1.9%) patients and in four proteins in 1 (0.6%) patient. The patient group with dMMR was statistically significantly older. However, there was no observed association between dMMR and other clinicopathological factors.

CONCLUSION: In conclusion, a notable association was observed in this cohort between the expression of MMR proteins and the age of the patients. No significant association was detected between other clinical, surgical and pathological factors and MMR protein expression.

Keywords: deficiency, endometrial cancer, mismatch repair protein

SS-054

The HALP Score as a Predictor of Maximal Cytoreduction in Advanced-Stage Epithelial Ovarian Cancer

Hande Nur Öncü, Gökçen Ege, Vakkas Korkmaz
Department of Gynecologic Oncology, Ankara Etlik City Hospital, Ankara, Turkey

BACKGROUND: The Hemoglobin, Albumin, Lymphocyte, and Platelet (HALP) score is a composite marker calculated as Hemoglobin × Albumin × Lymphocyte / Platelet. Although its prognostic value has been established in various cancers, its efficacy in predicting maximal cytoreductive surgery (MCR) success in advanced-stage epithelial ovarian cancer (EOC) remains unexplored. This study aims to determine whether the HALP score can predict MCR success in advanced-stage EOC.

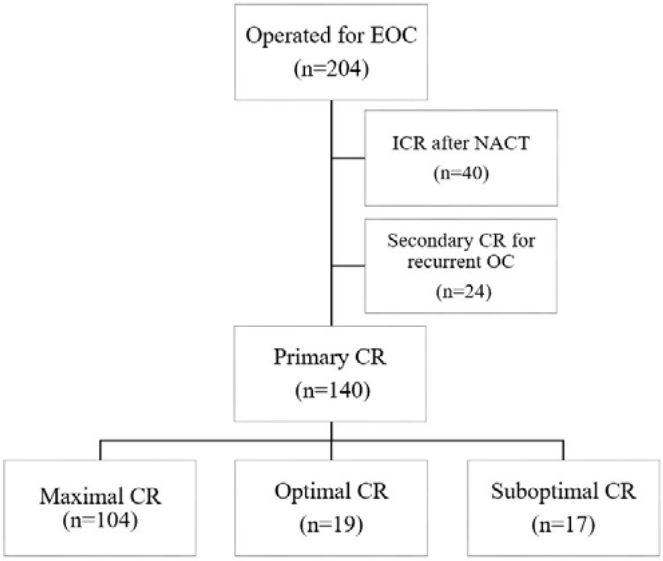
METHODS: We analyzed data from 140 patients with EOC who underwent primary cytoreductive surgery at our clinic between October 2022 and April 2024. Patients with prior malignancies, active infections, or those deemed inoperable were excluded. The patients were divided into three groups based on residual tumor size: maximal cytoreduction (MCR, Group 1, n=104), optimal cytoreduction (OCR, Group 2, n=19), and suboptimal cytoreduction (SCR, Group 3, n=17). We compared preoperative HALP scores, CA-125 levels, and other clinical and biochemical parameters among these groups.

RESULTS: Among the 140 patients, 104 (74.2%) achieved MCR, 19 (13.5%) achieved OCR, and 17 (12.1%) had SCR. Group 1 had higher preoperative hemoglobin and lymphocyte counts, lower platelet counts, and lower CA-125 levels ($p<0.005$). HALP scores were significantly higher in Group 1 compared to the other groups (35.37 vs 21.10 vs 20.19, respectively; $p<0.001$). ROC analysis revealed that the HALP score, with a cut-off value of 24.96, achieved a sensitivity of 72.1% and specificity of 72.2% for predicting MCR (AUC= 0.792, $p<0.001$). In comparison, CA-125, with a cut-off of 260.50 IU/mL, showed a sensitivity of 71.4% and specificity of 65.7% (AUC= 0.753, $p<0.001$). This performance was comparable to that of CA 125 and laparoscopic scoring systems.

CONCLUSION: The HALP score is a cost-effective and accessible tool to predict MCR in advanced-stage epithelial ovarian cancer, surpassing CA-125 in predictive accuracy. Its use could reduce the need for invasive procedures, minimizing surgical risks and associated costs. Further studies with long-term follow-up are needed to confirm its predictive value.

Keywords: halp score, hemoglobin-albumin-lymphocyte-platelet score, cytoreductive surgery, ovarian cancer, ovarian cancer surgery

Figure 1. Flowchart of patient selection.



CR: cytoreduction, EOC: epithelial ovarian cancer, IDS: interval cytoreduction, NACT: neoadjuvant chemotherapy, OC: ovarian cancer.

Figure 2. Comparison of HALP scores between groups

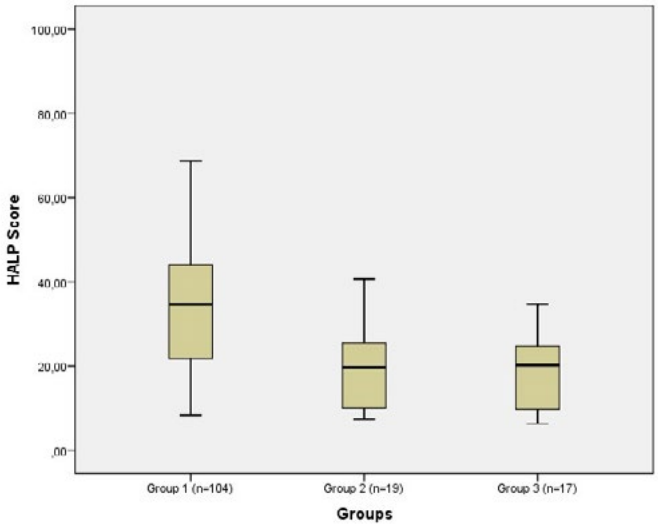


Figure 3. ROC analysis for predicting maximal debulking based on CA125 levels (negatively correlated).

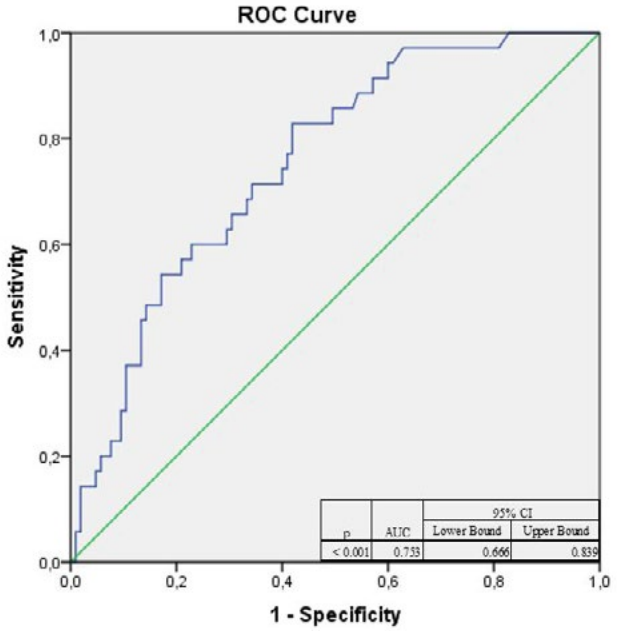
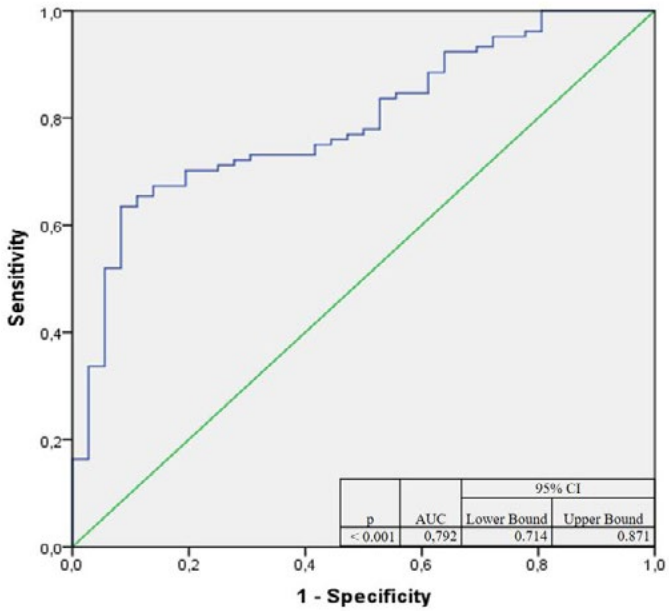


Figure 4. ROC analysis for predicting maximal debulking based on HALP score



Optimal Cut off: 24.96, Sensitivity 72.1%, Specificity 72.2%

Table 1: Comparison of Patients' Biochemical Parameters

	Group 1	Group 2	Group 3	p-value
Preoperative Hb (g/dL) Median (min-max)	12.9 (9.1-15.8)	11.3 (9.6-13.4) *	11.5 (8.7-13.4)*	<0.001
Lymphocytes (103/µL) Median (min-max)	2.01 (1.02-4.14)	1.64 (1.18-6.53)	1.58 (0.92-2.84) *	0.005
Platelets (103/µL) Median (min-max)	325 (160-977)	422 (268-870) *	408 (227-657) *	<0.001
Preoperative Alb (g/dL) Median (min-max)	4.1 (2.4-4.9)	3.9 (2.6-4.6)	3.9 (2.7-4.6)	0.038
Preoperative CA-125 Median (min-max)	143.5 (9-70818)	508 (118-5782) *	1233 (32-9427) *	<0.001
Intraopertive ascites (cc) Median (min-max)	100 (50-8000)	1000 (50-7000) *	3000 (200-9000)*	<0.001
Operation time (minutes) Median (min-max)	245 (90-480)	360 (120-540) *	110 (60-210)*, **	<0.001
HALP score Median (min-max)	35.37 (8.32-86.90)	21.10 (7.34-53.57)*	20.19 (6.37-34.61)*	<0.001

**p<0.05: vs Group 1 **p<0.005: vs Group 2*

SS-055

Recurrence Patterns in Adult-Type Granulosa Cell Tumors Patients with Lymph Node Metastasis

Tufan Arslanca[1], Çiğdem Kılıç[2], Işın Üreyen[3], Sevgi Koç[4], Mehmet Ali Narin[5], Tolga Taşçı[6], Salih Taşkın[7], Muzaffer Sancı[8], Hakan Raşit Yalçın[9], Burak Civelek[10], Nejat Özgül[11], Taner Turan[1]

[1]Department of Gynecologic Oncology, Ankara Bilkent City Hospital, Faculty of Medicine, University of Health Sciences, Ankara, Turkey.

[2]Department of Gynecologic Oncology, Hitit University, Faculty of Medicine, Corum, Turkey

[3]Department of Gynecologic Oncology, Antalya Training and Research Hospital, Faculty of Medicine, University of Health Sciences, Antalya, Turkey

[4]Department of Gynecologic Oncology, Etlik Zubeyde Hanim Women's Health Training and Research Hospital, Faculty of Medicine, University of Health Sciences, Ankara, Turkey.

[5]Department of Gynecologic Oncology, Adana City Hospital, Faculty of Medicine, University of Health Sciences, Adana, Turkey.

[6]Department of Gynecologic Oncology, Bahcesehir University, Faculty of Medicine, Istanbul, Turkey

[7]Department of Gynecologic Oncology, Ankara University, Faculty of Medicine, Ankara, Turkey

[8]Department of Gynecologic Oncology, Tepecik Training and Research Hospital, Faculty of Medicine, University of Health Sciences, Izmir, Turkey

[9]Department of Gynecologic Oncology, Zekai Tahir Burak Women's Health Training and Research Hospital, Faculty of Medicine, University of Health Sciences, Ankara, Turkey

[10]Department of Medical Oncology, Ankara Bilkent City Hospital, Faculty of Medicine, University of Health Sciences, Ankara, Turkey

[11]Department of Gynecologic Oncology, Hacettepe University, Faculty of Medicine, Ankara, Turkey

INTRODUCTION: Adult-type granulosa cell tumors (AGCT) are rare ovarian tumors that generally have a favorable prognosis. Lymph node metastasis is observed in 2-3% of patients. This study aimed to examine recurrence and recurrence patterns in patients diagnosed with AGCT who have lymph node positivity.

MATERIALS-METHODS: A total of 491 AGCT patients from 11 tertiary gynecologic oncology centers were included in the study. It was determined that lymphadenectomy was added to the surgical procedure in 343 (69.9%) of these patients, and 14 (4.1%) of them had lymph node metastasis. The study cohort was composed of 14 patients with lymph node metastasis.

RESULTS: The mean age of the patient group was 45.3±13.3 years. The median number of lymph nodes removed was 39 (range: 5-94). Three patients were in stage IV, and 11 were in stage IIIC. Grade 1 endometrioid-type endometrial cancer was detected in 1 patient. In the patient group with a median follow-up period of 84 months (range: 1-216 months), recurrence developed in 8 patients (57.1%) between 5 and 132 months after surgery. During the follow-up period, 3 patients (21.4%) died due to the disease. The 3-year disease-free survival (DFS) rate was 77%, the 5-year DFS was 48%, and the 3-year and 5-year overall survival (OS) were 85%, respectively. The first recurrence sites were identified as pelvic (25%), extra-abdominal (12.5%), pelvic-upper abdomen (50%), and upper abdomen-extra-abdominal (12.5%) in recurrent patients. It was observed that there was no recurrence in the lymphatic regions.

CONCLUSION: Lymph node metastasis in patients with AGCT has a significant impact on disease progression and recurrence patterns. Systemic recurrences appear to develop outside the lymphatic areas in those with lymph node positivity.

Keywords: Adult-type granulosa cell tumor, lymph node metastasis, recurrence pattern

SS-056

Evaluation Of Urogynecological And Sexual Functions In Patients With Vulvar Cancer

Belma Gözde Özdemir, Merve Nur Taşpınar, İpek Münteha Erdemli, Ahmet Bilgi, Çetin Çelik
1. Gynecology And Obstetrics Department, Selçuk University Faculty Of Medicine, Konya, Turkey

BACKGROUND-AIM: Vulvar cancer is a rare gynecological cancer. It may present with itching, areas of pigment change, mass, bleeding, and condulomatous lesions, or it may be asymptomatic. The boundaries of radical/preventive surgery are drawn with a selection including the tumor's connection with the lymph node, its region, stage, patient age and comorbidities. The vulva is at a key point as it is adjacent to the vagina and ureter. Therefore, surgery and CRT may cause urological and sexual symptoms. We aimed to present the degree to which surgery and treatment in malignancy of the vulva, which is an important region in terms of aesthetics and functionality, affect the urogynecological and sexual functions of patients.

MATERIAL/METHODS: Vulvar cancer and who applied to the outpatient clinic in the same age group were considered as two groups. A survey was administered to the patients. Female Sexual Function Scale (FSFI), Urinary Incontinence Quality of Life Scale (I-QOL) and Bristol Female Lower Urinary Tract Symptoms Index (BFLTS) were used. Retrospective review of patients with vulvar cancer 1.3. and 6th month scores were asked and queried with people of the same age group who did not have homogeneous vulvar cancer.

RESULTS: A total of 31 patients, 11 with vulvar cancer and 20 without vulvar cancer, were evaluated.There was a significant difference between the sexual function scores of patients without vulvar cancer and patients with vulvar cancer at the 1st, 3rd and 6th months ($p<0.05$). According to these data, the sexual function scores of patients without vulvar cancer were higher than the sexual function scores of patients with vulvar cancer at the 1st, 3rd and 6th months. According to these data, urinary system symptom scores of patients with and without vulvar cancer were similar. According to these data, urological document QoL scores of patients with and without vulvar cancer were similar.

CONCLUSION: It is important to provide counseling to patients on an individual approach. This will ensure patient compliance and maximize patient care in the postoperative period.

Keywords: Urogynecology,Sexual Functions,Vulva cancer

SS-057

The Impact of Postoperative Infection on Changes in Leucocyte Levels in the Early Postoperative Period in Patients Undergoing Splenectomy During Cytoreductive Surgery for Gynaecological Malignancy

Yesim Ozkaya Ucar[1], Tufan Arslanca[1], Okan Aytekin[1], Tuba Bıyık[1], Gülşah Tiryaki Güner[1], Serpil Ünlü[2], Günsu Kimyon Cömert[1], Fatih Kılıç[1], Aziz Ahmet Sürel[3], Taner Turan[1]
[1]Department of Gynecologic Oncology, Ankara Bilkent City Hospital, University of Health Sciences, Ankara, Turkey
[2]Department of Infectious Disease and Clinical Microbiology, Ankara Bilkent City Hospital, University of Health Sciences, Ankara, Turkey
[3]Department of General Surgery, Ankara Bilkent City Hospital, University of Health Sciences, Ankara, Turkey

OBJECTIVE: In cytoreductive surgery for gynecological cancers, 13-25% of patients require splenectomy. Therefore, hematological parameters change in the post-splenectomy period, especially leucocytosis and thrombocytosis. In this study, we aimed to evaluate the changing of leucocyte and neutrophil between the groups with and without infection in the early postoperative period in patients who underwent splenectomy during cytoreductive surgery for gynecological cancer.

METHODS: The data of patients who underwent splenectomy during cytoreduction for gynecological cancer between January 2010 and June 2022 were reviewed in two gynecologic oncology centers. Leucocyte, neutrophil, lymphocyte, platelet, hemoglobin, c-reactive peptid (CRP) and procalcitonin values were recorded at the preoperatively and on the first 7 days postoperatively.

RESULTS: Until the 4th postoperative day, leucocyte changes in both groups were above normal values.The changes in the 4th and 5th days were highlighting a critical period for monitoring potential infections.

CONCLUSION: Our study showed that within the first 4 days following splenectomy, there were no significant differences between the infected and non-infected groups.. However, the daily increase in leucocyte values from 4th to 5th days is considered significant in favor of infection

Keywords: gynaecological malignancy, infection, leucocyte changes, splenectomy.

SS-058

Knowledges and attitudes of HPV positive women about HPV vaccine

Serhan Can İşcan
Isparta Şehir Hastanesi

Human papillomavirus (HPV); It is an oncovirus that causes 6 cancers: anal cancer, cervical cancer, oropharyngeal cancer, penile cancer, vaginal cancer and vulvar cancer. HPV infection is the most common sexually transmitted disease in the world. Cancer occurs in 625,000 women and 70,000 men every year due to HPV. Vaccination against the human papillomavirus (HPV) effectively prevents HPV-related malignancies and following the introduction of the human papillomavirus (HPV) vaccine, awareness of HPV has significantly heightened; yet, vaccination rates remain low. Assessing the knowledge of vaccination among hpv positive women and learning their attitude helps us in strategizing the course we will do to enhance awareness.

A cross-sectional analytical survey was conducted in 2021-2024 with a sample of 579 HPV positive women. Women aged 21 to 75 were surveyed regarding their awareness of the vaccine, sources of information, and vaccination status.

83.9% (n:486) of these women who underwent colposcopic examination due to having high-risk HPV stated that they had no information about HPV. Subsequently, when women presenting with pathology results were inquired about their sources of information regarding HPV, 22.5% cited social media, 13.5% indicated their circle of friends, 1.9% mentioned family, 56.5% referred to health professionals, and 5.7% specified other sources.

The patients were also questioned about their smoking and alcohol use. No statistically significant difference in HPV vaccine awareness was observed between patients who smoke and consume alcohol and those who do not. Patients were categorized into two age groups: 20 to 40 years and over 40 years. No statistical difference was observed across age groups regarding knowledge of the HPV vaccine. Upon examining the knowledge and attitudes regarding the HPV vaccine among the study participants, it was noted that a minimal number of patients were aware of the HPV vaccine.

The number of patients who received the HPV vaccine was only 16 (2.8%). This study indicates that HPV-positive women lack enough understanding regarding the HPV vaccine. Unfortunately, vaccination rates are also very low. Patients who learn about the HPV vaccine get most of their information from social media, and the information they get from healthcare professionals is mostly provided at the hospital admission stage due to HPV positive results. This study shows that more effort needs to be made to raise public awareness about HPV and HPV vaccines.

Keywords: HPV, HPV VACCINE, CERVICAL CANCER

SS-059

Clinical Characteristics and Diagnostic Approaches in Peritoneal Tuberculosis Mimicking Advanced Ovarian Cancer

Feyzanur Verim, Derman Basaran, Hasan Volkan Ege
Obstetrics And Gynecology Department, Hacettepe University, Ankara, Turkey

OBJECTIVE: This study aims to examine the clinical features and diagnostic challenges of peritoneal tuberculosis which continues to pose diagnostic difficulties in clinical practice. We provide an overview of the clinical and demographic characteristics of patients diagnosed with abdominal tuberculosis, whose symptoms closely resembled those of advanced ovarian cancer.

METHOD: A retrospective analysis was performed on the clinical and demographic data of 24 patients diagnosed with peritoneal tuberculosis at Hacettepe University between 2005 and 2024. The findings were compared with existing literature on advanced ovarian cancer to highlight the diagnostic challenges.

RESULTS: The average age of patients diagnosed with peritoneal tuberculosis was 41.7 years (range: 15–71). The most common presenting symptoms were abdominal distention (46%), abdominal pain (42%) and fever (29%). Additionally, 17% of the patients initially presented with infertility. The mean duration of symptoms was 11 months (range: 1–60). Radiological evaluation revealed ascites in 71% of patients, peritoneal carcinomatosis in 50%, and omental thickening in 29.1%. Pelvic masses were detected in only 33.3% of cases. Among the 15 patients who underwent thoracic computed tomography (CT), 12 showed at least one pathological finding. Preoperative serum Ca125 levels averaged 386 U/mL (range: 11–1153), while the mean leukocyte count was 6.6 x 10^9/L. Laparotomy was performed in 54.1% of cases (13/24). Intraoperative findings included miliary implants (46%), ascites (42%), adhesions (38%) and omental thickening. Frozen section analysis, performed in 11 patients, suggested tuberculosis in 9 cases, identifying granulomatous reactions and necrotic granulomas.

CONCLUSION: In young patients presenting with clinical, radiological, and laboratory findings suggestive of advanced ovarian cancer but without adnexal masses, peritoneal tuberculosis should be considered as a differential diagnosis. Intraoperative frozen section analysis can play a crucial role in avoiding unnecessary organ resections in such cases.

Keywords: peritoneal tuberculosis, ovarian cancer, frozen

SS-060

Laparoscopic Transabdominal Cerclage: Case Report of a 10 Week Pregnant Patient with Cervical Insufficiency

Barışcan Aldanmaz, Nihal Çallıoğlu, Gokberk Dundar, Sinan Abeş, Süleyman Salman
Clinic of Obstetrics and Gynecology, University of Sağlık Bilimleri, Gaziosmanpaşa Training and Research Hospital, Istanbul, Turkey

Abdominal cerclage; usually recommended for those for whom cerclage was recommended based on a diagnosis of cervical insufficiency but could not be placed due to anatomical constraints or is reserved for patients with failed transvaginal cervical cerclage procedures resulting in second trimester pregnancy loss.

INTRODUCTION: Video report of a 10-week pregnant patient undergoing laparoscopic transabdominal cerclage.

METHODS: A 32-year-old G4P2A1Y0 patient, with a history of two preterm deliveries before 24 weeks and spontaneous abortion at 8 weeks, who delivered preterm at 23 weeks of gestation despite transcervical cerclage at 12 weeks in her third pregnancy, was admitted to our hospital with strong evidence of cervical insufficiency in her third pregnancy. Laparoscopic abdominal cervical cerclage was decided. At this time, the patient's Body Mass Index was 38.6kg/m2.

FINDINGS: Ultrasound examination confirmed a single intrauterine pregnancy with a consistent fetal size of 10w 1d and a functional length of the cervix of 27mm. On physical examination, the cervix appeared closed. The patient was thoroughly counseled about the risks and benefits of the procedure, which was performed via laparoscopy or laparotomy. The patient underwent laparoscopic cervical cerclage in the tenth week of pregnancy.

Bladder peritoneum was removed by sharp and blunt dissections. Bilateral uterine arteries were visualized. 5mm mercylene tape was placed medial to the left-sided uterine vessels. The ligature was pulled tightly to the posterior cervical isthmus. Similarly, the needle was placed medial to the right uterine vessels. The ligature was pulled tightly to the posterior cervical isthmus. Ligature ends were tied together posterior to the cervix with an intracorporeal knot. Reperitonization was not performed. Perioperative antibiotherapy was applied. Bleeding was controlled and the operation completed. The operation lasted 65 minutes and was successful. Estimated blood loss was 70mL. Fetal cardiac activity was confirmed before and after the operation. Preoperative and postoperative indomethacin therapy was given. The patient was discharged with full recovery after 36 hours of postoperative observation.

The patient was diagnosed with Gestational Diabetes Mellitus (GDM) in the 20th week of pregnancy and insulin treatment was started. No significant additional findings were detected during the rest of the pregnancy. After the onset of pain at 36 weeks of gestation, cesarean section was decided and delivery was performed. Mother and baby were discharged in a healthy condition. Mersilen tape was left in place due to the patient's fertility request.

DISCUSSION AND CONCLUSION: This case report shows that laparoscopic abdominals cerclage plays an effective role in painless second trimester labor in a pregnant woman who did not progress to term with cervical cerclage. In this case, we wanted to show that abdominal cerclage can be performed at the end of the first trimester in a patient with cervical cerclage failure. However, factors such as the experience of the surgical team, patient selection, detailed information of the patient about possible negative consequences and management of complications should be carefully evaluated.

Keywords: cerclage, early pregnancy loss, failed cerclage, laparoscopy, painless pregnancy loss, transabdominal cerclage

SS-061

Two giant cases of chorioangioma with mild adverse fetal outcome

Harika Bodur Öztürk[1], Engin Ciğercioğulları[2], Mehmet Murat Naki[1]
[1]Department of Obstetrics and Gynecology, Medipol Acıbadem Hospital, Istanbul, Turkey
[2]Department of Pathology, Acibadem Atasehir Hospital, Istanbul, Turkey

Placental chorioangiomas are the most common benign tumor of the placenta. Three histological pattern have been described: angiomatous, cellular and degenerated. Large tumors more than 4 cm may provoke fetal and maternal complications. We reported 2 cases of giant chorioangioma.

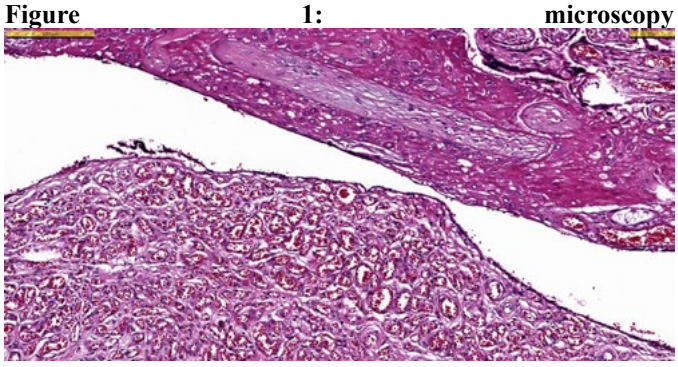
CASE 1: 43 years old primigravida pregnant women with gestational diabetes was admitted to the hospital with decreased fetal activity. Repeated nonstress test was non reactive, fetal biophysical profile score was 6 and we decided for induction of delivery. Cesarean delivery was performed due to fetal distress. 2820 gram, 48 cm female baby with Apgar skor 8/9 was delivered. At delivery 10*8*6 cm mass was present on the fetal surface of the placenta. Microscopic findings demonstrated with chorioangioma.

CASE 2: 37 years old G1 women was booked for antenatal follow up. She had a history of hysteroscopic myomectomy one year before the pregnancy. On her first trimester screening test combined risk was 1:50, NT 1.46 mm PAPPA MoM 0.23 and free beta hCG MoM 2.05. CVS was performed. Fetal anatomy was normal at second trimester ultrasound examination. We detected a well defined placental mass at 26 weeks of gestation and close surveillance was initiated and the follow-up antenatal ultrasound demonstrated intrauterine growth retardation. The delivery was planned at 37 weeks of gestation, and 2100 gram female baby was delivered by cesarean section. The mother was discharged home at postoperative second day. The pathology report 5.5 cm chorioangioma with 485 gram placenta.

CONCLUSION: Rapid growth of the tumor may provoke fetal anemia, hydrops fetalis and fetal heart failure leading to fetal death. Large mass may cause unfavorable perinatal outcome. The differential diagnosis is placental teratomas, degenerated myoma and blood clots. In the presence of fetal anemia findings prenatal interventions are necessary to obtained good fetal outcome. Blood transfusions, laser coagulations are the therapeutic options for such cases. Although the first case was diagnosed at delivery our patients are well managed and close follow-up ameliorate the survival rate of neonates.

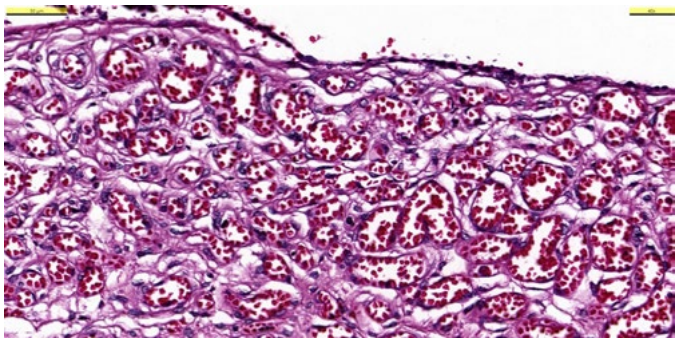
Keywords: placental tumor, chorioangioma, ultrasound, pregnancy disorder

Figure 1: microscopy



The sections revealed a vasculoproliferative lesion in the subchorionic area, consisting of capillary-sized vessels. This well-circumscribed lesion was identified as a chorioangioma (figure 1).

Figure 2: microscopy



Pathologic findings of choriangioma

SS-062

Low maternal serum levels of pregnancy-associated plasma protein-A during the first trimester screening are associated with preterm delivery with preterm premature rupture of membranes

Umutcan Kayıkçı, Fatma Caner Çabukoğlu, Özgür Deren
Department of Perinatology, Hacettepe University, Ankara, Turkey

OBJECTIVE: To evaluate the relationship between the first-trimester maternal serum pregnancy-associated plasma protein-A (PAPP-A) levels and pregnancies complicated by preterm prelabour rupture of membranes (PPROM) and preterm labour (PTL).

MATERIALS-METHODS: A retrospective analysis was performed on 143 patients who delivered at Hacettepe University Faculty of Medicine Delivery Unit between 2022 and 2023. Of these, 43 (30%) was PPROM and PTL and 100 (70%) was control group. Clinical and demographic characteristics (age, gravidity, parity), gestational age at the delivery, MoM values of PAPP-A, fetal weight were recorded and compared. The correlation between PAPP-A levels and gestational age at delivery and the probabilities of low PAPP-A multiples of the median (MoM) levels between preterm prelabour rupture of membranes and control population were analyzed by using SPSS for Windows (version 23.0, SPSS Inc., IL, USA). Data were presented as mean ± SD for continuously distributed variables and as median with interquartile range for non-normally distributed variables. The Mann-Whitney U test and Kruskal-Wallis test were used for comparisons between groups. A p-value <0.05 was considered statistically significant.

RESULTS: No statistically significant difference was found between the two groups in terms of gestational age and fetal weight. The cut-off value of the PAPP-A level was defined as the 0.4 multiple of median (MoM) which is in correspondence with the fifth centile. Lower PAPP-A MoM level had a significantly higher likelihood of PPROM and PTL delivery ($p < 0.05$).

CONCLUSION: Low levels of maternal serum PAPP-A in the first trimester could indicate a defect in trophoblast invasion at the maternal-fetal interface, which may lead to preterm delivery later on, especially in cases of PPROM. However, there were no significant differences in fetal weights. Larger randomised controlled trials are needed.

Keywords: PAPP-A, PPROM, Preterm

SS-063

The Comparison of Hemogram Parameters Between Cases of Hysterotomy and Normal Vaginal Delivery

Edip Alptuğ Kır[1], Bengi Su Yılan[2], Erdem Fadıloğlu[1], Özgür Deren[1]
[1]Department of Perinatology, Hacettepe University Faculty of Medicine, Ankara, Turkey
[2]Department of Obstetry and Gynecology, Hacettepe University Faculty Of Medicine

OBJECTIVE: Hysterotomy is defined as a method that can be used to terminate pregnancy at any gestational week. The aim of this study is to compare haemogram parameters before and after termination of pregnancy in patients who underwent hysterotomy and normal vaginal delivery.

METHODS: A retrospective analysis was performed on 126 patients who underwent termination of pregnancy at Hacettepe University Faculty of Medicine Delivery Unit between 2020 and 2024. Of these, 69 (54%) underwent termination via normal vaginal delivery and 57 (46%) underwent termination via hysterotomy. Clinical and demographic characteristics (age, gravidity, parity), induction methods used for vaginal deliveries, pre- and post-operative haemogram values, need for red blood cell transfusion, and length of hospital stay were recorded and compared. Analyses were performed using SPSS for Windows (version 23.0, SPSS Inc., IL, USA). Data were presented as mean ± SD for continuously distributed variables and as median with interquartile range for non-normally distributed variables. The Mann-Whitney U test and Kruskal-Wallis test were used for comparisons between groups. A p-value <0.05 was considered statistically significant.

RESULTS: When clinical and demographic characteristics were examined, gestational age was significantly higher in the hysterotomy group. No significant differences were found between the two groups with regard to maternal age, gravidity, parity, birth weight, need for red blood cell transfusion and length of hospital stay. In cases of vaginal delivery, despite similar preoperative haemogram values as in the hysterotomy group, postoperative haemogram parameters were significantly higher, regardless of the induction method used. In 16 cases where induction failed and hysterotomy was required, and in 41 cases where elective hysterotomy was performed, no significant differences in pre- and postoperative haemogram parameters were observed.

CONCLUSION: Although hysterotomy is a surgical method for termination of pregnancy, our study found that haemogram parameters, especially inflammatory markers, were more favourable in cases of normal vaginal delivery. However, there were no significant differences in the length of hospital stay or the need for blood and blood product transfusions between the two groups. Larger randomised controlled trials are needed to translate these findings into clinical practice.

Keywords: Hemogram, Hsyterotomy, Termination

SS-064

Evaluation of prenatal diagnosis and postnatal outcomes in intestinal atresias

Ayse Cigdem Bayrak, Murat Cagan, Ozgur Deren
Department of Obstetrics and Gynecology, Hacettepe University Faculty of Medicine, Ankara, Turkey

Congenital intestinal atresias account for approximately one-third of neonatal intestinal obstructions. Although the exact etiology is not fully understood, it is postulated to result from vascular insufficiency and failure of recanalization during the rotation of the midgut. The incidence in live births ranges between 1 in 2,500 and 1 in 5,000. Most cases are diagnosed in the late second or early third trimester through the detection of significant proximal bowel dilatation associated with polyhydramnios. Dilatation of the stomach, echogenic bowel walls, and increased peristalsis can be used to confirm the diagnosis. In cases of duodenal atresia, the classic "double-bubble" sign, along with the visualization of the connection between the two bubbles, is typically diagnostic. However, accurately determining the exact location of the obstruction in other small bowel segments is not always feasible.

In this study, we analyzed the clinical characteristics of 30 cases of intestinal atresia that were prenatally detected and followed at the Hacettepe University Perinatology Department between 2014 and 2023. All 14 cases with a prenatal suspicion of duodenal atresia were accurately confirmed postnatally. Among the 11 neonates diagnosed with jejunal atresia postnatally, five were correctly identified as having jejunal atresia during the prenatal period, while the remaining cases were reported as jejunoileal atresia without specific localization. Of the five neonates diagnosed with ileal atresia, one had a precise prenatal diagnosis, whereas the others were described as having jejunoileal atresia or a dilated colon segment. Preterm delivery occurred in 76% of the cases, with an average birth weight of 2365 grams. One neonate required immediate surgery within hours of birth due to perforation, and all underwent surgery within 11 days postnatally. The ostomy was performed in 13 neonates. Four died in the postoperative period. Trisomy 21 was diagnosed in two cases of duodenal atresia, and a pancake kidney anomaly was detected in one case of jejunal atresia on antenatal sonography. Among the neonates with jejunal atresia, one developed volvulus at six months of age, and another with ileal atresia developed short bowel syndrome at the age of eight.

In conclusion, careful evaluation for associated structural and chromosomal anomalies is crucial when intestinal atresia is detected. Detailed counselling should be given to parents about the need for postnatal intensive care unit admission and surgery, and delivery should be planned in a centre with pediatric surgery in place.

Keywords: Duodenal atresia, intestinal dilatation, jejunoileal atresia

SS-065

The outcomes of examination indicated rescue cerclage and the factors altering the outcomes

Lütfiye Uygur, Isil Ayhan
Sağlık Bilimleri Üniversitesi Zeynep Kamil Kadın ve Çocuk Hastalıkları Eğitim ve Araştırma Hastanesi, Perinatoloji Kliniği

OBJECTIVE: To present the outcomes of emergent cerclage in cases with membrane prolapsus and to detect the factors associate with cerclage failure.

METHODS: This is a retrospective monocentric study including 38 singleton pregnancies with painless cervical dilatation and bulged membranes who undergone cerclage. Preoperative examination and ultrasound results, and demographic data were obtained from patient records. The patients were assigned into four groups according to the level of membrane prolapsus. Group1: Membranes above external os, Group 2: Membranes at the external os, Group 3: Membranes below external os, in proximal vagina, Group 4: Membranes extending to distal half of vagina. Cerclage failure rates were detected, the pregnancy outcomes and factors affecting cerclage failure were evaluated in each group.

RESULTS: The mean gestational age at birth was 31 (± 6.93), the mean cerclage-to-delivery interval was 11.5 (3.75-15.25) weeks. Successful cerclage (delivery ≥32 weeks) rate was 57.9% (Table 1). Three cases were complicated with chorioamnionitis. Positive cervical/vaginal culture and need for administration of therapeutic antibiotics were significantly associated with early preterm delivery (p=0.05 and p=0.045, respectively). Group 1 had a rate of 80% for delivery ≥32 weeks (Table 1). The comparison of the outcomes of Groups 1+2 with groups 3+4 (Figure 1) revealed that the latter had significantly lower cerclage-to-delivery interval, gestational age at delivery and birthweight (Table 2).

CONCLUSION: All emergent cerclage cases should not be put in the same pot. The outcome of emergent cerclage is outstanding as long as membrane prolapsus does not extend beyond the half distance of vagina.

Keywords: rescue cerclage, membrane prolapsus, preterm delivery

Şekil 1

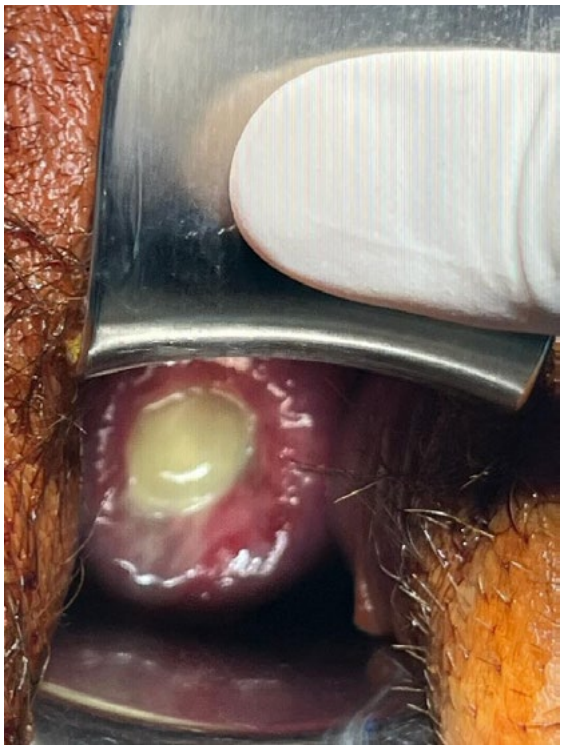


Image of a patient from group 2 with prolapsed membranes at the level of external cervical os

Tablo 1

	Number of cases (n)	Delivery >320 GW % (n)	Delivery >370 GW % (n)	Prolongation of pregnancy (in weeks)	GW at birth	Birth weight (grams)	Perioperative complication % (n)
All patients	38	57.9 (22)	36.8 (14)	11.5 (4-15)	31 (± 6.93)	1880 (598-3008)	36.8 (14)
Group 1	10	80 (8)	20 (2)	14 (11-17)	35.2 (±3.7)	2915 (2312-3037)	0
Group 2	7	71.4 (5)	28.6 (2)	16 (1-19)	32.2 (±9.3)	3200 (620-3380)	28.5 (2)
Group 3	14	64.2 (9)	35,8 (5)	11 (5-16)	31.9 (±6.06)	1770 (811-2775)	14.2 (2)
Group 4	7	0	0	2 (1-4)	22.1 (±1.5)	403 (370-530)	100 (7)

Table 1: Perinatal outcomes of rescue cerclage

Table 2: Comparison of pregnancy outcomes between group 1/2 and group 3/4

	Group 1/2 (n=17)	Group 3/4 (n=21)	p
GW at delivery	37 (31-39)	28 (23-36)	0.031
Cerclage-to-delivery interval (in weeks)	14 (7-17)	7 (3-13)	0.04
Birth weight	2990 (2460-3100)	1052 (480-2550)	0.006
Perioperative complications % (n)	11.7 (2)	42.8 (9)	0.073

GW: gestational weeks Data presented as median (interquartile range), n (percentage), a p value of ≤0.05 was considered statistically significant.

SS-066

The Association Between Serum Inflammatory Markers and Live Birth in Cases of Pre-viable Preterm Premature Rupture of the Membranes (p-PPROM)

Muhammed Enes Karakaya[1], Yıldız Akdaş Reis[1], Arife Akay[2], Sena Ünlü[1], Yaprak Engin Üstün[1]
[1]Etlik Zübeyde Hanım Maternity and Women's Health Teaching and Research Hospital
[2]Yalova State Hospital

AIM: The term " pre-viable preterm premature rupture of membrane " (p-PPROM) is used to describe the rupture of the amniotic membrane before the 24th week of gestation. In p-PPROM cases, maternal and fetal outcomes are poor, and maternal inflammation is considered to be a contributing factor. This study aimed to investigate the association between serum inflammation markers and live birth (LB) and early pregnancy loss (EPL) in p-PPROM cases.

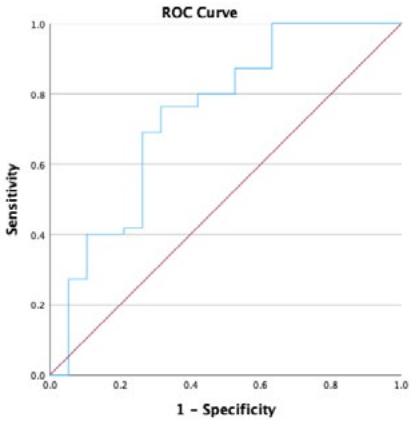
METHODS: The present study retrospectively evaluated singleton pregnancies that were hospitalized in the early pregnancy services due to p-PPROM between 2017 and 2023. The present study excluded cases that involved a preference for pregnancy termination. Conversely, ongoing pregnancies in cases of p-PPROM were included. The p-PPROM cases were divided into two groups: the LB group, comprising cases resulting in live birth after 24 weeks of gestation, and the EPL group, comprising cases resulting in spontaneous termination before 24 weeks of gestation. A retrospective evaluation of the demographic and obstetric characteristics and complication rates of the groups was conducted. Furthermore, inflammatory biomarkers, including C-reactive protein (CRP), leukocyte count, neutrophil/lymphocyte ratio (NLR), platelet/lymphocyte ratio (PLR), monocyte/lymphocyte ratio (MLR), systemic immune inflammation index (SII), systemic inflammatory response index (SIRI), and pan-immune inflammation value (PIV), were compared between the two groups using data from the initial blood tests.

RESULTS: The LB group comprised 55 cases (74.4%), while the EPL group comprised 19 cases (25.6%). There were no significant differences in age, obstetric characteristics, or duration of antibiotic use between the two groups ($p>0.05$, Table 1). The latent period was observed to be 18 days (1-211 days) in the LB group and 3 days (1-17 days) in the EPL group ($p < 0.001$). The rates of complications were found to be similar in both groups (Table 2). A significantly higher rate of normal amniotic fluid index was observed in the LB group (50.9% vs. 10.5%, $p < 0.001$). The comparison of serum inflammation markers revealed no significant differences in both groups for CRP, NLR, PLR, MLR, SII, SIRI, and PIV (Table 3). Only, leukocyte count was determined to be 12.51 (7.86-18.46) $x10^9$/L in the LB group, which was found to be significantly higher than the EPL group ($p=0.003$). In the ROC curve analysis, a leukocyte count of 10.325 x109/L was identified as the optimal cut-off value for predicting live birth, exhibiting 76.4% sensitivity and 68.4% specificity. The ROC curve of lökosit count is presented in Figure 1 (AUC=0.740, $p=0.002$, 0.598-0.882 95% CI). Furthermore, a negative correlation was identified between the latent period and neutrophil count, PIV, and SIRI ($r=-0.283$, -0.293, and -0.370, $p=0.015$, 0.011, and 0.001, respectively).

CONCLUSION: In cases of pPPROM, an increase in the leukocyte count has been identified as a predictive and diagnostic indicator for live birth. However, a decrease in the latency period has been observed as the neutrophil, PIV and SIRI values increase. Further studies are required to elucidate the underlying inflammatory processes in these cases.

Keywords: Live birth, Leukocyte, Inflammation, Preterm Premature rupture of membranes, Systemic inflammatory response index (SIRI)

Figure 1



ROC curve analysis of Leukocyte count

Table 1

Variables	Early pregnancy loos N (%) 19 (25.6 %)	Live birth N(%) 55 (74.4 %)	p value
Age (years), Median (min-max)	35 (18-43)	30 (21-46)	0.345
Gravida (n), Median (min-max)	2 (1-6)	2 (1-5)	0.865
Parity (n), Median (min-max)	0 (0-5)	1 (0-4)	0.800
Previous miscarriages, (n), Median (min-max)	0 (0-2)	0 (0-3)	0.156
Number of children, Median (min-max)	0 (0-5)	1 (0-4)	0.816
Stillbirth, (n), Median (min-max)	0 (0-2)	0 (0-1)	0.982
Ectopic pregnancies, (n), Median (min-max)	0 (0-0)	0 (0-1)	0.575
Cesarean birth, (n), Median (min-max)	0 (0-1)	0 (0-3)	0.108
Duration of antibiotics (days), Median (min-max)	4 (1-37)	7 (2-30)	0.816
Gestational age at diagnosis (week), Median (min-max)	17 (15-23)	23 (11-24)	**0.005**
Ultrasonographic gestational age (days), Median (min-max)	17 (14-23)	23 (11-24)	**<0.001**
Latent period (days), Median (min-max)	3 (1-17)	18 (1-211)	**<0.001**
Final week of pregnancy (week), Median (min-max)	18 (15-23)	26 (24-42)	**<0.001**

Mann Whitney U Test, p values < 0.05 is statistically significant.

Demographic and obstetric characteristics of the groups

Table 2

		Early pregnancy loos N (%) 19 (25.6 %)	Live birth N(%) 55 (74.4 %)	p value
Assistd reproductive techniques	No	17 (89.5 %)	52 (94.5 %)	0.143
	In vitro fertilization	2 (10.5 %)	3 (5.5 %)	
Comorbid systemic disease	No	17 (89.5 %)	52 (94.5 %)	0.143
	Yes	2 (10.5 %)	3 (5.5 %)	
Presence of active amniotic flow	No	2 (10.5 %)	3 (5.5 %)	0.382
	Yes	17 (89.5 %)	52 (94.5 %)	
Amniotic fluid index	Oligohydramnios or anhydramnios	17 (89.5 %)	27 (49.1 %)	**<0.001**
	Normal	2 (10.5 %)	28 (50.9 %)	
AmniSure ROM test	No	17 (89.5 %)	29 (52.7 %)	0.232
	Yes	2 (10.5 %)	26 (46.3 %)	
Cesarean section or hysterotomy	No	18 (94.7 %)	26 (46.3 %)	**<0.001**
	Yes	1 (5.3 %)	29 (52.7 %)	
Gender	Unspecified	15 (78.9 %)	0 (0 %)	**<0.001**
	Girl	1 (5.3 %)	27 (49.1 %)	
	Boy	3 (16.5)	28 (50.9 %)	
Chorioamnionitis	No	18 (94.7 %)	50 (90.9 %)	0.513
	Yes	1 (5.3 %)	5 (9.1 %)	
Maternal sepsis	No	18 (94.7 %)	55 (100 %)	0.257
	Yes	1 (5.3 %)	0 (0 %)	
Abruptio placentae	No	19 (100 %)	51 (92.7 %)	0.296
	Yes	0 (0 %)	4 (7.3 %)	
Placental rest	No	18 (94.7 %)	53 (96.4 %)	0.595
	Yes	1 (5.3 %)	2 (3.6 %)	
Endometritis	No	18 (94.7 %)	55 (100 %)	0.257
	Yes	1 (5.3 %)	0 (0 %)	
Blood transfusion	No	18 (94.7 %)	52 (94.5 %)	0.730
	Yes	1 (5.3 %)	3 (5.5 %)	
Postpartum or postabotion hemorrhage	No	18 (94.7 %)	53 (96.4 %)	0.595
	Yes	1 (5.3 %)	2 (3.6 %)	

Chi-Square test, p values < 0.05 is statistically significant.

Complication rates and some other obstetric outcomes of the groups

Table 3

Variables	Early pregnancy loos N (%) 19 (25.6 %)	Live birth N(%) 55 (74.4 %)	p value
C-reactive protein (mg/l), Median (min-max)	42 (1-347)	26 (1-557)	0.22
Leukocyte count, (x10^9/L), Median (min-max)	9.54 (4.71-20.60)	12.51 (7.86-18.46)	**0.033**
Neutrophil count, (x10^9/L), Median (min-max)	9.11 (3.81-19.53)	9.69 (0.73-18.36)	0.595
Lymphocyte count, (x10^9/L), Median (min-max)	1.72 (0.86-3.31)	1.44 (0.06-3.72)	0.891
Monocyte count, (x10^9/L), Median (min-max)	0.46 (0.21-1.19)	0.44 (0.01-1.26)	0.595
Platelet count, (x10^9/L), Median (min-max)	215 (149-433)	256 (127-449)	0.144
NLR, Median (min-max)	6.27 (1.45-19.93)	7.32 (0.40-177.17)	0.595
PLR, Median (min-max)	152.04 (76.32-297.67)	172.477 (72.99-3566.67)	0.287
MLR, Median (min-max)	0.28 (0.13-0.65)	0.26 (0.2-2.65)	0.595
PIV, Median (min-max)	680.47 (111.39-1900.39)	596.24 (44.93-15591.2)	1.000
SIRI, Median (min-max)	2.81 (0.48-12.75)	2.18 (0.18-45.46)	0.287
SII, Median (min-max)	1417.65 (337.54-2969.36)	1753.23 (91.51-37913-67)	0.110

Mann Whitney U Test, p values < 0.05 is statistically significant.
MLR; Monocyte-lymphocyte ratio, NLR; Neutrophil-lymphocyte ratio, PIV; Pan-immune inflammatory value, PRL; Platelet-lymphocyte ratio, SII; Systemic immune-inflammatory index, SIRI; Systemic inflammatory response index

Comprassion of serum inflammation markers of the groups

SS-067

Pubo Suburethral Suture Placement for Treatment of Stress Urinary Incontinence in a Woman with Mesh Exposure and Recurrent Incontinence

Metin Kaba
Sağlık Bilimleri Üniversitesi; Antalya Eğitim ve Araştırma Hastanesi, Kadın Hastalıkları ve Doğum Bölümü, Antalya

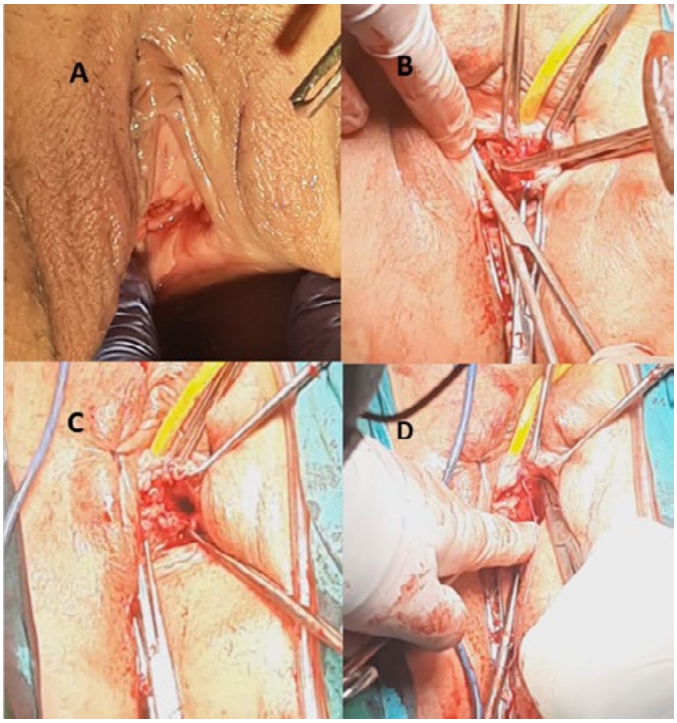
BACKGROUND: Stress urinary incontinence (SUI) is an ongoing concern among both patients and physicians. To date, over than a hundred surgical techniques have been described. However, no completely effective treatment has yet been established. Although the implementation of midurethral slings is considered the first-line treatment for SUI, it has some disadvantages such as mesh exposure and recurrent SUI. Thus, there is a need for a new surgical approach for SUI treatment. Therfore, a new surgical technique, pubo suburethral suture placement (PSUSP), was developed and described in this case report.

CASE: A 56-year-old woman, who had undergone transobturator tape (TOT) surgery, present with recurrent SUI. SUI and suburethral mesh exposure were observed during examination. (Fig. 1A). Under spinal anesthesia, the mesh was dissected and partially removed (Fig. 1B). The vaginal mucosa was dissected from the vesicovaginal fascia and the bilateral retropubic region was visualized (Fig. 1C). A two-needle polyester suture was inserted into the retropubic fibrous tissue and vesicovaginal fascia on the left side (Fig. 1D). The same suture was then inserted into the right retropubic fibrous tissue and vesicovaginal fascia. Then the suture was loosely ligated to avoid over tension on the urethral tissue. On post-operative first day, the urethral catheter was removed. The patient urinated without difficulty, SUI symptoms resolved and the patient was discharged. Twenty days later, the patient presented with mixed urinary incontinence symptoms. Local incisional dehiscence, separation of the suture on the right retropubic side, and SUI were observed during examination. Under spinal anesthesia, reoperation was initiated with a vertical incision. Vaginal mucosa was dissected from the vesicovaginal fascia. The bilateral retropubic region was visualized and PSUSP was performed as described above. The separated vesicovaginal fascia was repaired. The urethral catheter was removed on postoperative day one and the patient urinated without difficulty. The symptoms of mixed incontinence were resolved. Postoperative healing was successful. The patient was discharged on postoperative day two with continence.

CONCLUSION: The present case suggests that PSUSP could be a new surgical technic for SUI treatment. Further studies are required to evaluate its efficacy and applicability.

Keywords: Mesh exposure, Midurethral sling, Polyester suture, Pubo-suburethral suture placement, Transobturator tape, Stress urinary incontinence

Figure 1



Represents mesh dissection and insertion of the pobu suburethral suture in the left retropubic area. (A) Mesh exposure at the midurethral location. (B) Mesh dissection. (C) Dissected vaginal mucosa from the vesicovaginal fascia and visualization of the left retropubic region. (D) Placement of suture at the left retropubic area.

SS-068

Postoperative evaluation of laparoscopic burch colposuspension

Akın Usta, Duygu Lafcı, Ceyda Sancakli Usta
Department of Gynecology and Obstetrics, Balikesir University, Balikesir, Turkey

AIM: Even though the mid-urethral sling procedure is the gold standard, we believe that Laparoscopic Burch Colposuspension deserves reconsideration for treating stress urinary incontinence, especially due to ongoing concerns about complications associated with mesh.

MATERIAL-METHODS: Twenty-one patients with a mean age of 55 were included in the study. The diagnosis of stress urinary incontinence was defined objectively by a Q-type test and stress test and subjectively by answering 'yes' to the third question of the UDI-6 questionnaire. In the postoperative questionnaires, patients who answered 'no' to the third question of the UDI-6 questionnaire and patients with a PGIC score below 4 were considered postoperatively unrecovered.

RESULTS: In the questionnaires, 3 patients (14.2%) received a PGIC score below 4, and 1 patient (4.76%) answered 'no' to question 3 of the UDI-6 questionnaire. Altogether, the treatment was deemed unsuccessful for 4 patients (19.04%)

CONCLUSION: Laparoscopic Burch Colposuspension is a safe and effective method for the treatment of stress urinary incontinence.

Keywords: burch colposuspension, laparoscopy, stress urinary incontinence

SS-069

Concomittant scrofuloderma and papulonecrotic tuberculid in immunocompetent pregnant woman: A diagnostic challange and rare case presentation

Mehmet Bora Bozgeyik[1], Ahmet Karabulut[1], Selin Canpolat[1], Ayça Bozgeyik[2], Yaşam Kemal Akpak[1]
[1]Izmir City Hospital
[2]Health Sciences University Izmir Tepecik Training and Research Hospital

INTRODUCTION: Tuberculosis (TB) is one of the top 10 causes of death in the world according to World Health Organization report in 2016. Of all the patients that present with extra-pulmonary manifestations of tuberculosis, 1% to 2% suffer from cutaneous tuberculosis. We describe a case of concomittant scrofuloderma and papulonecrotic tuberculid as the main manifestations of TB presenting during pregnancy.

CASE PRESENTATION: A 31-year-old Papua New Guinean woman, with a history of four vaginal deliveries, presented to our hospital at 38 weeks of pregnancy due to labor pains. Examinations revealed a fetus small for gestational age, a firm-soft mass measuring 5-6 cm pressing against the left vaginal wall, two hyperpigmented and fibrotic scar lesions on the neck and a tumorous swelling approximately 15 cm in diameter and 10 cm deep with minimal heat increase on the sternum (figure 1), multiple lymph nodes were palpable in the cervical, supraclavicular, submandibular, and axillary regions. Other than widespread xerosis, no other findings were noted.

DISCUSSION: Scrofuloderma results from contiguous involvement of the skin overlying tuberculosis in a deeper structure (lymph node, bone, or joint). Clinically, it presents as a nodule which later breaks down to form discharging sinuses and progresses to form puckered scars.

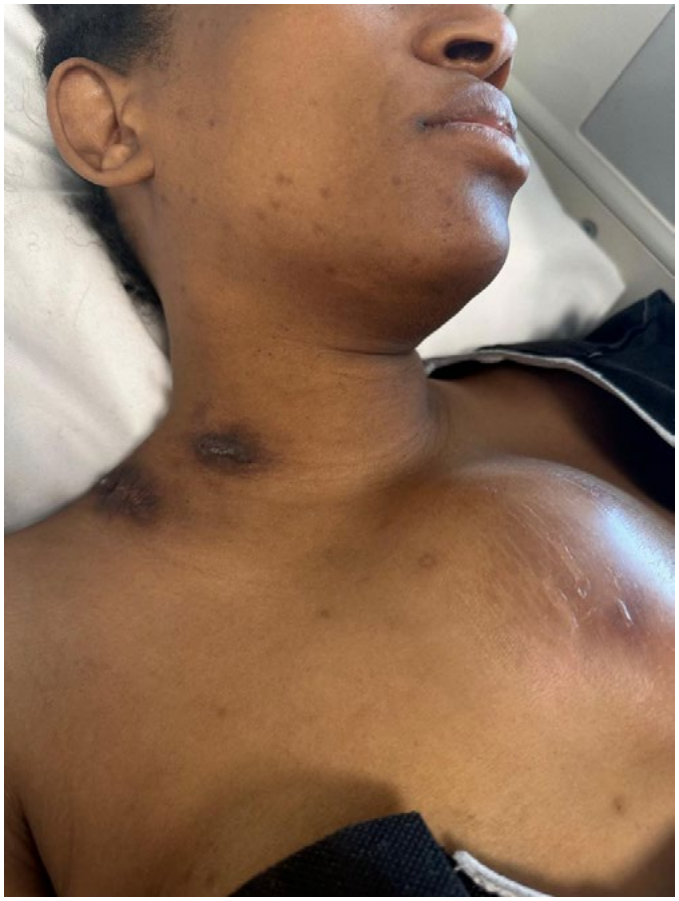
As in our case, PNT is an uncommon type of tuberculid, and predominantly affects young, immunocompetent people (figure 2). Even when papulonecrotic tuberculid is suspected, diagnosis can be challenging since acid-fast staining of lesions is usually negative and polymerase chain reaction testing for M. tuberculosis has a low positivity rate. In our case, the diagnosis was made through physical examination, clinical suspicion, a skin biopsy,granuloma structure containing giant cells as well, in microscopic examination (figure 3) and a positive QuantiFERON-TB Gold in-tube (QFT-GIT) test which is one of the mature γ-interferon release test (IGRA) methods. Since the skin features are not always obvious, a multidisciplinary approach is recommended for these patients.

CONCLUSION: Due to its rare occurrence, cutaneous tuberculosis and the associated scrofuloderma and PNT, which

can be challenging to diagnose, may occasionally present as a key findings in pregnant women.

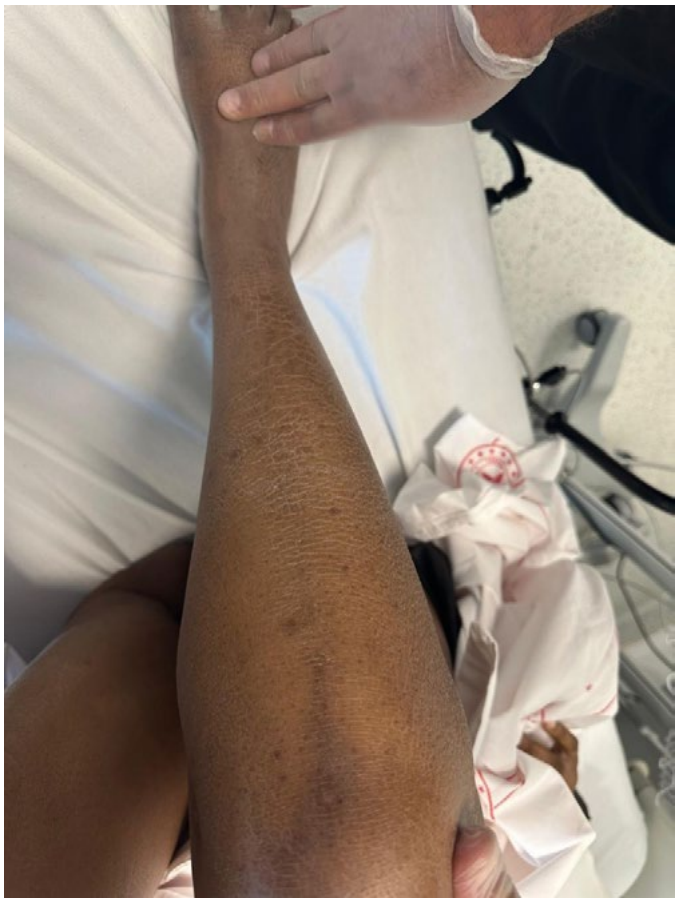
Keywords: Papulonecrotic tuberculid, pregnancy, scrofuloderma, skin, tuberculosis,

Figure 1.



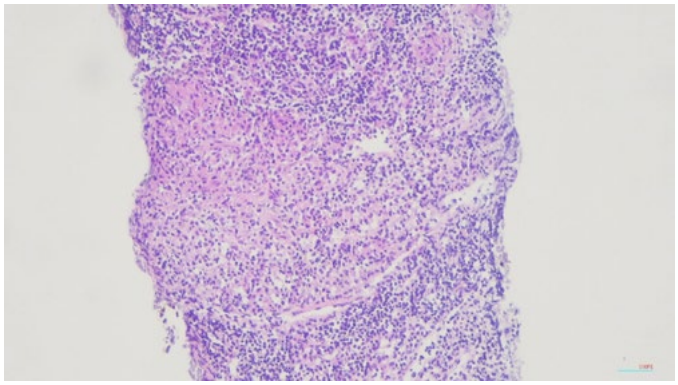
Concomittant scrofuloderma and papulonecrotic tubercle

Figure 2.



Papulonecrotic tubercle

Figure 3.



Granuloma structure containing giant cells as well, in microscopic examination

SS-070

Heterotopic Pregnancy with Twin Intrauterine Gestation and Tubal Ectopic Pregnancy Following Ovulation Induction with Clomiphene Citrate: A Video Case Report

Sertaç Ayçiçek, Mesut Bala, İbrahim Akkuş,
Pelin Değirmenci Ayçiçek
Clinic of Gynecology and Obstetrics, Health Sciences University Gazi Yaşargil EAH, Diyarbakır

INTRODUCTION: Heterotopic pregnancy, defined as the coexistence of an intrauterine and ectopic pregnancy, is a rare clinical condition, with an incidence of approximately 1 in 30,000 spontaneous pregnancies. However, the use of assisted reproductive technologies (ART), including ovulation induction agents like clomiphene citrate, has increased the risk of heterotopic pregnancy to as high as 1 in 100 pregnancies. This report presents a case of a 23-year-old primigravid woman with dichorionic diamniotic twin intrauterine gestation and a concurrent tubal ectopic pregnancy following ovulation induction with clomiphene citrate.

CASE PRESENTATION: Patient Demographics: A 23-year-old woman, gravida 1, para 0, with no previous history of pregnancy, presented to our clinic. Ovulation induction was achieved using clomiphene citrate (Clomid). Clinical Presentation: At approximately 9 weeks of gestation, the patient presented with acute lower abdominal pain. A transvaginal ultrasound confirmed a dichorionic diamniotic twin intrauterine pregnancy with fetal heartbeats, as well as an adnexal mass suggestive of an ectopic pregnancy. Diagnostic Workup: Serum β-hCG levels were significantly elevated, consistent with both intrauterine and ectopic pregnancies. A decision was made to proceed with a diagnostic laparoscopy to evaluate the adnexal mass.

SURGICAL FINDINGS: Procedure: The patient underwent diagnostic laparoscopy under general anesthesia using a single-port technique (Gel-Point, Applied Medical, USA). Intraoperatively, the uterus was noted to be enlarged, consistent with a 12-week gestation size. A hematoma-enlarged swelling was observed in the ampullary region of the left fallopian tube. Additional Findings: Both ovaries and the right fallopian tube appeared normal. There was mild to moderate free fluid in the pelvic cavity and minimal hematoma in the pelvic region. Intervention: A left salpingectomy was performed due to the tubal ectopic pregnancy, with careful preservation of the intrauterine twin pregnancies.

Postoperative Course: The patient recovered uneventfully from surgery. Serial ultrasound examinations confirmed the continued viability of both intrauterine fetuses, and she was subsequently managed conservatively with close monitoring of her pregnancy.

DISCUSSION: Heterotopic pregnancy poses a significant diagnostic and therapeutic challenge, especially in cases of multiple gestations following ovulation induction. The rarity of the condition and the potential for life-threatening complications, such as tubal rupture and hemorrhage, necessitate a high index of suspicion in patients presenting with abdominal pain and/or vaginal bleeding in early pregnancy. In this case, early recognition and prompt surgical intervention preserved the intrauterine twin pregnancy while addressing the ectopic gestation.

According to current literature, the incidence of heterotopic pregnancies has increased due to the widespread use of ovulation induction agents and ART. Recent studies emphasize the importance of early ultrasound evaluation in cases of assisted reproduction to rule out the possibility of ectopic or heterotopic pregnancies.

CONCLUSION: This case highlights the importance of timely diagnosis and intervention in the management of heterotopic pregnancies, especially in patients undergoing ovulation induction. Early laparoscopic management allowed for the preservation of a twin intrauterine pregnancy, underscoring the importance of a multidisciplinary approach in such complex cases.

Keywords: Heterotopic pregnancy, Laparoscopic salpingectomy, Ovulation induction, Tubal ectopic pregnancy, Twin pregnancy

SS-071

Case Study: Migration of Copper Intrauterine Device (IUD) Into the Mesocolon

Sezin Çömez[1], Kubra Adsaz Parlar[1], Mehmet Ferdi Kıncı[1], Yaşam Kemal Akpak[2]
[1]Izmir City Hospital, Department of Obstetrics and Gynecology
[2]Health Sciences University, Izmir Faculty of Medicine, Department of Obstetrics and Gynecology

BACKGROUND: An intrauterine device (IUD) is a universal contraceptive method that is well enduring, immensely applicable, cost-efficient, and revocable (1). Commonly used devices are copper IUD or Mirena (Levonorgestrel) IUD (2). Despite their efficacy, IUDs can elicit severe complications, such as lost IUD (5), ectopic pregnancy, bleeding, infection, and uterine perforation (4). Once the uterus is perforated, an IUD can migrate to various locations throughout the abdomen, including the pouch of Douglas, omentum (7), peritoneum, bladder, rectosigmoid, and adnexa (2). Studies have advised promptly removing a displaced IUD once it enters the peritoneal cavity; it can cause intra-abdominal adhesions, volvulus, fistulae, and intestinal perforations (8). This report presents a case of a migrated IUD into mesocolon within two months of insertion, underscoring the need for constant vigilance in IUD management.

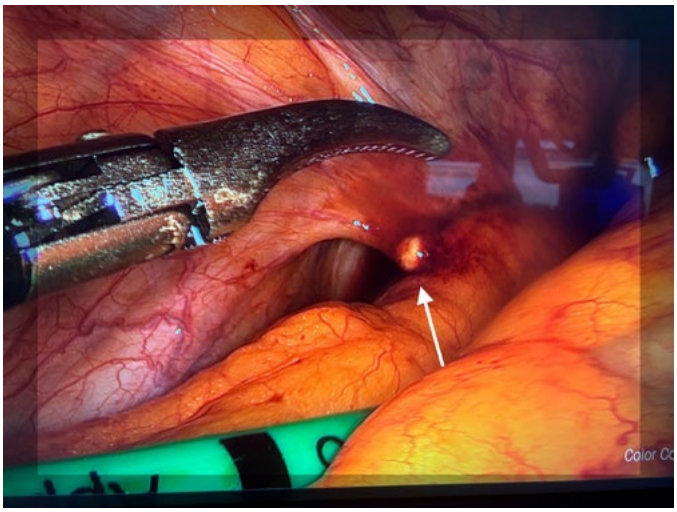
CASE PRESENTATION: A 30-year-old woman with a history of two vaginal deliveries presented to our clinic three months post-partum with lower abdominal pain. She had a copper IUD inserted six weeks after birth in an outpatient clinic. String of the IUD was not visible on vaginal examination, which was otherwise normal. Sonographic examination appeared normal, and no IUD was detected. Abdominal x-ray showed the radio-opaque IUD in the left lower quadrant. An explorative laparoscopy was done, and the IUD emerged fixed between the left abdominal wall and the mesocolon. Through blunt dissections, we performed adhesiolysis and removed the IUD as one piece. The colon was intact, as confirmed by general surgeons intraoperatively. The source of perforation was not visible, and we ended the operation without any complications, having thoroughly examined the abdominal cavity.

DISCUSSION: An IUD may erode the uterine wall, resulting in uterine perforation with an incidence of 0.3-2.2 in 1000 insertions (6). Almost 80% of IUDs are recognized in the peritoneal cavity after perforation, followed by displacement into adjacent organs (9). In our case, the IUD adhered to the mesocolon outside the peritoneum. The etiology of IUD perforations is unequivocal. Studies propose that it can result from misplacement owing to insertion techniques or even after correct placement due to transmural, transcervical, and transtubal migration (10). The failure rate is 0.2% for Levonorgestrel IUD and 0.8% for copper-IUD (3), associated with a higher perforation risk. Other risk factors comprise inadequate operator experience, fixed and retroverted uterus, myometrial weakness, lactation, device placement within the first six months after delivery, nulliparity, and a prior history of miscarriages (10). Correspondingly, our patient had a copper IUD placement in an outpatient clinic six weeks post-partum; she was lactating and had a retroverted uterus. Because she had the procedure done outside our center, we cannot comment on the insertion technique and clinical expertise.

CONCLUSION: While uncommon, uterine perforation and IUD relocation are severe complications of IUD insertion. Evaluating the risk factors and individual patient characteristics before the procedure is crucial. Equally important is the need for vigilant and proactive follow-up care after IUD placement, which is critical to detecting and preventing potential damage, should the IUD become dislocated, through appropriate radiologic and clinical evaluation.

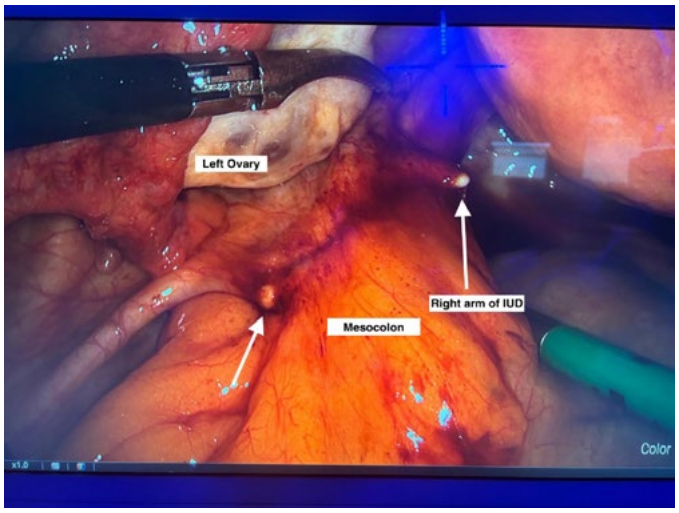
Keywords: copper IUD, Mirena (Levonorgestrel) IUD, intrauterine device (IUD), mesocolon

Picture 1



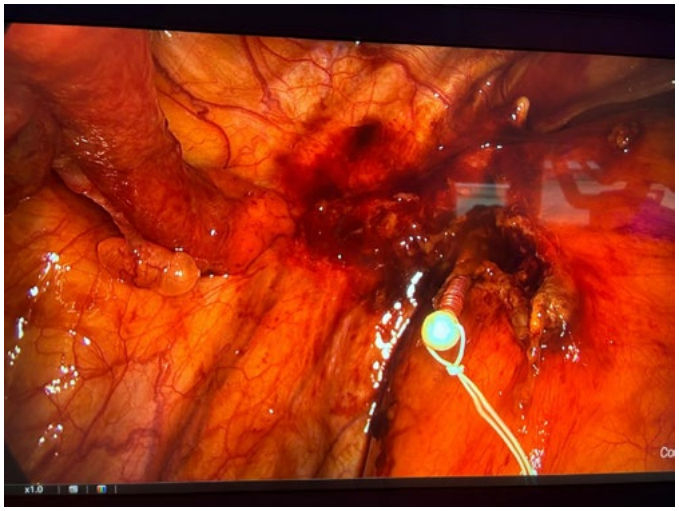
IUD Adhered to Mesocolon

Picture 2



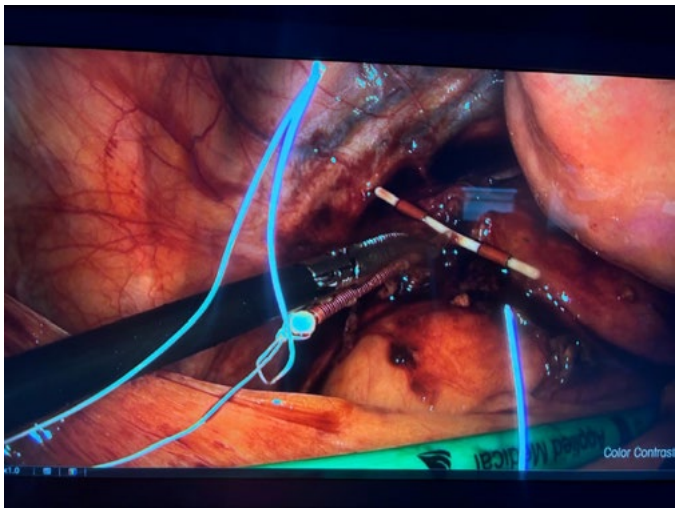
IUD Visible Between the Left Pelvic Wall and Mesocolon

Picture 3



IUD Partially Removed by Its String

Picture 4



IUD Removed Completely

Referanslar

1. C.A. Ferguson, D. Costescu, M.A. Jamieson, L. Jong, Transmural migration and perforation of a levonorgestrel intrauterine system: a case report and review of the literature, Contraception 83 (2016) 81–86.

2. K. Ertopcu, C. Nayki, P. Ulug, U. Nayki, E. Gultekin, A. Donmez, Y. Yildirim, Surgical removal of intra-abdominal intrauterine devices at one center in a 20-year period, Int. J. Gynecol. Obstet. 128 (2015) 10–13.

3. CDC, "U.S. Selected Practice Recommendations for Contracep- tive Use," 2013.

4. Sinha M, Gupta R, Tiwari A. Minimally invasive surgical approach to retrieve

migrated intrauterine contraceptive device. Int J Reprod Contracept Obstet Gynecol

2013;2:147–51.

5. L. Nilsestuen, "IUD perforation to the urinary bladder: Ultra- sonographic diagnosis," Journal of Diagnostic Medical Sonogra- phy, vol. 29, no. 3, pp. 126–129, 2013.

6. Heinemann K, Reed S, Moehner S, Do Minh T. Risk of uterine perforation with levonorgestrel-releasing and copper intrauterine devices in the European active surveillance study on intrauterine devices. Contraception. 2015;91(4):274–279. doi: 10.1016/j.contraception.2015.01.007.

7. Ibghi W, Batt M, Bongain A, Declemy S, Proton A, HassenKodhja R, et al. Iliac vein stenosis caused by intrauterine device migration. J Gynecol Obstet Biol Reprod 1995;24:273–5.

8. Grimaldo Arriaga J, Herrera Aviles A, Garcia Taxilaga A. Perforation of the large intestine caused by a type 7 medicated copper IUCD. Ginecol Obstet Mex 1993;61:235e7.

9. S. Narayanamoorthy, A. Christensen, R. Apostol, Intrauterine device perforation and adhesion formation [14J], Obstet. Gynecol. 133 (2019) 110S, 1S.

10. K. Carmody, B. Schwartz, A. Chang, Extrauterine migration of a MIRENA intrauterine device: a case report, J. Emergency Med. 41 (2) (2011) 165–166.

SS-072

Primary Pelvic Retroperitoneal Hydatid Cyst: A Rare Case Presentation

Gökçen Ege[1], Firdevs Şahin Duran[2], Özgün Ceylan[1]
[1]Department of Gynecologic Oncology, Ankara Etlik City Hospital, Ankara, Turkey
[2]Department of Pathology, Ankara Etlik City Hospital, Ankara. Turkey

Hydatid disease, or echinococcus, is a zoonotic parasitic infection caused by the larvae of Echinococcus species, most commonly Echinococcus granulosus. It is endemic in regions such as the Middle East, the Mediterranean, South America, and Africa. Humans contract the disease through consuming contaminated vegetables or contact with infected animals. The parasite's ova hatch in the small intestine and travel through the portal vein to the liver, the most commonly affected organ (52-77%), followed by the lungs (10-40%). Primary retroperitoneal hydatid disease is extremely rare, with most cases being secondary to a hepatic cyst rupture.

We report a case of a 60-year-old woman who presented with an incidentally discovered pelvic mass. An initial lumbar MRI, performed for back pain, revealed a complex septated cystic mass approximately 14 cm in size in the pelvis and an 8 cm cortical cyst in the right kidney. No abnormalities were detected in the liver or lungs, and tumor markers were negative. The patient underwent planned laparoscopic surgery. Intraoperatively, a firm, fixed mass was identified beneath the broad ligament of the uterus, separate from the ovaries and fallopian tubes. Conversion to laparotomy was required due to the mass being firmly adherent to surrounding tissues, the uterus, and iliac vessels. During dissection, the cyst ruptured, releasing daughter cysts and scolexes, confirming the diagnosis of a hydatid cyst. Steroid and antihistamine therapy were administered to prevent anaphylaxis, the abdomen was irrigated with hypertonic saline, and the cyst wall was totally excised. The cortical mass in the right kidney was palpated and excised. After the excision of both cysts, no other cysts or masses were observed in the liver or abdomen, the operation was concluded. In the postoperative period, albendazole therapy was administered. The histopathological examination of the cystic mass confirmed the diagnosis of a hydatid cyst. Scolexes, a germinative membrane with nuclei, and an outer acellular laminated membrane (cuticle) were identified, which are distinctive features of a hydatid cyst. The kidney cyst was reported as a simple cyst. Further imaging, including hepatobiliary ultrasound and thoracoabdominal CT, did not reveal any primary focus, leading to the diagnosis of a primary pelvic retroperitoneal hydatid cyst. The patient was discharged without complications.

Primary retroperitoneal hydatid cysts are exceedingly rare and present a diagnostic challenge due to nonspecific symptoms. In endemic regions, clinicians should consider hydatid disease in the differential diagnosis of pelvic masses, even in the absence of liver or lung involvement. Imaging studies are essential, but definitive diagnosis often depends on intraoperative and histopathological findings.

CONCLUSION: This case emphasizes the need to consider hydatid disease in the differential diagnosis of pelvic masses in endemic areas, regardless of hepatic or pulmonary involvement. Early surgical intervention, coupled with appropriate perioperative management, is critical to prevent severe complications such as cyst rupture and anaphylaxis. Despite their rarity, primary pelvic retroperitoneal hydatid cysts should be approached with a multidisciplinary strategy to ensure favorable patient outcomes.

Keywords: Echinococcus, hydatid cyst, retroperitoneal neoplasm

Fig. 1 Preoperative MRI showing pelvic mass and kidney cyst

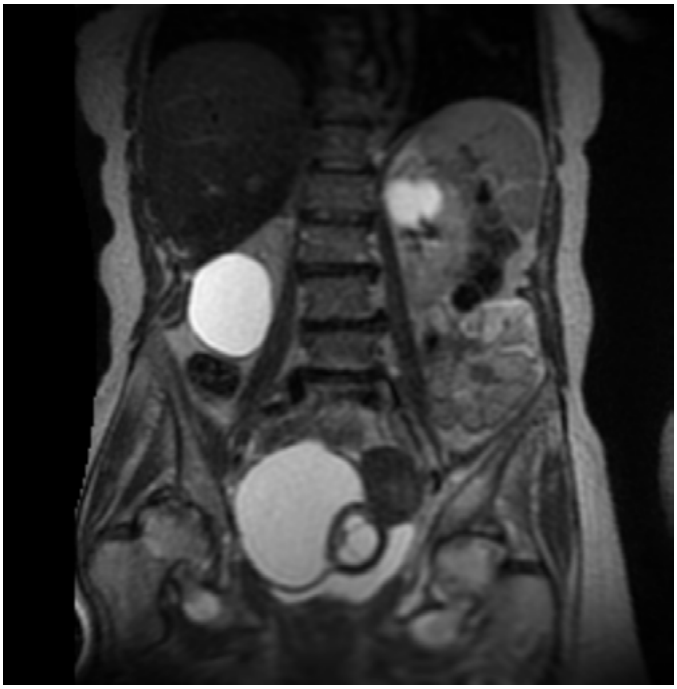


Fig. 2 Intraoperative Retroperitoneal Mass Image

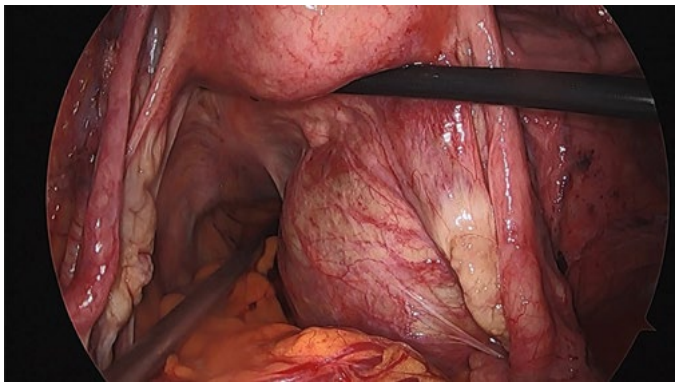
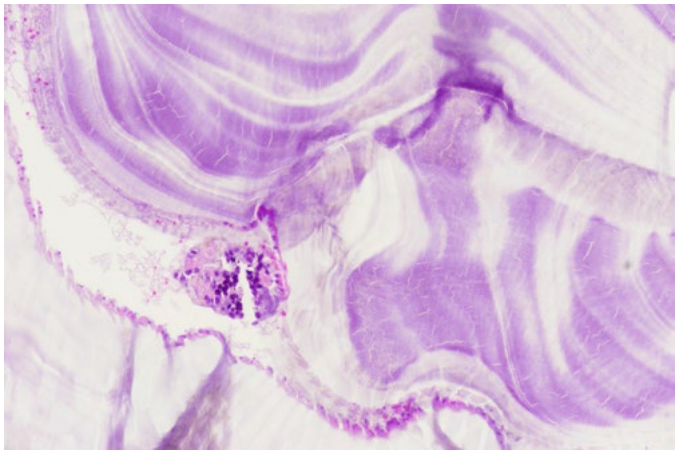


Fig. 3 Pathologic Findings



Scolex and germinative membrane

SS-073

Management of Pelvic Inflammatory Disease with acute abdomen with Minimally Invasive Surgery: Video presentation

Sertaç Ayçiçek, Pelin Değirmenci Ayçiçek, Berfin Bulut
Clinic of Gynecology and Obstetrics, Health Sciences University Gazi Yaşargil EAH, Diyarbakır

INTRODUCTION: Frozen pelvis, characterized by dense adhesions of the pelvic organs, is a challenging condition, often linked to endometriosis, pelvic infections, or prior surgeries. However, it may also arise in patients with a history of assisted reproductive technology (ART) due to potential complications like ovarian hyperstimulation. Here, we present a case of a 32-year-old woman, who conceived twins via ART, and presented with acute abdominal pain and vaginal discharge, later diagnosed with frozen pelvis and managed surgically.

CASE PRESENTATION: A 32-year-old female, with a history of ART-conceived twin pregnancy, presented to the emergency department with complaints of lower abdominal pain and vaginal discharge. She denied any prior history of pelvic infections or surgeries. On physical examination, pelvic tenderness with guarding and rebound was noted, and the cervix appeared tender and erythematous. Despite these findings, her laboratory results, including inflammatory markers, were normal.

IMAGING: Transvaginal ultrasound revealed a normal-sized uterus but bilateral adnexal enlargement and free fluid in the pelvic cavity. There was no evidence of adnexal masses or intrauterine abnormalities. These findings, coupled with the patient's clinical presentation, raised suspicion for pelvic adhesions.

SURGICAL MANAGEMENT: Diagnostic laparoscopy was performed under general anesthesia. A 10 mm trocar was inserted through the umbilicus, and two 5 mm trocars were placed in the left lower quadrant. Intraoperative findings revealed a frozen pelvis, with dense adhesions involving the uterus, adnexa, and pelvic sidewalls. Adhesiolysis was carefully performed using irrigation and aspiration techniques. Due to extensive tubal involvement, a bilateral salpingectomy was necessary. No complications occurred during the procedure, and the patient was stable throughout.

POSTOPERATIVE OUTCOME: The patient had an uncomplicated postoperative recovery and was discharged the following day. At her two-week follow-up, she reported complete resolution of symptoms and no further complications.

DISCUSSION: Frozen pelvis is typically associated with conditions like endometriosis or pelvic infections. In this case, the patient had no such history, raising the possibility that

ART may have contributed to the development of adhesions. ART, particularly ovarian hyperstimulation, can cause subclinical infections or inflammation, increasing the risk of pelvic adhesions. Laparoscopy remains the gold standard for diagnosing and managing frozen pelvis, allowing for direct visualization and precise surgical intervention. Bilateral salpingectomy was performed due to the extensive involvement of the fallopian tubes, a common finding in severe cases of frozen pelvis.

CONCLUSION: This case highlights the importance of considering frozen pelvis in patients with a history of ART who present with abdominal pain. Laparoscopic intervention is crucial for both diagnosis and treatment, allowing for timely management and prevention of further complications. Early identification and appropriate surgical intervention can significantly improve patient outcomes.

Keywords: Assisted reproductive technology (ART), Bilateral salpingectomy, Frozen pelvis, Laparoscopy, Pelvic adhesions

SS-074

aparoscopic Hysterectomy in a Patient with Myoma Uteri and Treatment-Resistant Abnormal Uterine Bleeding with Dense Adhesions

Sinan Abeş, Fatma Ketenci Gencer, Barışcan Aldanmaz, Turgut Özbay, Süleyman Salman
gynaecology and obstetrics clinics, gaziosmanpaşa eğitim araştırma hastanesi sağlık bilimleri university, istanbul, turkey

Laparoscopic hysterectomy is shorter hospital stay,less blood loss, less postoperative pain and less risk of wound infection compared to abdominal hysterectomy.There are some factors that may complicate this procedure.Adhesions due to previous operations may change the anatomy, limiting the surgeon's working area and increasing the risk of complications

OBJECTIVES: Video demonstration of laparoscopic hysterectomy in a difficult case with dense adhesions

METHODS: A 49-year-old patient with 4 normal deliveries who underwent multiple myomectomy,bilateral salpingectomy and left oophorectomy with pfannenstiel incision in 2015, developed gastrointestinal symptoms such as constipation as a result of adhesions secondary to the operation in the late postoperative period.The patient, who was afraid of experiencing similar symptoms when she underwent laparotomy again, was informed in detail and laparoscopic hysterectomy was decided with the indications of myoma uteri and treatment-resistant abnormal uterine bleeding.USG examination of the patient revealed a 7 cm subserous myoma core on the left lateral aspect of the uterus.The operation was started under general anaesthesia in dorsal lithotomy position.Following abdominal vulva vaginal batikonage, sterile drapes were covered, sterile ureter catheter was inserted into the bladder, and V-Care uterine manipulator was placed in the cervix. The abdomen was entered with a 10 trocar from the umbilicus. The abdomen was inflated with about 3 litres of CO2. The whole abdomen was observed with a telescope. Intestines fundus posteriorly and uterus left lateral dense adhesions were observed. Left adnexa was not observed secondary to previous operation. Right ovary was atrophic and right rotundum adhesion was observed. The patient was placed in trendelenburg position.The abdomen was entered with a 5 trocar 2-3 cm medial to the left and right crista iliaca anterior superior and left paraumbilical area.Adhesions were separated by sharp dissections using scissors. Bilateral round ligaments were grasped, burned and cut with a voyant.Bilateral infundibulopelvic ligaments were grasped with voyant, burned and cut. Bladder peritoneum was separated from the cervix by sharp and blunt dissections.After the tissues were separated, the cervix was cut anteriorly with a harmonic.V-Care manipulator was removed and a tampon was placed in the vagina. The rest of the cervix was incised with the

harmonic.The materials(uterus and right adnexa) were taken out of the abdomen through the vaginal cuff. The vaginal cuff was laparoscopically sutured with vicryl number1. Peristalsis of both ureters was visualised. The abdomen was washed with plenty of saline. Bleeding was controlled and the operation was terminated.

DISCUSSION AND CONCLUSION: This case report demonstrates that laparoscopic hysterectomy can be technically and clinically successful in patients with adhesions who have had a previous laparotomy for myomectomy. The patient's previous gastrointestinal symptoms decreased in the 1st postoperative month. In this case, in order to minimise the risk of bowel injury, we preferred to perform sharp dissection mostly with scissors instead of bipolar energy in places far from the main vessels.In this way, it can reduce the risk of complications while accelerating the patient's postoperative recovery process. However, factors such as the experience of the surgical team, patient selection and management of complications should be carefully evaluated.

Keywords: adhesion,laparoscopic hysterectomy, myomectomy

SS-075

Management of asymptomatic giant adnexal mass: A case report

Fatma Başak Sargın[1], Mehmet Murat Naki[1], Şükriye Leyla Altuntaş[2], Yaren Tuba Bektaş[1], Nur Betül Tekiner[1]
[1]Obstetrics and Gynecology, Medipol Acıbadem District Hospital, Istanbul, Turkiye
[2]Obstetrics and Gynecology, Koşuyolu Medipol Hospital, Istanbul, Turkiye

INTRODUCTION: Ovarian tumors with diameters exceeding 10 cm are classified as giant ovarian masses. With advances in technology and increased frequency of routine examinations, the incidence of such masses has decreased. However, in cases with an asymptomatic course, diagnosis may be delayed, making management and treatment more complex. This case report discusses the management of a giant adnexal mass that was diagnosed late due to its asymptomatic nature.

CASEREPORT: A 40-year-old nulliparous, premenopausal woman was referred to our clinic due to an adnexal mass and suspicion of malignancy based on MRI findings, following an 8-9 month history of abdominal distension and discomfort. Initially asymptomatic, the patient attributed the gradual abdominal enlargement to weight gain and sought various treatment options for weight management. However, as the distension worsened, she pursued further medical evaluation. Aside from mild respiratory distress caused by the mass effect, no significant symptoms were noted. Ultrasonography revealed a large, bilobed mass measuring 40-50 cm originating from the left adnexal region, containing a 3x2 cm solid component with no papillary structures or increased vascularity (Figure 1). A 5 cm anechoic cystic lesion was also identified in the right ovary. The preoperative CA125 level was 192.6 U/mL, and there were no familial risk factors in this case.

The Risk of Malignancy Index (RMI) was calculated as 385.2, indicating high risk (>200). The IOTA-ADNEX model estimated a 47.4% probability of a malignant/borderline tumor (Evidencio model number 945) (Figure 2).

With a preliminary diagnosis of an ovarian mass with suspected malignancy, a unilateral salpingo-oophorectomy was performed following a midline incision. A mass measuring 50x30x15 cm and weighing 11.42 kg was sent for frozen section pathology and was reported as a mucinous borderline tumor. Subsequently, cystectomy of the right ovary, omentectomy, and appendectomy were performed, and the surgery was completed without complications. The patient was discharged on the second postoperative day, with a follow-up planned for 3 months later. The final pathology confirmed a mucinous borderline tumor of the left ovary, consistent with the frozen section findings; no involvement of the right ovary was observed.

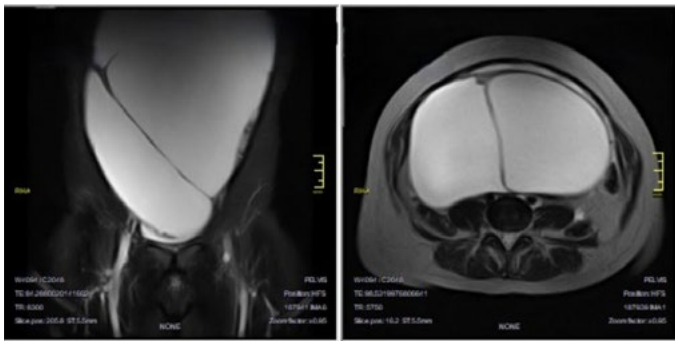
DISCUSSION: Mucinous cystadenomas constitute 10-15% of all ovarian masses, with approximately 80% of them being benign.

However, rapidly growing masses should always be considered suspicious for malignancy. Due to the high risk of rupture during laparoscopic procedures, laparotomy is generally preferred in the management of large masses. In our case, the mass was removed intact via laparotomy. Complete excision of the mass without rupture is crucial in preventing the spread of potentially malignant pathology.

CONCLUSION: The growth of the mass can lead to multisystemic symptoms and complicate treatment. Although complete recovery was achieved postoperatively in our case, there are reports in the literature of giant mass cases resulting in mortality and morbidity. Early diagnosis and appropriate surgical intervention can improve patient outcomes and reduce the risk of complications in such cases.

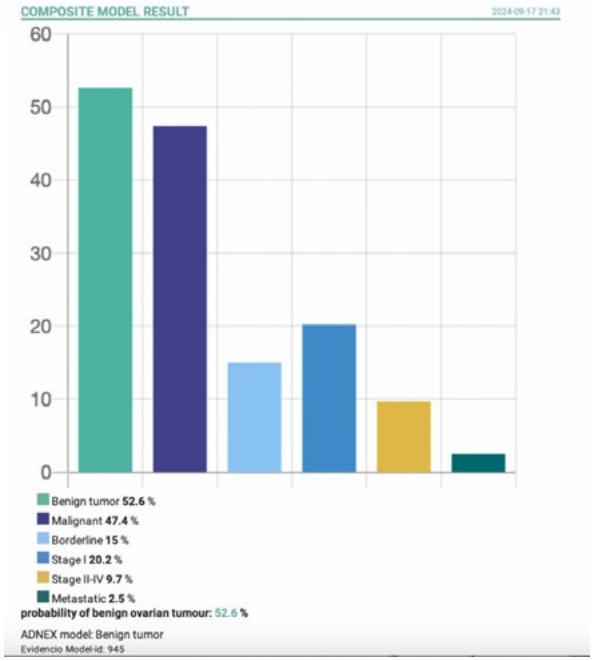
Keywords: borderline tumor, giant ovarian mass, mucinous cystadenoma, surgical approach

Figure1



MRI of the ovarian mass

Figure2



ADNEX model of the ovarian mass

SS-076

Migrated intrauterine device: A case of asymptomatic bowel perforation

Elif Avşaroğlu[1], Fatma Başak Sargın[2], Mehmet Murat Naki[2], Harika Bodur Öztürk[2]
[1]Obstetrics and gynecology, Adana 5 Ocak State Hospital, Adana, Turkiye
[2]Obstetrics and gynecology, Medipol Acıbadem District Hospital, Istanbul, Turkiye

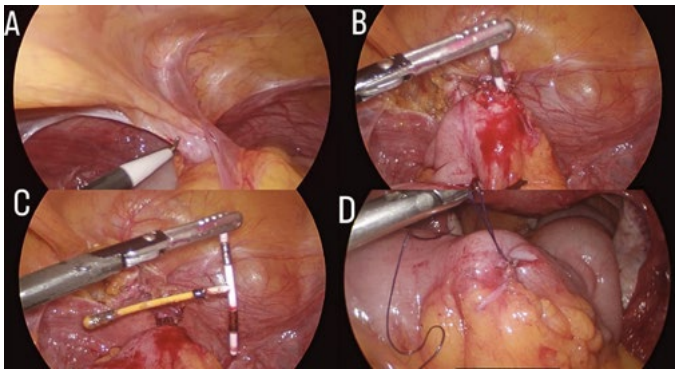
INTRODUCTION: Intrauterine devices (IUDs) are among the most commonly used contraceptive methods due to their non-reliance on daily medication and lack of hormonal side effects. Copper IUDs, through the release of copper ions, impair sperm motility and induce a sterile inflammatory response that inhibits implantation, thus preventing pregnancy. While IUD displacement usually occurs during insertion or removal, it can also occur more rarely due to uterine contractions. Extrusion of the IUD from the uterine cavity not only increases the risk of pregnancy but can also result in organ injury or functional loss. Removal of the IUD is often necessary once displacement is detected. This video presentation aims to demonstrate the safe endoscopic surgical removal of a translocated IUD and to visualize the complications that can arise from late detection, highlighting the increased risk associated with such scenarios.

CASE: A 42-year-old multiparous woman presented to our clinic for routine evaluation. She reported no active complaints aside from chronic pelvic pain. The patient had an IUD inserted five years prior. On examination, the IUD was not visualized within the uterine cavity. Non-contrast computed tomography (CT) imaging revealed that the IUD had dislocated to the left pelvic sidewall, with suspected localization within the bowel wall. Laparoscopic surgery was performed, and the IUD was found to have perforated into the sigmoid colon. The IUD was successfully removed, and bowel repair was performed (image1). The patient experienced no postoperative complications and was discharged on the second day after surgery.

CONCLUSION: In this case, despite uterine perforation followed by intestinal perforation, the IUD remained asymptomatic due to peritonealization and adhesions. However, given the potential risks of infection and bowel dysfunction, removal was deemed necessary. Early detection of such cases underscores the importance of regular follow-up for patients with IUDs. Regular monitoring is crucial to prevent complications associated with translocated IUDs.

Keywords: device migration, intrauterine devices, intestinal perforation

Image1



Steps of the laparoscopic surgery A: identification of the area containing the IUD, B: removal of the IUD, C: observation of the intact IUD, D: repair of the intestinal defect.

SS-078

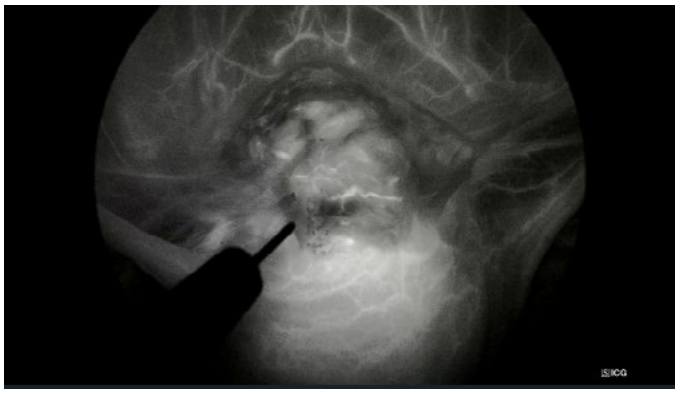
Identification of the Isthmic Area Using Indocyanine Green and Perfusion Control After Repair

Umut Sıncı, Hasan Volkan Ege, Murat Cengiz, Feyzanur Verim, Murat Gultekin, Derman Basaran
Kadın Hastalıkları ve Doğum Ana Bilim Dalı,Hacettepe Üniversitesi, Ankara,Türkiye

Isthmocel (also called uterine scar defect) is considered a late complication of the increasingly frequent cesarean (C/S) surgeries worldwide. Isthmocel is characterized by a defect in the myometrial tissue secondary to impaired tissue integrity in the lower uterine segment. The resulting defect can lead to problems such as abnormal uterine bleeding, dysmenorrhea, or infertility, and can also cause life-threatening clinical issues like placental adhesion anomalies or rupture. In our case, we aimed to identify the isthmocel tissue by detecting possible perfusion changes using intravenous (IV) indocyanine green (ICG). A 33-year-old patient with a history of one cesarean section presented with complaints of spotting like vaginal bleeding. A transvaginal ultrasound (TVUSG) revealed a defect compatible with isthmocel measuring 6x5 mm in size at the C/S scar. The patient was scheduled for laparoscopic (L/S) isthmocel repair surgery. The patient was placed in the lithotomy position. The operation began laparoscopically. The bladder peritoneum was incised to create adequate vesicovaginal space and access the cesarean scar. Subsequently, hysteroscopy (H/S) was used to identify the isthmocel sac and its borders. During this process, 4 mg of intravenous (IV) indocyanine green (ICG) was administered, allowing the laparoscopic identification of the isthmocel sac, which had different perfusion from the healthy myometrial tissue (Figure-1). The isthmocel sac, whose borders were defined, was excised using cold scissors. After the excision, the resulting defect was closed in two layers, deep and superficial, using 0 V-Loc™ barbed suture. After closing the defect, 4 mg of IV ICG was again used to confirm the perfusion of the repaired isthmocel area. After verifying the repair and suture placement within the uterus using hysteroscopy, the procedure was concluded. The use of intravenous (IV) indocyanine green (ICG) to detect the isthmocel sac, which has different perfusion from normal tissue, has been applied for the first time to the best of our knowledge. Using IV ICG to identify the defective area could eliminate the need for hysteroscopy in isthmocel surgeries, potentially reducing both the cost of the procedure and the risks associated with the operation.

Keywords: Isthmocel,indocyanine green,

Figure-1: Detection of the isthmocel sac using ICG (hypoperfusion)



SS-079

Florid cystic endosalpingiosis presenting as an ovarian cancer

Ceyda Karadağ[1], Saniye Merve GÜL KARA[2], Sezen Kocarslan[3]
[1]Department of Obstetric and Gynecology Division of Gynecologic Oncology, Antalya City Hospital Antalya, Turkey
[2]Department of Obstetric and Gynaecology, Antalya City Hospital Antalya, Turkey
[3]Department of Pathology, Antalya City Hospital Antalya, Turkey

INTRODUCTION: Endosalpingiosis is a rare condition characterised by the presence of tubal epithelium outside the fallopian tube. Endosalpingiosis typically refers to the presence of benign glands lined by tubal-type epithelium, and involves the peritoneum, subperitoneal tissues, omentum, retroperitoneal nodes, etc.The prevalence of endosalpingiosis varies from 7.6% to 12.5%.The most accepted pathogenesis is metaplastic change of the coelomic epithelium into tubal-like epithelium. Endosalpingiosis is associated with dysmenorrhoea and chronic pelvic pain. It is important to differentiate it with papillary serous adenocarcinoma due to presence of papillary and grapes like excrescences on the pelvic peritoneum, ovary and uterus as the management of this condition is primarily conservative.Its an important condition because of possible implications endosalpingiosis has regarding high-grade serous neoplasms and the tubal origin of these malignancies.

CASE: A 53-year-old woman presented with chronic lower abdominal pain for a while. She had two living issues, both were born by lower segment caesarian sections. An ultrasound of the pelvis was performed in which the uterus and the right ovary were normal and the left ovary had a cyst of 4.0x2.7 cm with multiple septations and a mural nodul. CA 125 was normal.In view of her symptoms and ultrasound findings, she was admitted to the hospital for a laparoscopic removal of this abnormal mass. Laparoscopic bilateral salpingo-oophorectomy was performed and has been sent to frozen. It was interpreted as an epithelial malignant tumor. Due to the frozen section result, the patient underwent laparotomy with a median incision below the umbilicus, hysterectomy, bilateral pelvic-paraaortic lymph node dissection, cytology and total omentectomy were performed. No complications developed and the patient was discharged on the 3rd day of the operation.However, the final pathology result of the patient was reported as serous cystadenofibroma containing cystic atypical endosalpingiosis foci in focal areas.

DISCUSSION: The clinical presentation of endosalpingiosis is not specific. The common symptoms are pelvic pain, dysmenorrhoea, menorrhagia and infertility; some patients are asymptomatic, with an incidental finding of ovarian

cysts on imaging or during laparotomy for other indications. Endosalpingiosis represents a diagnostic challenge that can only be made by histopathological examination. On rare occasions, it presents as a macroscopic mass that can be confused with a neoplasm. Although endosalpingiosis is considered a benign condition, atypical epithelial changes have been reported as “atypical endo- salpingiosis.” There are diagnostic difficulties in distinguishing “atypical endosalpingiosis” from serious borderline tumor or borderline implants; diagnosis is further complicated when peritoneal washings are used in the evaluation of gynecological cancer. The possibility of malignant transformation of endosalpingiosis should be considered, similar to those arising in endometriosis. In their immunohistochemical study of tubal, ovarian, and serous neoplastic lesions. Only a few reports in the literature have described the presentation of florid cystic endosalpingiosis as ovarian mass.

The recognition of endosalpingiosis also needs correct differential diagnoses both clinically and pathologically. It may be initially misdiagnosed as neoplastic lesion by imaging examination, which clinician and pathologist to avoid a misdiagnosis as a malignancy. Larger studies must be undertaken to evaluate the association between endosalpingiosis and gynecologic malignancies.

Keywords: atipical,endosalpingiosis,ovariancyst,neoplasm,

POSTER BİLDİRİLER

www.obstetrikjinekolojitartismalikonular.org

EP-001

Widespread Subcutaneous Emphysema and Pneumomediastinum Developing During Laparoscopic Hysterectomy: A Case Report

Enes Burak Mutlu, İrem Ece Sönmez
Muradiye District State Hospital, Van, Turkey

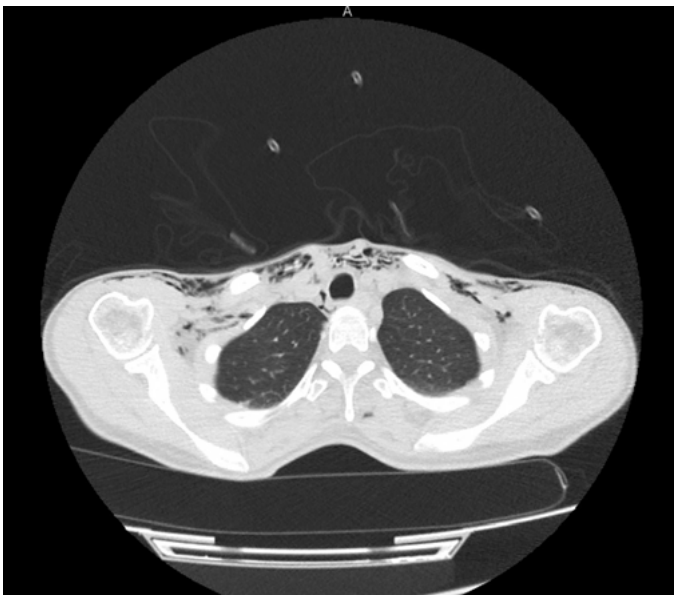
INTRODUCTION: Laparoscopy is a frequently used method in gynecological surgeries. In this technique, pneumoperitoneum is created by insufflating the abdominal cavity with CO2. During this procedure, complications such as subcutaneous emphysema, pneumomediastinum, and pneumothorax may occur. In the literature, the incidence of subcutaneous emphysema is reported as 2.3%, while the incidence of pneumomediastinum and pneumothorax is 1.9%. In this case, we aim to present a case of widespread subcutaneous emphysema and pneumomediastinum that developed during laparoscopic hysterectomy.

CASE PRESENTATION: A 51-year-old female patient presented to our clinic with complaints of persistent bleeding despite one year of using a levonorgestrel-releasing intrauterine device (L-IUD). In her medical history, she was gravida 4, parity 3, abortus 1, and had been in menopause for 2 years. The patient had no history of prior abdominal surgery or additional illnesses, and a laparoscopic hysterectomy was planned. The patient was taken to surgery, and following sterile preparation and draping, the abdomen was accessed using a direct trocar. Pneumoperitoneum was established, and laparoscopic hysterectomy and bilateral salpingo-oophorectomy were performed. The cuff was sutured laparoscopically. The end-tidal CO2 was measured at 63, and ventilator settings were adjusted accordingly. Despite this, persistent elevated CO2 levels were noted. On physical examination, widespread subcutaneous emphysema, crepitus, and swelling in the right eye were observed. Arterial blood gas analysis revealed a pH of 7.15 and a pCO2 of 69 mmHg. The surgery was terminated, and before the patient was awakened, a thoracic and abdominal computed tomography (CT) scan was performed. The scan revealed widespread subcutaneous air densities and pneumomediastinum. The patient was monitored for pneumothorax. She was transferred to a level 3 intensive care unit and supported with positive pressure ventilation. Following a decrease in pCO2 levels, the patient was extubated. On postoperative day 1, the subcutaneous emphysema regressed, and the patient was transferred to the obstetrics and gynecology ward. She was discharged in good health on postoperative day 3.

CONCLUSION: Subcutaneous emphysema, pneumomediastinum, and pneumothorax are potential complications that can occur during laparoscopic surgeries. Factors such as working at high pressures, multiple trocar insertions, wider trocar sites, and retraction of trocars from the abdomen into the subcutaneous tissue during the procedure may contribute to these complications. In this case, we aimed to highlight these rare complications.

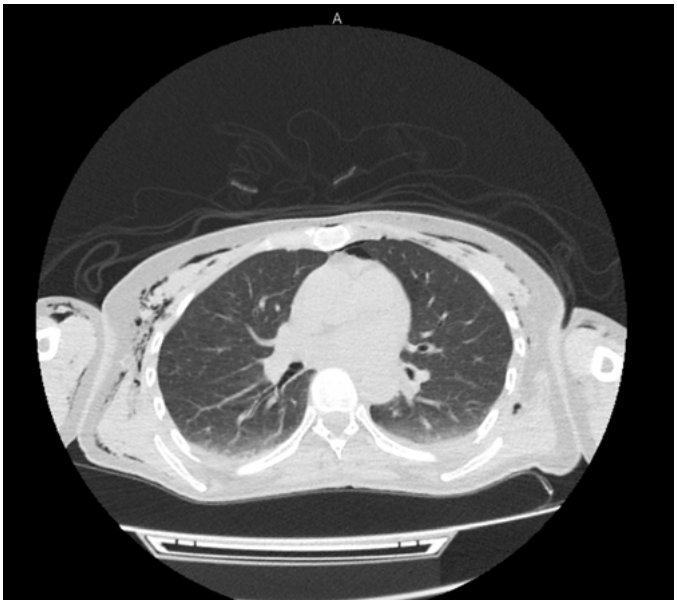
Keywords: laparoscopy, subcutaneous emphysema, pneumomediastinum

Resim 1



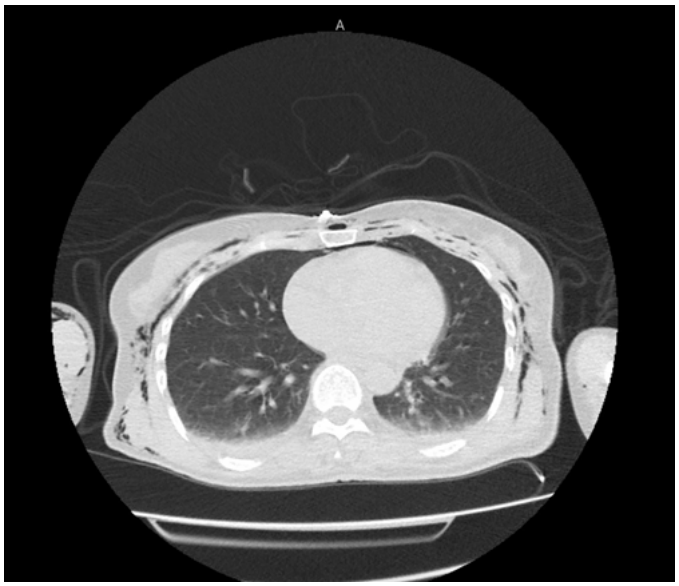
cilt altı amfizem ve pnömomediastinum

Resim 2



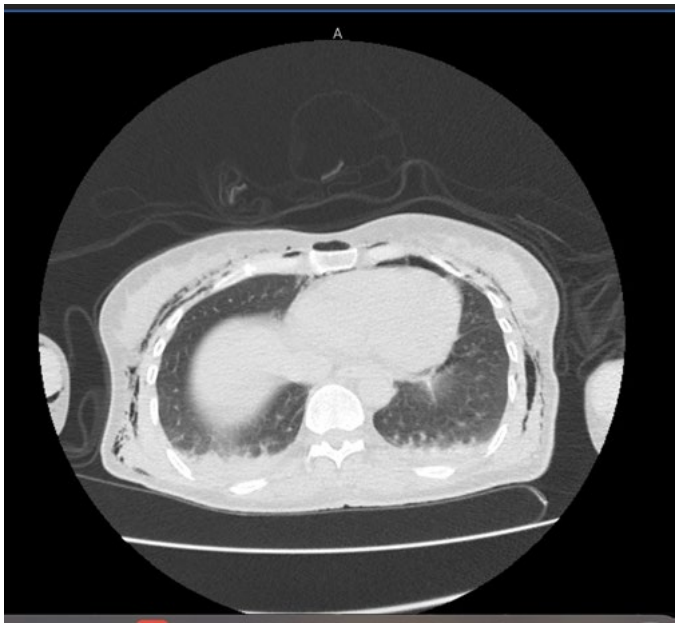
cilt altı amfizem ve pnömomediastinum

Resim 3



cilt altı amfizem ve pnömomediastinum

Resim 4



EP-002

Endometrioma mimicking inguinal lymphadenopathy: A case report

Hale Çetin Arslan
Department of Obstetrics and Gynecology University of Health Sciences, Kanuni Sultan Suleyman Training and Research Hospital, Istanbul, Turkey

INTRODUCTION: Endometriosis is a gynecological disease that frequently affects women of reproductive age. It is mostly painful and occurs due to the settlement of endometrial tissue in the organs of the pelvis. Endometriosis foci are frequently seen in the abdominal cavity, in the ovaries, fallopian tubes, and ligament structures on the outer surface of the uterus and the inner surface of the pelvis. Rarely, it can also be seen in the intestines, anal canal, bladder, vagina, cervix, and external reproductive organs, and even in the scars of previous abdominal surgeries. In this case, we will present the case of a patient who presented with a rare swelling in her right groin, which was evaluated after her excision was reported as endometriosis.

CASE: A 31-year-old gravida 1 parity 1 female patient with a history of cesarean section applied to the general surgery clinic with a complaint of a palpable swelling in the right inguinal region. It was learned that the swelling had been present for the last year and that there was no known disease or surgery history other than cesarean section in her medical history. Excision was planned for examination with a preliminary diagnosis of soft lymphadenopathy or cyst palpable approximately 3 cm in the right inguinal region. She was referred to the gynecology clinic upon detecting endometriosis in the histopathological examination. In the patient's gynecological evaluation, she had a cesarean section five years ago. In her anamnesis, she had noticed an increase in the swelling in her right groin, especially during menstrual periods, and that it was partially painful. She stated that she felt relieved after the operation and had no additional gynecological complaints. In the ultrasonographic examination, the uterus was normal in size and mobility, and the bilateral adnexa was normal. No sacrouterine nodularity was detected. CA-125 level was average. She was called for a follow-up at a later date.

CONCLUSION: The exact incidence of inguinal endometriosis has not been determined. Furthermore, the reason for its frequent detection on the right side has yet to be fully discovered. The fact that most general surgeons see the case before the gynecologist may cause delays in diagnosis. However, menstrual-related pain is a pathognomonic finding, especially in endometriosis. Since some of these cases are accompanied by pelvic endometriosis, diagnostic laparoscopy or MRI imaging will help us detect endometriosis.

Keywords: Endometrioma, endometriosis, groin

EP-003

A rare case in a postmenopausal patient; mature cystic teratom

Elif Aydın, Pınar Fatma Yıldız, Fatmanur Ceylan, Mustafa Ayhan Ekici
Department of Obstetrics and Gnynecology, Bolu Abant Izzet Baysal University, Bolu, Turkey

Mature cystic teratoma is a germ cell tumor that usually develops in the ovary and is usually benign. This tumor is the most common germ cell tumor in women and is usually seen in women of reproductive age; it is rare in the postmenopausal period. These teratomas are usually asymptomatic and are detected incidentally during routine gynecological examinations or imaging. In this presentation, we aimed to present a case of mature cystic teratoma detected during routine gynecological examination in a postmenopausal patient.

A 62-year-old patient who has been in menopause for 15 years applied to us for routine gynecological examination. Abdominal USG showed a 90x125 mm semisolid mass originating from the right ovary, filling the pelvis, and containing solid and cystic components, while the left ovary was observed to be normal. The MRI report of the patient showed a cystic lesion extending from the right adnexal area to the superior bladder cavity, measuring 109x108x112 mm, consistent with mature cystic teratoma (Figure-1). Total abdominal hysterectomy and bilateral salphingoophorectomy (TAH BSO) were planned for the patient. During the operation, the mass was sent for frozen section examination. After the frozen section examination, the material was found to be consistent with mature cystic teratoma, and the operation was completed with TAH BSO procedure (Figure-2). The final pathology result was reported as “negative cytology for malignancy” in the abdominal washing fluid and the mass as “mature cystic teratoma”. The patient’s postoperative course was uneventful, and informed consent was obtained from the patient to allow her information and accompanying images to be used in scientific activities.

Mature cystic teratoma contains tissues derived from all germ cell layers and typically contains ectoderm-derived structures such as hair, teeth, and fat. The clinical presentation of tumors is variable. About 20% of mature teratomas are asymptomatic at the time of diagnosis and are usually detected incidentally during imaging examinations, pregnancy, or abdominal or pelvic surgery for other reasons. Larger tumors may present with abdominal pain, symptoms of increased pelvic pressure, and a palpable mass during abdominal examination. Ultrasonography (USG) is used as the initial diagnostic method and is characterized by the presence of fat and solid components, a dermoid plug or Rokitansky nodule is considered strong evidence for a teratoma. It is characterized by one or more highly echogenic nodules within the cyst. Advanced imaging methods such as magnetic resonance imaging (MRI) and computed tomography (CT) are also helpful in diagnosis. Although mature cystic teratomas are generally benign, they may show malignant transformation in rare cases. This condition is more common in postmenopausal women and the malignant transformation rate has been reported as 1-2%. Squamous cell carcinoma is the most common, accounting for approximately 80–85% of malignant transformations. The management of is influenced by the risk of malignancy, the age of the patient, and the fertility reserve requirement. Surgical removal is an effective treatment for ovarian dermoid cysts. Chemotherapy is considered when there is any malignant change or when it is combined with other ovarian cancers.

Keywords: Ovarian tumors, teratom, postmenapousal patient

Figure-1

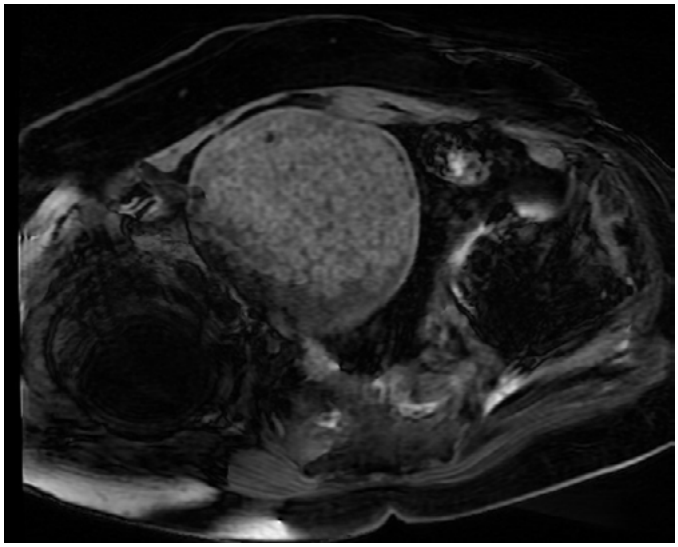


Figure-1: MRI image of the mass

Figure-2

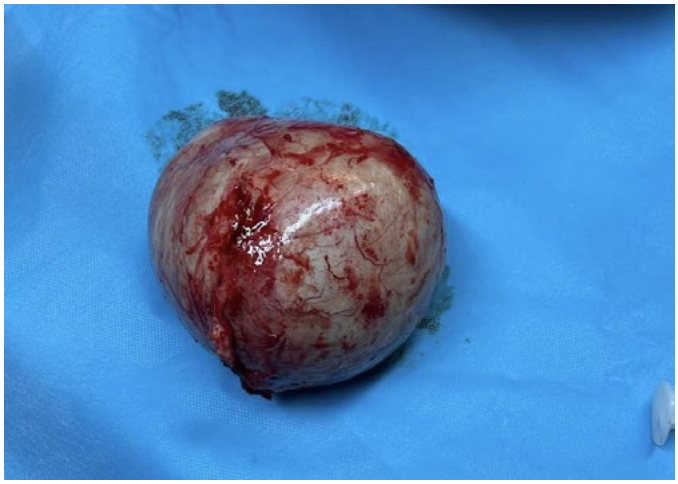


Figure-2: Intraoperative image of the mass

EP-004

Nodular vulvar lesions in an elderly patient: case presentation

Ece Türkbaşarır, İbrahim Uyar, Mehmet Emin Güneş, Yaşam Kemal Akpak
Izmir City Hospital

OBJECTIVE: To discuss the diagnosis and treatment of multiple hard, elevated, and partially painless epidermal cysts that developed in the vulvar region of an elderly patient.

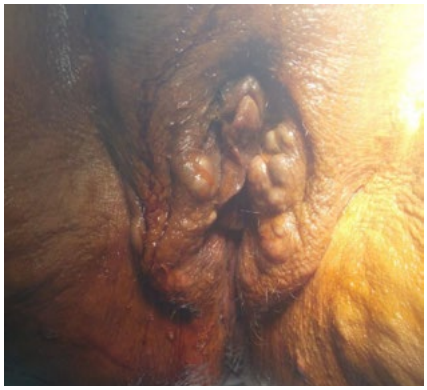
CASE PRESENTATION: A 68-year-old patient, who has been postmenopausal for 20 years, presented to our clinic with hard, partially painful lesions in the vulvar region that had appeared approximately 15 years ago. The patient had no previous gynecological complaints and had been treated in a neurology clinic one year ago for cerebrovascular disease. The patient, who has diabetes and hypertension, exhibited menopausal findings during gynecological examination. Numerous elevated, hard, yellowish, mobile, and discrete nodular lesions were observed in the bilateral vulvar region. Laboratory tests revealed hyperglycemia and hypercholesterolemia, while a superficial ultrasound showed solid areas with smooth surfaces, the largest being 1.5 cm in size. A total excisional biopsy was performed, and the pathology report confirmed epidermal cysts.

DISCUSSION: Epidermal cysts are benign lesions that can be found in various body regions, but they are rare in the vulvar area. They can vary in size and number and may affect the patient's quality of life both aesthetically and symptomatically. These cysts may arise spontaneously or due to traumatic or iatrogenic causes (such as genital mutilation or piercing). Differential diagnosis should consider other vulvar lesions such as steatocystomas multiplex, pigmented follicular cysts, trichilemmal cysts, and malignant vulvar masses. Surgical excision is usually sufficient for treatment.

CONCLUSION: Epidermal cysts should be considered in the differential diagnosis of nodular lesions in the vulvar region.

Keywords: lesion, postmenopausal, vulva

Picture 1



EP-005

Isolated Tubal Torsion Caused by Paratubal Cyst

Gökçe Ünal, Yaşam Kemal Akpak, Oktay Akgün, Mücahit Furkan Balcı, Begüm Köse
Department of Obstetrics and Gynecology, İzmir City Hospital, İzmir, Turkey

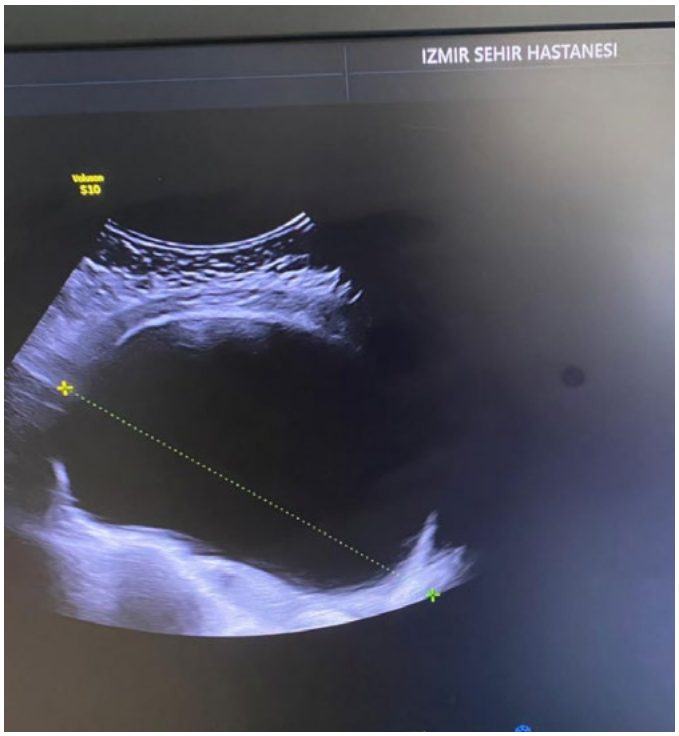
Paratubal cysts arise from embryological remnants of the urogenital system (paramesonephric, mesonephric ducts) or intussusception of the serosa of the uterine tube (mesothelial cyst). Adnexal torsion is a common gynecological emergency and its prevalence varies between 2.7-3%.Isolated tubal cyst torsion is very rare and its incidence is reported as 1/500000 to 1/1500000 in studies. Hydrosalpinx, previous tubal surgery, pelvic congestion, ovarian-paraovarian cysts, trauma and long fallopian tubes are predisposing factors.

Our patient, who is 40 years old, applied to our clinic with severe abdominal pain. She had complaints of abdominal bloating, groin pain and constipation for 3 months. No pathology was detected in the vaginal examination. Transvaginal ultrasonography (USG) revealed a cyst approximately 12 cm in size in the left adnexal region (Resim 1), which showed no blood flow on Doppler USG. Preliminary diagnosis was adnexal torsion. CA-125 values, B-hCG and laboratory findings were within normal limits.The patient underwent laparotomy with the preliminary diagnosis of adnexal torsion. Cystectomy was performed on the patient who was found to have tubal torsion around the left paratubal cyst (Resim 2). The patient underwent right salpingectomy and paratubal cyst excision. The cyst reported as simple serous paratubal cyst bt pathology.

In conclusion tubal torsion with paratubal cyst is an extremely rare condition. Preoperative diagnosis at this stage is challenging. Fallopian tube torsion secondary to paratubal cyst torsion without ovarian involvement should be considered in the differential diagnosis of adnexal cystic masses. Its timely treatment contributes to the preservation of the affected fallopian tube.

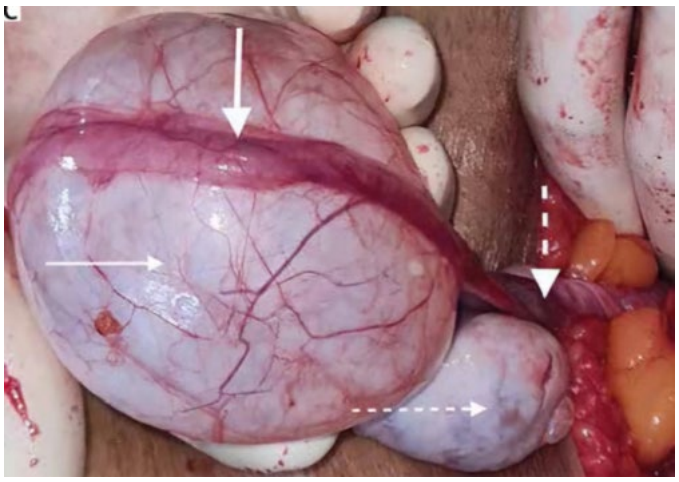
Keywords: abdominal pain, paratubal cyst, adnexal torsion, overian torsion

Figure 1



Paratubal cyst appearance on TVUSG

Figure 2



Paratubal cyst

EP-007

Extrapelvic endometriosis - Scar endometriosis

Sevinj Shirinova, Ramazan Adan
Prof. Cemil Taşcıoğlu Şehir Hastanesi

ABSTRACT: Endometriosis is the presence of endometrial tissue outside the uterine cavity. It is most commonly found in the pelvis, but may also occur in extrapelvic areas. It affects approximately 6-10% of women of reproductive age and can cause pelvic pain in 50-60% of cases, as well as infertility in 50%. Other common symptoms include dyspareunia and dysmenorrhea (1).

THEORIES OF DEVELOPMENT: 1. Sampson's Theory 2. Halban's Theory 3. Mayer's Theory 4. Immunological Theory 5. Neonatal Uterine Bleeding (2,3,4)

**Clinical FINDINGS: The most common symptoms are chronic pelvic pain, dysmenorrhea, dyspareunia, heavy menstrual bleeding, and infertility. Endometriosis is classified into four stages based on its extent. The classification system helps standardize the reporting of surgical findings.

Diagnosis: Physical examination, laboratory tests, and imaging techniques can only suggest the presence of endometriosis. The definitive diagnosis is made through pathological examination.

Treatment: Treatment options include medical, surgical, traditional, or observational approaches, particularly for patients with mild symptoms or those desiring to preserve fertility. No treatment offers a complete cure, making individualized management essential.

MATERIALS AND METHODS: Our patient is a 30-year-old woman (G2P2Y3), with one previous vaginal delivery and a cesarean section due to twin pregnancy. She presented to the emergency department with abdominal pain and a mass. On examination, an old scar was observed, with a firm, immobile mass measuring approximately 3 cm in width and 7 cm in length extending along the midline incision towards the xiphoid process. A provisional diagnosis of lipoma, scar endometriosis, or fibrotic tissue was made, and she was operated on accordingly.

Keywords: Endometriosis, Extrapelvic Endometriosis, Scar Endometriosis

EP-008

Subseröz Fibroid Torsion Presenting With Acute Abdomen

Merve Avcı, Cansu Önal Kanbaş, Beyzanur Kahyaoglu
Istanbul Kartal Dr. Lütfi Kırdar City Hospital Gynecology and Obstetrics

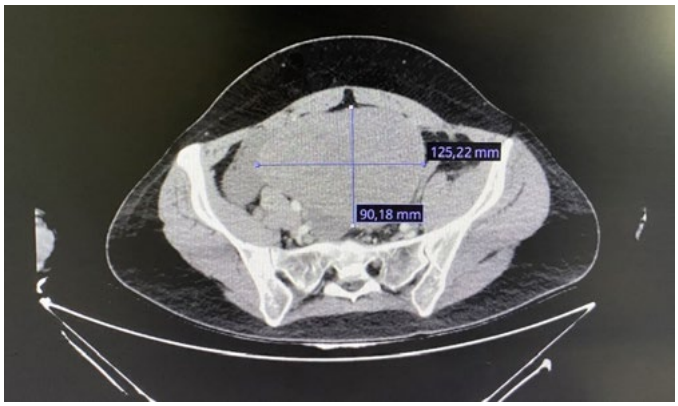
A 29-year-old virginpatient presented to the emergency department with complaints of severe pain in the right lower quadrant. The patient with positive right lower quadrant defense and rebound was operated on by general surgery with a prediagnosis of acute appendicitis. Lower abdominal tomography performed under emergency conditions showed a 125*79 mm mass with a soft tissue component and smooth contour in the pelvic region.(Figure 1).When the abdomen was entered through the median incision below the umbilicus, the appendix and all intestinal anuses of the patient were natural and the mass was thought to be of uterine origin. On exploration, approximately 12 cm torsiated and necrotic subserous myoma originating from the right cornual region of the uterus was observed.(Figure 2).Bilateral adnexae were normal.The subserous myoma was fixed in the abdomen because it was torsiated 3 times.(Figure 3).It was detorsiated in the abdomen and removed.(Figure 4).The subserous myoma was excised by grasping the stem. It was sent to pathology for histopathologic diagnosis. The pathologic diagnosis was compatible with myoma.

DISCUSSION: Leiomyomas are benign uterine masses that are often found incidental. Their incidence has been shown to be 12.8/1000 in women of reproductive age(1).They often present as abnormal uterine bleeding and may present with different symptoms depending on the location. Less common subserous fibroids with stalks may present with to option necrosis and acute abdomen as seen in our case. Techniques such as removal with appropriate surgical technique and uterine artery embolization are also used in treatment(2).

CONCLUSION: With this case, we aimed to draw attention to the fact that previously undiagnosed torsiated fibroids may present with acute abdomen and may be confused with other causes of acute abdomen.

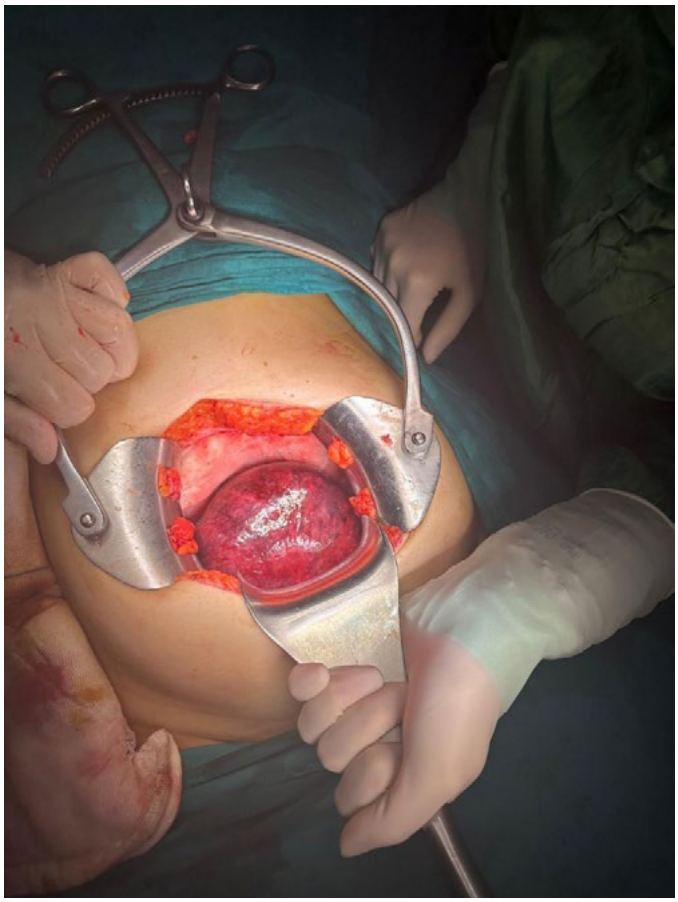
Keywords: ACUTE ABDOMEN,SUBSEROUS FIBROID, ORSION

Resim 1



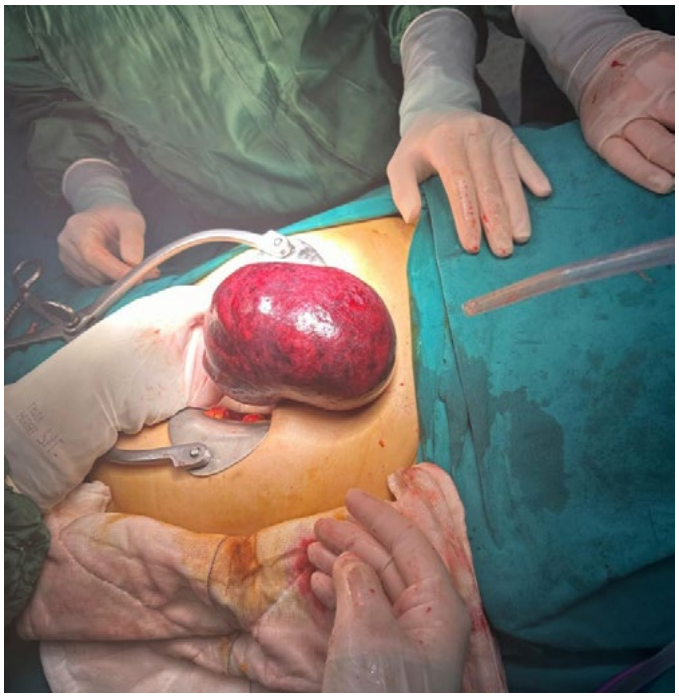
*Alt batın tomografisinde pelvik bölgede 125*79 mm boyutlarında yumuşak doku komponenti ve düzgün konturlü kitle*

Resim 2



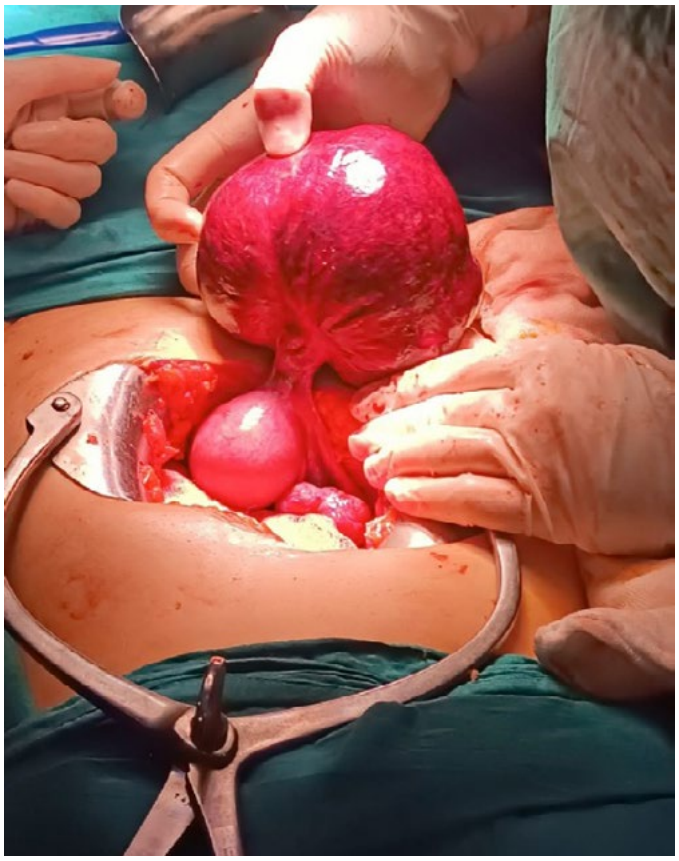
12 cm torsiyone ve nekrotik görünümde subseröz myom

Resim 3



Subseröz myom 3 kez torsiyone görünümdeydi

Resim 4



Detorsiyone edilerek dışarı çıkarılan subseröz myom

EP-009

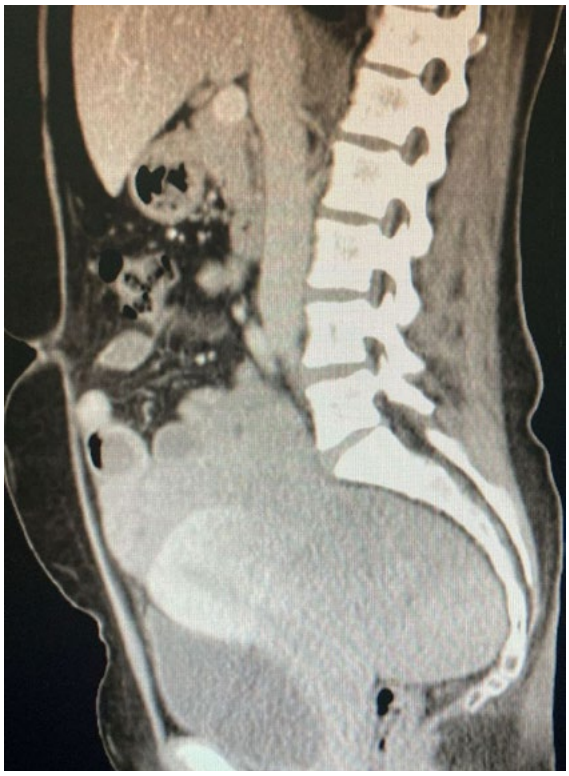
Leiomyomatosis peritonealis disseminata: A case report

Akın Usta, Duygu Lafcı, Esra Şimşekoğlu
Balikesir University, Faculty of Medicine, Department of Obstetrics and Gynaecology, Türkiye

Leiomyomatosis peritonealis disseminata (LPD) is an uncommon condition characterized by the widespread presence of smooth muscle-like nodules on the omental and peritoneal surfaces. The exact cause of LPD remains unclear, but it may be related to hormonal influences or iatrogenic factors. It's crucial for clinicians to recognize this rare disease. In This report, we present a case involving a 38-year-old woman, who had no prior history of leiomyoma, presenting with right groin pain at the emergency department. Initially, the CT scan was interpreted as indicating a hematoma. However, laparoscopic examination revealed a mass with a diffuse, vegetative appearance, affecting the abdominal cavity and attached to the posterior uterine wall. Following a postoperative histopathological examination, the diagnosis of LPD was confirmed. The patient's prognosis is favorable, and she is under ongoing follow-up.

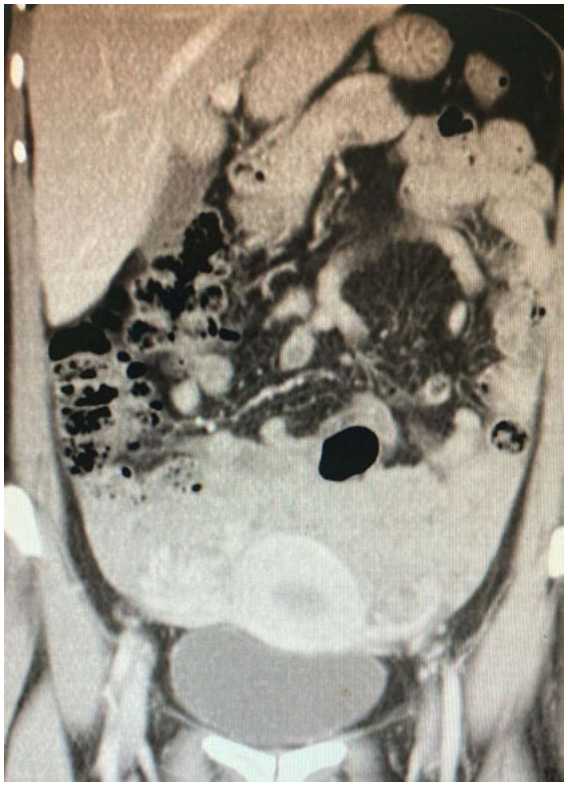
Keywords: Abdominal mass, Leiomyoma, Leiomyomatosis peritonealis disseminata

CT



Sagittal section of the CT scan of the abdomen and pelvis

CT



Coronal section of the CT scan of the abdomen and pelvis

Laparoscopy

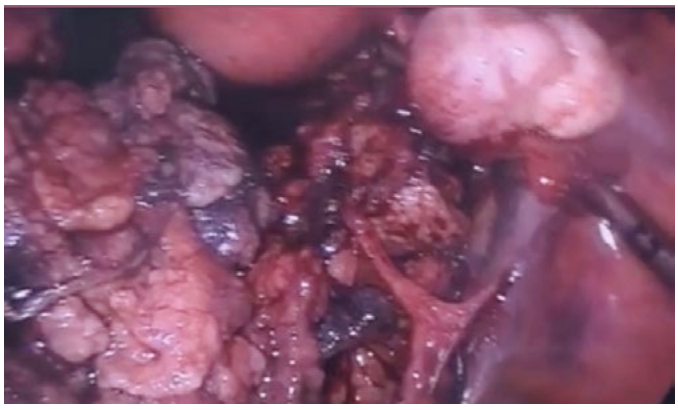


Image of the mass during laparoscopic intervention

Laparoscopy

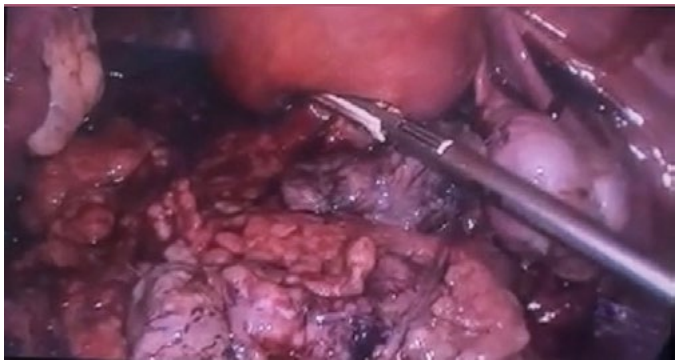


Image of the mass during laparoscopic intervention

EP-010

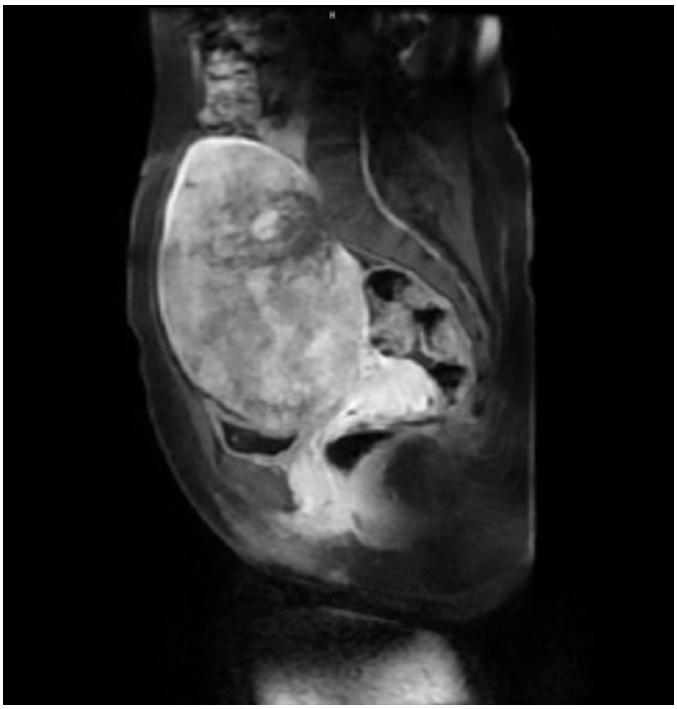
Giant Myoma Developing in a Rudimentary Uterine Horn: A Case Report

Sultan Can, Meryem Hocaoglu, Oguz Devrim Yardimci
Department of Obstetrics and Gynecology Goztepe Prof. Dr. Suleyman Yalcin City Hospital, Istanbul, Turkey

Rudimentary uterine horn anomalies arise from incomplete Müllerian duct development during embryogenesis, often leading to diagnostic challenges due to their varied presentations and under-recognition. Despite their size and abnormal development, rudimentary horns may host conditions such as myomas, contributing to clinical symptoms like pelvic pain and abnormal bleeding. In this report, we describe a case of a 45-year-old nulligravid woman presenting with abdominal distension and a palpable mass. Imaging revealed a large lesion suggestive of a degenerated myoma. Surgical exploration unveiled a 17 cm myoma within a non-communicating non-cavity uterine horn. The patient underwent myomectomy to preserve fertility, with subsequent satisfactory postoperative outcomes. This case highlights the rarity and clinical complexity of myomas within rudimentary uterine horns. Large myomas within rudimentary horns pose additional diagnostic and therapeutic challenges, underscoring the importance of multidisciplinary collaboration and advanced imaging techniques for evaluation and treatment planning.

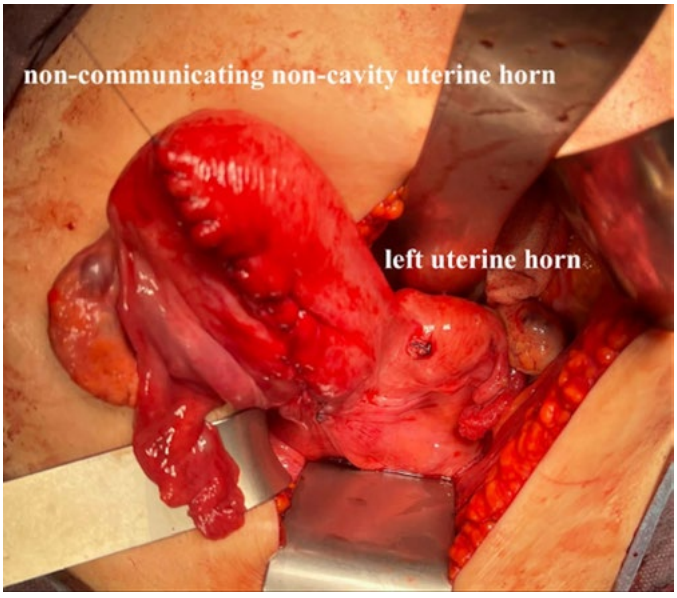
Keywords: Leiomyoma, uterine anomalies, rudimentary horn

figure 1



MRI revealed a 16x13 cm lesion extending to the supraumbilical area

figure 2



After a myomectomy, the appearance of the left uterine horn and the non-communicating, non cavity uterine horn

EP-011

Use of intermittent plasmapheresis in hemolytic disease of the fetus and newborn due to Rh incompatibility in pregnancy

Önder Onur Balkaya, Fatma Özdemir
Erciyes University Gynecology and Obstetrics Kayseri, Turkey

Intermittent plasmapheresis treatment is safe in cases with anti-M immunization.

Keywords: obstetrics, rh immunization, plazmaferezis

EP-012

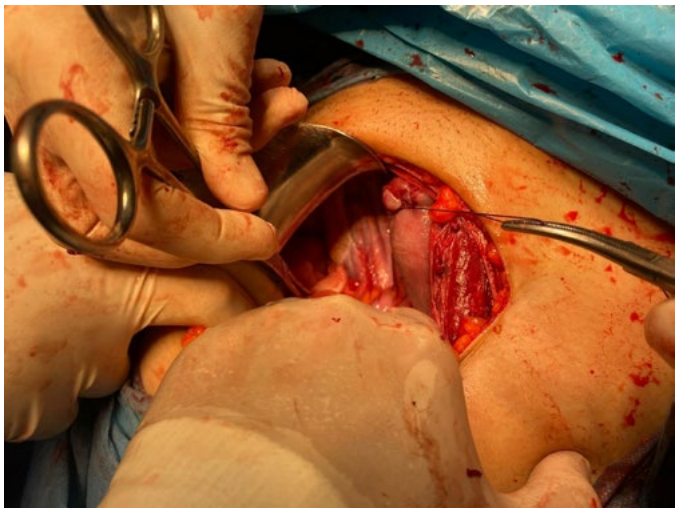
31 weeks gestation with unicornuate uterus and associated ectopic kidney case report

Ruhşat Dere
Gynecology and Obstetrics, İzmir City Hospital, İzmir, Turkey

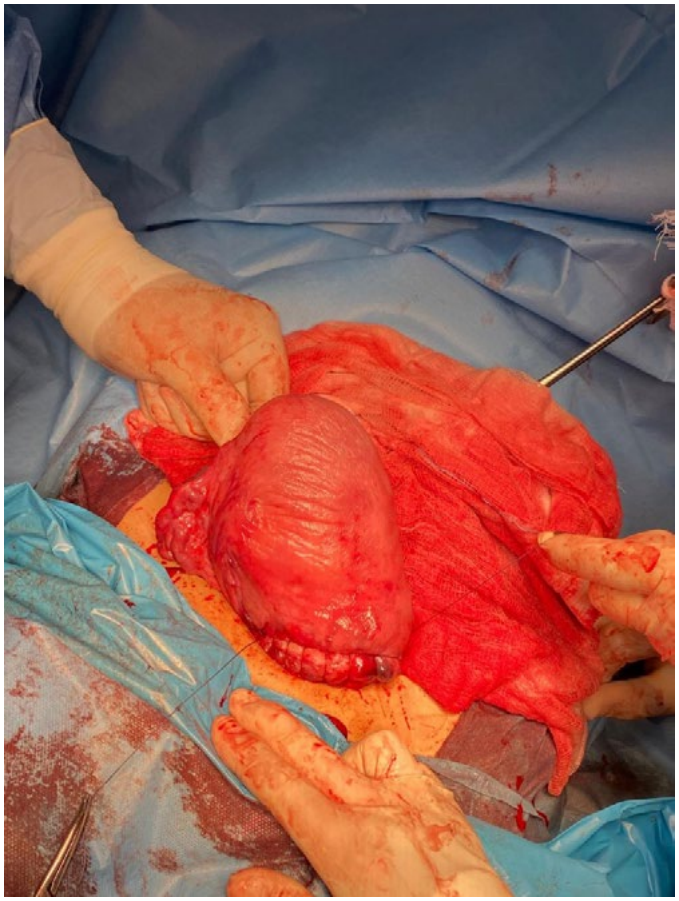
Patients with Congenital uterine anomalie are at increased risk of having renal, skeletal, or abdominal wall abnormalities, or a history of inguinal hernia. Renal anomalies are found in 20 to 30 percent of patients with müllerian defects. The three main mechanisms for abnormal uterine development are agenesis/ hypoplasia, defective lateral fusion, and defective vertical fusion. Ultrasonography, hysterosalpingography and magnetic resonance imaging can be used in the diagnosis of congenital uterine anomalies. The gold standard among these is magnetic resonance imaging. Our patient was 18 years old, gravida 1, parity 0, last menstrual period 31 weeks and 2 days and presented to our hospital with the complaint of labor pains. Our patient had 50 montevideo unity 3 contractions in 10 minutes of NST follow-up. When the patient's contractions did not regress and recurrent deselerations were observed in the follow-ups, the patient was informed and cesarean section was decided with the indications of fetal distress+near complete patency. Observation during cesarean section showed a right unicornuate uterus, left ovary adherent to the lateral abdominal wall. Right ovary and right salpinges were normal. Adhesion of the left ovary and fimbria to the side abdominal wall was observed. No cavity associated with the left rudimentary horn of the uterus was observed. In the unicornuate uterus, a cavity is usually normally associated with the fallopian tube and cervix, while the failed müllerian duct has various configurations.In our case, the affected mullerian duct did not develop at all. Patients with unicornuate uterus are at higher risk for endometriosis, preterm labor and breech presentation. Unicornuate uterus is associated with renal anomalies with a particularly high rate (40 percent). In our case, the left kidney was observed radiologically as ectopic in the left lower quadrant. In conclusion, patients with unicornuate uterus have an increased risk of preterm delivery, ectopic pregnancy, endometirosis. They are recommended to be investigated for ectopic renal location. In patients with unicornuate uterus associated with rudimentary horn, removal of the rudimentary horn is recommended.

Keywords: unicornuat uterus, Pregnancy, ectopically located kidney

adhesive ovary to the left abdominal side wall



Right unicornuate uterus



EP-013

Normal spontaneous delivery in a term pregnant patient with osteogenesis imperfecta

Temel Uslu, Nigar Kerimli, Yaşam Kemal Akpak,
Ece Türkbaşarır
Izmir City Hospital

INTRODUCTION: Osteogenesis imperfecta (OI) is a genetic disorder characterized by defective collagen synthesis. It leads to skeletal anomalies and increased fragility of bones and tissues. In patients with OI types I, II, III, and IV, the synthesis of type 1 collagen, a crucial structural protein for bones, tendons, ligaments, and most connective tissues, is defective due to mutations in the COL1A1 and COL1A2 genes. Consequently, affected individuals exhibit bone fragility, reduced bone density, and skeletal anomalies.

FINDINGS: A 19-year-old G1P0 patient diagnosed with Type I OI underwent an unmonitored pregnancy and presented to our hospital with a complaint of fluid leakage. She was unsure of her last menstrual period date. The patient, who is 37+6 weeks gestation, with a height of 162 cm and body weight of 61 kg, has a history of one operation due to multiple bone fractures. There is no family history of OI other than her sister. Previous pregnancy screenings could not be accessed. On hospital ultrasound:

• Fetal head presentation with anterior placenta, no previa was observed.

• Measurements:

• BPD: 36+2 weeks

• AC: 34+2 weeks

• FL: 36+2 weeks

• Estimated fetal weight (EFW): 2679 grams

A vaginal examination revealed no contraindications for normal delivery. The patient, with a cervical dilation of 3 cm and 50% effaced, spontaneously delivered and was subsequently monitored in the delivery room with induction therapy. Postpartum monitoring was conducted normally. A full-body X-ray was performed postpartum with no fractures detected. An orthopedic consultation was obtained, with no additional recommendations. The patient was discharged in good health.

CONCLUSION: During pregnancy, patients with osteogenesis imperfecta may experience new fractures and increased musculoskeletal pain due to deformities. Our patient did not encounter these risks during pregnancy. Bleeding issues related to platelet aggregation disorders and cardiovascular abnormalities also increase risk during pregnancy in patients with OI. The patient's platelet function tests were normal,

and no bleeding diathesis was observed during or after delivery. Pregnancies in patients with OI are high-risk. It is advisable for these pregnancies to be monitored in centers with a multidisciplinary team. Although there is no definitive recommendation for the mode of delivery in OI patients, efforts are generally made to reduce birth trauma, leading to a preference for cesarean delivery. However, uncomplicated cases with normal vaginal delivery, like in our case, do exist.

Keywords: osteogenesis imperfecta, pregnancy, vaginal delivery

EP-014

Moderate-severe ovarian hyperstimulation syndrome in a spontaneous pregnancy

Pinar Fatma Yildiz, Elif Betül Esmer
Department of Obstetrics and Gnynecology, Bolu Abant Izzet Baysal University, Bolu, Turkey

Ovarian hyperstimulation syndrome (OHSS) is a serious, potentially fatal complication of supraphysiological ovarian stimulation in assisted reproductive techniques, usually iatrogenic, and is rarely seen in the natural ovulatory cycle. In moderate-severe OHSS, clinical findings include abdominal distension, nausea, vomiting, and ultrasonographically enlarged ovaries and ascites. Biochemically, an increase in hematocrit level, an increase in white blood cell count, and hypoproteinemia are observed. This case report aims to present a case of moderate-severe OHSS in a patient with spontaneous pregnancy who applied to our clinic. Thirty-three years old, first pregnancy patient, applied to our clinic with complaints of nausea, vomiting, abdominal pain when she was 7 weeks and 2 days old according to her last menstrual period. Ultrasonographic examination showed an embryo with a CRL of 2.9 mm, a fetal heartbeat compatible with 6+2 weeks, and bilateral ovaries with increased dimensions containing numerous follicles. The left ovary was measured as 87x66 mm and the right ovary as 78x52 mm, and 47 mm of free fluid was observed in the Douglas. Sensitivity due to peritoneal irritation was observed in the physical examination, and vital signs were evaluated as stable. Laboratory values included hemogram, liver and kidney function tests, coagulation and electrolyte tests, and serum estradiol was over 1000 ng/l. The patient was hospitalized for monitoring and supportive treatment with the diagnosis of moderate OHSS, and during follow-up, 2000 ml of intravenous fluid was given daily and plenty of oral fluid intake was encouraged. Daily weight monitoring and abdominal circumference measurements were performed during hospitalization. There was a 1 kilogram increase during the follow-up, but no respiratory distress or oliguria was observed. The patient, who responded well to the treatment, continued to be followed up as an outpatient. In the weekly follow-ups, the intra-abdominal free fluid and ovarian dimensions gradually decreased and the clinical picture regressed. The development of the fetus was compatible with the gestational week and the amniotic index was normal. The patient, whose pregnancy follow-ups were uneventful, had a single live birth by cesarean section at 39 weeks and 2 days according to the last menstrual date, and in the intraoperative examination, both ovarian sizes appeared to have increased. The patient's postoperative course was uneventful and informed consent was obtained from the patient for the publication of the case report and accompanying images. OHSS is characterized by enlarged ovaries, multiple cysts,

stromal edema, increased capillary permeability and leakage of fluids into the third spaces. As a result, intravascular volume decreases and hypovolemic shock, renal failure and thromboembolism may occur. OHSS can be classified as mild, moderate and severe. Risk factors include polycystic ovaries, young age, high serum estradiol levels, low body mass index, multiple pregnancy and hydatidiform mole. OHSS is rare in spontaneous pregnancy. In our case, OHSS occurred spontaneously in association with a singleton pregnancy. In conclusion, it is emphasized that all women with ovarian masses and/or ascites complicating pregnancy should be meticulously evaluated, differential diagnosis of OHSS is necessary, and ultrasound evaluation is important in diagnosis and follow-up.

Keywords: OHSS, Pregnancy, Birth

Figure-1

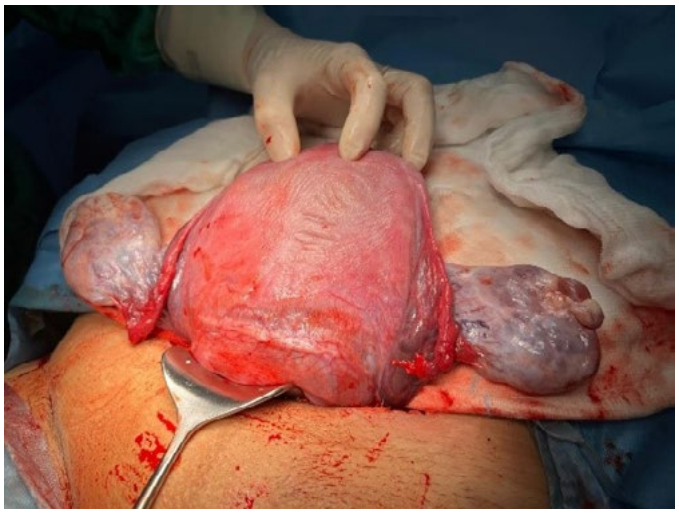


Figure 1. Intraoperative appearance of the ovaries

EP-015

Management of Oxytocin-Induced Anaphylaxis During Caesarean Section: A Case Report

Fatmanur Ceylan, Ebru Kaynar Varlık, Elif Aydın, Mustafa Ayhan Ekici
Abant Izzet Baysal University Faculty of Medicine, Department of Obstetrics and Gynaecology

OBJECTIVE: Anaphylaxis is clinically defined as 'a severe allergic or hypersensitivity reaction with rapid onset that may lead to death' (1). The lifetime prevalence of anaphylaxis in the general population is estimated to be 0.05% to 2% (2). Anaphylactoid reaction to oxytocin is rare but has been described in the literature. The reactions described include patchy erythema, hypotension, and bronchospasm (3). In this case report, we aimed to present a case of anaphylaxis following oxytocin administration during a caesarean section.

CASE: A 29-year-old gravida 1 patient underwent elective caesarean section due to breech presentation after an uneventful pregnancy. She had no history of asthma, atopy, or drug allergy and was in good health. A Caesarean section was started under spinal anesthesia. At the beginning of the operation, arterial blood pressure was 120/70 mmHg, pulse rate was 78 beats/min, and oxygen saturation was 98%. The baby was delivered in 12 minutes, and oxytocin was given to the patient. 5-10 minutes after oxytocin was given, burning and itching in her hands, feeling unwell, nausea started, and she became hypotensive. Ephedrine was administered intermittently by the anesthetist. The patient developed itching and redness all over the body. Shortness of breath and swelling of the tongue started. Dexamethasone and pheniramine maleate were administered by anesthesia. Anaphylaxis was diagnosed when uvula oedema was observed on examination, hypotensive state persisted, and general condition deteriorated. The patient was administered 0.1 mg of adrenaline. The patient was sent 20% lipid emulsion to rule out local anesthesia toxicity. Since all symptoms started after oxytocin, oxytocin anaphylaxis was considered in the foreground. The patient whose vitals stabilized after adrenaline treatment was taken to the ward follow-up. She was discharged with healing on the 2nd postoperative day. Informed consent was obtained by signing the informed consent form before the patient information was used in this presentation.

DISCUSSION: Anaphylaxis is a life-threatening, severe, systemic reaction that occurs after contact with any allergen. It is analyzed in 4 groups according to the severity of systemic findings. Stage 1: skin redness, itching, and oedema. Stage 2: arterial hypotension, respiratory distress, or cough in addition to skin findings. Stage 3: cardiovascular collapse, tachycardia or bradycardia, arrhythmia, severe bronchospasm. Stage 4: cardiac arrest and/or respiratory arrest.Oxytocin-induced anaphylaxis is rare.Oxytocin-induced anaphylactic

reaction with severe airway obstruction has been reported very rarely in the literature (4).Other causes of anaphylaxis seen in caesarean sections have been reported due to latex, ranitidine, antibiotics, colloidal fluids, general anesthetics, and local anesthetics. In terms of allergy, it has been observed that the proposed homology in the protein sequence of oxytocin and latex allergens may facilitate antigen recognition during oxytocin infusion and may lead to an anaphylactic response to both agents. It has been reported that severe anaphylactic reactions may develop with cross-reaction if other allergens are encountered in patients who develop a systemic reaction with any allergen. The incidence of allergic reactions to synthetic oxytocin is very low, but should always be kept in mind by those involved in obstetric practice.(5)

Keywords: Anaphylaxis,Caesarean,Oxytocin

EP-016

A case report of recurrent term breech cesarean deliveries in a woman with a uterine fusion abnormality

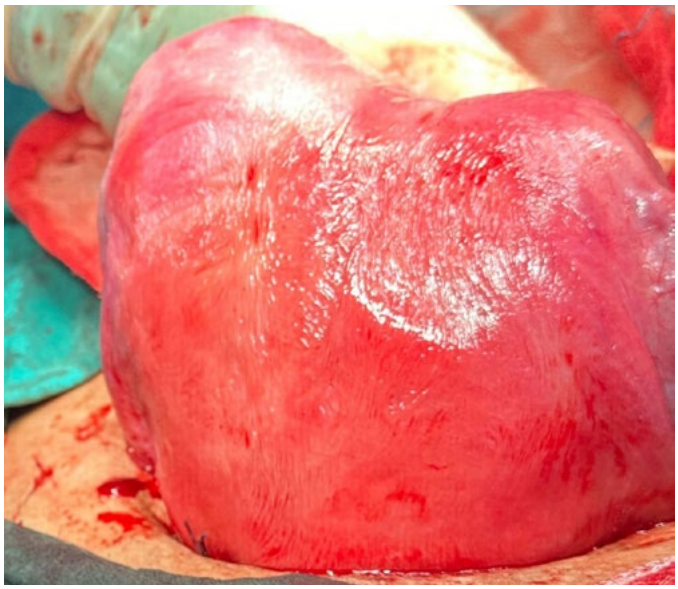
Sena Ünlü, Muhammed Enes Karakaya, Rahmi Sinan Karadeniz, Yaprak Üstün
Etlik Zübeyde Hanım Hastanesi, Kadin Hastaliklari ve Doğum, Ankara

We performed an emergency cesarean delivery due to previous cesarean section in labor, at the same time we noticed our patient has fetal breech presentation. We questioned the indication of first cesarean, it was breech presentation too. With the intra-operative observation, it is revealed that the women has septate uterus and bicournuat uterus, resulting from failure of fusion of the Müllerian ducts. Both pregnancies of our patient were spontaneously, eventuated term delivery, complicated by breech presentations and two healthy babies. Through the case study, it was emphasized that in the follow-up of patients with uterine abnormalities, fetuses were frequently delivered in breech presentation and a literature review was conducted regarding this.

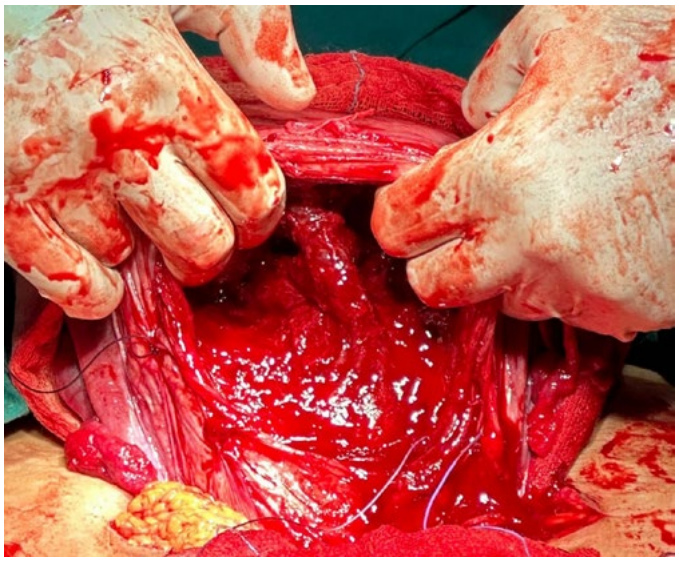
Various complications as recurrent miscarriages, premature labor and delivery, intrauterine growth retardation, abnormal fetal presentations may accompany the pregnancies of women with uterine anomalies. Although in some cases the pregnancy may proceed without trouble and result in normal labor, breech presentation has been observed in most patients with uterine septum.

Keywords: breech presentation, uterine septum, fusion of the Müllerian ducts

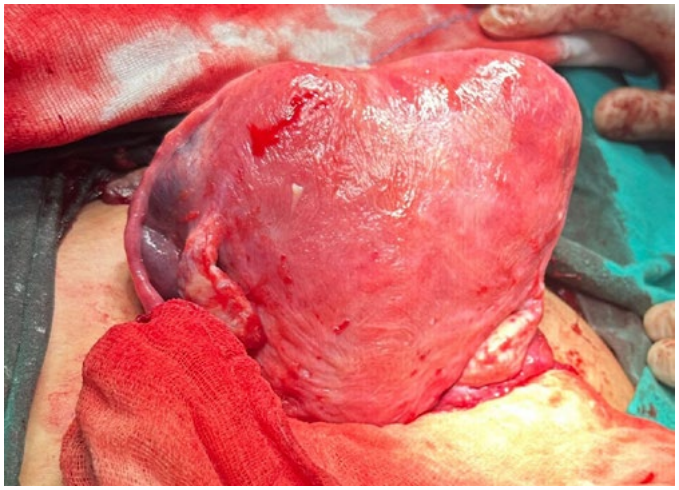
1



2



3



EP-018

A case of eclampsia seen in the late postpartum period

Ömür Albayrak, Merve Ecem Albayrak
Bolu İzzet Baysal Devlet Hastanesi

INTRODUCTION: The occurrence of convulsions in a patient with signs and symptoms of preeclampsia is defined as eclampsia and this condition can be seen in the antepartum, intrapartum or postpartum period. Traditionally, eclamptic convulsions occur in the first 24 hours following birth and convulsions seen after 48 hours should be considered suspicious and causes other than eclampsia should be investigated in these patients. In this article, we aimed to present our case who developed postpartum eclampsia after discharge from the hospital.

CASE: A 22-year-old 40-week pregnant patient applied to our emergency department with high blood pressure. The measured blood pressure value was determined as: 170/110. TIT: ++ protein was detected in her tests. Hata did not complain of headache, and she did not describe any neurological symptoms. The patient, whose blood tests were normal, was diagnosed with preeclampsia and a C/S decision was made. The patient was taken into surgery. A single live baby girl weighing 3200 gr was delivered. The patient, whose postpartum blood pressure values were normal, was discharged on the 2nd postpartum day. The patient re-applied to the emergency department via 112 after having a tonic-clonic seizure at home 4 days after discharge. A brain MRI was performed and neurology was consulted. Eclampsia was considered in the patient. The patient, who was admitted to the neurology department, was discharged two days later.

CONCLUSION: It should be kept in mind that eclampsia can be seen after 48 hours of delivery, almost half of the postpartum eclampsia cases are late postpartum eclampsia, and not all patients have clinical and laboratory findings of preeclampsia. Convulsions seen in the late postpartum period in patients should be considered as eclampsia until proven otherwise and should be treated accordingly. At the same time, a comprehensive evaluation should be performed including the patient's anamnesis, routine laboratory tests, neurological examination, EEG and MRI tests to rule out other possible causes.

Keywords: eclampsia, preeclampsia, convulsion

EP-019

A Case Presented with Acute Chest Pain and Increased Cardiac Biomarkers during Pregnancy

Hüma Arda Pedirik, Nurşen Kurtoğlu Aksoy
Department of Obstetrics& Gynecology, SBU Bagcilar Research and Training Hospital, Istanbul, Turkey

Pregnancy associated MI occurs in 2.8 to 8.1 per 100000 deliveries10–12 which is 4-fold higher than the MI among nonpregnant, reproductive-aged women. The incidence of PAMI is increasing and may relate to improved case detection and greater numbers of older women with underlying cardiovascular risk factors becoming pregnant. The case fatality rate is estimated at %12 and is higher than MI fatality rates among nonpregnant women. Risk factors include age >35 years, cigarette smoking, hypertension, diabetes mellitus, and hyperlipidemia. Less common risk factors include preeclampsia, multiple gestation, thrombophilia, blood transfusions, and postpartum infections. A number of serious conditions may have a similar clinical presentation as PAMI occasionally with abnormal ECG and biomarker elevation. These are aortic dissection, pulmonary embolism, Takotsubo cardiomyopathy, peripartum cardiomyopathy, myocarditis, preeklampsis. Myocarditis may present with chest pain and ST-segment elevations. The incidance of myocarditis is not known to be increased during pregnancy and should be considered as suggested by the clinical context. Ionizing radiation from coronary angiography (and PCI) is considered an acceptable risk in pregnancy when the procedure is otherwise indicated. Fetal radiation effects are unlikely to occur for dose levels below 50 mSv. Given that the fetal radiation dose associated with coronary angiography is expected to be <1 mSv, the risk of radiation injury to the fetus.

Our case is 36-year-old, g1p0, IVF pregnancy, at 36th gestational week lady. She has no concurrent illnesses but she take 81 mg acetylsalicylic acid (ASA) daily since 11th gestational week. She had stop taking ASA three days ago because she was at 36th week of pregnancy. She appiel from emergency service for acute onset and sharp chest pain and dispnea. the test results were Troponin I 98.01 (max: 47), lökosit 7000, hemoglobin 11.3, hematokcrit 33.5, CRP 8.39, TSH 1.14, T4 8.72, T3 2.9. The coagulation tests (like PT, aPTT, INR, protein C, protein S, lupus anticoagulants) were at normal range. There was no ischemic changes on ECG but sinus tachycardia was present. In serial troponin follow-up, troponin increased up to 2238. Echocardiogram was performed by cardiologist but there was no pathological findings. ASA 100 mg daily was ordered. A few hours later chest pain and troponin levels were decreased. Thats why coronary angiography wasn't planned urgently. In this period countinous fetal monitorization was performed and fetal heart rate was normorhythmic and reactive. Patient was consultated to perinatology, at 37th week the c-section was planned because patient became stable for cardiac aspect. C-section delivery was performed at 37th week of gestation with no complications. We suggested to continue ASA during postpartum period. At postpartum second day, coronary angiography by cardiologists and there was no pathological findings. At the end of the point the reason of the acute chest pain and high levels of troponin is myocarditis, we started colchicine 0.5 mg additional to ASA. At the post partum period there was no obstetrical or cardiological complications. At conclusion, myocarditis may present with chest pain and ST-segment elevations and should be considered as suggested by the clinical context.

Keywords: acute myocardial infarction, myocarditis, troponin, acute chest pain

EP-020

Type 2 Chiari Malformation in the Light of Ultrasonographic Criteria: Case Report

Ayşe Kübra Topal Aköz, Elif Betül Esmer, Funda Dağıstanlı, Ebru Kaynar Varlık
Abant İzzet Baysal Üniversitesi, İzzet Baysal Eğitim ve Araştırma Hastanesi, Kadın Hastalıkları ve Doğum Ana Bilim Dalı, Bolu

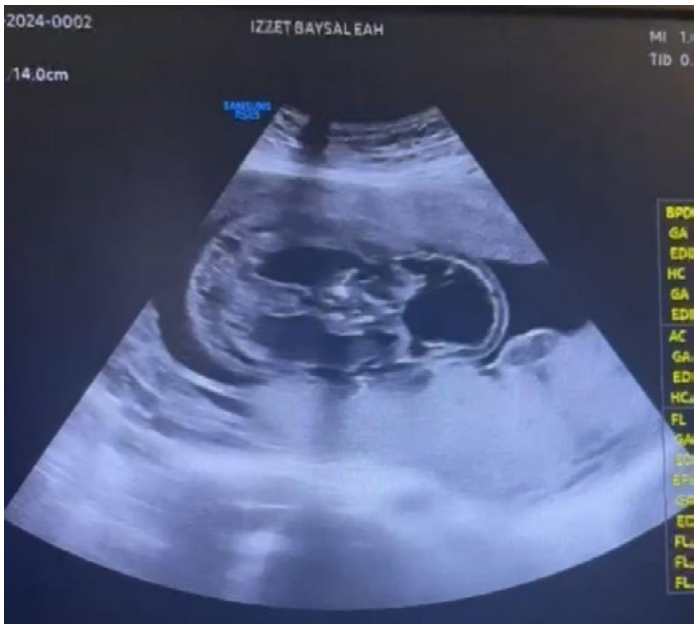
INTRODUCTION: Chiari type 2 malformation which is a congenital disease characterised with downward displacement of the medulla oblongata, cerebellar tonsil, pons and fourth ventricle was first described by Schwalbe and Gredig in the laboratory of Chiari and Arnold(1,2). Nicolaides et al. were the first to describe ultrasonographic signs characterising Chiari type 2 malformation in axial sections of fetuses(3). Spina bifida is classified as open and closed according to whether the spinal lesion is surrounded by skin or not. Closed type spina bifida is not accompanied by cranium findings.Typical cranial findings include ventriculomegaly, lemon sign(bifrontal indentation), banana sign(Chiari II malformation), cisterna magna obliteration and small biparietal diameter and body measurements according to gestational age.Spinal longitudinal sonography may show an open spinal and skin defect as well as enlargement of the spinal canal diameter and increase in the interpeduncular distance.These findings in prenatal ultrasonography contribute to the accurate and effective detection of Chiari type 2 malformation in early pregnancy.In this study, we aimed to present the follow-up and management of a patient with type 2 Chiari malformation and accompanying congenital anomalies who presented to our clinic at 22 weeks of gestation in the light of the literature.

CASE: An 18-year-old woman with gravida 1 had no additional features in her medical history and came for a routine follow-up. According to her last menstrual period, the patient had a live pregnancy of 22 weeks, and there were no screening tests and no past imaging. In the transabdominal ultrasonography performed on the patient, fetal biometry measurements were compatible with 21 weeks and biconcavity in the frontal bones(lemon sign), severe bilateral ventriculomegaly, obliterated cisterna magna and herniated cerebellar vermis were observed in the fetal cranium.(Figure1) In the vertebral column examination, there was an increase in the interpeduncular distance in the spinal longitudinal sonogram.(Figure2) A defect was observed at the lower lumbar level, and a spinal defect was demonstrated on a long axis of approximately 20 mm open dorsally.(Figure3) Open spina bifida in the lumbosacral region and pes equinovarus in bilateral feet were observed(Figure4). The family was counselled about the advanced deformities and the pregnancy was terminated upon the family request. Type2 Chiari malformation was diagnosed with postmortem images(Figure5).

DISCUSSION: Cerebellar appearance findings and abnormalities in the contour of the cranium on prenatal ultrasonography are important markers for neural tube defects. Again, lemon sign and banana sign on axial sections in pregnancies younger than 25 weeks are important findings for Type 2 Chiari malformation and these signs may be masked in cases with ventriculomegaly(4,5). Lemon sign is not specific for spina bifida and Dandy-Walker malformation accompanied by encephalocele, cystic hygroma, diaphragmatic hernia, agenesis of corpus callosum and fetal hydrops are also included in the differential diagnosis. Therefore, cranial findings including ventriculomegaly, obliteration of the cisterna magna, compression of the cerebellar hemispheres and careful evaluation of the vertebral column are required for diagnosis(6,7). In conclusion, maternal AFP level, detailed sonographic examination and prenatal counselling to the family are important in the early diagnosis of spina bifida.

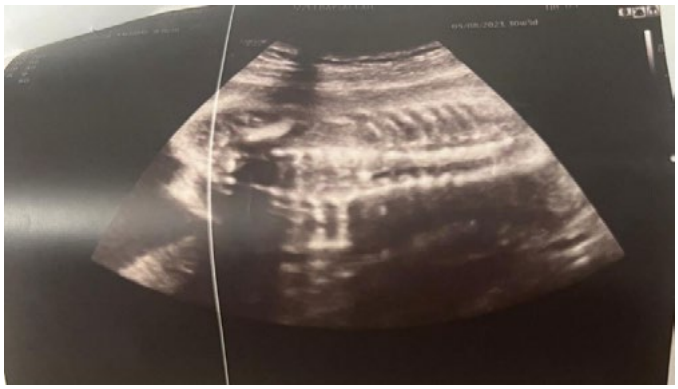
Keywords: banana sign, Chiari type 2 malformation, lemon sign, open spina bifida

figure 1



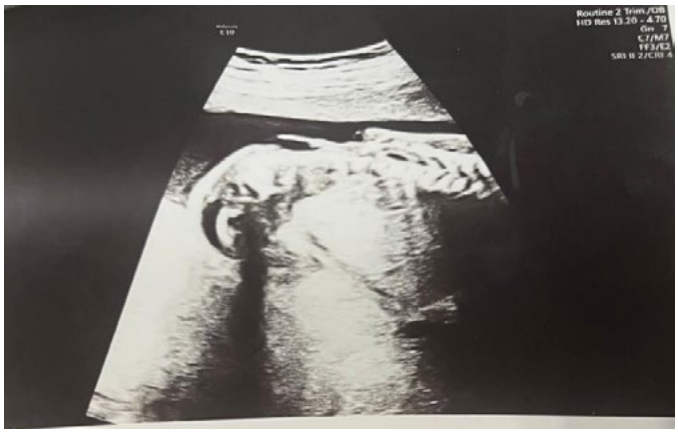
Bilateral ventruculomegaly, herniated cerebellar vermiş, lemon sign

figure 2



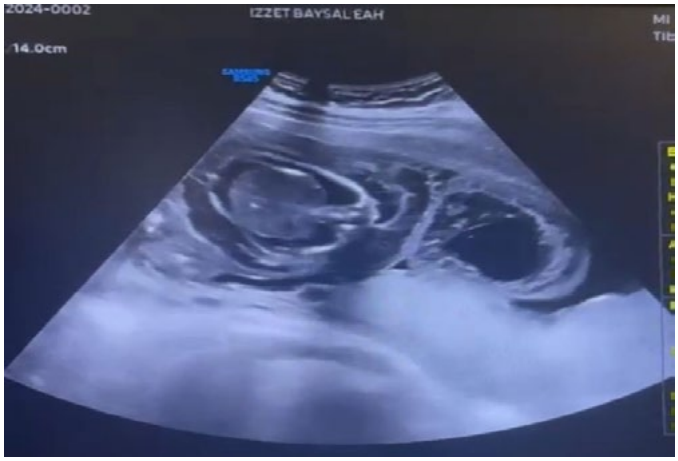
Longitudinal sonogram of the fetal spinal canal: enlarged canal and increased interpeduncular distances

figure 3



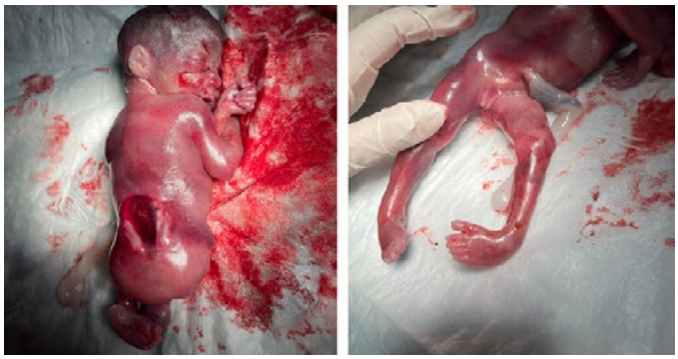
Open spinal defect seen on detailed examination

figure 4



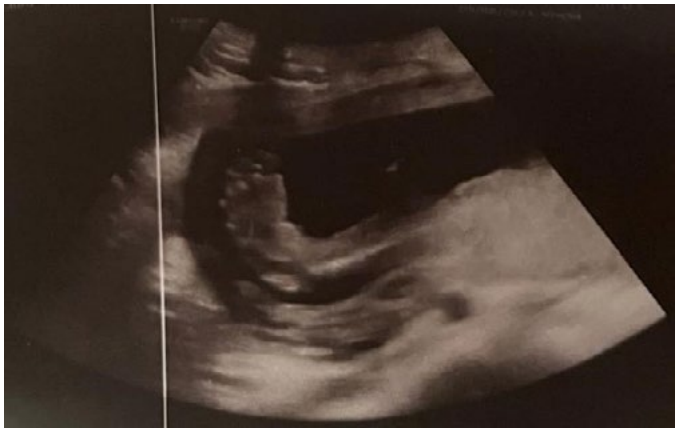
Open spina bfida in the lumbosacral region

igure 5.1



Open spina bifida(left), bilateral pes equinovaru(right)

figure 5.2



Open spina bifida(left), bilateral pes equinovaru(right)

EP-021

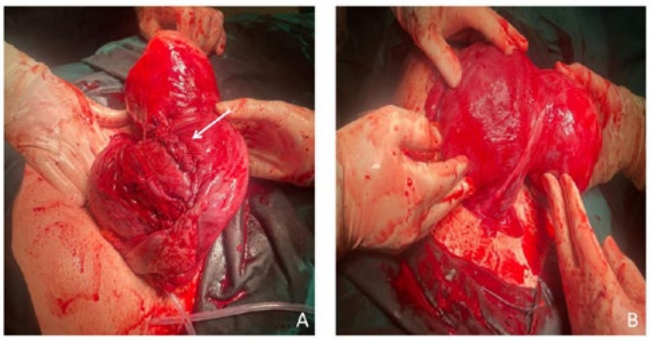
A Case of Postpartum Hysterectomy Due to Uterine Torsion and Courvalier Uterus in Myomatous Pregnant Uterus: Case report

Güner Yaman, Havva Can Ozdemir, Hüseyin Aksoy, Seda Şahin Aker
Department of Obstetrics and Gynaecology, Kayseri City Hospital,Kayseri,TURKEY

Uterine torsion is defined as rotation of the uterus around its longitudinal access by more than 45 degrees. It is associated with increased morbidity and is difficult to diagnose antenatally, resulting in diagnosis during caesarean section, often after the fetus has been delivered via incision into the posterior uterine wall. This has ongoing ramifications for the patient associated with increased risk of uterine rupture in future pregnancies and possibly increased bleeding intraoperatively. Aetiology of uterine torsion is unknown but an association exists with uterine anomalies and fetal mal-presentations.We present a case of a 29-year-old primigravida, at 37-week gestation, who had a posterior classical uterine incision due to a huge posterior wall leiomyoma associated with uterine torsion. The rarity of this type of uterine incision, the size of the uterine myoma and the uterine torsion prompted this case report. During caesarean section, the diagnoses of uterine torsion and a huge anterior wall leiomyoma were made. She had safe delivery of the fetus through a posterior classical caesarean section.During the follow-up after cesarean section, uterine torsion,courvalier uterus and atony developed. Post partum hysterectomy was performed. Afterwards, the patient and her baby were discharged in good health.As a result, uterine torsion is a rare condition in pregnant women. It is difficult to diagnose because of the nonspecific nature of its symptoms. Torsion should be kept in mind, especially in cases with pregnancy with fibroids. Changing the location of the placenta on ultrasound and noting the vascularization in the ovary may be useful in order not to miss the clinical diagnosis

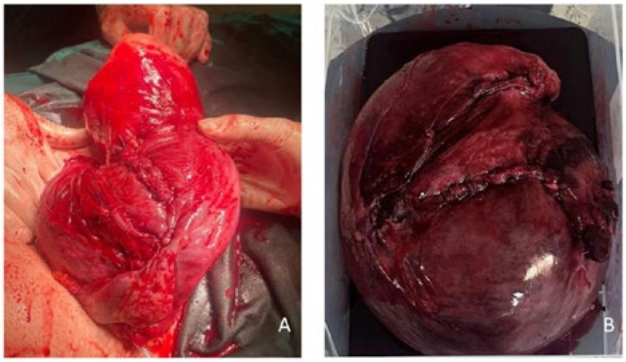
Keywords: Couvelaire uterus,Uterine torsion,Posterior uterine wall,Transverse caesarean section

FIGUR 1



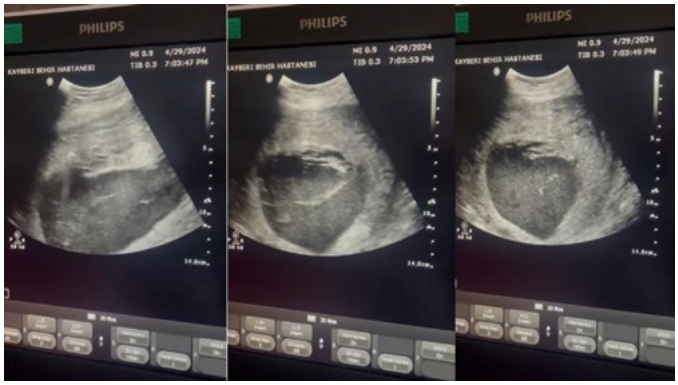
A-POSTERIOR LOWER SEGMENT INCISION B- MYOMA UTERI AND UTERINE TORSION

FIGUR 2



A-POST OP CS UTERUS B-COURVALIER UTERUS

FIGUR 3



UTERİN ATONİ ULTRASOUND İMAGE POST OP CAESAREAN SECTİON

EP-022

Case report: pregnancy with bilateral theca lutein cysts associated with complete hydatidiform mole and co-existing live fetus

Zeliha Öcal[1], Çağla Ezgi Uğuz Candemir[2], Ece Çalık[2], Mehmet Ferdi Kıncı[2], Yaşam Kemal Akpak[2]
[1]Department of Obstetrics and Gynecology, Tepecik Training and Research Hospital, Health Science University, Izmir, Turkey
[2]Department of Obstetrics and Gynecology, Izmir City Hospital, Health Science University, Izmir, Turkey

AIM: A twin pregnancy comprising a complete molar gestation alongside a fetus with a positive fetal heartbeat is an exceptionally rare occurrence. In this report, we present a case of pregnancy characterized by the coexistence of a complete molar pregnancy with a live fetus and bilateral theca lutein cysts. Due to timely diagnosis and comprehensive counseling provided to the family, the pregnancy was successfully terminated without any associated complications.

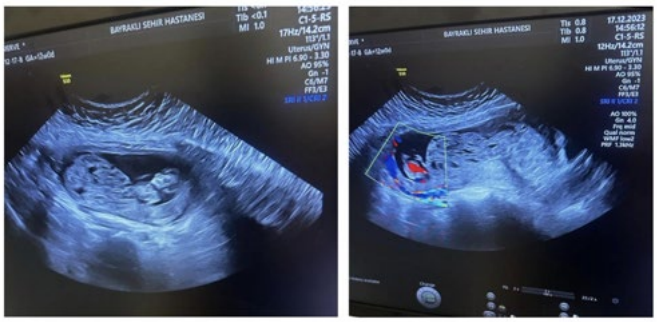
METHOD: This report discusses the admission, follow-up, and management of a patient who presented to the Izmir City Hospital Gynecology and Obstetrics Emergency Department with complaints of abdominal pain and vaginal bleeding, initially diagnosed with a complete molar pregnancy and a viable fetus.

CASE: A 32-year-old woman, gravida 1, para 0, presented to the emergency department with complaints of abdominal pain, vaginal bleeding in the form of spotting, nausea and vomiting. She had no known additional medical conditions or history of surgeries. According to her last menstrual period, her pregnancy was consistent with 11+5 weeks. During the examination, minimal vaginal bleeding was observed on speculum inspection. Abdominal examination revealed no guarding or rebound tenderness. Ultrasound showed a single fetus with a crown-rump length (CRL) of 47 mm, consistent with 11+4 weeks, with positive fetal heart activity. In the posterior uterus, a heterogeneous area containing numerous vesicles, consistent with a complete molar pregnancy, was observed separated from the amniotic sac. Bilateral ovaries showed theca lutein cysts enlarging the ovarian size. Laboratory tests, including blood count and coagulation parameters were within reference ranges. Beta-hCG was 649,388 mIU/mL, and TSH was 0.4. The chest X-ray was normal. After the examination, the family was informed in detail about the pregnancy follow-up and potential complications. The family elected for termination of the pregnancy. Misoprostol was administered for abortion induction, followed by vacuum curettage performed in the operating room with appropriate blood preparation. A follow-up ultrasound after the procedure showed a regular endometrium within the cavity. On the morning following the procedure, beta-hCG was measured at 48,960. The patient was referred to the gynecologic oncology unit for further follow-up. After the pathology result indicated a partial molar pregnancy, the pathology department was contacted. The specimens were re-examined with immunohistochemical p57 staining, and due to the absence of staining, the final pathology diagnosis was reported as a twin pregnancy with a healthy 11-week fetus and a complete molar pregnancy

CONCLUSION: A twin pregnancy that combines a complete molar pregnancy with a healthy normal fetus is an extremely rare obstetric condition. Its incidence ranges between 1 in 22,000 to 1 in 100,000 pregnancies. Maternal complications associated with this condition may include preeclampsia, hyperthyroidism, vaginal hemorrhage, uterine rupture, theca lutein cysts and the development of malignant neoplasia in the form of a trophoblastic tumour. From a fetal perspective, potential complications include preterm birth and intrauterine fetal demise. Although the reporting of live births in cases where termination was not performed has recently highlighted the conservative approach, it remains a subject of debate due to the potential for life-threatening complications.

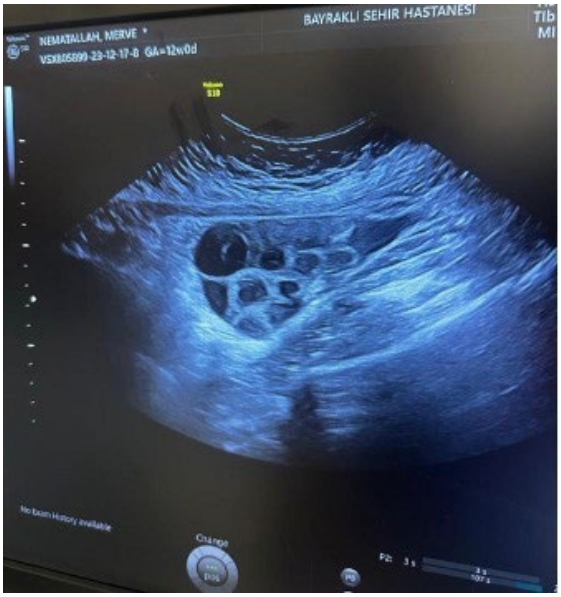
Keywords: preeclampsia, molar pregnancy, misoprostol, theca lutein cysts, crown-rump length

Figure-1



Trophoblastic appearance consistent with hydatidiform mole and a fetus with positive fetal cardiac activity

Figure-2



Ultrasonographic image of theca lutein cysts likely attributed to elevated levels of beta-hCG.

EP-023

Malignant Thyroid Papillary Neoplasm in Struma Ovarii: A Case Report

Yagmur Arslan[1], Oguzhan Kuru[2], Rengin Coskun[3]
[1]Department of Gynecology and Obstetrics, Istanbul University - Cerrahpasa
[2]Department of Gynecologic Oncology, Istanbul University - Cerrahpasa
[3]Department of Gynecology and Obstetrics, Istanbul University - Cerrahpaşa

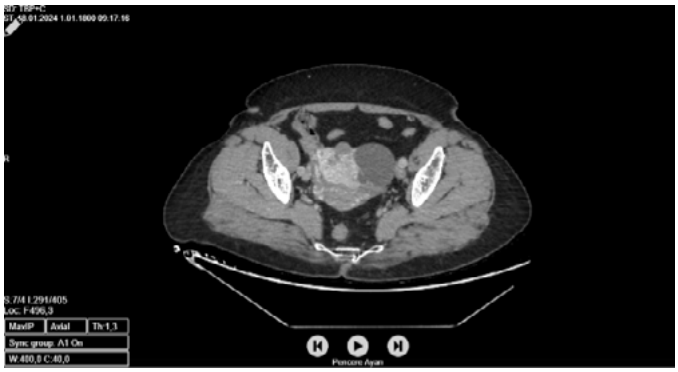
INTRODUCTIONX Struma ovarii, a rare germ cell tumor, accounts for 2-5% of mature teratomas and 1% of ovarian tumors. It is diagnosed when thyroid tissue makes up >50% of the teratoma. Malignant cases are rare (<5%). Most common in women aged 40-60, it presents with nonspecific symptoms like lower abdominal pain, abnormal menstrual cycles, and ascites. Hyperthyroidism is uncommon. Malignant cases metastasize in 5-23% of cases, especially if associated with papillary thyroid carcinoma >2 cm. Diagnosis is often incidental during imaging or surgery. Treatments include total hysterectomy, bilateral salpingo-oophorectomy, and omentectomy, or unilateral salpingo-oophorectomy/cystectomy for those desiring future pregnancy. Total thyroidectomy and radioactive iodine (I-131) are advised for metastatic disease. A case of a 77-year-old woman with struma ovarii and papillary microcarcinoma is presented.

CASE PRESENTATION: A 77-year-old multiparous female presented with abdominal pain and distention. She had a history of hypertension. Preoperative blood count was normal, and thyroid hormone levels were within the normal reference range (TSH: 0.43 µIU/ml, free T3: 3.33 pg/ml, free T4: 1.15 ng/dl). Basal tumor markers were: CA-125: 3.37 U/ml, CA 15-3: 25.9 U/ml, CA 19-9: 17 U/ml, AFP: 1.49 IU/ml, CEA: 1.21 ng/ml. Transvaginal ultrasound revealed an 8 cm complex cystic mass with papillary projections in the right adnexal fossa. Abdominal CT showed a 56 mm cystic mass with solid components in the left adnexal fossa, compressing the bladder. Thorax CT revealed millimetric hypoechoic nodules in the thyroid tissue. The patient underwent total abdominal hysterectomy, bilateral salpingo-oophorectomy, appendectomy, and omentectomy. Perioperatively, the frozen section result of the right unilateral salpingo-oophorectomy specimen indicated struma ovarii. Final pathology confirmed struma ovarii, with the specimen measuring 8x6x6 cm, containing a cystic area of 3x1x1 cm and a solid area of 4x4x3.5 cm. All specimens were composed of thyroid tissue, with a 0.3 mm focus of papillary microcarcinoma detected in one. The papillary microcarcinoma was capsule-free, non-sclerosing, and follicular in pattern. The pseudocyst wall showed old hemorrhage, cholesterol crystals, and a foreign body reaction in focal areas. No other teratomatous component was observed. Immunohistochemical staining was positive for HBME-1. The left ovary, fallopian tube, uterus, omentum, and appendix were unremarkable. Following the pathological diagnosis, the patient refused all treatments and declined further investigation.

CONCLUSION: Malignant struma ovarii is a less common ovarian tumor. There are no established criteria for its diagnosis. The criteria for malignancy in struma ovarii are disputable. Malignant struma ovarii is diagnosed by surgery. There are different recommendations for postoperative management, including iodine therapy and total thyroidectomy Therapeutic decisions should be made individually based on clinical and pathological data. Further investigation is necessary for diagnosis, treatment and postoperative management.

Keywords: Struma ovarii, Malignant Struma Ovari, Papillary Thyroid Carcinoma

CT Scan, Malignant Thyroid Papillary Neoplasm in Struma Ovarii



EP-025

A Rare Case: Coexistence of Borderline Ovarian Carcinoma and Omental Endosalpingiosis

Kübra Sevinç, Belma Gözde Özdemir, Çetin Çelik
Selçuk University Faculty Of Medicine, Gynecology And Obstetrics Department, Konya, Turkey

Endosalpingiosis is a benign condition characterized by the presence of ectopic ciliated epithelial cells located outside the fallopian tubes, often found in the pelvic organs. However, in recent years, the association between endosalpingiosis and malignant gynecologic neoplasms has gained increasing attention. This case report presents a 48-year-old woman with borderline ovarian carcinoma and omental endosalpingiosis. The relationship between this case and the Serous Tubal Intraepithelial Carcinoma (STIC) hypothesis is particularly noteworthy.

The STIC hypothesis suggests that most high-grade serous ovarian carcinomas originate from premalignant lesions in the fallopian tubes. This theory represents a significant breakthrough in understanding the pathogenesis of serous carcinomas. STIC refers to an in situ carcinoma arising from the ciliated epithelial cells of the fallopian tubes, which undergo malignant transformation, leading to the development of high-grade serous carcinomas. While borderline tumors are generally considered to have low malignant potential, some histologic and molecular features resemble the early stages of serous carcinomas. Consequently, it has been proposed that borderline ovarian tumors may be associated with STIC and represent a premalignant stage.In this case, the coexistence of omental endosalpingiosis and borderline ovarian carcinoma must be evaluated within the context of the STIC hypothesis. Although endosalpingiosis is typically considered a benign condition and often discovered incidentally, recent studies highlight its histological similarities to pelvic serous neoplasms. These findings suggest that endosalpingiosis may possess the potential for malignant transformation. Given that endosalpingiosis likely originates from fallopian tube epithelium, it shares a common cellular origin with STIC, which could imply a similar risk of malignant transformation.

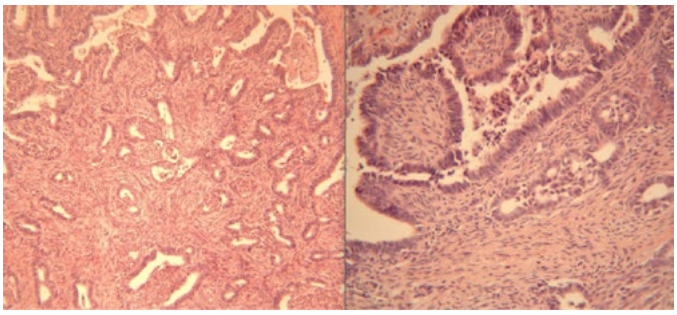
According to the STIC hypothesis, most serous carcinomas arise from premalignant lesions in the fallopian tubes, with these cells potentially spreading to other pelvic organs, including the ovaries and omentum. This mechanism of spread may also explain the relationship between endosalpingiosis and borderline ovarian tumors. For instance, it is hypothesized that endosalpingiosis develops from the ectopic implantation of fallopian tube epithelial cells in pelvic organs, similar to how STIC cells can spread and contribute to carcinogenesis. In this theoretical framework, the cells in areas of endosalpingiosis may be at increased risk of undergoing malignant transformation, which could lead to the development of borderline tumors.

In this patient, the coexistence of a borderline ovarian tumor and endosalpingiosis could be explained by a pathogenic model supported by the STIC hypothesis. While borderline tumors have low malignant potential, the idea that they may represent early forms of serous carcinomas originating from STIC cells aligns with the hypothesis that the borderline tumor in this case may have developed through the malignant transformation of cells originating in the fallopian tubes. Furthermore, benign-appearing conditions such as endosalpingiosis may play a role in this process and eventually contribute to malignancy.

In conclusion, borderline tumors could be considered premalignant lesions within the framework of the STIC hypothesis and that endosalpingiosis may contribute to this process requires further investigation. This is particularly relevant for high-risk groups, such as patients with BRCA mutations, where long-term risk assessment and appropriate management should consider the potential for malignancy.

Keywords: Borderline Ovarian Tumor, Endosalpingiosis, Fallopian Tube Epithelium, Malignant Transformation, Serous Tubal Intraepithelial Carcinoma (STIC),

pathology slide



In the examined sections, endometrioid glands forming lobular structures of varying sizes and shapes surrounded by an adenofibromatous stroma were observed. In the cystic areas, sparse simple papillary structures lined with epithelial cells displaying occasional stratification, low to moderate atypia, and scattered mitoses were present. The lesion was accompanied by foci of squamous metaplasia, and no stromal invasion was observed.

EP-026

Endocervical adenocarcinoma diagnosed after placental abruption: a case report

Ayşe Hazırbulan, Gözde Şahin
Department of Gynecological Oncology Surgery, Basaksehir Cam ve Sakura City Hospital, Istanbul, Turkey

OBJECTIVE: Adenocarcinomas are the most common type of cervical cancer after squamous cancer (frequency 25%). It occurs at a younger age (2nd-3rd decade) compared to squamous cancer. Among the subtypes of adenocarcinomas, mucinous adenocarcinoma is the most common. Endocervical is the most common mucinous cancer subtype. About 70% of endocervical adenocarcinomas are HPV-associated and the most common subtype is termed usual or endocervical. In this case report, we aimed to emphasize the importance of cervical cancer screening and the importance of questioning cervical cancer screening in the first follow-up of pregnancy according to the Prenatal Care Management Guidelines implemented in our country.

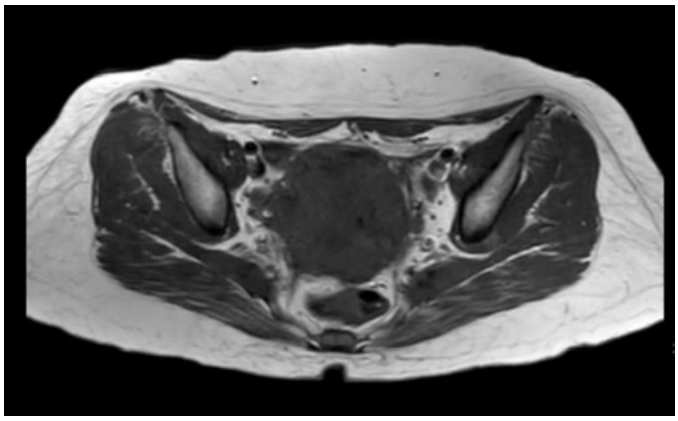
CASE: A 31-year-old patient who underwent cesarean section 3 months ago due to placental abruption was admitted to the emergency department of our hospital with the complaint of malodorous discharge and bleeding. She had gravida 2, parity 2, no smoking and no conic disease. She had never been screened for cervical cancer. Cervical examination revealed purulent discharge and bleeding. During bimanual examination, cervical movements were painful. The ultrasonography showed a cervical mass of approximately 5 cm. Cervical biopsy was taken. She was hospitalized with a prediagnosis of cervicovaginal abscess.

FINDINGS: The Magnetic Resonance Imaging report showed a centrally necrotic, wall contrast enhancing and diffusion restricting area located in the cervix and corpus uteri with axial dimensions of 68 x 65 mm and craniocaudal extension of 59 mm, and the differential diagnosis was endometritis or pelvic abscess. There were lymph nodes in the left para-aortic area, the short axis of the largest of which measured 12 mm. Positron Emission Tomography showed intense increased FDG uptake in a mass lesion measuring approximately 78x75x69 mm in the largest part located at the uterine cervix-corpus level (Standardized Maximum Uptake Value (SUVmax): 13.8). Increased FDG uptake was observed in bilateral posterior external iliac lymph nodes, the largest of which measured approximately 13x8.5 mm in size (SUVmax:5.1). Slightly increased FDG uptake was observed in a millimeter-sized spherical lymph node located in the paraaortic area just superior to the aortic bifurcation (SUVmax:1.8). The pathology of the cervix biopsy was reported as endocervical adenocarcinoma, HPV (Human Papilloma Virus) associated type.

CONCLUSION: According to the ASCCP (American Society for Colposcopy and Cervical Pathology) guidelines, the starting age for cervical cancer screening is 21 years. Between 21-29 years of age, screening is performed every 3 years with cytology. Between the ages of 30 and 65, screening is done every 3 years with a smear or every 5 years with a cotest or every 5 years with a primary HPV test. We should offer cervical cancer screening tests to our patients. Studies have shown that microinvasive adenocarcinoma of the cervix is correctly diagnosed in 42.5% of cytologic preparations, while overdiagnosis is 17.5% and underdiagnosis is 40%. The patient was treated with chemoradiotherapy for endocervical adenocarcinoma. In addition to the presence of conditions that increase the risk of primary or secondary bleeding or puerperal sepsis in the postpartum period, we should evaluate cervical intraepithelial neoplasms in the differential diagnosis.

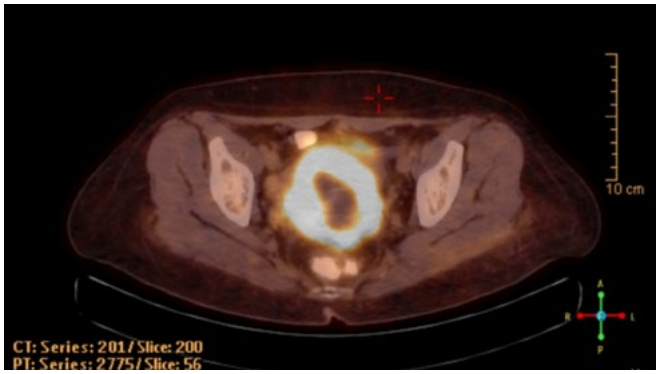
Keywords: Endocervical Adenocarcinoma, Servical Cancer Screening, Placental Abruption

Magnetic Resonance Imaging



Magnetic Resonance Imaging

Positron Emission Tomography



Positron Emission Tomography

EP-027

Frozen Section Borderline Reported High-Grade Serous Ovarian Tumor

Erkan Mavigök[1], Kemal Hansu[1], Alev Özer[1],
Ayşe Nur Mavigök[2]
[1]Department of Obstetrics and Gynecology,Kahramanmaraş Sütçü İmam University, Kahramanmaraş,Turkey
[2]Department of of Medical Pharmacology,Kahramanmaraş Sütçü İmam University,kahramanmaraş,Turkey

Frozen Section Borderline Reported High-Grade Serous Ovarian Tumor:

INTRODUCTION: A lymph node dissection was performed on a 60-year-old patient because approximately 10-30% of cases with a mass reported as borderline in a frozen section are found to be malignant (usually high-grade serous carcinoma) in the final pathology according to the literature (1,2,6,7).

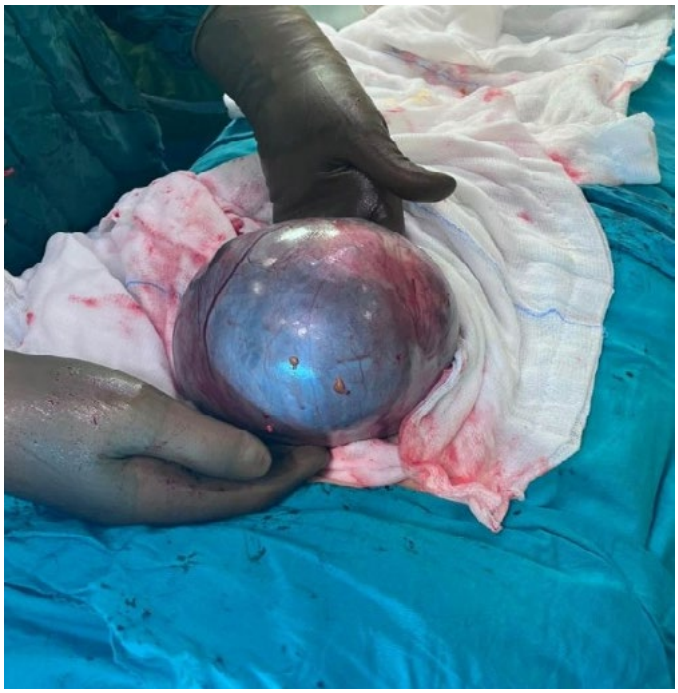
A lymph node dissection was performed on a 60-year-old patient because approximately 10-30% of cases with a mass reported as borderline in a frozen section are found to be malignant (usually high-grade serous carcinoma) in the final pathology according to the literature (1,2,6,7).

CASE: A 60-year-old patient presented to our clinic with a 14 cm anechoic cyst diagnosed at an external center. An ultrasound revealed a 14x15 cm cystic structure with dense content in the left adnexa, and a CT scan showed a contrast-enhancing heterogeneous mass with minimal free fluid in the abdomen. The patient's CA125 level was 74, with no other significant laboratory findings, and she was taken into surgery. Upon entering the abdomen, a 15 cm mass with hemorrhagic areas and a highly vascular appearance, with thickened cyst walls in places, was removed and sent for frozen section analysis. After the frozen section analysis indicated a borderline ovarian tumor, the patient underwent TAH+BSO+lymph node dissection.

DISCUSSION: The rate at which borderline ovarian tumors diagnosed as borderline on frozen section analysis are later found to be malignant in the final pathology varies between approximately 10% and 30% (1,2). Therefore, in this case, a lymph node dissection was performed due to the risk of malignancy in the final pathological evaluation of cases identified as borderline in frozen sections. The final pathology result of high-grade serous ovarian tumor in this case prevented the patient from undergoing a secondary surgical procedure. This procedure was performed to ensure the complete removal of tumors with malignant potential in cases reported as borderline on frozen sections and to allow for a more accurate surgical and pathological evaluation

Keywords: Frozen Section Borderline,serous over tumour,Hıgh grade over tumor

tumor



EP-028

Granulosa Cell Tumor of the Ovary

Abdullah Serdar Açıkgöz[1], Oğuzhan Kuru[1], Şeyma Okumuş[1], Ender Dulundu[2], Egemen Özdemir[2], Bilgehan Sağlık Gökmen[1], Atacem Mert Aytekin[1], Alara Macit[1]
[1]Department of Gynecologic Oncology,Istanbul Universty Cerrahpasa,İstanbul, Turkey
[2]Department of General Surgery,Istanbul Universty Cerrahpasa,İstanbul, Turkey

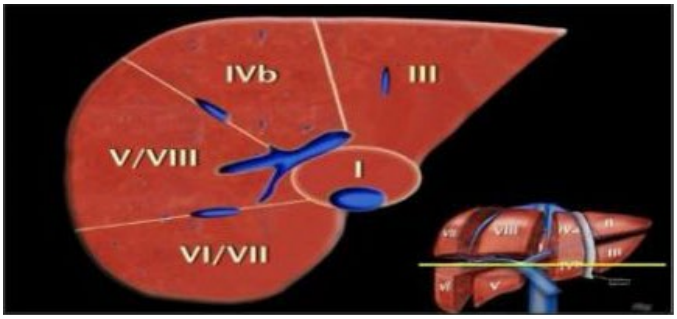
INTRODUCTION: Granulosa cell tumor (GCT) is a rare tumor of the ovary originating from the stromal cord. GCT constitutes approximately 3% of all ovarian cancers.Surgical intervention is essential for definitive pathological diagnosis and staging.They are known as hormone-active tumors due to the estrogen they secrete from the stromal component. Endometrial thickness should be evaluated with transvaginal ultrasound against the risk of endometrial cancer and hyperplasia due to the estrogen they secrete, and endometrial biopsy should be performed when necessary. Since it is a hormone-active tumor, serum tumor markers such as inhibin A, inhibin B, estradiol and AMH can be used in diagnosis and postoperative follow-up. However, these markers are not specific to the tumor. Postmenopausal vaginal bleeding resulting from long-term exposure to estrogen secreted from the stroma and abdominal and pelvic pain resulting from the size of the mass in the ovary are the two most common findings.

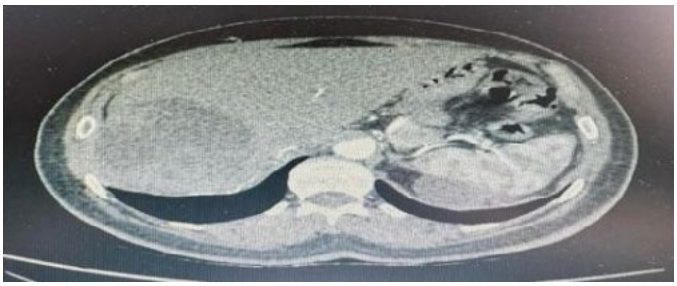
CASE PRESENTATION: A 58-year-old patient applied to an external center with complaints of constipation and abdominal pain. Transabdominal ultrasound showed non-parenchymal dysplastic appearance in liver segments 6-7. The liver tru-cut biopsy result was consistent with a neuroendocrine tumor. No features were detected in the colonoscopy performed on the patient. PET CT performed on the patient showed a 10x8x8 cm hypodense mass in the right upper lobe of the liver, a 28x26 mm mass in the right lateral cervix, and wall thickening in the right anterolateral rectum. The patient was referred to a higher center with these findings and the liver tru-cut bx was repeated. The repeated liver tru-cut biopsy result was found to be consistent with granulosa cell ovarian cancer. The patient was planned to receive 6 cycles of carboplatin and paclitaxel treatment. 3 cycles of treatment could be applied due to the development of pancytopenia. The anamnesis showed that she had an operation in 2018 due to ovarian cyst rupture. The patient reported that she did not follow the pathology result. In the examination, a painful nodule was palpable in the rectovaginal septum. A 43 mm irregularly bordered mass was observed in the right adnexal area in the transvaginal ultrasound. A 11x7 cm mass lesion was observed in liver segments 7-8 and a 4 cm mass lesion was observed in the posterior spleen in the transabdominal ultrasoundThe patient's liver tru-cut biopsy performed at an external center was revised in our center. The result was found to be compatible with granulosa cell ovarian cancer. An operation decision was made in light of these findings. No left ovary was observed in the exploration. The patient underwent total abdominal hysterectomy, right salpingo-oophorectomy, tumor excision from liver segments 7-8, splenectomy, diaphragm stripping, pelvic peritonectomy and infragastric omentectomy.

CONCLUSION: Granulosa cell ovarian cancer is a low-grade malignancy and requires long-term follow-up. Since granulosa cell tumors are hormone-active tumors, different tumor markers can be used for follow-up in the postoperative period. Although estradiol, AMH, inhibin A, inhibin B and FSH can be used as serum tumor markers, none of these markers are specific to tumor.

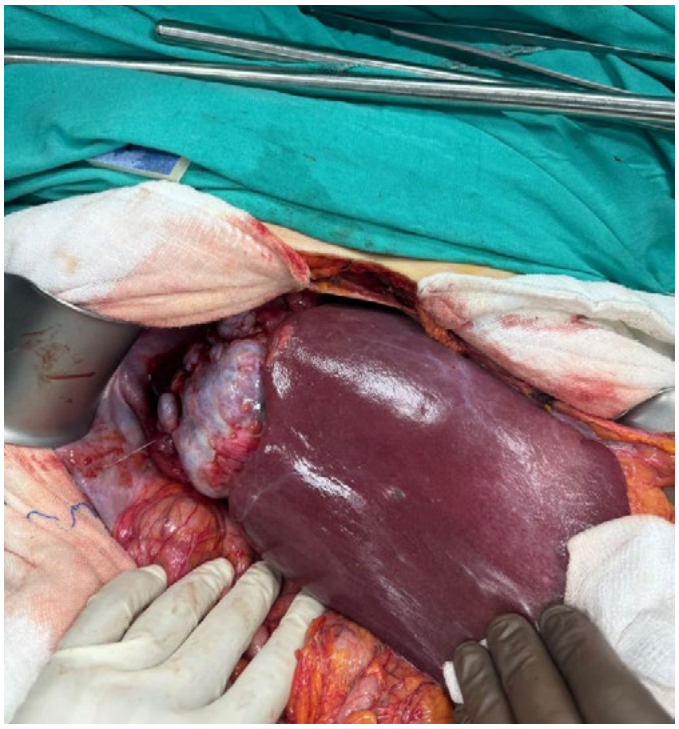
Keywords: granülosa cell over ca,relapse,surgical treatment

bt



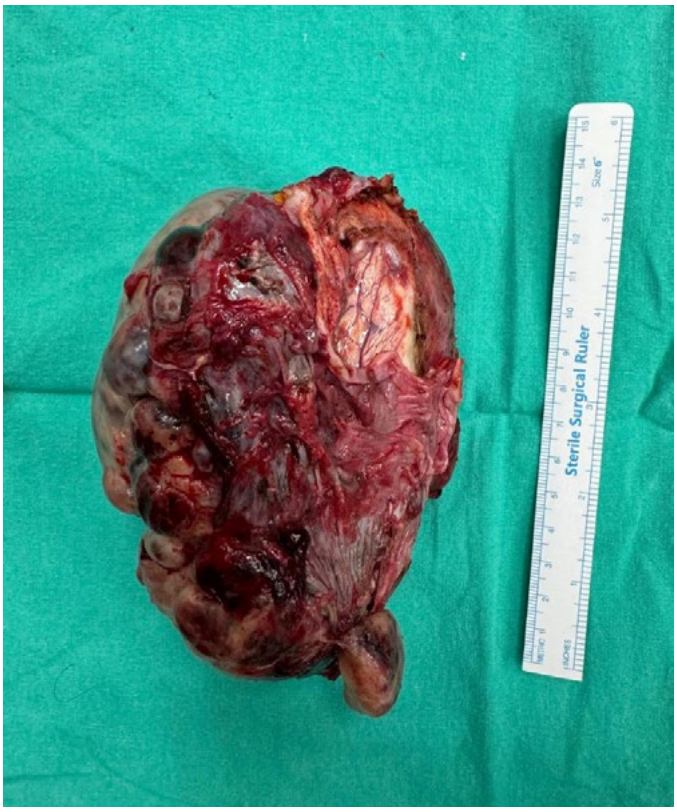


liver



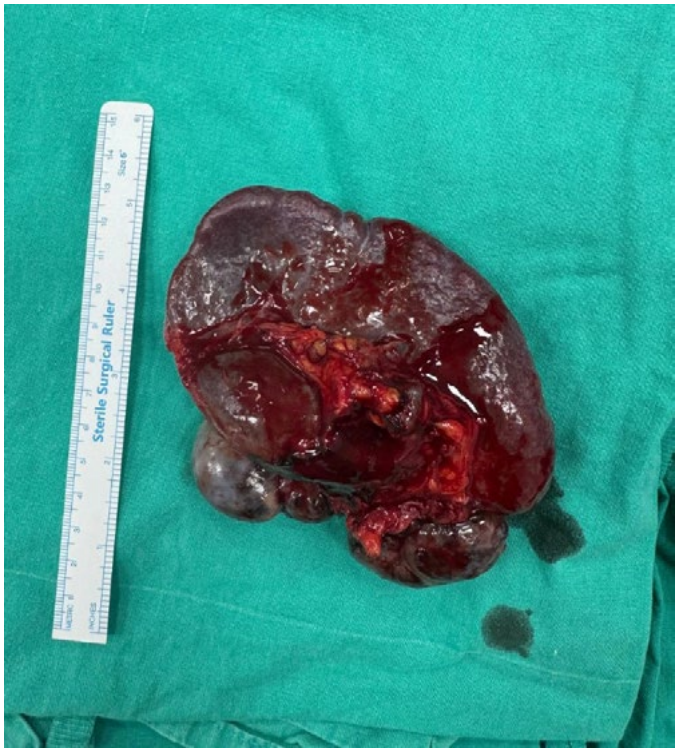
kc segment

tumor



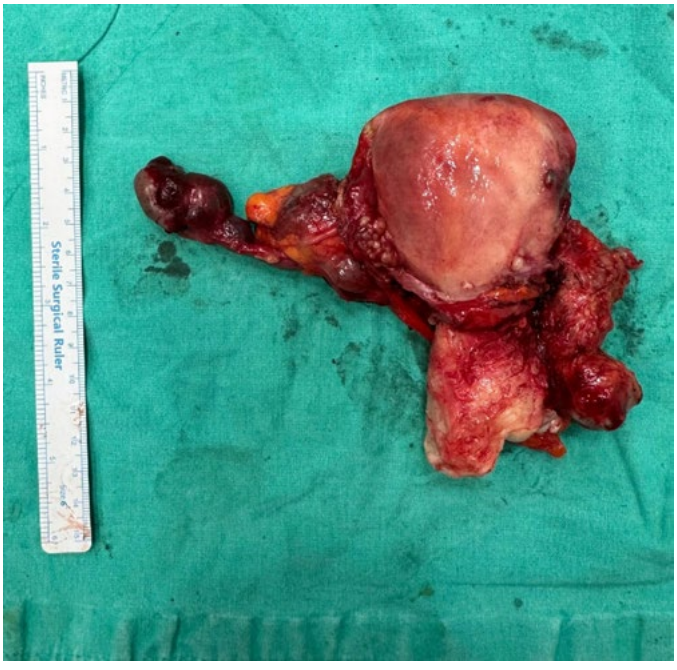
tm eksizyon

spleen



splenektomi

uterus



uterus

EP-030

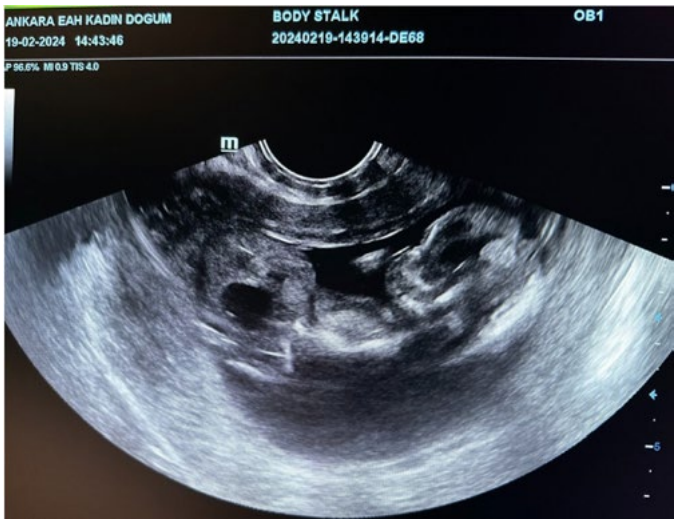
Body Stalk Anomaly: Case Report

Nimet Alyörük Geçici[1], Gülay Balkaş[1], Okan Oktar[1], Büşra Hüsam Konan[1], Betül Aydoğdu[2], Yusuf Üstün[1]
[1]Department of Gynecology and Obstetrics,Health Sciences University Ankara Training and Research Hospital, Ankara,Turkey
[2]Department of Family Medicine, Health Sciences University Ankara Training and Research Hospital, Ankara,Turkey

Body stalk anomaly is a rare and severe malformation syndrome, the exact pathophysiology and triggering factors of which remain unknown, characterized by abdominal wall defects, scoliosis, and a short or absent umblical cord. The estimated incidence of this rare malformation syndrome in pregnancies ranges from 1 in 14,000 to 1 in 31,000. We present the case of a 30-year-old patient who underwent ultrasound at 12 weeks of gestation, revealing a fetus with a large abdominal wall defect involving liver, stomach, intestine, and bladder, alongside thoracolumbar kyphoscoliosis and a short umbilical cord. Due to the severe malformation incompatible with life, termination of the pregnancy was offered to the family. Since no direct etiologic factor is known, early detection and termination of the pregnancy are the main preventive measures. Upon the consent of the patient and her husband, the pregnancy was terminated by administering misoprostol. The autopsy findings also confirmed the diagnosis of body stalk anomaly. The cytogenetic studies did not reveal numeric alterations in chromosomes 13, 18, and 21. It's noteworthy that karyotype analysis in body stalk anomaly cases like ours is usually normal, which means that patients do not have an increased risk of recurrence. Therefore, they can be reassured about future pregnancies.

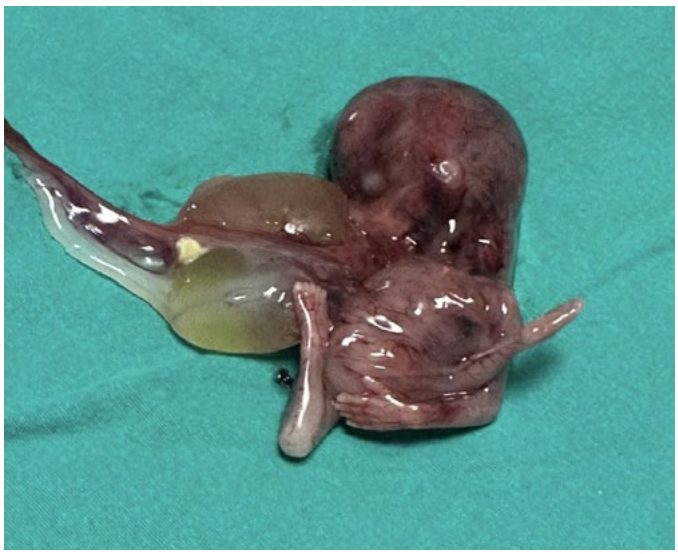
Keywords: Anterior wall defect,body stalk anomaly,prenatal diagnosis

Figure 1



Ultrasonographic image of body stalk anomaly

Figure 2



After medical abortion, the fetus

EP-031

Prenatal diagnosis and management of fetal intraabdominal umbilical vein varix (FIUVV): A case report

Elif Ayan Avcı, Hasan Berkan Sayal, Gul Alkan Bulbul
Health Sciences University, Antalya Training and Research Hospital, Department of Perinatology, Antalya

INTRODUCTION: Fetal intraabdominal umbilical vein varix (FIUVV) is defined as a focal dilation of the umbilical vein located between the fetal abdominal wall and the inferior aspect of the liver. The incidence of FIUVV ranges 0.4 - 1.1 per 1,000 births, approximately 4% of all umbilical vein anomalies.Intrahepatic UV varices are less common due to hepatic support. Normally, the diameter of the UV increases from 3 mm at 15 weeks of gestation to 8 mm at birth. The diagnosis of FIUVV is made when the umbilical vein diameter exceeds 9 mm, when the varix is 50% larger than the intrahepatic umbilical vein diameter, or when the umbilical vein diameter is more than 2 standard deviations above the mean for the gestational age.FIUVV can be observed as a round or fusiform cystic structure and venous flow demonstrated using color and pulsed Doppler ultrasound. Prenatal detection of FIUVV is crucial for effective pregnancy management.This study aims to raise awareness regarding the diagnosis and management uncertainties associated with FIUVV.

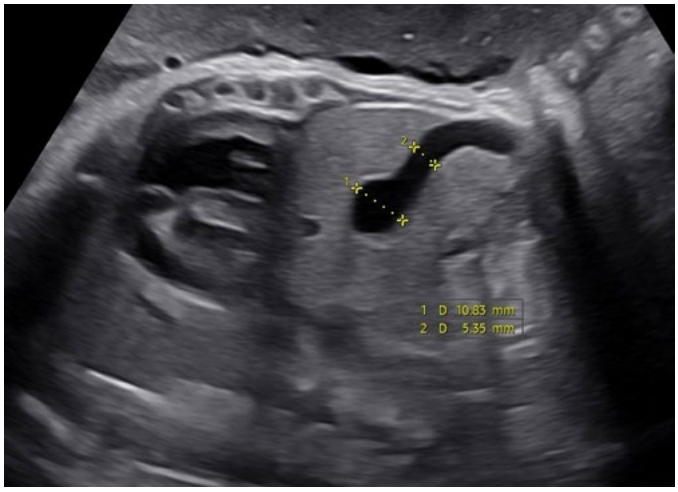
CASE: A 25-year-old primigravida patient undergoing insulin therapy with gestational diabetes mellitus was referred to our clinic at 34 weeks and 3 days of gestation.First-trimester screening tests were low risk, nuchal translucency measurement of 1.6 mm. The second-trimester ultrasound demonstrated normal.Fetal biometry was consistent with the gestational age.A focal dilation of the intrahepatic UV measuring 10.8 mm x 13.9 mm was identified just before entering the ductus venosus, turbulent flow observed on color Doppler.Umbilical artery Doppler were normal, and no major organ anomalies were detected. The patient was placed under weekly monitoring.At 37 weeks of gestation, she delivered a live female infant via cesarean section, 49 cm and 2909 g, with Apgar scores of 9 at one minute and 10 at five minutes.The newborn was monitored in the neonatal intensive care unit for tachypnea, postnatal evaluation of the umbilical vein was reported as normal.

DISCUSSION: FIUVV is a rare prenatal finding, and guidelines for obstetric management remain unclear. A 2021 case series reported that 78% of FIUVV cases were isolated, while 8% were associated with major malformations and 3% with aneuploidies. Cardiovascular and urogenital malformations were the most frequently observed anomalies, along with associations with diaphragmatic hernia, pulmonary sequestration, ventriculomegaly, and echogenic bowel.Complications that may arise with FIUVV include thrombus formation within the varix, low birth weight, hydrops, intrauterine fetal demise, and neonatal coagulopathy. Recent studies indicate that the risk of complications in isolated FIUVV cases is low.Upon diagnosis, a detailed fetal anatomical assessment and echocardiography are recommended.Close monitoring should take into account factors such as fetal growth, varix size, thrombus, hydrops, and signs of cardiac decompensation.Karyotype analysis is advised in the presence of associated anomalies or risk factors.

CONCLUSION: The prenatal diagnosis and management of FIUVV have not yet reached a definitive consensus.If complications are present, fetal prognosis may deteriorate, necessitating early delivery decisions. In the absence of complications, delivery is recommended between 38 and 39 weeks of gestation. Future case series could help establish guidelines for the obstetric management and complications associated with FIUVV.

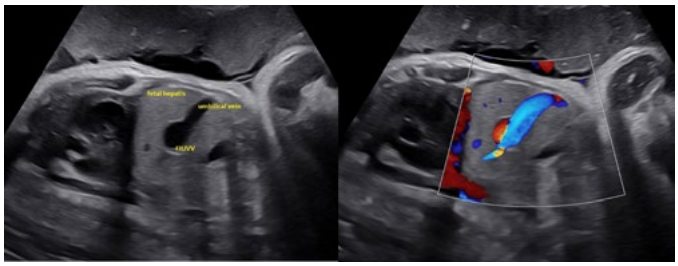
Keywords: FIUVV, Umbilical ven, varix

figure 1



Ultrasound image showing the intrahepatic umbilical vein varix (FIUVV). The varix is markedly enlarged compared to the normal intrahepatic umbilical vein. (FIUVV:fetal intraabdominal umbilical vein varix)

figure 2



The gray scale image of the umbilical vein varix typically shows a focal dilation of the umbilical vein. It appears as an anechoic cystic structure on the left, The color Doppler image of the umbilical vein varix reveals blood flow dynamics within the varix (right). The varix may show turbulent flow, often depicted with color changes indicating the direction and speed of the blood flow.

EP-032

Posterior Reversible Encephalopathy Syndrome (PRES) and Review of The Literature

Onur Karaaslan[1], Erkan Şimşek[2]
[1]Department of Gynaecology and Obstetrics, Van Yüzüncü Yil University, Van, Turkey
[2]Department of Gynecological Oncology, Gaziantep City Hospital, Gaziantep, Turkey

The patient was referred to intensive care on the first postpartum day due to high blood pressure and liver enzyme levels during postpartum follow-ups at an external center, and was monitored with a preliminary diagnosis of HELLP syndrome. In the patient, who reported blurred vision, the addition of thrombocytopenia to the existing clinical picture led to the consideration of PRES syndrome as the primary diagnosis, and follow-up and treatment were initiated accordingly.

Keywords: Press Syndrome, HELLP, Postpartum

EP-033

Rare Case: Prenatal Diagnosis of Ellis-van Creveld Syndrome

Şeyma Dağlıtuncezdi Çam, Mustafa Bertan Demir
Kayseri City Hospital, Kayseri, Turkey

INTRODUCTION: Chondroectodermal Dysplasia (Ellis-van Creveld Syndrome: EvC Syndrome) is a rare congenital multisystem disorder. After the initial description of three cases by Ellis and van Creveld in 1940, a limited number of cases have been reported in the literature to date. Ellis-van Creveld (EvC) syndrome is an autosomal recessive ciliary disorder that manifests with a wide range of features affecting the ectoderm, skeleton, and heart. While it is known that the disease follows an autosomal recessive inheritance pattern, the underlying biochemical defect and its exact incidence are not fully understood. Although EvC syndrome is relatively rare, it is more frequently observed in the Amish population due to consanguineous marriages. Characteristic features of the disease include postaxial polydactyly, short-limbed dwarfism, dental, nail, and hair dysplasias, as well as various congenital heart defects, most commonly ostium primum or secundum type atrial septal defects. Additionally, rarer defects such as multiple frenula, thoracic hypoplasia, mandibular hypoplasia, syndactyly, genu valgum, epispadias, sexual infantilism, abnormal pulmonary venous return, and persistent superior vena cava have been reported. EvC syndrome is caused by mutations in the EVC or EVC2 genes, which code for cilia-related proteins. Mutations in the EVC or EVC2 genes can also lead to Weyers acro-dental dysostosis, an autosomal dominant disorder characterized by postaxial polydactyly, abnormalities of the mandible, dental structure, and oral vestibule. EVC and EVC2 proteins are localized in the basal bodies of primary cilia.

CASE: A 32-year-old patient in her first pregnancy was referred to perinatology at 18 weeks of gestation due to shortening of fetal long bones and a narrow thoracic appearance. The patient and her spouse were not related. Detailed ultrasound at 18 weeks of gestation revealed shortening of long bones (consistent with 15 weeks, <3rd percentile), thoracic constriction, short ribs, an atrioventricular septal defect, coarctation of the aorta, and hypoplasia of the inferior vermis (Figure 1). The family was informed about the pregnancy prognosis, including the option for genetic diagnosis and pregnancy termination if desired. The family declined amniocentesis/cordocentesis. With the consent of the patient and her spouse, the pregnancy was terminated. The abortus material revealed a male fetus weighing 242 grams, exhibiting postaxial polydactyly of the hands and feet, thoracic dysplasia, and shortening of long bones (Figure 2). Subsequently, a tissue sample from the fetus was sent to a genetic laboratory for diagnosis. The patient was later discharged. Upon the patient's return to the clinic with the genetic results, the exome sequencing of the tissue sample obtained from the fetus revealed heterozygous variants in the EVC gene. Specifically, heterozygous variants c.1652delC and c.2305-1G>A were identified in the EVC gene.

CONCLUSION: This case highlights the prenatal diagnosis of the rare EVC syndrome with multiple anomalies. EVC syndrome can be recognized through second-trimester prenatal ultrasonography. Genetic screening and pregnancy termination may be offered to families who desire it. However, differential diagnosis of EVC syndrome from thoracic asphyctic dystrophy (Jeune syndrome) and short rib polydactyly syndromes is necessary.

Keywords: Skeletal, Dysplasia, Prenatal, Diagnosis

Figure-1: Fetal Thoracic Narrowing

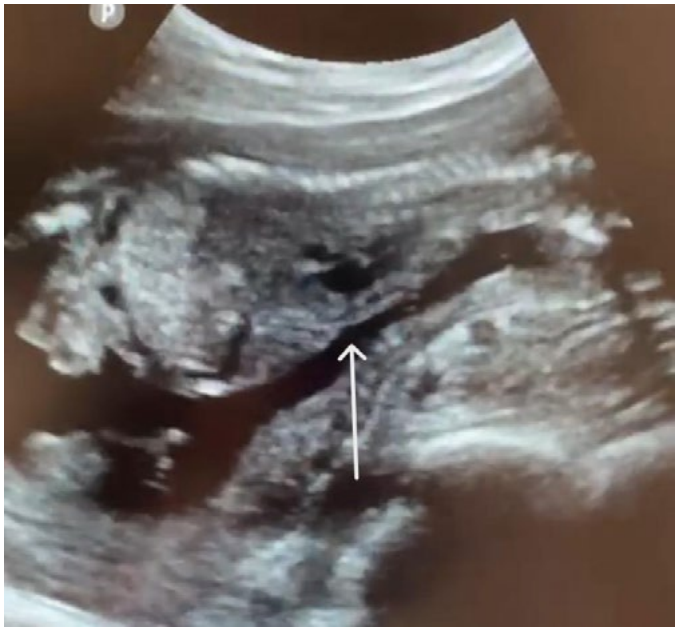
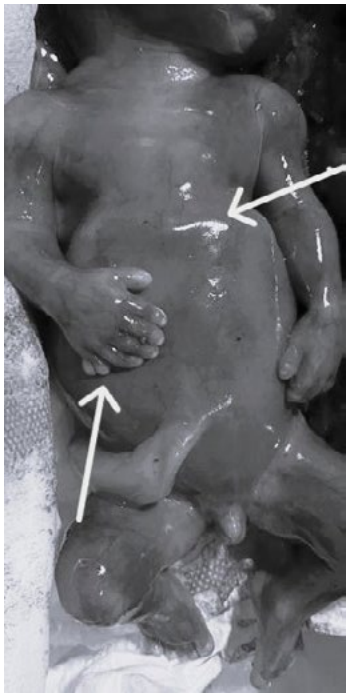


Figure-2: Polydactyly of Hands/Feet and Narrow Thoracic Appearance



EP-034

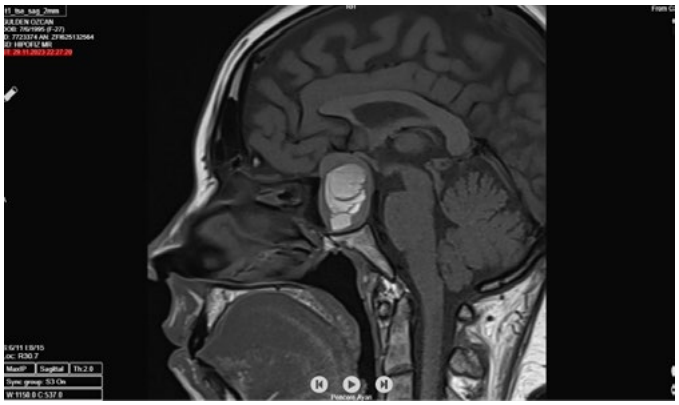
Pituitary Apoplexy in Pregnancy – A Case Report

Esra Nuhoglu Bilgin, Ayşe Berin Acar, Pınar Tokdemir Çalış, Hatice Aydın Salman, Arzu Sümer Ortaç, Esin Şahin Toruk, Tuncay Nas, Deniz Karçaaltıncaba
Department of Perinatalogy, Medical Faculty of Gazi University

Although pituitary apoplexy is a rare clinical condition, its occurrence in pregnancy is also exceptional and is of importance in terms of diagnostic difficulties and management. The presence of an underlying space-occupying lesion and anticoagulant therapy are the most important risk factors. This clinical condition, which is very important in terms of fetal and maternal outcomes, rarely requires surgical intervention. In our case report, we discuss a 29-year-old primigravid IVF patient was on LMWH due to MTHFR 1298 heterozygous mutation who presented with visual symptoms (bitemporal hemianopsia) and was diagnosed with pituitary apoplexy in the 25th weeks of gestation. The patient was followed up conservatively throughout her pregnancy and no signs of pituitary insufficiency developed. The patient was discussed in the Neonatology-Perinatalogy-Neurosurgery council and decided to deliver at term. At 37 weeks and 5 days the patient has presented with complaints of contractions, nausea and vomiting at and was delivered by cesarean section, 3020 gram male baby was delivered with an APGAR of 7/8. Although there is no definite recommendation for the route of delivery, our patient was delivered by cesarean section to prevent an increase in intracranial pressure. Postnatal follow-up and surgical treatment were performed. The patient underwent transsphenoidal pituitary adenoma surgery 2 months after delivery and the pathology was reported as gonadotropic adenoma. In patients with a previous history of pituitary adenoma, pituitary apoplexy should be considered as a rare diagnosis in the presence of risk factors; such as anticoagulant use in association with visual symptoms and headache. The use of anticoagulants for the correct indication is important in this respect.

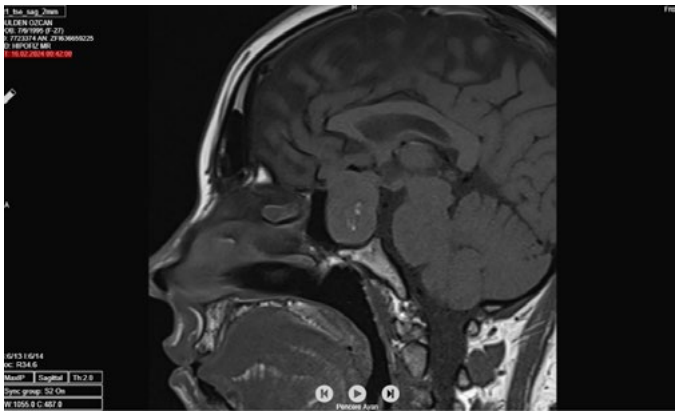
Keywords: pregnancy, pituitary apoplexy, bitemporal hemianopsia, LMWH

figure 1



hemorrhagic space occupying lesion

figure 2



MRI after 8 weeks

EP-035

Congenital high airway obstruction syndrome (CHAOS) case report

Ahmet Zeki Nessar
Mersin University Faculty of Medicine, Department of Obstetrics and Gynecology, Division of Perinatology, Mersin Turkey

F.N. is 38 years old, has 6 healthy living children from her previous 12 pregnancies and a history of 6 abortions. She had 4 cesarean deliveries following 2 vaginal deliveries. She was followed up at Mersin City Hospital during this 13th pregnancy. She did not want to have the first and second trimester screening tests done on her own request. She has a history of chronic hypertension and GDM in her previous pregnancy. She was referred to our hospital for further examination because ascites was detected in the fetus during a routine check-up at 17 weeks of gestation. A live fetus compatible with 18 weeks of gestation was observed in the sonography performed on the patient. Intracranial structures, face, extremities, vertebrae, and urogenital structures were observed as normal. In the examination of the thorax, both lung lobes were enlarged and hyperechogenic (Figure 1), and the heart was detected as compressed in the middle (Figure 2). Intracardiac structures and great vessels were observed as normal. Widespread free fluid was observed in the abdomen and intraabdominal organs were seen as normal (Figure 3). Based on the current findings and typical appearance, a diagnosis of isolated upper airway obstruction syndrome (CHAOS) was made. The patient was informed about the prognosis and treatment options of the disease. The family preferred to continue the pregnancy under all circumstances and routine antenatal follow-up was recommended.

Congenital High Airway Obstruction Syndrome (CHAOS): A rare congenital airway and lung anomaly. The prevalence of the disease is around 1 in 50,000 births. The disease occurs as a result of stenosis or agenesis of a segment of the upper airways (trachea or larynx). Rarely, it may occur as a result of a laryngeal cyst or web. The diagnosis is usually made after the 16th week of pregnancy. Large hyperechogenic lungs, compressed heart, ascites, flattening or inverted diaphragm and widening of the trachobronchial tree are the main ultrasonographic indicators of the disease. Due to its typical appearance, there is no differential diagnosis.

The incidence of chromosomal anomalies is not increased, but genetic syndromes accompany approximately 50% of the cases. Fraser Syndrome is the most common (autosomal recessive, microphthalmia, facial cleft, bilateral renal agenesis, cardiac defect and syndactyly or polydactyly). The risk of recurrence does not increase in isolated cases. In Fraser syndrome, the risk of recurrence is about 25%.

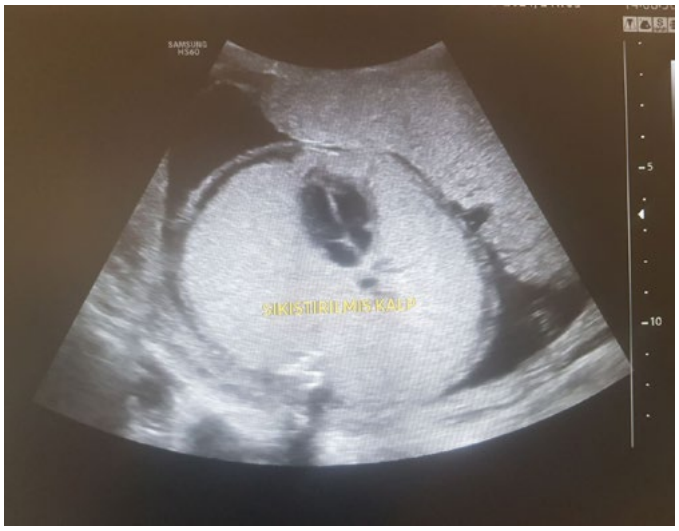
In addition to detailed ultrasound for diagnosis, fetal MRI can

be used to determine the level and type of obstruction.

In case of continuing pregnancy, birth can be planned in a center with neonatal intensive care, at the 38th week of pregnancy. Cesarean section, EXIT procedure and tracheostomy are required as the method of delivery.

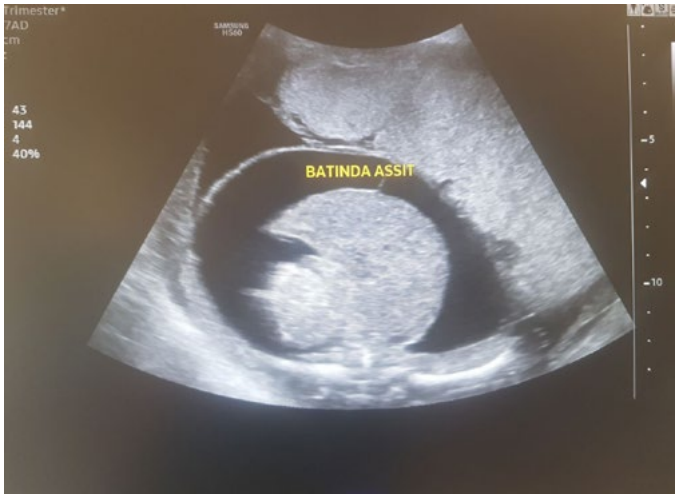
Keywords: CHAOS syndrome, congenital anomaly, thoracic anomalies

figur 1



enlarged lungs and the heart appearing to be stuck in the middle

figur 2



ascites in the abdomen

EP-036

Duplike üreter sistemi olan hastada laparoskopik histerektomi sonrası gelişen triple üreter yaralanması ve vezikovajinal fistül: Kabus komplikasyonun yönetimi

Yaren Tuba Bektaş[1], Berkan Şimşek[2], Tümay İpekçi[2], Oktay Akça[2]
[1]Department of Obstetric and Gynecology, Bahcesehir University; VM Medical Park Hospital Maltepe, Istanbul, Turkey
[2]Department of Urology, Bahcesehir University; VM Medical Park Hospital Maltepe, Istanbul, Turkey

GIRIŞ: Genital organların alt üriner sistem ile yakın komşuluk içinde olması nedeniyle, jinekolojik cerrahi operasyonlarda mesane ve üreter yaralanmaları görülebilmektedir. Vezikovajinal fistüllerin %50-60'ının abdominal yolla total histerektomi sırasında meydana geldiği ve üreter yaralanmasının da 1.3/1000 oranında geliştiği bildirilmiştir. Bu olgumuzda, konjenital sağ duplike üreteri olan hastanın geçirmiş olduğu total abdominal histerektomi nedeniyle gelişen bilateral üreter yaralanması ve vezikovajinal fistül onarımını sunmayı amaçladık.

OLGU: Anormal uterin kanama ile başvuran ve submukoz myomları olan 51 yaşındaki kadın hastaya endometriyal kalınlık nedeniyle kuretaj yapılmasının ardından sonuç alınamayınca laparoskopik total histerektomi yapılmıştır. Per-op inspeksiyonda uterusun normalden büyük ve ön duvarın mesaneye yapışık izlenmesi dışında anormal bir bulgu veya komplikasyon not edilmemiştir. Yakın postop takiplerinde belirgin şikayeti olmayan ve patoloji sonucunda benign bulgular gelen hasta, postoperatif 10.günde vajenden ıslatma, karın ağrısı ve ateş şikayetiyle başvurmuştur. Hospitalize edilen hastaya yapılan kontrastlı BT'de mesane superior komşuluğunda ürinom ile uyumlu 15cm ebadında alan gözlenmiştir. Bunun üzerine hastaya perkutan drenaj kataterı yerleştirilmiştir ve gelen sıvıdan gönderilen kreatinin idrar ile uyumlu gelmiştir.

Hastaya tanısal amaçlı genel anestezi altında sistoskopi ve üreterorenoskopi uygulandı. Mesane trigon arkası hiperemik ve mukoza üzerinde prolen sutur materyalleri gözlendi ve holmium laser ile kesildi. Sağ tarafta çift orifis ve çift toplayıcı sistem vardı. UltraThin URS ile her iki üreter orifisinden girilerek distal üreterlerde, her ikisinde de parsiyel termal defekt gözlendi. Ardından sol URS yapıldı ve sol üreterin de yine aynı seviyede termal tama yakın hasarlı olduğu gözlendi. Sağdaki iki üretere ve sol üretere DJ kataterler yerleştirildi. Ardından spekulum yardımıyla vajinal muayene yapıldı ve cuff açık değildi. Vajene ped yerleştirilerek mesane metilen mavisi ile doldurulduu ve vajendeki pedin ıslanmadığı gözlendi. Eş zamanlı hastanın batında olan drende mavi boyanma oldu.

Bu durum DJ katater kaynaklı, mesaneden ürinom alanına olan reflü olarak değerlendirildi ve hastaya 18F Foley sonda yerleştirilip takibe alındı.

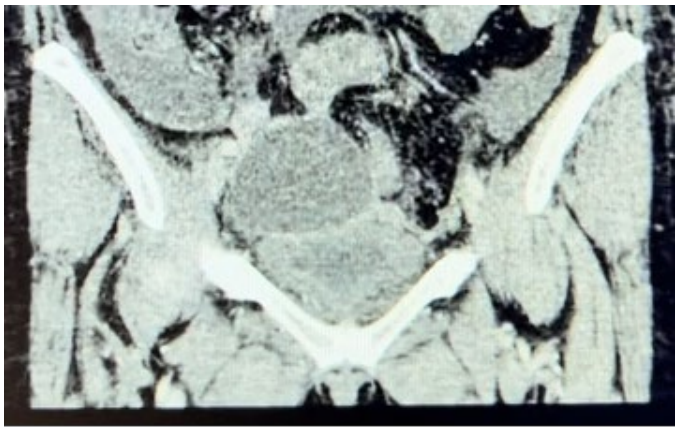
Yaklaşık 1 ay sondalı takip edilen hastaya sonda çekildikten sonra vajinal ıslatmasının tekrarlaması nedeniyle yeniden sistoskopi yapıldı. Trigonun hemen arkasında yaklaşık 0,5 cm fistül traktı gözlendi. URS yardımıyla fistül traktından guide gönderildi ve ardından vajinal yolla fistül traktı debride edilerek 4/0 PDS ile çift kat onarıldı. Tekrar sistoskopi yapılarak fistül alanının tamamen kapandığı izlendi. Hasta tekrar foley sondalı olarak takibe alındı.

Postop 15. Günde hastanın vezikovajinal fistülü nüksetti. Bunun üzerine tekrar sistoskopi ve URS yapıldı. Mesane trigon arkasındaki fistül traktının yeniden açıldığı ve etrafının granüle olduğu gözlendi. URS'de ise sağ taraftaki üreterin yaralanma alanında birbirlerine fistülize olduğu gözlendi ve sol üreter de tamamen daralmıştı. Bunun üzerine hastaya üriner drenaj amacıyla her üretere ayrı ayrı olmak üzere 3 adet üreter katateri yerleştirilerek definitif cerrahi; bilateral üreteroneosistostomi ve vezikovajinal fistül tamiri planlandı.

Hastaya orta hat insizyonu ile girildi. Problemli olan distal üreterler bilat olarak eksize edildi. Ardından O'Connor tekniğiyle omental flep vajen ön duvarı ve mesane arasına yerleştirildi. Ardından sağ taraftaki duplike üreterler Wallace tekniğiyle önce birbirine anastomoz edildi. Sağ taraftaki üreterler ve sol üreter içlerine DJ katater yerleştirilerek antireflüksif şekilde yeniden mesaneye anastomoz edildi. Takiplerinde problemi olmayan hastanın dreni postop 3. gün, sondası postop 10.gün ve D-J stentleri postop 8. haftada çekildi. Tüm klinik bulguları normale döndü.

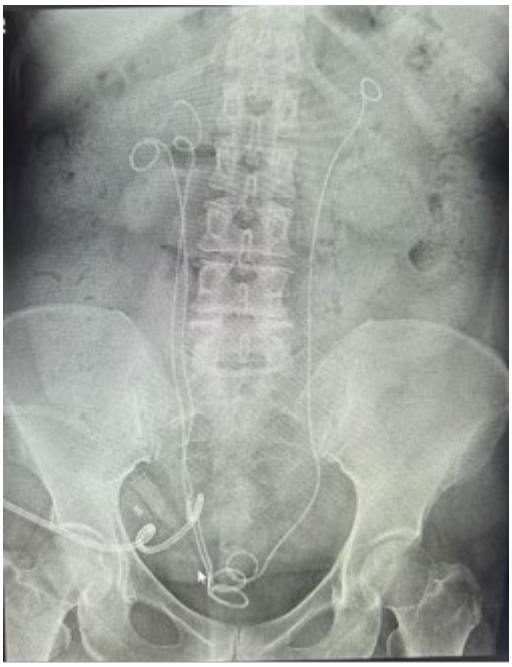
Keywords: Histerektomi, Üreter, Vezikovajinal, Fistül, Üreteroneosistostomi

Resim 1



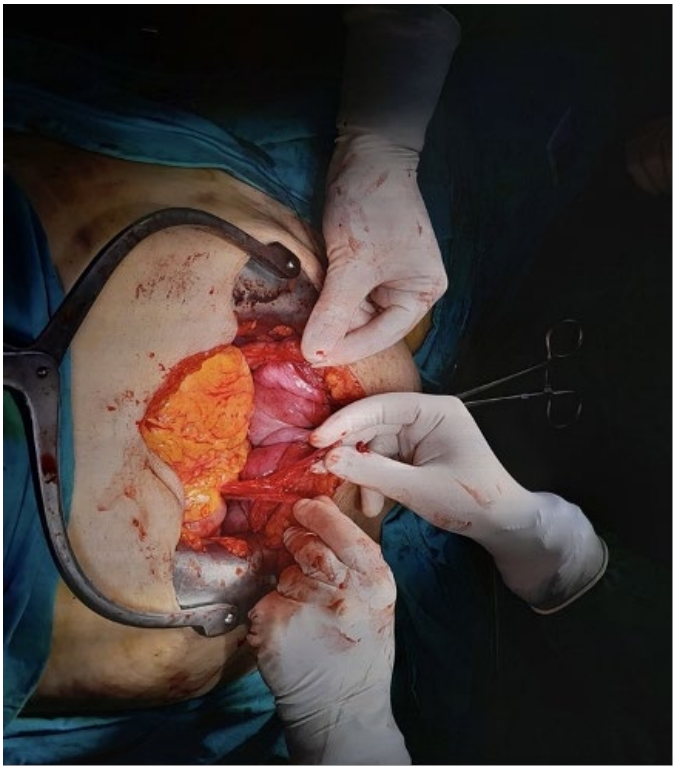
CT'de gözlenen ürinom

Resim 2



Sağ tarafta 2 adet üreter içerisindeki ve sol üreter içerisindeki DJ kataterler

Resim 3



Omental flep ve bilat neosistostomize edilecek üreterler.

EP-037

A case of vulvovaginal hematoma seen in the postpartum period

Merve Ecem Albayrak, Ömür Albayrak
Bolu İzzet Baysal Devlet Hastanesi

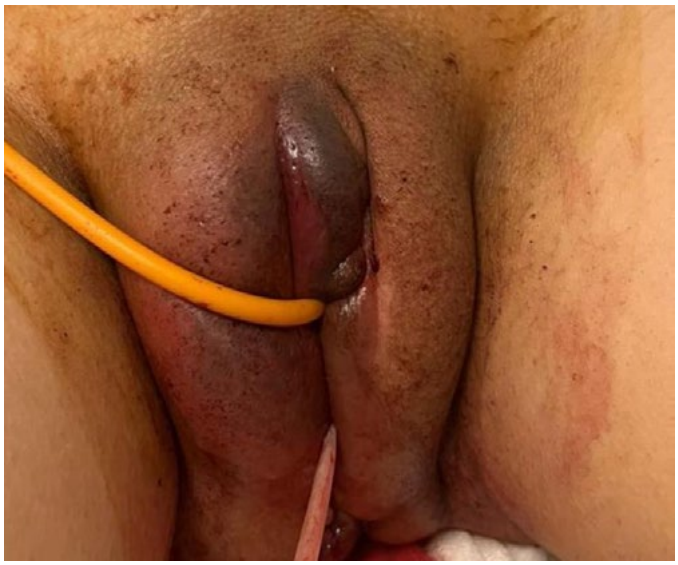
INTRODUCTION: Puerperal vulvovaginal hematomas are life-threatening obstetric emergencies. Puerperal hematomas are mostly seen in episiotomy deliveries or in cases with laceration. In addition, they are also seen in spontaneous vascular injuries. Although puerperal hematomas are rare, they can cause serious complications after delivery. When intrapartum vulvovaginal hematoma occurs, the patient may experience excessive blood loss due to the disruption and evacuation of the hematoma. When puerperal hematoma develops, bleeding can be fatal if the patient is not cardiac and hemodynamically stable. In this case report, we aimed to present a case of vulvovaginal hematoma that developed in the postpartum period.

CASE: Our patient was 31 years old and 41 weeks pregnant, and was hospitalized with a normal delivery plan due to being overdue. Induction was started and the patient was taken under follow-up. At the 10th hour of her hospitalization, a single live male baby weighing 3800 grams was delivered by normal delivery. No episiotomy was performed on the patient. The spontaneous desure that occurred was repaired. The patient who described severe pain at the 3rd hour postpartum was taken to the lithotomy table. A hematoma of approximately 4 cm in diameter extending posteriorly was observed on the right vaginal inner wall. The hematoma in the vagina was explored with a linear incision. There were bleeding and varicose veins in the exploration. After the hematoma was drained, the bleeding vessels were sutured and hemostasis was achieved. Since the patient's postpartum Hb was 7.9, 2 erythrocyte suspensions were applied. The patient was discharged on the 2nd postoperative day in good condition.

CONCLUSION: Puerperal vulvovaginal hematomas are serious obstetric complications that can be life-threatening. In order to minimize morbidity, it is necessary to make the diagnosis quickly and apply the correct treatment method. Diagnosing postpartum vaginal hematomas, especially in risky cases, with close monitoring and early follow-up examination and applying the appropriate treatment approach will reduce possible morbidity and mortality rates.

Keywords: hematoma, normal delivery, vulva

vulvaginal hematoma



Hematoma and swelling in the vulva-vaginal area

EP-038

A Rare Complication After Injection: Nicolau Syndrome

Riza Madazli, Ebru Alici Davutoglu, Ceren Cebi, Necla Simay Okay
Department of Obstetrics and Gynecology,Istanbul Unİversity Cerrahpaşa Faculty of Medicine,Istanbul,Turkey

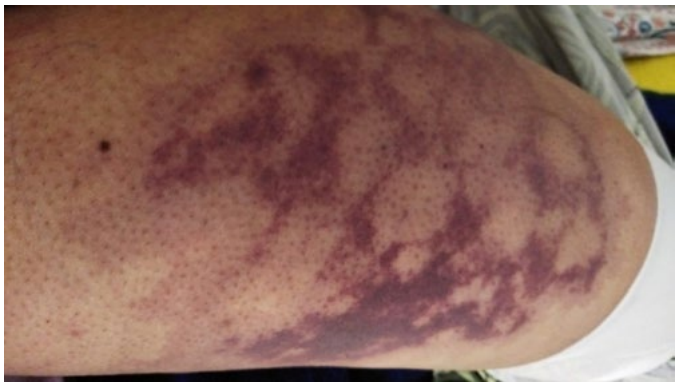
INTRODUCTION: Nicolau syndrome is a rare condition characterized by necrosis of the skin and subcutaneous tissues following injection. Due to the potential for scar formation, contractures, and secondary infections, a multidisciplinary approach is important. Our case represents a 36- year-old patient who, following a cesarean section, received a diclofenac sodium injection and subsequently experienced pain and ecchymotic changes in the right thigh.

CASE: During postoperative follow-up of a 36-year-old patient, we observed pain and ecchymotic changes in the injection area following a diclofenac sodium injection. The patient, a postpartum woman with a known history of type 2 diabetes, had undergone a cesarean section the day before. Patient's vital signs were stable. There was an ecchymotic area approximately 10x5 cm in size on the anterior aspect of the right thigh. Examinations of the lower extremity were normal. Laboratory results were compatible with postoperative period. The dermatology team did not classify the lesion as an allergic reaction. The report of ultrasound indicated increased thickness of the subcutaneous fat tissues, with linear effusions observed under the skin (hemorrhagic effusions?). No hematoma or collection was detected. The patient, who remained stable during hospitalization, was discharged on the second postoperative day, directed to The Plastic Surgery Department. On the fifth postoperative day, the patient applied to the hospital due to worsening symptoms and was admitted to Perinatology Department. On physical examination, the patient had stable vital signs. It was observed that the anterior aspect of the right thigh had a purplish lesion approximately 20x10 cm in size, tenderness on palpation, but no increase in temperature. Examinations of the lower extremity were normal. The new ultrasound showed increased echogenicity, linear effusions, and a dirty appearance in the subcutaneous fat, but no collections. The lower extremity CT angiography showed open vascular structures with no signs of extravasation or necrosis, but there was an increased density in the skin and subcutaneous tissues. Based on the infectious disease,prophylactic intravenous treatment with ampicillin-sulbactam 4x2 g was initiated. The plastic surgery, deciding against debridement, recommended symptomatic treatment, elevation, and mupirocin application. Two days after the patient's admission, due to increased local warmth, piperacillin-tazobactam 3x4.5 g was started. Daily dressings were applied to the wound. On the eighth postoperative day, MRI showed increase in the diameter of both deep and superficial tissues. Poorly contrasted focal areas in the vastus lateralis are consistent with an infection. No air and hematoma were detected. Piperacillin-tazobactam treatment was stopped after ten days. The plastic surgery began applying silver sulfadiazine to the wound site with necrotic area. The patient was discharged to continue follow-up at The Plastic Surgery Department. One month later, the patient was readmitted to The Plastic Surgery Department for debridement, VAC (vacuum-assisted closure) therapy, and skin graft.

CONCLUSION: Nicolau syndrome is an iatrogenic syndrome that can occur following injection via any route. Multidisciplinary approach is necessary for managing the condition. Proper antibiotherapy and wound care are as important as early diagnosis.Despite all efforts, healing may result in scars, limb deformity or other complications.

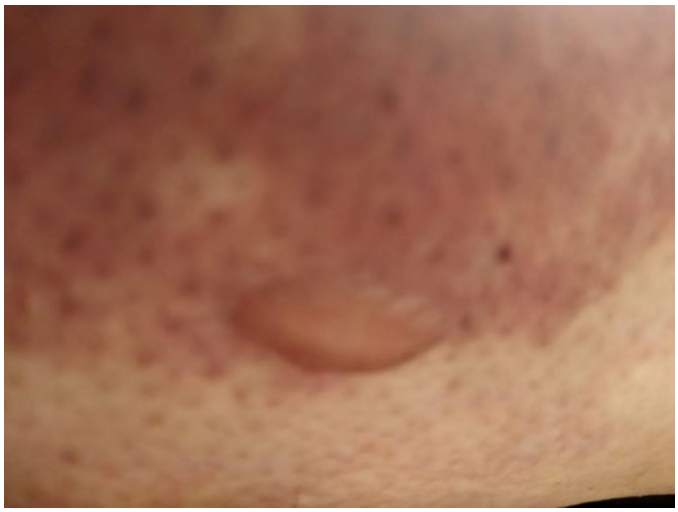
Keywords: Embolia cutis medicamentosa, Intramuscular injection, Nicolau syndrome, Skin necrosis

Initial purplish discoloration around the injection site



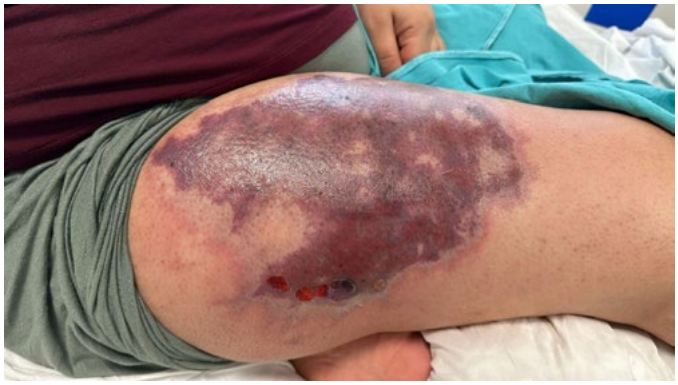
Ecchymotic changes in the injection area and surrounding tissues following a diclofenac sodium injection.

Bullous lesion at the injection site.



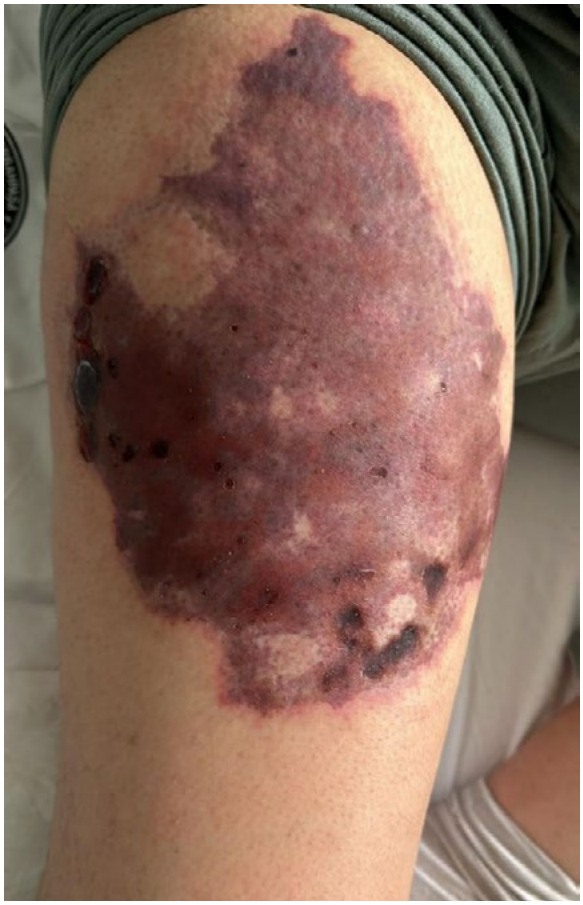
Bullous lesion in the injection area following a diclofenac sodium injection.

Purplish discoloration of the wound site upon second admission.



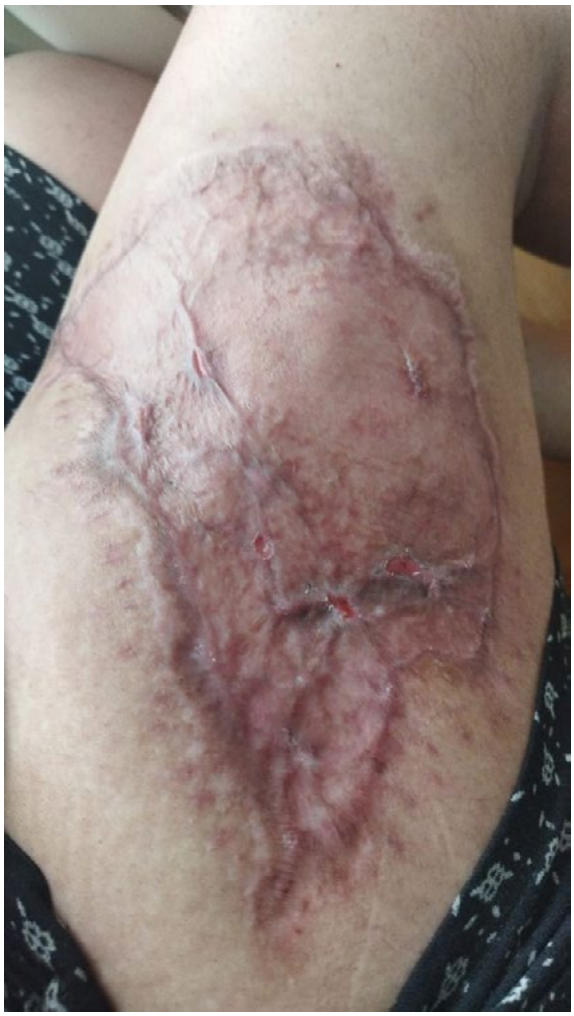
Ecchymotic changes with areas of intact skin at the wound site upon second hospitalization.

The wound site with necrotic areas



On the sixteenth postoperative day, the wound site with necrotic areas.

Final appearance of the wound.



Last appearance of the wound following debridement, vacuum-assisted closure (VAC) therapy and skin graft.

EP-039

Self-attempted labioplasty with resulting in necrosis

Mürüvet Korkmaz Baştürk[1], Mehmet Ak[1], Seda Şahin[2]
[1]Kayseri Şehir Hastanesi, Kadın Hastalıkları ve Doğum, Kayseri, Türkiye
[2]Kayseri Şehir Hastanesi, Jinekolojik Onkoloji, Kayseri, Türkiye

PURPOSE - METHOD AMAÇ - YÖNTEM: Labia minora hypertrophy can be characterized by the labial tissue extending beyond the labia majora. While the prevalence of labia hypertrophy is very common among women, taboo/ controversial attitudes and surgical interventions still dominate. Self-perception of poor cosmetic appearance is common in young patients and not necessarily pathologic.

FINDINGS - BULGULAR: A 32-year-old woman presented with genital pain nausea and foul odor after self-tie with thread to her labia minora. The thread were tie for a self-perceived abnormal appearance. Surgical debridement of the labia ligated with thread was performed by cutting the distal part of the ligated tissue. Debridement was performed with the remaining tissue facing each other, and the inner lips were revised by continuous suturing.

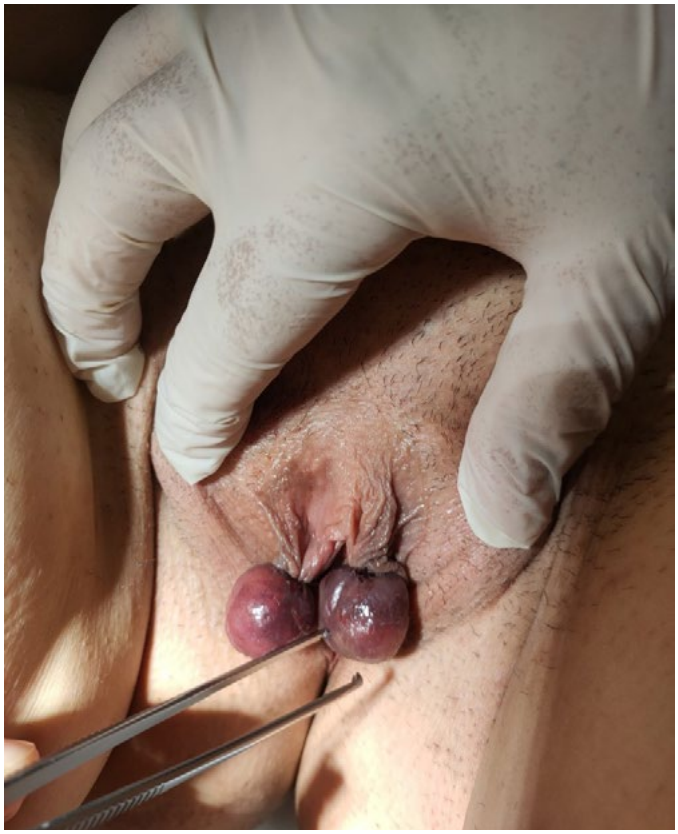
RESULT - SONUÇ: Self-attempted labioplasty can result in necrosis and infection. Education and counseling of patients on the normal variants of labial anatomy and the recommended therapeutic methods will lead to better cosmetic results and prevent self-mutilation.

Kaynaklar - References

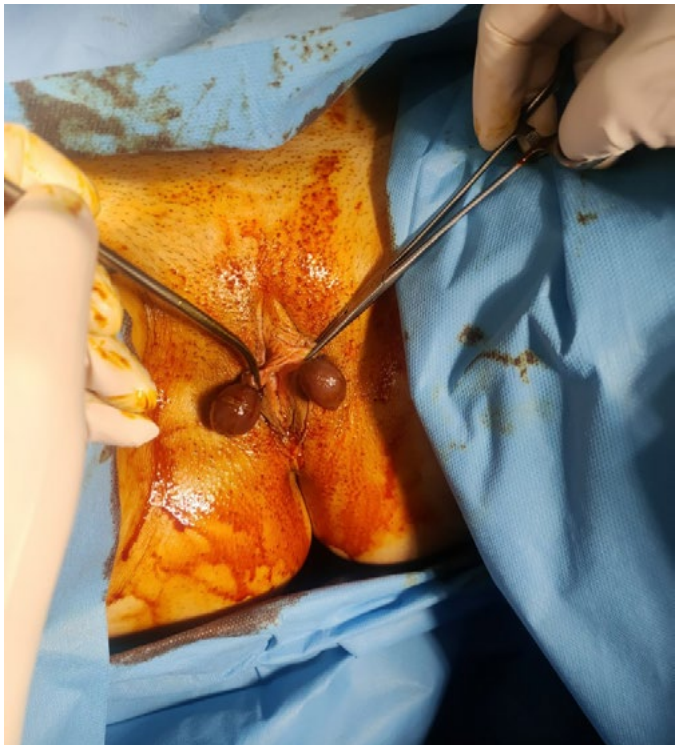
Journal of Lower Genital Tract Disease-Self-Attempted Labioplasty With Elastic Bands Resulting in Severe Necrosis (Farahani, Farimah DO; Gentry, Adrienne DO; Lara-Torre, Eduardo MD, FACOG; McCuin, Elizabeth MD, FACOG),2015

Keywords: Labioplasti, nekroz, self labioplasti

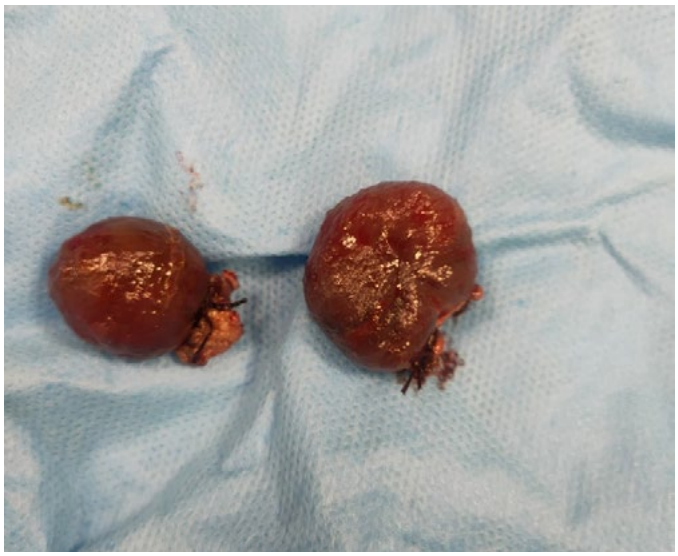
Self labioplasti 1



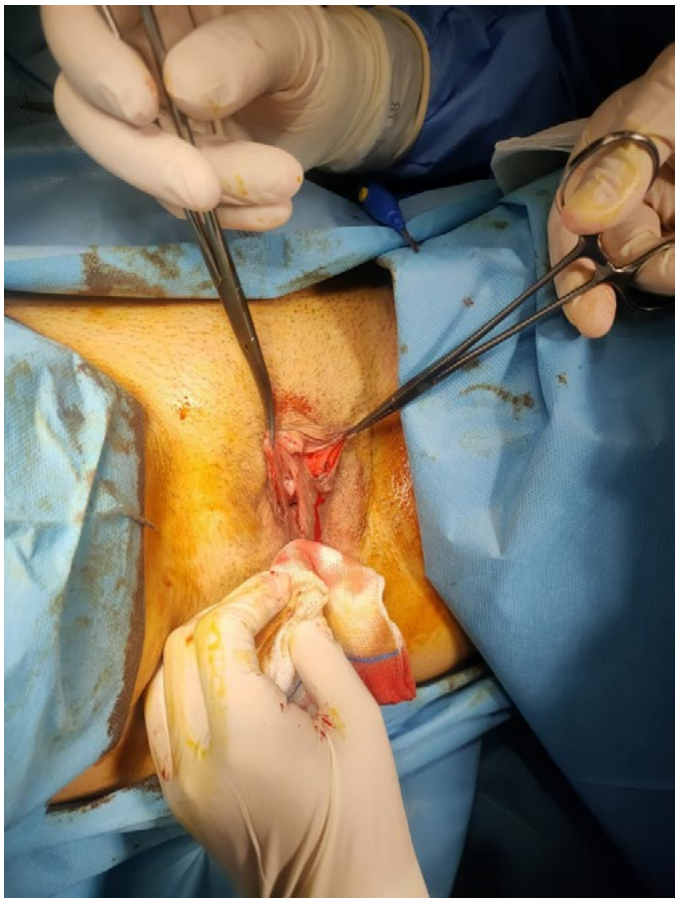
Self labioplasti 2



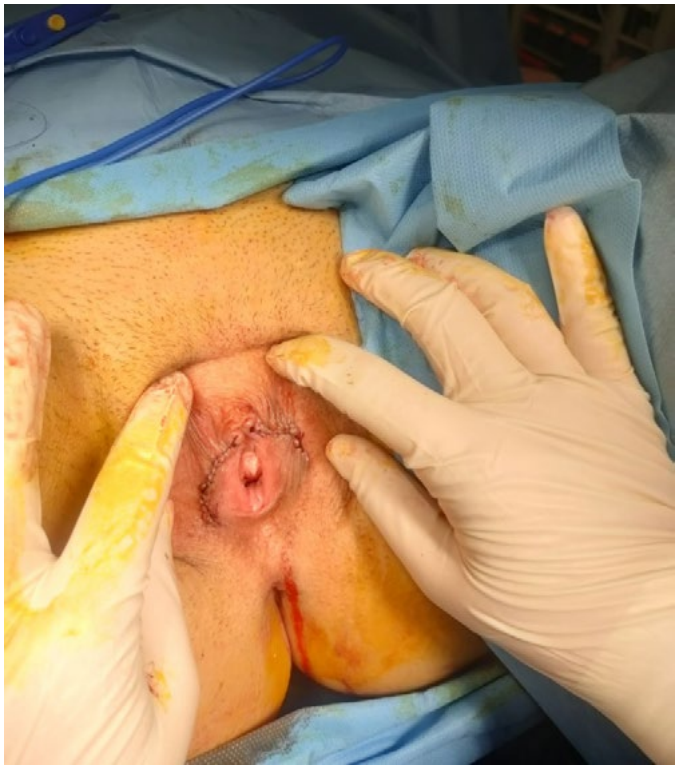
Self labioplasti 3



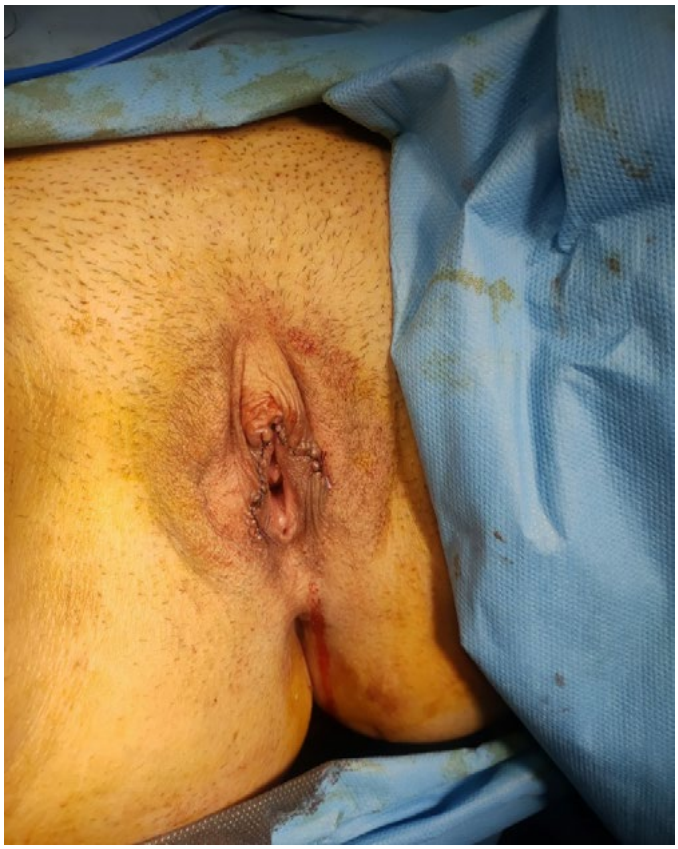
Self labioplasti 4



Self labioplasti 5



Self labioplasti 6



EP-040

A Case Report Of Ectopic Pregnancy In The Ipsilateral Distal Stump After Partial Salpingectomy

Büşra Hüsam Konan, Mustafa Can Akdoğan, Yusuf Üstün
Department of Gynecology and Obstetrics, Health Sciences University Ankara Training and Research Hospital, Ankara, Turkey

We report a case of ectopic pregnancy located in the distal stump following ipsilateral partial salpingectomy. A 31-year-old woman presented with vaginal bleeding and right lower abdominal pain. She had a history of right partial salpingectomy due to tubal pregnancy. Ultrasonography revealed a right adnexal mass in the presence of a positive blood pregnancy test. The presence of an ectopic pregnancy in the distal stump formed due to a previous partial salpingectomy on the right was confirmed by laparoscopy. This case highlights the potential for ectopic pregnancy recurrence on the same side despite prior tubal ligation or salpingectomy. Therefore, total salpingectomy is recommended as the preferred surgical management for ectopic pregnancy to effectively minimize these risks.

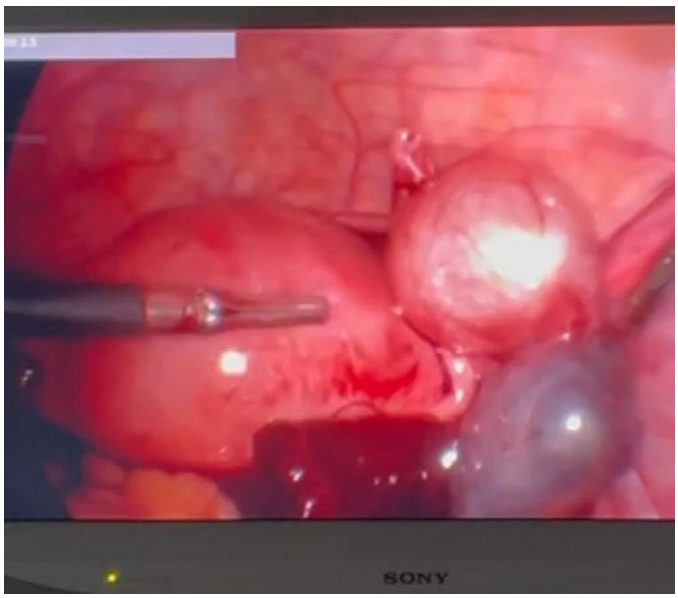
INTRODUCTION: Ectopic pregnancy, characterized by embryo implantation outside the uterus, poses a clinical challenge, primarily occurring within the fallopian tube. Surgical management options include conservative approaches like salpingostomy or radical methods such as total or partial salpingectomy. However, the occurrence of ectopic pregnancy on the same side as a previous salpingectomy is exceedingly rare, with limited cases reported in the literature. This report presents an unusual case of recurrent ectopic pregnancy in the distal remnant of the right fallopian tube following a prior partial salpingectomy. Possible explanations for this phenomenon include transperitoneal migration of human embryos or sperm. It's important to note that previous tubal ligation or salpingectomy does not ensure the absence of future ectopic pregnancies on the same side. Therefore, total salpingectomy is recommended as the preferred surgical treatment for ectopic pregnancies if surgical intervention is necessary.

CASE: A 31-year-old female patient presented with vaginal bleeding and right lower abdominal pain six weeks after her last menstrual period. She had a history of laparoscopic segmental isthmus resection surgery performed 10 years ago due to an ectopic pregnancy. The patient underwent laparoscopy with a preliminary diagnosis of ruptured ectopic pregnancy. During laparoscopic examination, a salpingectomy stump due to the previous ectopic pregnancy rupture was observed on the right side. The left ovary and tube appeared normal. The distal remnant and products of conception were removed, and a left total salpingectomy was performed considering the patient's request for sterilization. The postoperative recovery was uncomplicated.

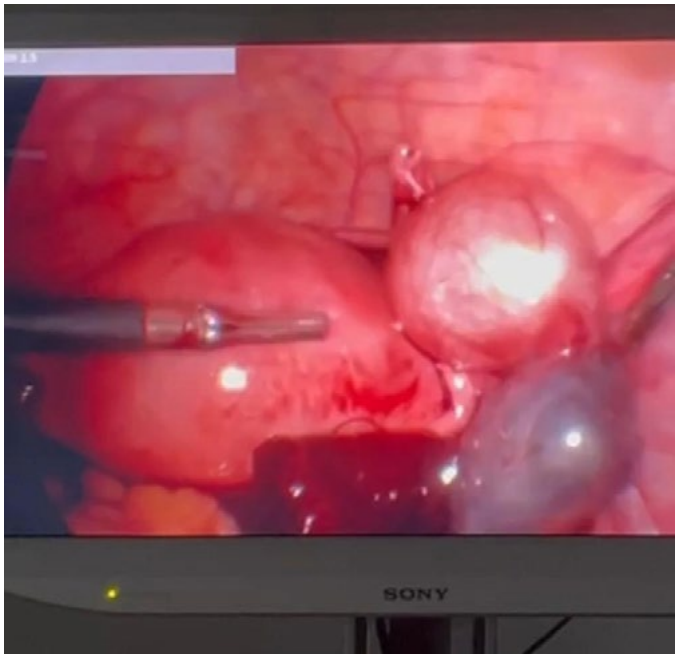
DISCUSSION: Ectopic pregnancies account for nearly 1.5–2% of all pregnancies, with recurrent ectopic pregnancies following salpingectomies being even rarer. Diagnosis requires consideration, even if a mass is seen on the side where salpingectomy was previously performed. Possible mechanisms for ectopic pregnancy occurrence include sperm migration or ovum transmigration. In conclusion, if surgery is required for an ectopic pregnancy, we recommend total salpingectomy as the preferred treatment over partial or segmental salpingectomy. If tubal ligation is to be performed due to sterilization, enough tissue should be removed to leave enough gap between the both of stumps and the risk of ectopic pregnancy should be reduced by coagulating both stumps using bipolar coagulation and preventing recanalization.

Keywords: ectopic pregnancy, distal stump, post-partial salpingectomy

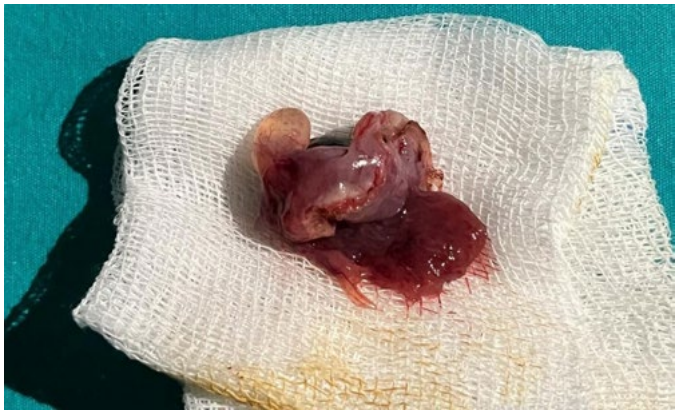
exu1



exu2



exu3



EP-041

Conjoined twins with thoracopagus adhesion: early week diagnosis and management

Mehmet Bora Bozgeyik, Begüm Köse, Mehmet Ferdi Kıncı, Yaşam Kemal Akpak
Izmir City Hospital, Izmir

INTRODUCTION: Multiple pregnancies occur when a single oocyte and sperm divide post-fertilization or when more than one oocyte is fertilized by sperm. Conjoined twins are formed due to a division that occurs after the 13th day post-fertilization. They typically have a monochorionic monoamniotic placenta. Depending on the region of attachment, conjoined twins are associated with high morbidity and mortality rates, with an incidence ranging from 1 in 50,000 to 1 in 200,000. In this case report, we present the ultrasound findings and management of an 12-week pregnancy with thoracopagus conjoined twins.

CASE REPORT: A 24-year-old woman, gravida 1, parity 0, was referred from the emergency department due to vaginal bleeding. She had no comorbidities or previous abdominal surgeries. Ultrasound revealed a conjoined twin pregnancy, suspected to be thoracopagus, consistent with 12 weeks of gestation. MRI was requested for a detailed evaluation of the organs and region of attachment. The MRI report confirmed conjoined twins with thorax and abdomen fused, sharing internal organs. The cranial structures were observed to be normal (figure 1). After consultation with a perinatology team, the family was informed, and the pregnancy was terminated through abortion (figure 2).

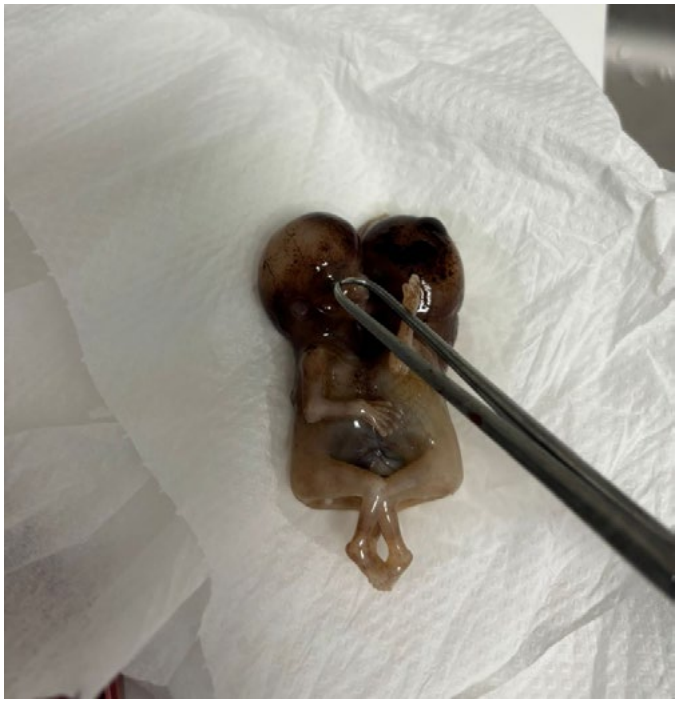
DISCUSSIION: The first documented conjoined twins were girls born in England in 1100, who lived for 34 years. The most famous conjoined twins were the Bunker brothers, born in Siam (now Thailand) in 1811, who lived until the age of 64, from whom the term “Siamese twins” originated. The exact incidence of conjoined twins is unknown due to early miscarriages and a stillbirth rate of around 60%. The variation in the region of conjoined twin attachment occurs during the embryonic process, depending on where the embryonic disks fuse—either dorsal or ventral. About 86% of cases are ventrally joined, ranging from the upper chest to the lower abdomen (thoraco-omphalopagus). Prognosis largely depends on the anatomy of the heart. Conjoined twins carry a high mortality rate, with 35% of infants dying within the first 24 hours. The highest mortality rates are seen in thoracopagus, craniopagus, and omphalopagus twins. Even today, infants with complex single heart physiology have a 100% mortality rate. A study from the University of São Paulo reported on the obstetric management of 36 conjoined twin cases between 1998 and 2010. Due to fatal prognoses, surgical separation was deemed impossible in 30 cases. Of the pregnancies, 14 delivered

vaginally, and 16 delivered by cesarean section. Termination of pregnancy was requested in 19 cases, and 14 of these were successfully terminated. In our case, an early diagnosis was made, and the pregnancy was terminated early on.

CONCLUSION: Conjoined twin pregnancies are extremely rare. Early diagnosis is crucial to avoid delays in intervention. MRI is recommended when necessary for further evaluation.

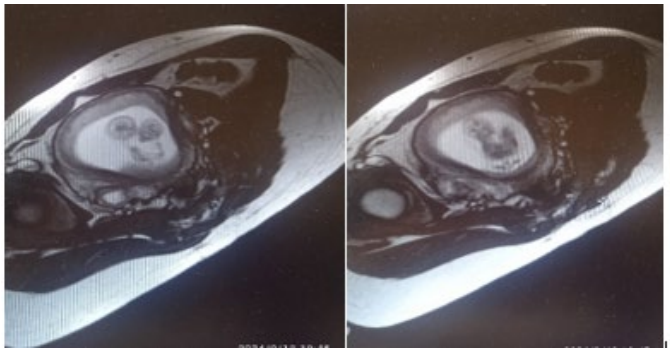
Keywords: Conjoined twins, magnetic resonance, siamese twins, thoracopagus adhesion,

Figure 1.



Abort material of conjoined twin

Figure 2.



MRI image of conjoined twins with thorax and abdomen fused, sharing internal organs

EP-042

A case report: Primary malignant melanoma of the vagina

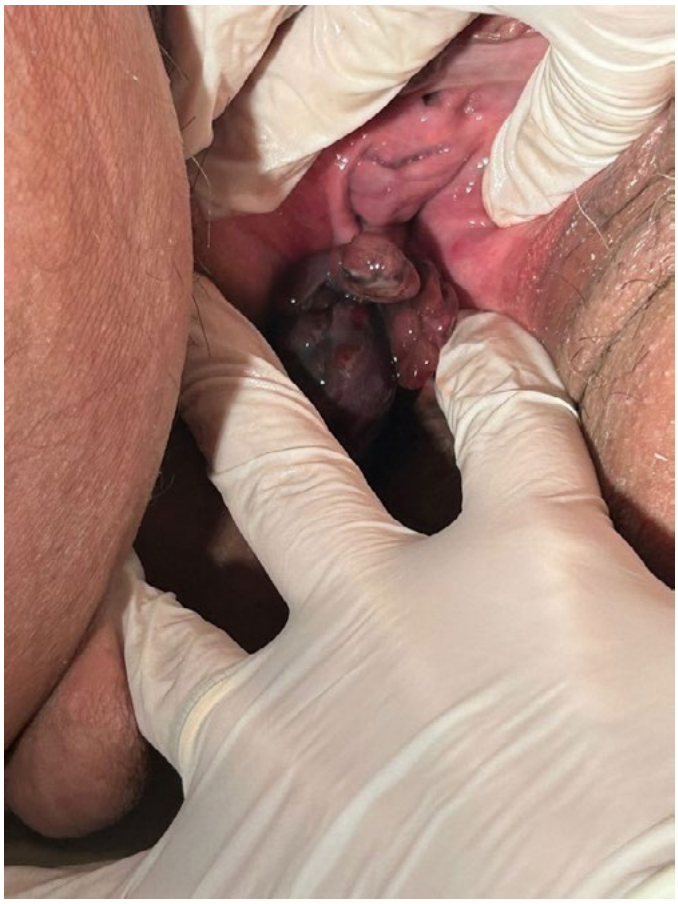
Ceren Cebi[1], Tugan Bese[2]
[1]Department of Obstetrics and Gynecology, Istanbul University - Cerrahpasa, Istanbul, Turkey
[2]Department of Gynecological Oncology, Istanbul University - Cerrahpasa, Istanbul, Turkey

CASE PRESENTATION: A case with primary malignant melanoma located in the posterior fourchette, lower third of the vagina was treated by surgery. The patient was a 69-year-old obese woman with a body mass index of 42. The patient was admitted to our clinic after a biopsy taken at another center revealed malignant melanoma. After gynecologic and ultrasonographic examination, primary five-centimeter tumor originating from the 1/3 lower vaginal posterior wall protruding from the vagina and a three-centimeter mass lesion in the left obturatuar area were detected.The primary tumor was in a location where it could be removed with a clear surgical margin. However, it was difficult to reach the mass lesion in the left obturator area surgically. The patient was discussed in the gynecologic oncology council in order to approach it in a multidisciplinary manner. Since surgery is the primary treatment for mucosal melanomas, the patient was planned to undergo surgery. The patient underwent vaginal mass excision (with a 2 cm clear surgical margin) + sentinel lymph node sampling + left pelvic bulky lymph node excision and bilateral salpingo-oophorectomy. Left obturator lymph node frozen resulted as malignant. The patient was discharged without any complications. There were no pathological findings in the examination performed on the fourteenth postoperative day. However, the final pathology result has not obtained yet. The patient was discussed again in the Gynecological Oncology Council. Due to the poor effectiveness of chemotherapy for mucosal melanomas, immunotherapy was chosen as a treatment option. In order to provide immunotherapy, it was advised to look for BRAF and PD-L1 receptors in the pathology material. Vaginal and pelvic radiotherapy was scheduled up because mucosal melanomas have an aggressive prognosis.

CONCLUSION: The rarity of primary malignant melanoma of the vagina and the limited data on its treatment allowed us to discuss the case. In addition, while most vaginal malignant melanomas are seen on the anterior vaginal wall, the tumor in our patient was on the posterior vaginal wall. This situation allowed us to review the literature. In this case report, we focused on the treatment of a patient with primary vaginal malignant melanoma.

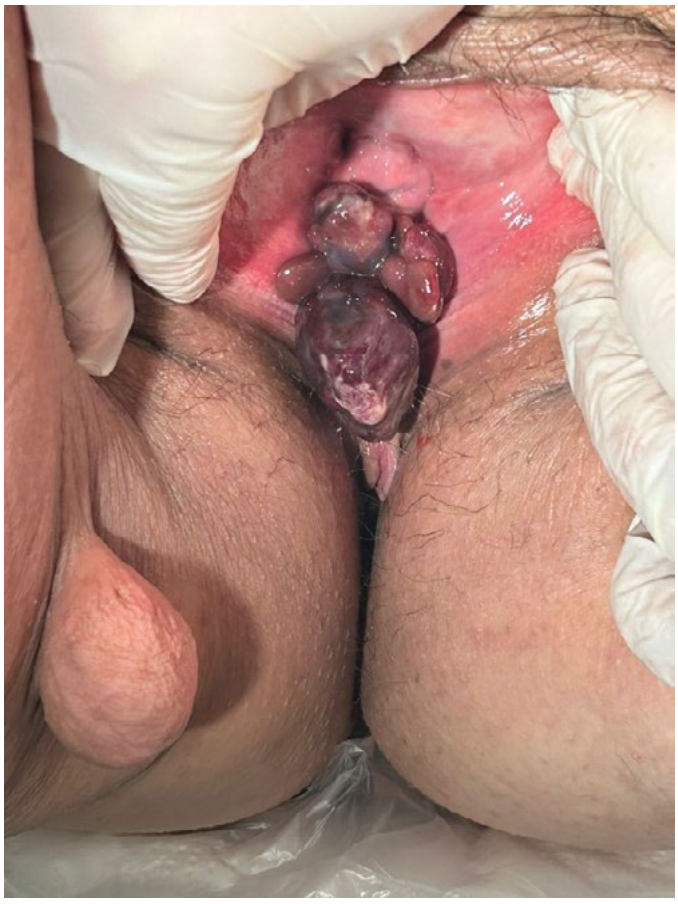
Keywords: vaginal malign melanoma, mucosal melanoma, primary vaginal tumor

Primary lesion in the vaginal mucosa



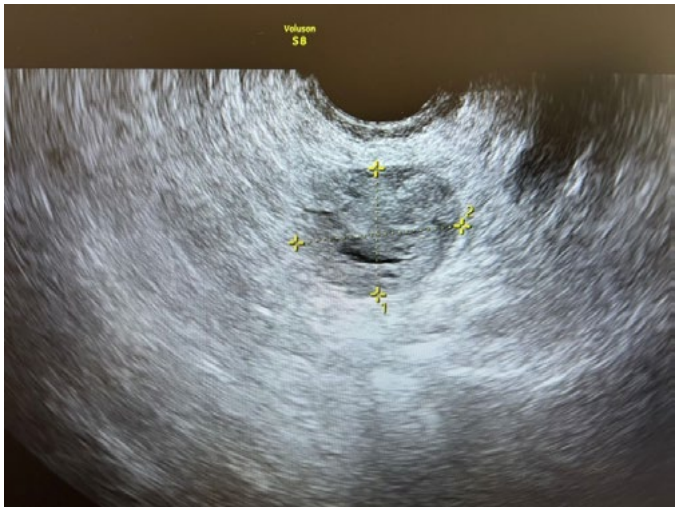
Primary lesion in the vaginal mucosa

Primary lesion in the vaginal mucosa



Primary lesion in the vaginal mucosa

Ultrasonographic imaging of the lymph node in the left obturator fossa



Ultrasonographic imaging of the lymph node in the left obturator fossa

EP-043

Hydatid cyst mimicking adnexal malignancy: case report

Günay Safarova, Fazıl Avcı, Mehmet Kulhan, Ahmet Bilgi, Çetin Çelik
Department of Gynecology and Obstetrics, Selçuk University, Konya, Turkey

Hydatid cyst is a common parasitic cystic disease in our country, mostly caused by Echinococcus granulosus and rarely by Echinococcus alveolaris. Although it can be seen in all organs, the most common organs are the liver and lungs. Hydatid cyst disease seen in the adnexal area is quite rare. Lower abdominal pain, cycle irregularities, infertility, acute abdomen, vomiting and anaphylaxis can be observed in pelvic hydatid cyst. This case is a 29-year-old gravida 1, parity 1, normal vaginal delivery patient who was followed up due to hydatid cyst in the liver in her past history and was admitted to the clinic due to a septate cyst measuring 8*6 cm in control magnetic resonance imaging. The patient's vital signs were stable. Transvaginal ultrasound showed an endometrial thickness of 4 mm, and an 8 cm papillary and septate cystic mass was observed in the right adnexa. The patient was informed about the adnexal mass and a laparoscopic examination was planned. In laparoscopic observation, bilateral tubes and ovaries were observed as normal. An 8x6 cm cystic mass covered with peritoneum was observed between the external iliac artery, vein and right round ligament on the right side of the symphysis pubis. During dissection, vesicles were seen in the cyst in a 1 cm area. Intraoperative general surgery was involved in the operation. The cyst wall was excised. The abdomen was washed with saline solution, aspirated and the procedure was terminated. No complications were observed and the patient was discharged with recovery. The pathology result was reported as hydatid cyst. This case report emphasizes the importance of diagnosis and treatment of a rare case of hydatid cyst in an asymptomatic patient mimicking adnexal malignancy.

Keywords: adnexal mass, echinococcus granulosus,laporoscopic cystectomy, ovarian hydatid

Figure 1

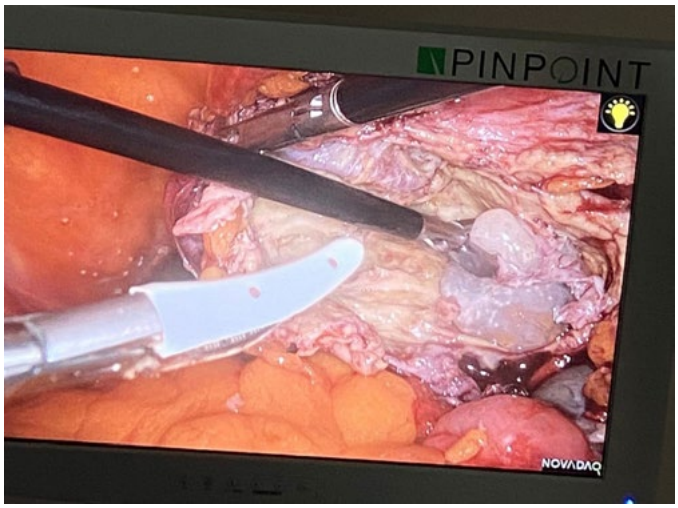
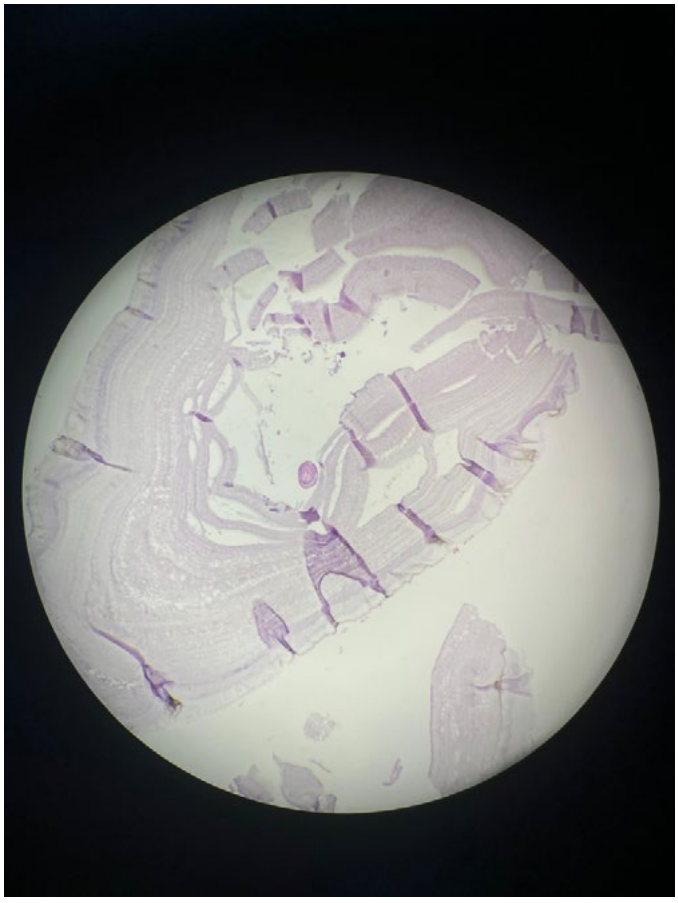


image of cystectomy in laparoscopic surgery

Figure 2



Histopathological view of the case

EP-044

Ovarian Torsion in a Twin Pregnancy at 23 weeks

Kubra Adsaz Parlar[1], Emre Bayram[1], Oktay Akgün[1], Sezin Çömez[1], Yaşam Kemal Akpak[2]
[1]İzmir Şehir Hastanesi
[2]Sağlık Bilimleri Üniversitesi İzmir Tıp Fakültesi

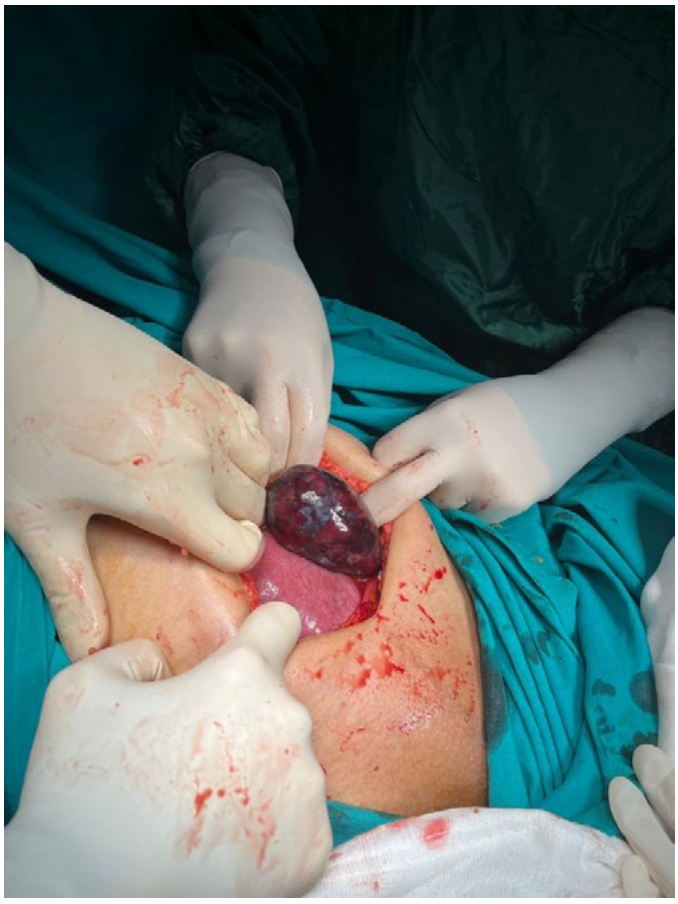
OBJECTIVE: To present case of ovarian torsion in twin pregnancy.

CASE: A 28-year-old twin pregnant woman with gravida 1 (G1), parity 0 (P0), 23+1 weeks according to the last menstrual period, presented to our emergency department with the complaint of left flank pain. Adnexes could not be evaluated clearly on ultrasonography. Magnetic resonance imaging (MRI) showed increased left ovarian size and necrosis. On laparotomy, salpingoopherectomy was performed in the left adnexa because the ovary was torsionised and necrotic. The patient was discharged uneventfully on the 2nd postoperative day.

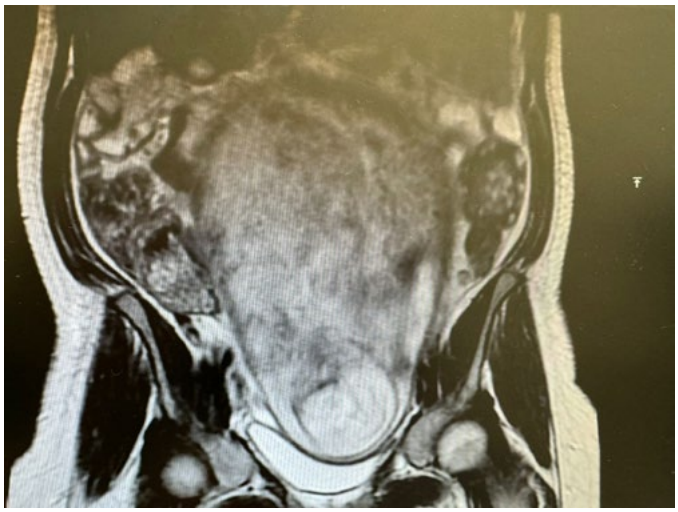
CONCLUSION: Ovarian torsion should be considered in pregnant women presenting with acute abdominal pain. Keywords: Pregnancy, ovarian torsion, salpingoopherectomy

Keywords: Ovarian torsion, Pregnancy, Salpingoopherectomy

ovarian torsion at laparotomy



ovarian torsion on MR



EP-045

Diagnosis of Infiltrative Mucinous Ovarian Cancer During Pregnancy: A Case Report and Literature Review

Mehmet Baran Mollalar, Celal Akdemir, Yaşam Kemal Akpak, Mücahit Furkan Balcı, Ayhan Gül
İzmir Şehir Hastanesi

The aim of this case report is to present a case of mucinous ovarian cancer with an infiltrative stromal invasion pattern detected during pregnancy and to share our experience with this rare condition diagnosed in gestation.

A 38-year-old woman was referred to our clinic at 12 weeks of gestation. An adnexal mass, detected at 6 weeks and monitored regularly, led to referral after abdominal distension and pain developed. Ultrasound showed no fetal malformations. A 25 cm cystic lesion with internal echogenic content, thought to originate from the right ovary, was observed.

Contrast-enhanced MRI suggested malignancy. The patient, with symptomatic pain, underwent right oophorectomy via mini-laparotomy with spinal-epidural anesthesia at 14 weeks, preserving cyst integrity. The frozen pathology report identified borderline mucinous carcinoma. Omentum and multiple peritoneal biopsies were taken; pelvic and paraaortic lymph nodes were normal intraoperatively.

Final pathology reported a mucinous carcinoma with an infiltrative invasion pattern, well-capsulated, with no surface neoplastic cells, and confined to one ovary (FIGO Stage 1A). Following a multidisciplinary meeting, the patient was informed about the aggressive nature and risks of the disease. Termination of the pregnancy and cytoreductive surgery were recommended based on literature and patient expectations.

Termination occurred at 19 weeks. Four weeks later, the patient underwent cytoreductive surgery (hysterectomy, left unilateral salpingo-oophorectomy, bilateral pelvic and paraaortic lymph node dissection, infracolic omentectomy, and appendectomy). Paraaortic lymph nodes were fixed and bulky. Final pathology revealed carcinoma metastasis in the omentum and paraaortic lymph nodes (14/15) (FIGO Stage 3B). Adjuvant chemotherapy was recommended following maximal cytoreduction.

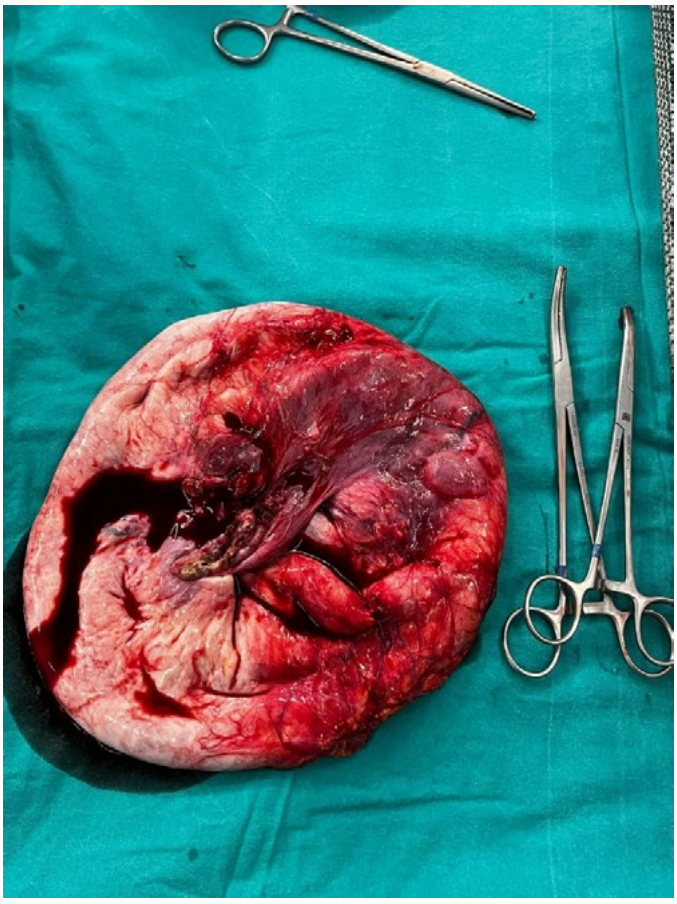
Management of epithelial ovarian cancers, including mucinous types, involves surgical staging for early stages and cytoreductive surgery followed by platinum-based chemotherapy for advanced stages.

Reports of mucinous ovarian cancers diagnosed during pregnancy are rare. A 2012 case involved a patient with FIGO Stage IA mucinous ovarian carcinoma at 6 weeks, who continued her pregnancy. At 39 weeks, metastasectomy and cesarean section were performed due to a 12×11 cm mass. Neoadjuvant chemotherapy and cytoreductive surgery followed, leading to FIGO Stage IIIC. While similar, our case progressed more rapidly (70 days) to FIGO Stage 3B with omental and paraaortic lymph node metastases.

Treating mucinous ovarian carcinoma during pregnancy presents significant challenges due to limited experience and potential fetal effects. Management of suspicious adnexal masses in pregnant women should not be delayed, as treatment delays can worsen maternal prognosis. Conservative treatment may be acceptable for early-stage ovarian carcinomas, but aggressive mucinous cases require individualized management.

Keywords: pregnancy, mucinous ovarian cancer, Diagnosis

Adnexal mass excised during surgery



Adnexal mass excised during surgery

EP-047

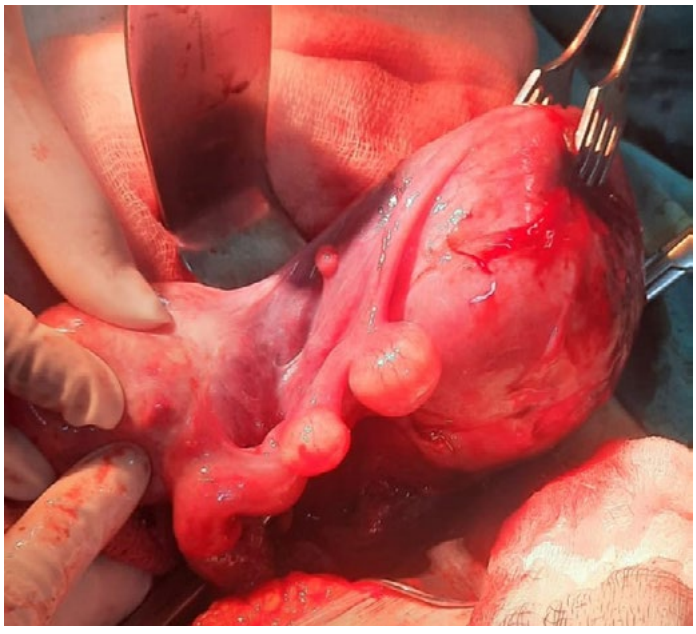
Tubal Leiomyoma Observed During Total Abdominal Hysterectomy, Case Report

Gülşen Gülözer[1], Ebru Kaynar Varlık[1], Mustafa Ayhan Ekici[1], Metin Özgür Erdoğan[2]
[1]Department of Obstetrics and Gnynecology, Bolu Abant Izzet Baysal University, Bolu, Turkey
[2]Department of Pathology, Bolu Abant Izzet Baysal University, Bolu, Turkey

Uterine myomas are the most common benign smooth muscle tumors of the uterus, and while the incidence in the general population is 20-25%, this rate increases to 70-80% in studies conducted with histological or ultrasonographic imaging (1). Fallopian tube leiomyomas are rare and are usually detected incidentally during surgery or autopsy. In most cases, the course of the disease is asymptomatic and these tumors are single, small-sized, and unilaterally located nodules, so preoperative diagnosis is sporadic (2,3). This case report aims to present and discuss a case of tubal leiomyoma detected incidentally during surgery.

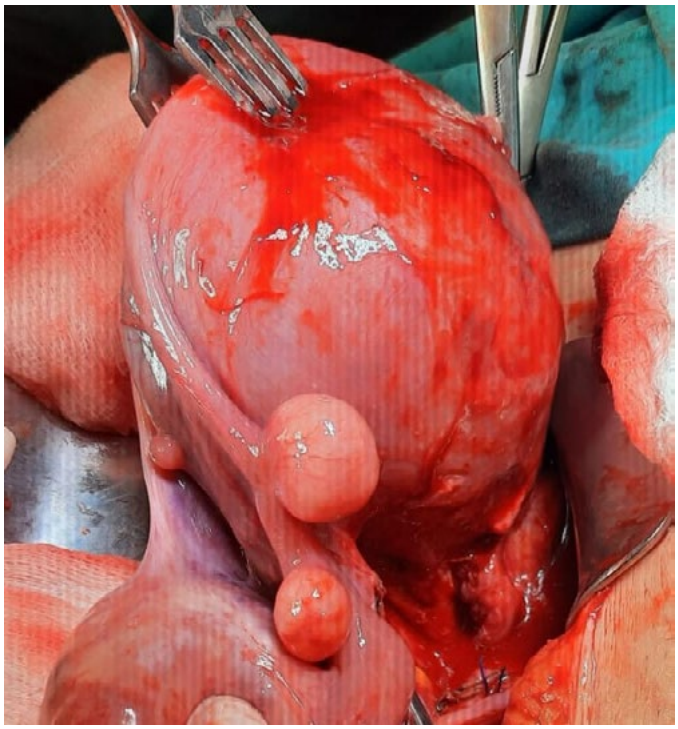
Keywords: tubal myoma, uterin myoma, leiomyoma

Figure-1



tubal leiyomyoma intraoperative image

Figure-2



tubal leiyomyoma intraoperative image

EP-048

Ovarian hydatid cyst presenting as an abdominal mass mimicking ovarian neoplasm

Ertuğrul Şen
Department of Gynocogy and Obstetrics, Erciyes Universty, Kayseri, Turkey

Hydatid cyst is a parasitic infection caused by Echinococcus larvae. The incidence of ovarian hydatid cysts is approximately 1% and it is a very rare condition. our case is an elderly patient with abdominal pain and suspected malignancy. Adnexal lesion may be misdiagnosed on clinical and radiologic examination suggesting malignancy. Ovarian hydatid cysts can be treated medically and surgically, but the gold standard treatment method is surgical treatment. If an ovarian mass is detected, hydatid cyst should be kept in mind even if there is a low probability.

Keywords: hydatid cyst,malignancy,mass

EP-049

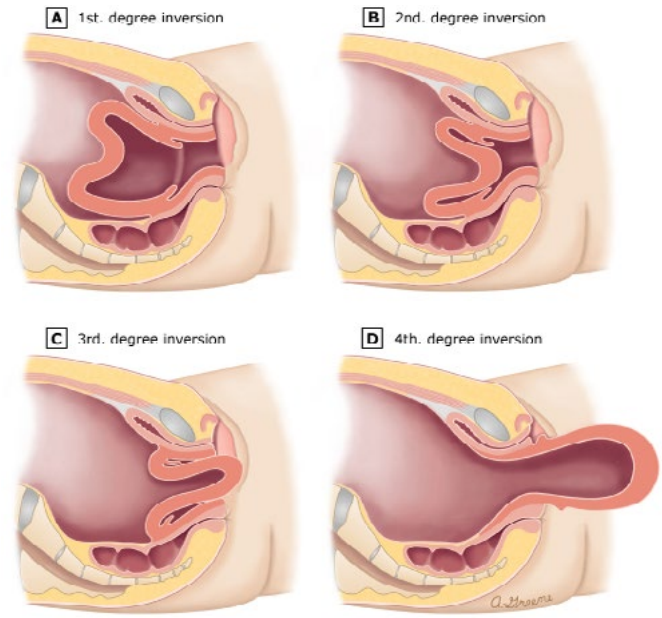
Uterine Inversion in Endometrial Cancer Case Report

Sümeyye Nur Ünsal, Okan Oktar, Yusuf Üstün
Department of Gynecology and Obstetrics Department, Republic of Turkey Health Sciences University Faculty of Medicine Ankara Training and Research Hospital, Ankara, Turkey

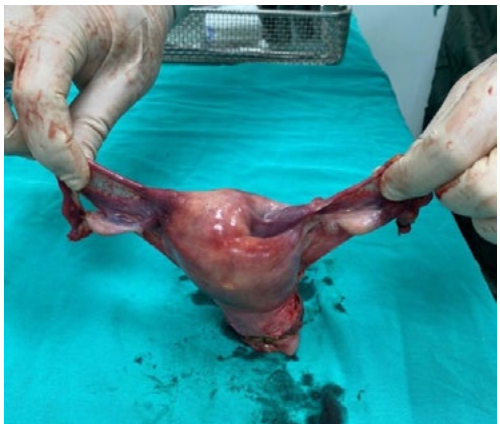
Uterine inversion is a condition characterized by the partial or complete inversion of the fundus towards the endometrial cavity (1). Although it frequently occurs as an acute complication of birth, it also rarely occurs as a result of an endometrial or myometrial mass due to non-puerperal causes (2).The most common etiological cause is tumor lesions (3). Factors causing tumor-induced uterine inversion; It is stated as tumor size, uterine region where the lesion is located, thickness of the tumor pedicle, presence of cervical dilatation and thin uterine wall (5-6).Treatment of uterine positions in non-puerperal uterine inversion may differ depending on the type of inversion (i.e. acute or chronic). In the acute form of this disease, it is possible to manually restore the uterus to its normal position. However, in the chronic type, manual repositioning is not possible and requires surgical intervention to be planned according to the patient's age and the patient's decision to have uterine repositioning or hysterectomy (9).In this case, our patient was sent to the medical oncology department for chemotherapy after total abdominal hysterectomy + bilateral salipngoophorectomy + pelvic-paraaortic lymph node dissection + total omentectomy + cytology. The patient continues to be treated with carboplatin + paclitaxel. A decision regarding radiotherapy will be made after the chemotherapy protocols are completed. The patient's final pathology was endometrial adenocarcinoma (Endometrioid type) Grade 3. The tumor has covered the entire endometrium and extends to the cervix. The tumor has exceeded ½ of the myometrium. Cervical stromal involvement is positive. Lymphovascular invasion was not observed. Parametrium and omentum are intact. In the immunohistochemical study performed on the lesion, tumor cells were negatively stained with p53. As a result, non-puerperal uterine inversion is a very rare complication. It most commonly develops due to tumoral lesions. It is important to know this complication, which obstetricians are very unlikely to encounter when looking at the literature, and to identify it radiologically. Typically, keeping magnetic resonance imaging findings in mind will increase the chances of early intervention of this clinical entity.

Keywords: Endometrial adenocarcinoma, uterine inversion, complications

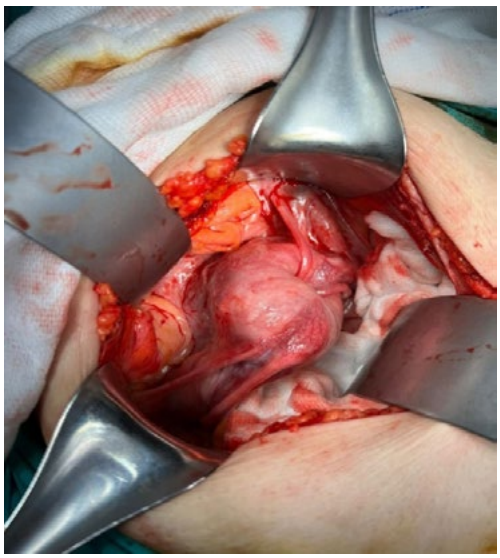
Figure-1: Uterine inversion degrees



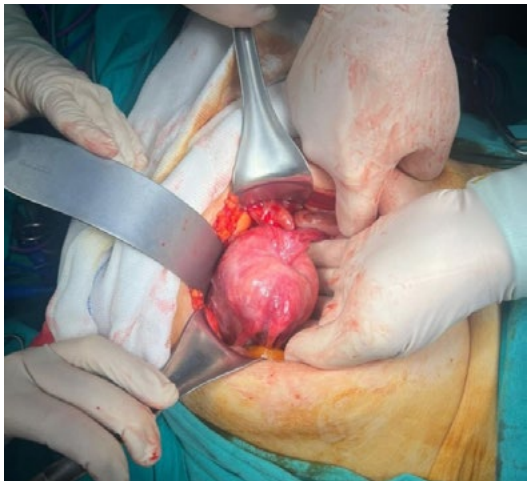
Picture-1



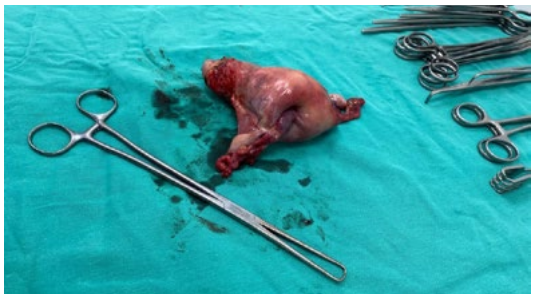
Picture-2



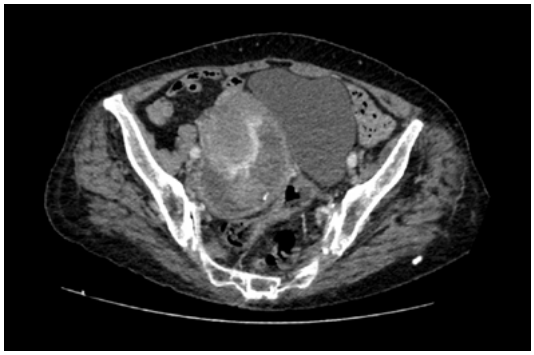
Picture-3



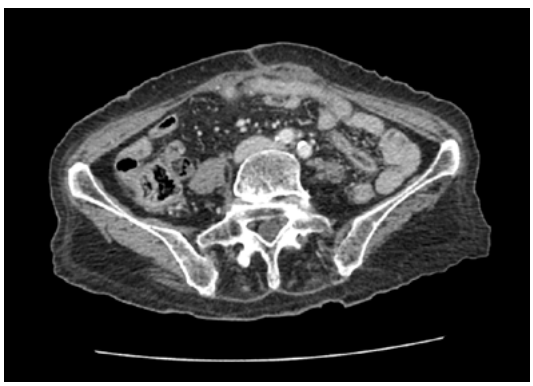
Picture-4



Picture-5



Picture-6



EP-051

Malpositioned Intrauterine Device Associated With Ureter Migration: Laparoscopic Management

Buğra Tunç, Osman Murat Guler, Güven Fatma Akalın
Obstetrics and Gynecology Clinic, Başakşehir Cam and Sakura City Hospital, Istanbul, Turkey

PURPOSE: The purpose of this case presentation is to examine the diagnosis and treatment process of ureter migration, a rarely encountered condition, following the application of an intrauterine device (IUD) as a method frequently requested by patients for sterilization.This case, involving the migration of a malpositioned IUD to the ureter without causing damage to neighboring organs, aims to raise awareness among clinicians and provide information on the management of such cases. Additionally, this case presentation intends to contribute to the literature by enhancing the understanding of complications that may develop after IUD applications and the processes that should be followed.Our primary objectives are to increase patient safety and emphasize critical considerations for practitioners.

CASE: Our patient, a 43-year-old woman with a history of four cesarean sections, presented to the emergency department with abdominal pain.An ultrasound examination revealed a malpositioned IUD extending from the fundus of the uterus to the left, leading to her admission to the gynecology service for further evaluation. It was learned that the patient had an IUD inserted in Egypt four years ago.A contrast-enhanced CT scan showed a malpositioned IUD extending posteriorly to the right lateral uterus and into the intra-abdominal fatty tissue.It was suspected that the malpositioned IUD was exerting pressure on the right distal ureter. The right ureter was observed to be dilated at 6 mm, and grade 2 hydronephrosis was noted in the right kidney. The patient was referred to urology, which recommended nephrostomy placement. With a CRP value of 181, the patient was also consulted by infectious diseases specialists, who recommended starting tazocin.Following a 14-day course of antibiotic therapy, the patient's infection markers improved, and an operation was decided for the removal of the IUD. The operation was initiated laparoscopically. Upon observation, the uterus, left fallopian tube, and left ovary were normal; however, the right ovary and tube were adhered to the lateral abdominal wall. The right ureter was visualized, and adhesions involving the ureter and bowel were dissected. The IUD was found among the adhesions and was removed from the abdomen. Urology was involved in the case, and a double-J stent was placed. The nephrostomy was clamped. The operation was completed without complications, and the patient was admitted for monitoring. The nephrostomy was removed on the second postoperative day, and the patient was discharged on the fourth postoperative day. One month after discharge, the double-J stent was removed during a routine follow-up.

CONCLUSION: This case highlights the successful management of asymptomatic ureter migration following the application of an intrauterine device (IUD) for sterilization, a rare occurrence. The antibiotic therapy and multidisciplinary consultations played a significant role in infection control.This case underscores critical points to consider in the management of malpositioned IUDs and provides valuable insights for clinical practice.Early recognition of such complications and the development of effective treatment strategies will be crucial for managing similar cases in the future. It is believed that this case will contribute to the literature by enhancing patient safety and enriching the knowledge base in clinical practice.

Keywords: Intrauterine device,ureter,contraception,migration

EP-052

A Rare Case Of Primary Amenorrhea With Trisomy 22 Mosaicism

Onur Atakul, Hasan Volkan Ege, Nejat Özgül
Department of Obstetrics and Gynecology, Hacettepe University, Ankara, Turkey

The etiology of primary amenorrhea can be mainly categorized as functional disorders, anatomical disorders or genetic disorders. Although the most common cause of primary amenorrhea is gonadal dysgenesis, patients should be evaluated in detail with genetic counseling. In this case, we will present a patient who presented with primary amenorrhea and was diagnosed with trisomy 22 mosaicism.

A 34-year-old female patient was admitted to our clinic with the preliminary diagnosis of primary amenorrhea. The patient had complaints of short stature, epilepsy and hair loss, and recurrent abdominal pain. It was determined that he had been admitted to the hospital with seizures in the past and antiepileptic treatment was started. In laboratory examination, FSH and LH values were found to be high and E2 was low. In the imaging, it was observed that the uterus was smaller than normal and the ovaries were atrophic. Due to the phenotypic characteristics of the patient with primary amenorrhea as well as the laboratory findings showing hypergonadotropic hypogonadism, the patient was consulted to the genetics department with a preliminary diagnosis of gonadal dysgenesis. In the genetic analysis, a diagnosis of Mosaic Trisomy 22 was detected. Symptoms were questioned to investigate additional anomalies observed in the syndrome. It was determined that the patient had hearing loss in the left ear and weakness in the lower extremities. Endocrinology, neurology and orthopedics departments were consulted. The patient, whose TSH level was found to be high, was diagnosed with hypothyroidism. As a result of the imaging, tibia vara deformity, short femur,sacroiliitis and osteoporosis were detected.. The patient was started on estrogen replacement therapy.

In primary amenorrhea cases, the sex chromosomal abnormalities may be of numerical and structural types. Trisomy 22 is a rare genetic disease and 25 postnatal cases have been described in the literature. Of the 25 patients in the literature, 4 patients were found to have primary ovarian failure and amenorrhea. In case of trisomy 22 mosaic diagnosis, anomalies specified in the literature such as clinodactly, cardiac anomalies, skletal anomalies, urogenital anomalies, craniofacial anomalies should be investigated. In our case, treatment for the diagnosed hearing loss, short boots, extremity anomaly and epilepsy was planned with a multidisciplinary approach by the endocrinology, neurology and orthopedics departments. It draws attention to the importance of detailed questioning and genetic counseling in case of clinical necessity and the multidisciplinary approach.

Keywords: Amenorrhea, Gonadal dysgenesis, Trisomy 22 mosaicism,

EP-053

Complicated management of pregnancy with bilateral tubo-ovarian abscesses developing in the second trimester: a case report

Fatma Caner Çabukoğlu, Betül Güngör, Mert Eyüpoğlu, Hasan Volkan Ege, Özgür Deren
Department of Obstetrics and Gynecology, Hacettepe University, Ankara, Turkey

Tuboovarian abscess is rarely seen in pregnant women presenting with an acute abdomen. Treatment typically involves the use of antibiotics and surgical drainage.

A 41-year-old patient with a history of endometrioma, who was G1P0 (spontaneous). At 12w6d of pregnancy, was admitted to an external center with complaints of lower right abdominal pain and fever. Abdominal ultrasound showed: “Grade I hydronephrosis in the right kidney. A single live fetüs, consistent with 12 weeks and 6 days of gestation. Foci of endometrioma were observed in both ovaries, and 2.5 cm of free fluid in the pelvis.” After 9 days of hospitalization, the patient received treatment with piperacillin-tazobactam and ceftriaxone. The patient was discharged with moxifloxacin.

10 days later, the patient presented with abdominal pain and 38,6 °C fever. Blood tests showed, leukocytosis (13500 /ul) and elevated acut phase reactans(CRP 48,4 mg/L, prokalsitonin 0,372 ng/ml). The patient described spotting type bleeding and abdominal tenderness. The abdominal examination revealed signs of acute abdomen. Ultrasound showed a single live fetus consistent with 14 weeks and 3 days of gestation.There was a well-defined isoechoic lesion measuring 68x42 mm in the right adnexa. There is a subchorionic hematoma present. No fluid mass was observed in the Douglas. An MRI was requested for the patient with acute abdominal findings. MRI RESULTS: “7 cm complex lesion including the right ovary and tube (TOA?), 2,5 cm fluid in the Douglas, Appendix is normal (Figure-1).”

Diagnostic laparotomy was planned under general anesthesia. Initially, 400 cc of puy was drained. An abscess related to a 7 cm infected endometrioma in the right ovary and a 2 cm abscess in the left ovary was observed. The Douglas pouch was obliterated. Abscess foci were drained. An appendectomy was performed. During the traction of the uterus, no surgical instruments were used. One sump drain was placed. Intraoperative ultrasound showed positive fetal heartbeat. There was no bleeding or complications. Anesthesia included sevoflurane, remifentanil, propofol, rocuronium, and sugammadex.

Empirical treatment with ertapenem 1g/24h was started. The patient progressed orally with gas output. On postoperative day 5, the drain was removed. The patient received 6 days of ertapenem therapy. Puy culture grew Escherichia coli and

sulbactam-ampicillin (SAM) 4x3 g was started for 14 days. Daily fetal heart rate monitoring. Showed no increase in the subchorionic hemorrhage area. After 4 days of SAM therapy with a good response (CRP levels 11,9 mg/l, Prokalsitonin 0,175 ng/ml), the patient was discharged on oral clavulonate-amoxicillin 2x1 g. Pathology results: "Acute appendicitis." At 22 weeks of gestation, the patient and fetus were evaluated as normal, and no signs of infection were detected."

Keywords: abcess, acute abdomen, endometrioma, pregnancy

Figure-1: The appearance of a tuboovarian abscess on MRI

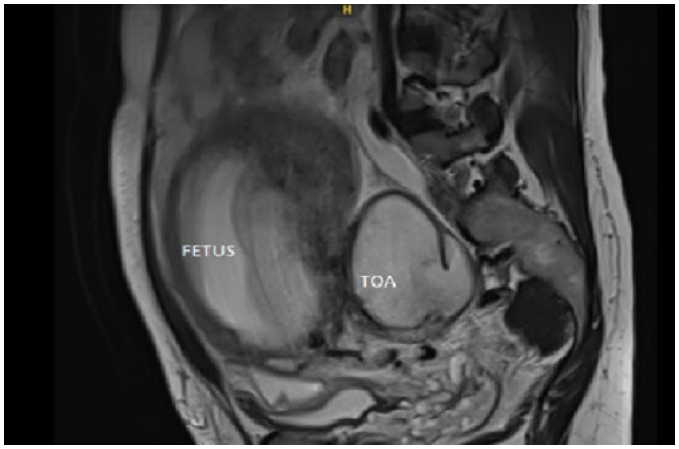
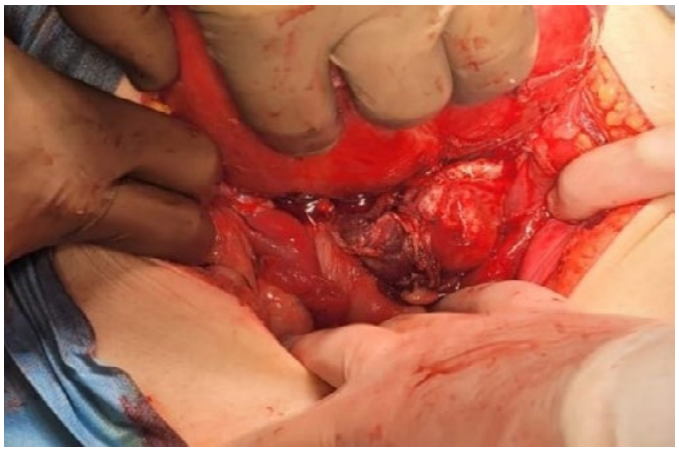


Figure-2: Intraoperative Appearance of a Tubo-Ovarian Abscess



EP-054

Uterine rupture in a pregnant woman diagnosed with primiparous previa: Case Report

Günay Safarova, Mehmet Kulhan, Çetin Çelik
Department of Gynecology and Obstetrics, Selçuk University, Konya, Turkey

Placenta previa and uterine rupture are rare but serious obstetric emergencies during pregnancy. This case report describes a primiparous woman with placenta previa complicated by uterine rupture and the resulting fetal distress.A 33-year-old, primiparous, 35-week pregnant woman with a history of 2 abortions and a diagnosis of placenta previa presented to our clinic with complaints of severe right flank pain radiating from her back to her legs. The patient had never had a history of this type of pain before. The patient had no history of previous uterine surgery. In the obstetric ultrasonography, it was determined that the fetus was in vertex presentation, there were no anomalies in fetal biometric measurements, and the placenta was located posteriorly and covered the cervical os. No bleeding was detected in the vaginal examination and the cervical length was evaluated as adequate.The patient's vital signs were stable. The patient was continuously monitored with a non-stress test in the delivery room and initially the non-stress test was reactive and no contractions were observed. According to the initial evaluations, the patient was monitored considering possible preliminary diagnoses such as kidney stones, ablatio placenta, gallstones or bile duct pathology. Despite the application of serum to the patient, no relief was achieved in the pain. Renal ultrasonography was performed to rule out kidney pathology.During the approximately three-hour follow-up period, the patient developed sudden fetal bradycardia; the fetal heart rate dropped to 70 bpm, but recovered shortly thereafter. Five minutes later, the patient described severe pain and the fetal heart rate dropped to 50 bpm. The decision for emergency cesarean section was made and the patient was taken into surgery.The patient was operated on under general anesthesia with a Pfannenstiel incision. During laparotomy, approximately 300-400 cc of hemorrhagic fluid was observed in the abdominal cavity. The fetus was found in the amniotic pouch in the abdominal cavity. Clear amniotic fluid was detected by opening the amniotic sac. The newborn was delivered without any problems and handed over to the neonatal team. The placenta was removed manually. Irregular ruptured areas were observed in the fundus region of the uterus, extending to both corneal regions and spreading towards the anterior and posterior walls. Uterine rupture areas were repaired with double-layer continuous sutures. Uterine tone was assessed as appropriate. After cleaning the abdominal cavity and controlling bleeding, a rubber drain was placed into the abdomen.This case emphasizes that serious complications such as uterine rupture can develop even in primiparous

pregnancies diagnosed with placenta previa. Uterine rupture and related fetal distress were successfully managed with early detection and rapid intervention. It should always be kept in mind that serious complications such as uterine rupture, i.e. the risk of uterine rupture, can develop even in primiparous pregnancies diagnosed with placenta previa, and patients should be closely monitored.

Keywords: Cesarean section, placenta previa, primiparous, uterine rupture

Figure 1

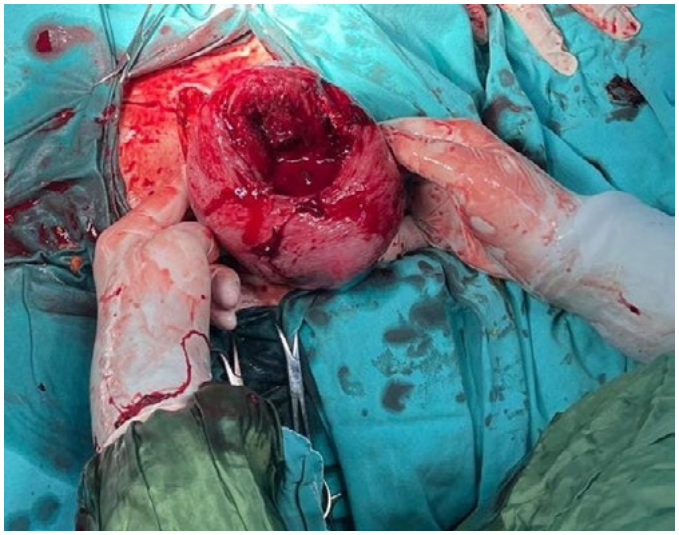


Figure 2

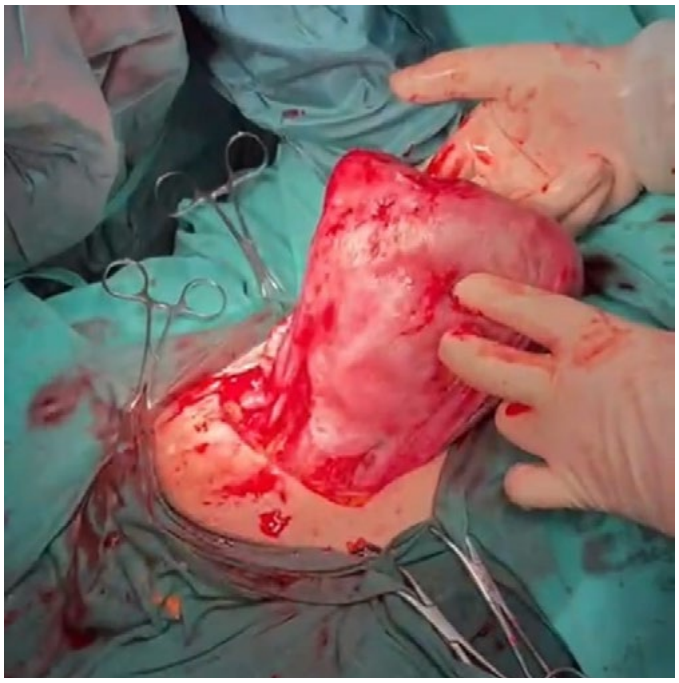
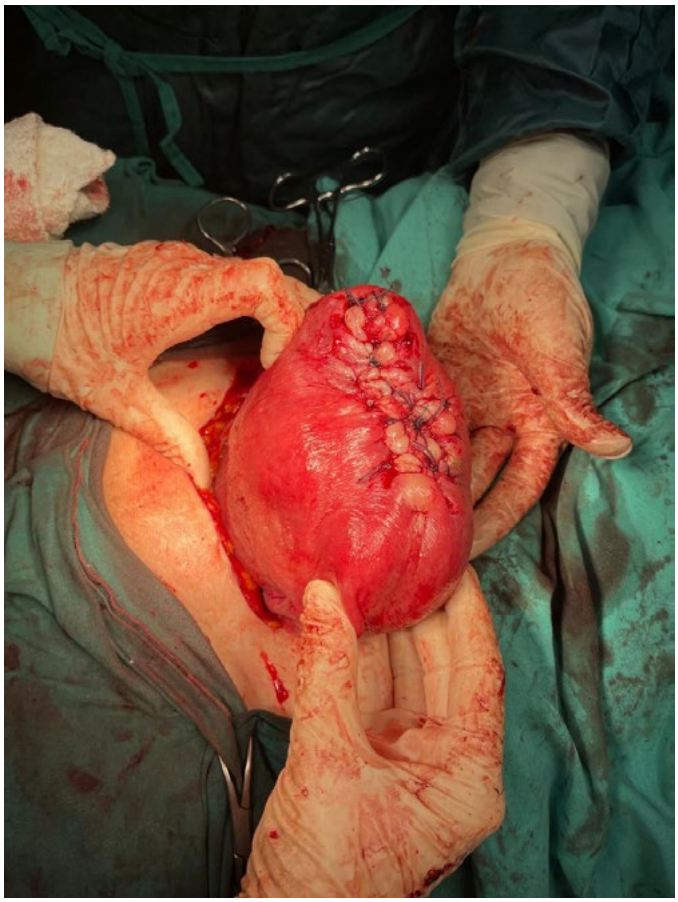


Figure 3



EP-056

First Reported Case of a Viable Fetus in Androgenetic/Biparental Mosaic/ Chimeric (ABMC) Pregnancy

Büşra Tsakır, And Yavuz
Department of Obstetrics and Gynecology, University of Health Sciences Antalya Training and Research Hospital, Antalya, Turkey

INTRODUCTION: Androgenetic/biparental mosaic/chimeric (ABMC) pregnancies are rare and complex pathological conditions classified under gestational trophoblastic diseases (GTD). These pregnancies feature two distinct cell populations: one entirely paternal (androgenetic) and the other containing both maternal and paternal genetic material (biparental). ABMC pregnancies result from mosaicism or chimerism. These different cell populations are typically identified through discordant p57 immunohistochemical staining, varying villous structures, and complex genotype profiles. To date, only 13 ABMC cases have been reported in the literature, mostly diagnosed from missed abortion or curettage specimens. Notably, there are no previous reports of ABMC cases involving a live fetus, which makes this case particularly rare and significant. ABMC cases that include a molar component present substantial clinical risks, making accurate diagnosis and close follow-up essential.

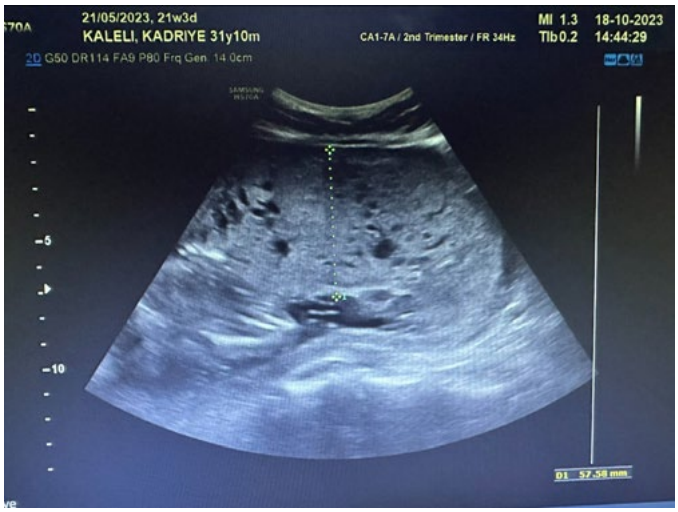
CASE PRESENTATION: A 32-year-old patient was referred to our clinic due to an elevated risk of Trisomy 21 (1:71) discovered during prenatal screening. Ultrasound examination revealed fluid-filled cystic structures with a honeycomb appearance and placentomegaly in the placenta. Both chorionic villus sampling (CVS) and amniocentesis (AS) were performed, with CVS indicating triploidy and AS revealing diploidy. A preliminary diagnosis of partial molar pregnancy coexisting with a live fetus was considered. MRI confirmed the presence of multiple cystic structures within the anterior placenta, supporting the diagnosis of partial molar placenta.

As the pregnancy progressed, the patient developed severe preeclampsia at 27 weeks, followed by intrauterine growth restriction (IUGR). At 33 weeks, the patient experienced premature pre-labor rupture of membranes (PPROM). A male infant weighing 1200 grams, measuring 40 cm, and with an Apgar score of 9/10 was delivered via cesarean section at 34 weeks. Postnatal genetic testing of fetal blood showed a normal DNA profile. Examination of the placenta revealed grape-like structures, and histopathological analysis showed significant edema and irregularly dilated vascular structures, though typical trophoblastic proliferation or extensive cistern formation was absent. Immunohistochemical analysis displayed discordant p57 expression, with positive staining in villous trophoblasts and negative staining in villous stromal cells, which was consistent with an ABMC diagnosis. Long-term follow-up was recommended, and monthly hCG levels were monitored for one year, with no evidence of pathology.

DISCUSSION: This case represents the first reported instance of ABMC identified in conjunction with a live fetus, differentiating it from previously documented cases, which were primarily diagnosed from missed abortion or curettage specimens. The uniqueness of this case contributes valuable insights for both diagnosis and clinical management. Accurate diagnosis of ABMC requires clinical suspicion, followed by advanced diagnostic methods such as p57 immunohistochemical staining and genotyping. The management of ABMC cases with a molar component requires close monitoring to prevent persistent trophoblastic disease. This case contributes significantly to the literature as the first documented example of ABMC with a live fetus, emphasizing the importance of precise diagnosis and vigilant clinical management.

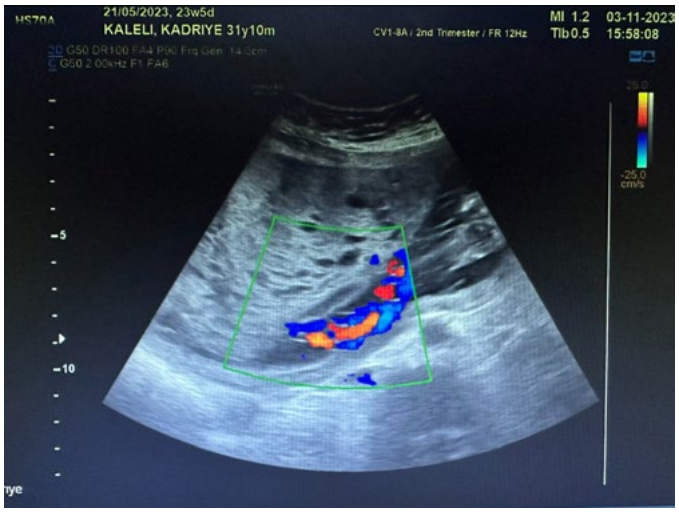
Keywords: Androgenetic/biparental mosaicism, Chimerism, Gestational trophoblastic disease (GTD), p57 immunohistochemistry, Placental mosaicism

Ultrasound at 21 Weeks Showing Placentomegaly with "Honeycomb" Appearance



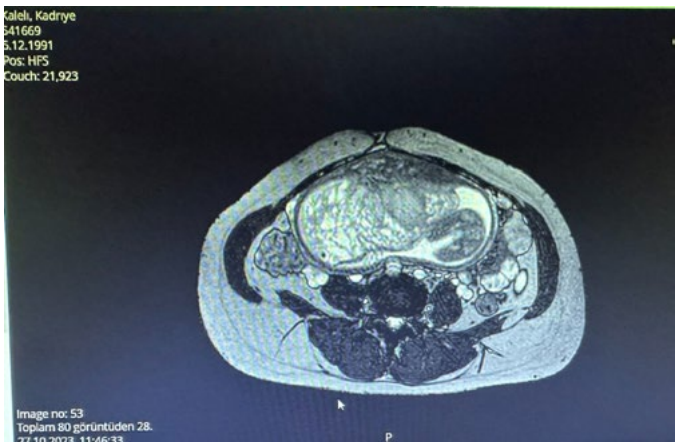
At 21 weeks of gestation, ultrasound shows significant placentomegaly with a characteristic "honeycomb" appearance, featuring fluid-filled vacuoles. This finding is indicative of potential gestational trophoblastic disease, such as molar pregnancy, requiring further genetic testing and pathological evaluation.

Ultrasound at 24 Weeks Showing Cord Insertion into the Vacuolized Placenta



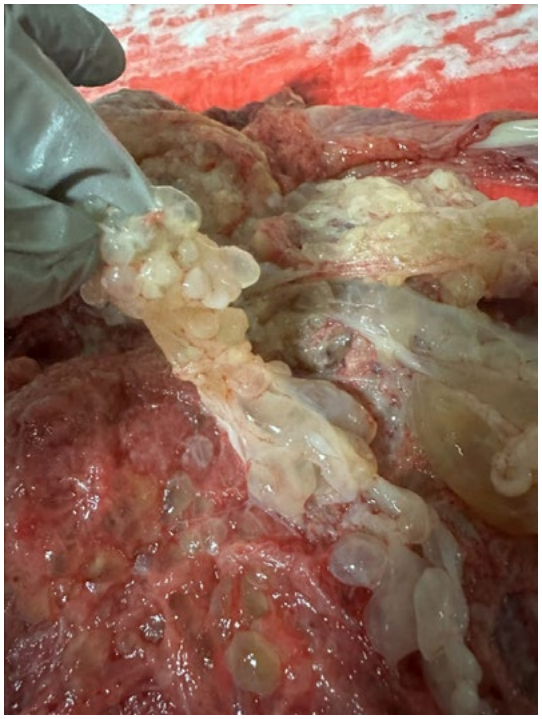
Ultrasound at 24 weeks shows cord insertion into the vacuolized placenta, confirming its association with the living fetus and excluding the demised twin.

MRI of the Placenta Showing Extensive Cystic Structures



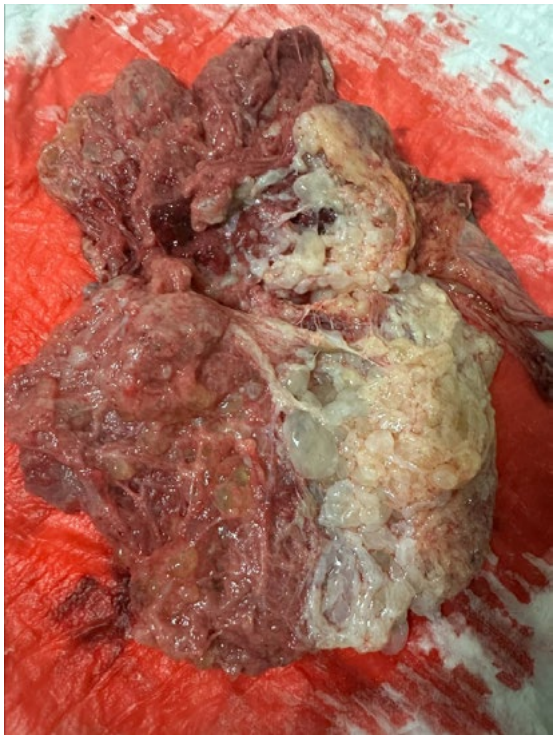
MRI of the placenta reveals extensive cystic structures consistent with vacuolization, supporting the diagnosis of a molar component.

Macroscopic appearance of the placenta



The macroscopic examination of the placenta reveals grape-like structures, consistent with hydropic villi, a feature commonly associated with molar pregnancy.

Total view of the placenta showing areas of placental edema and hydropic villi.



The total macroscopic appearance of the placenta shows marked edema and hydropic villous structures, consistent with placental hydrops.

EP-057

Discussion of the Role and Effects of Obesity Surgery in Polycystic Ovary Syndrome with a Case Report

Zehra Pınar Cengiz, Nurşen Kurtoğlu
Sağlık Bilimleri Üniversitesi Bağcılar Eğitim ve Araştırma Hastanesi,Kadın Hastalıkları ve Doğum Ana Bilim Dalı,İstanbul

Polycystic Ovary Syndrome (PCOS) is a multifactorial endocrine disorder with a complex etiology. Polycystic ovary syndrome (PCOS) is seen in 30% to 70% of obese women of reproductive age and is associated with a high risk of infertility. Obesity and insulin resistance are also very common problems in women with PCOS. The most important symptom of the disease is irregular menstruation. The coexistence of polycystic ovary syndrome and obesity is associated with a poor androgenic profile, increasing the rate of menstrual irregularity and the risk of endometrial cancer. Weight loss with diet and exercise and lifestyle changes can improve the symptoms of hyperandrogenemia and insulin resistance associated with PCOS

Case: 28-year-old patient came to the outpatient clinic with complaints of amenorrhea. During the gynecological examination, the uterus was normal in size and the endometrium was 8 mm. More than 15 follicle cysts were observed in the right ovary, consistent with PCOS. The left ovary was evaluated as normal. When the patient's history was examined, it was learned that she was diagnosed with PCOS 2 years ago and had irregular menstrual periods. It was also learned that the patient complained about not being able to lose weight and therefore underwent sleeve gastrectomy. The patient added that she lost weight from 100 kilos to 65 kilos after obesity surgery. She stated that her menstrual periods became regular due to the effect of losing weight, but she had experienced a delay in her menstrual periods again in the last month.

Since the patient wanted to have a child, she was referred to the infertility clinic. As a result of the tests performed, it was seen that Fsh:9, Lh:5, E2: 29, prolactin:10. The patient's values before obesity surgery were Fsh:7, Lh:14, Prolactin:12, Insulin:13.

DISCUSSION: Bariatric surgery offers a highly effective mode of treatment for obese patients.In terms of weight loss therapy, bariatric surgery is a first-line treatment for morbid obesity. The benefits of bariatric surgery for PCOS include, recovery from irregular menstrual cycles, and improvement in both hormonal and metabolic profiles.In light of the superior efficacy of bariatric surgery, surgical treatment should be prioritized for treating patients with obesity and PCOS. Although RYGB was found to be the gold standard procedure, the most commonly performed procedure in many countries is currently the sleeve gastrectomy. Laparoscopic sleeve gastrectomy is a restrictive procedure that is characterized by the removal of most of the fundus of the stomach without alteration of intestinal absorption; it is considered to be relatively safe with low morbidity.

CONCLUSION: Obesity is associated with a number of adverse pregnancy outcomes, including miscarriage, preeclampsia, gestational diabetes, macrosomia, cesarean delivery and possibly congenital anomalies. Obesity also increases the risk of maternal complications during pregnancy, including venous thromboembolism and chorioamnionitis, endometritis, and wound infections.Bariatric surgery is an alternative strategy for weight loss in women with PCOS. Postoperative weight loss improves the multiple hormonal changes associated with polycystic ovary syndrome (PCOS) (e.g., insulin resistance, androgen levels), reducing anovulation and improving the potential for pregnancy

Keywords: menstrual irregularity, obesity, polycystic ovary syndrome,

EP-058

Right-Sided Ectopic Pregnancy in a Remnant Tube After Right Salpingo-Oophorectomy: A Case Report

Bengi Su Yilan[1], Murat Cengiz[1], Neslihan Dişcioğlu[2], Hasan Volkan Ege[1], Zafer Selcuk Tuncer[1]
[1]Department of Obstetrics and Gynecology, Hacettepe University, Ankara, Turkey
[2]Department of Obstetrics and Gynecology, Bingol State Hospital, Bingol, Turkey

INTRODUCTION: Ectopic pregnancy occurs in 1-2% of pregnancies and remains a leading cause of maternal mortality during the first trimester. While salpingectomy or salpingo-oophorectomy is a definitive treatment for ectopic pregnancy or other gynecologic conditions like ovarian torsion, rare cases of ectopic pregnancies occurring in residual tubal structures post-surgery have been documented.

CASE: This report presents the case of a 24-year-old woman with a history of right salpingo-oophorectomy due to ovarian torsion who was diagnosed with a right-sided ectopic pregnancy in a remnant fallopian tube. The patient presented to the clinic with complaints of persistent pelvic pain localized to the right lower quadrant. A serum beta-hCG test revealed an elevated level of 3933.2 mIU/mL, indicating an early pregnancy. Based on her last menstrual period, her gestational age was 5 weeks and 5 days at the time of presentation. Transvaginal ultrasound revealed no evidence of an intrauterine pregnancy with endometrial thickness being 10 mm but revealed a right adnexal mass, resembling 22x23 mm gestastational sac and fetus with no heartbeat, near the site of the prior surgery. 3 cm depth of free fluid was noted in the pelvis. These findings, along with her clinical presentation and elevated beta-hCG levels, led to the suspicion of an ectopic pregnancy in a remnant right fallopian tube. Given the high risk of tubal rupture and the patient's clinical condition, laparoscopic surgery was performed. Intraoperatively, a remnant segment of the right fallopian tube was identified, containing an ectopic pregnancy. Approximately 500 cc of blood was aspirated from the pelvic cavity, confirming intra-abdominal bleeding. The ectopic pregnancy and the remnant tubal tissue were excised without complications. Histopathological examination of the excised tissue confirmed the presence of placental tissue, consistent with the diagnosis of ectopic pregnancy. Postoperatively, the patient recovered uneventfully and was discharged on the third postoperative day. Her beta-hCG levels were monitored and showed a gradual decline, confirming the resolution of the ectopic pregnancy. She had a histerosalpingography, five months later. In the left fallopian tube, minimal dilation and slight kinking secondary to small adhesions which allow passage are observed. Free peritoneal distribution of contrast medium is observed on the left side. DISCUSSION: This case highlights the importance of considering ectopic pregnancy in ipsilateral tuba even if a woman had history of salpingo-oophorectomy on that side though it is rare. Despite the definitive nature of salpingo-oophorectomy, residual tubal segments can persist and serve as sites for future ectopic implantation. It should not be forgotten that an ectopic pregnancy can still occur in the remnant tube where salpingoophorectomy was performed and the patient should be thoroughly evaluated. This way, unnecessary interventions on the contralateral tube can be avoided.

CONCLUSION: In patients who undergo salpingectomy for any indication, it is recommended that care be taken to ensure that no remnant tube remains.Laparoscopic excision of the remnant tube and ectopic pregnancy, as performed in this case, is an effective treatment option, providing definitive management.

Keywords: ectopic pregnancy, laparoscopic surgery, remnant tube

Figure 1: Transvaginal ultrasonographic finding of a gestational sac with a fetus in the right adnexal region (arrow).

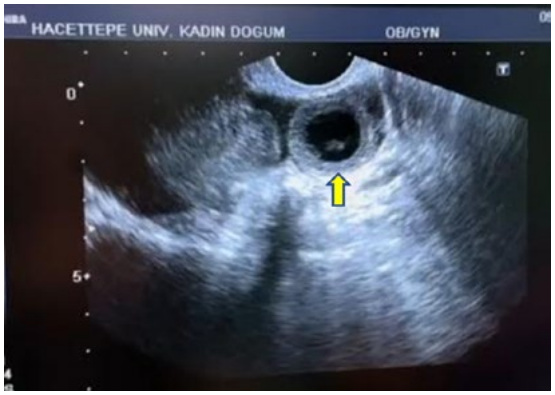
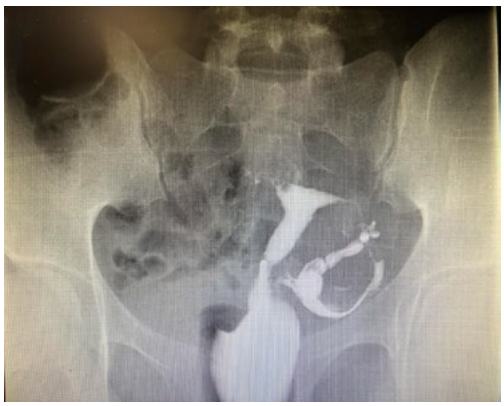


Figure 2: Histerosalpingography, performed five months after ectopic pregnancy surgery.



The contours and configuration of the uterine cavity are normal. The right fallopian tube is not visible (operated). In the left fallopian tube, minimal dilation and slight kinking secondary to small adhesions which allow passage are observed. Free peritoneal distribution of contrast medium is observed on the left side.

EP-059

Post-Vaginoplasty Wound Infection and Dehiscence

Osman Selim Dalkılıç, Hamit Çetin, Yaşam Kemal Akpak, Mücahit Furkan Balcı
Department of Obstetrics and Gynecology, Izmir City Hospital, Izmir, Turkey

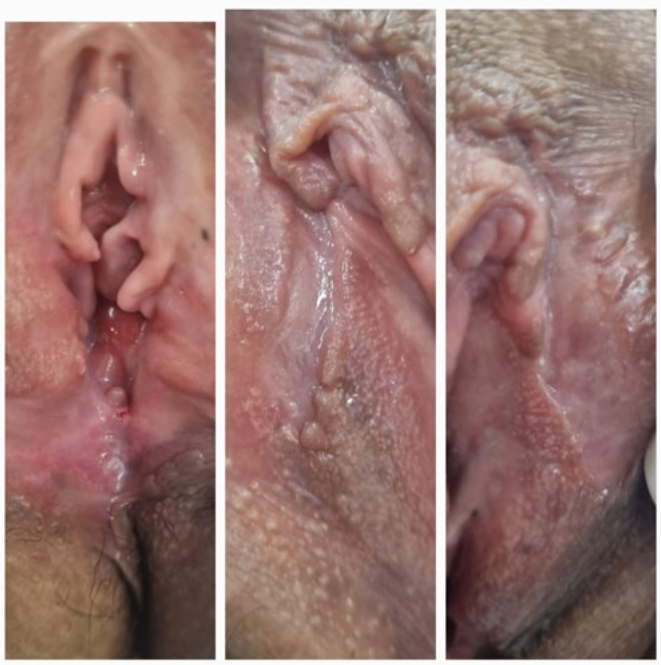
INTRODUCTION: Labiaplasty of the minora refers to the surgical procedure for the aesthetic or functional reshaping and reduction of the labia minora. Asymmetric or prominent labia minora are trimmed and repaired using a scalpel, scissors, or laser, with subsequent suturing. During the procedure, a 1 cm wide portion of the labia minora, which is rich in vascular structures, should be preserved for functional and aesthetic purposes. Leaving less than 1 cm of tissue can lead to dyspareunia, loss of sensation, and chronic pain. Various centers employ cauterization during the procedure for hemorrhage control, smooth tissue cutting, and shaping. However, this method can cause tissue damage due to the additional heat applied to the incision site, potentially impairing the healing process.

CASE PRESENTATION: A 41-year-old female patient presented to our center with complaints of foul-smelling vaginal discharge and burning. Her medical history and discharge summary revealed that approximately 2 weeks prior, she had undergone rectocele repair and genital aesthetic surgery including vaginoplasty and labiaplasty at an external facility. During this procedure, bleeding points were cauterized, and resuturing was performed 4 days post-operation due to incomplete dehiscence of the wound. Laboratory and imaging results were within normal limits. Physical examination revealed that the bilateral labia minora had been excised, with incision lines sutured using simple continuous sutures. However, the incision line had separated, and the wound was covered with a gray-green biofilm. The incision line at the posterior fourchette was not intact, showing a tunnel-like opening accompanied by infection-related discharge. The patient was diagnosed with wound infection and dehiscence and was treated with a 7-day course of intravenous ceftriaxone and metronidazole. Upon completion of the antibiotic therapy, the patient was discharged with the incision line left for secondary healing. The dehiscence line was observed to have closed by secondary healing at the 2-week follow-up.

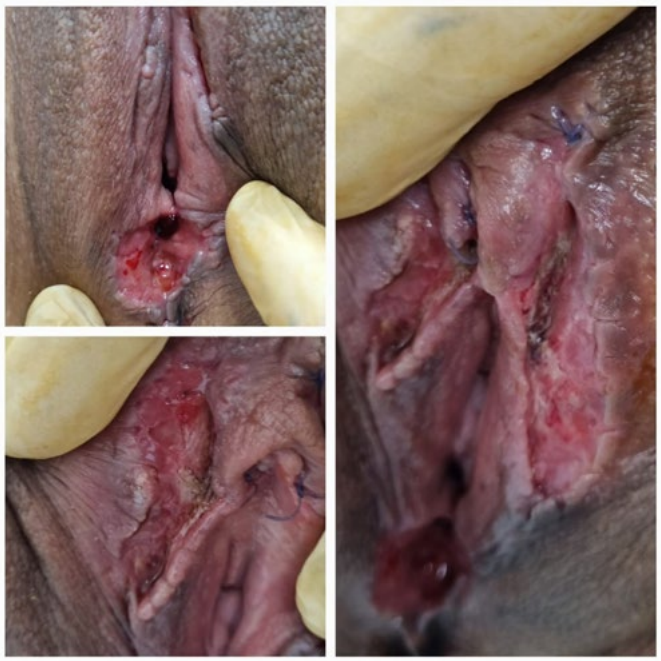
DISCUSSION: In labiaplasty of the minora, leaving less than 1 cm of tissue may disrupt the vascularization of the labia minora, which is rich in blood vessels and possesses erectile tissue. This disruption can adversely affect wound healing, and proper delineation of surgical margins may reduce the risk of complications. Tissue damage caused by cauterization during surgery may delay tissue healing and increase the risk of wound infection. Therefore, minimizing the use of electrocautery during labiaplasty, or using it minimally if required, could reduce the risk of complications. Further multicenter and large-scale studies are needed on this subject.

Keywords: Dehiscence, Labioplasty, Vaginoplasty

The patient's condition at the 2-week follow-up examination after discharge



The patient's condition at the time of the initial presentation, after the sutures were removed and the wound was cleaned



ORGANİZASYON SEKRETARYASİ

FİGÜR
KONGRE & ORGANİZASYON

Figür Kongre Organizasyonları ve Tic. A.Ş.

19 Mayıs Mah. 19 Mayıs Cad. Nova Baran Center
No:4, 34360 Şişli / İstanbul
Tel: 0 212 381 46 00 - Faks: 0 212 258 60 78
E-posta: obstetrikjinekolojitartismalikonular@figur.net

www.obstetrikjinekolojitartismalikonular.org